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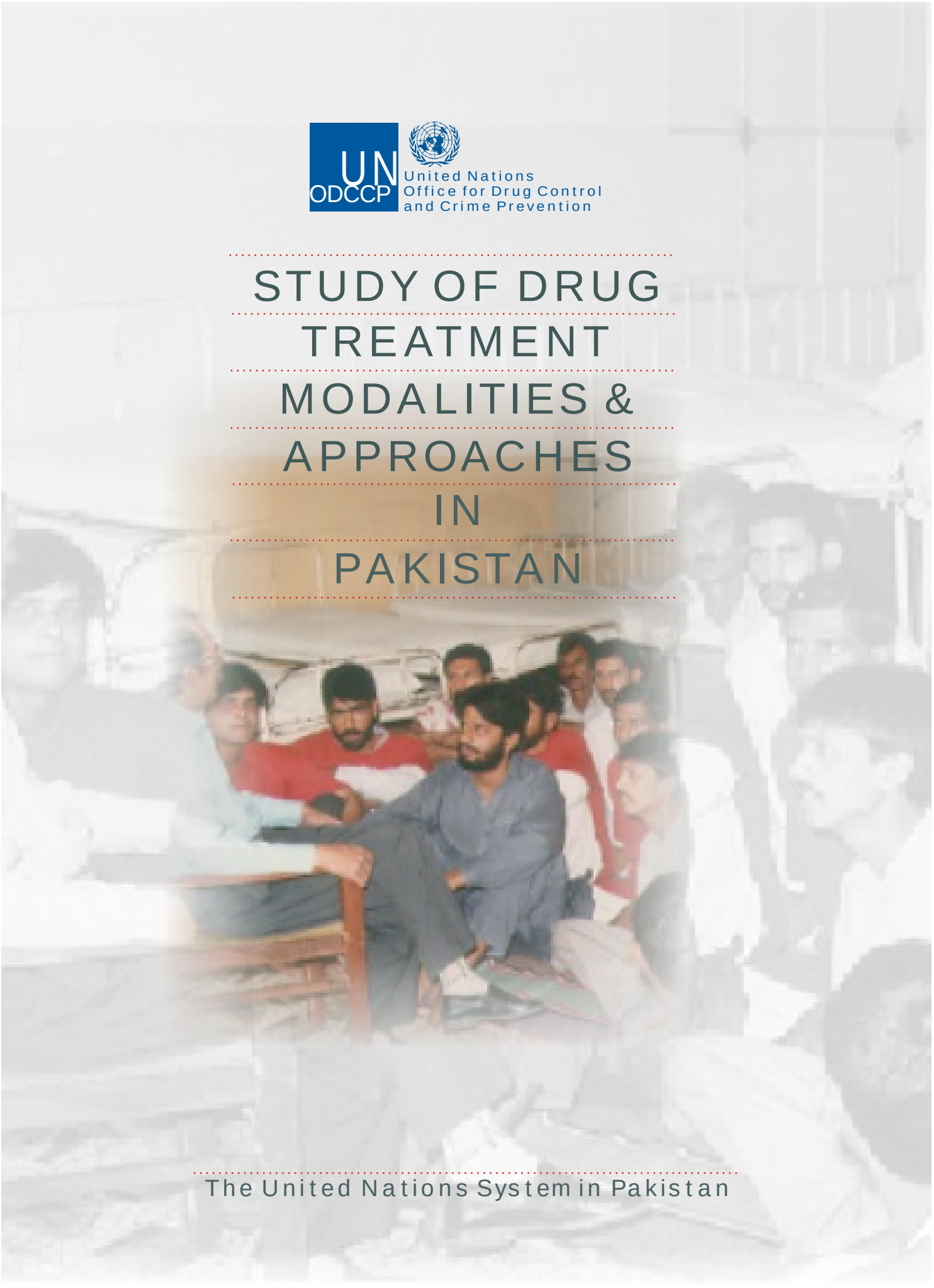
STUDY OF DRUG TREATMENT MODALITIES & APPROACHES IN PAKISTAN



The United Nations System in Pakistan

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United Nations
Office for Drug Control
and Crime Prevention

UNITED NATIONS INTERNATIONAL DRUG CONTROL PROGRAMME

STUDY OF DRUG TREATMENT MODALITIES & APPROACHES IN PAKISTAN

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LIST OF ABBREVIATIONS

ANF	ANTI NARCOTICS FORCE
CIT	COMMUNITY INTERVENTION TEAM
CRS	CATHOLIC RELIEF SERVICES
DAPRC	DRUG ABUSE PREVENTION RESOURCE CENTER
EU	EUROPEAN UNION
IDDRP	INTEGRATED DRUG DEMAND REDUCTION PROJECT
NCD	NARCOTICS CONTROL DIVISION
NGO	NON GOVERNMENTAL ORGANIZATION
NZ	NAI ZINDAGI (an NGO)
PNCB	PAKISTAN NARCOTICS CONTROL BOARD
TLC	THIN LAYER CHROMOTGRAPHY
UNDCP	UNITED NATIONS INTERNATIONAL DRUG CONTROL PROGRAMME
UNFDAC	UNITED NATIONS FUND FOR DRUG ABUSE CONTROL
WHO	WORLD HEALTH ORGANISATION

EXECUTIVE SUMMARY

This study was conducted in six major cities of the country: Quetta, Karachi, Lahore, Faisalabad, Peshawar, and Rawalpindi/Islamabad. The institutions assessed included nine government-run facilities situated within departments of psychiatry at teaching hospitals, three prisons and eight private or NGO-run facilities. Additionally, three focus group discussions were held with eighteen clients regarding their perceptions about treatment and recovery.

More than half of treatment services are located among the private sector and NGOs. Most of the NGOs are restrained by finances and are largely dependent on donors for programme funding and provision of services. They have yet to develop the capacity for financial management and self-sustainability of their programmes. Regulation and monitoring of NGOs' activities and quality of service delivery by a government body has been an issue of long debate and remains unresolved.

Most of the drug treatment organizations are following no particular model, but rather have adopted into their programme's tools and components from various modalities. Some of the modalities highlighted were related to self-help groups (e.g., Narcotics Anonymous), therapeutic communities and/or community-based outreach and outpatient, non-residential rehabilitation.

All the government-run facilities located within teaching hospitals are essentially providing short term medical detoxification as the main intervention for drug treatment. Some institutions, especially those in Karachi, are providing these services on an outpatient basis only. The majority of government-run centres allow a maximum stay of up to two weeks for the clients. Most of the government-run facilities were initially supported and developed with the financial assistance of the UN Fund for Drug Abuse Control (UNFDAC). Currently, many of these facilities do not have sufficient funds for treatment programmes.

The government-run facilities within the departments of psychiatry in hospitals, due to their orientation as medical facilities are limited in the scope and nature of interventions they can provide. The prisons do not have personnel who either have the orientation or training to deal with problems related to drug dependence beyond the medical intervention for acute withdrawal syndrome.

Prisons were found to have the largest numbers of drug addicts, at any given time, of any institution in the country. Prison drug addicts constitute between 20 and 40 percent of the total prison population Most prison addicts languish in custody for prolonged periods and receive extremely limited drug-related care. The District Jail in Peshawar was the only prison identified as having a programme for drug addicts, run by a local NGO, utilizing concepts of self-help and those of the Narcotics Anonymous programme.

Lack of political will and lack of understanding about mechanisms, approaches and strategies for social reintegration and rehabilitation are the main reasons for the limited provision of drug-related services found in most government-run facilities, as well as in many NGO-run facilities. Also, given the overall state of health care delivery in the public sector and the pressing needs for its improvements, drug treatment and rehabilitation is not a high priority on the list of health care issues.

Those programmes which were found during the study to have some success exhibited a genuine commitment, among the programme leadership, to the program, to the facilitation of

learning new concepts, and to the application and adaptation of these concepts within the programme. The majority of successful programmes included components addressing the needs of the clients with an orientation towards community-based aftercare and rehabilitation. They provided opportunities for initial training as well as ongoing training of programme staff in treatment and rehabilitation concepts. In addition, they had multidisciplinary teams providing the continuum of care needed for effectual drug treatment and successful rehabilitation. In most instances, these successful programmes enjoyed uninterrupted financial support from donors as well as community support for the programme.

Some suggested strategies for future programmes are the development of advocacy strategies for programmes addressing treatment of drug dependencies as one of the priorities within the health care delivery system and the development of mechanisms for coordination and cooperation within private and public sector organizations for delivery of drug treatment and rehabilitation services. In addition, it is suggested that relevant organizations develop protocols and demonstration projects for selected modalities, especially those for community-based service delivery of drug treatment and rehabilitation programmes. Other future programmes could include the institution of multidisciplinary training about drug dependence and addictive behaviors with special emphasis on treatment of problems arising as a result of harmful use of drugs, and the development of programmes to meet the needs of drug dependent prison inmates.

I. INTRODUCTION

A. Background

In response to the General Assembly's Special Session on Drugs held in June 1998, the United Nations International Drug Control Programme's Country Office for Pakistan (UNDCP) commenced the formulation and design of a comprehensive drug demand reduction programme for Pakistan. The programme is envisaged to be formulated in close consultation with all the stake holders involved in drug demand reduction in Pakistan including Government agencies, NGOs, private sector institutions and multi- and bilateral donors. The programme's overall objective aims at reducing the demand for drugs and the extent of drug abuse and resultant problems in Pakistan.

The expected outcomes for this study were:

- Provision of a general overview on the availability of treatment services for heroin addicts in Pakistan and the capacity of the treatment institutions to care for them
- To describe the major treatment approaches currently practiced in governmental, non-governmental and private sector institutions
- To compare the different treatment approaches in terms of cost-effectiveness, relapse rates and other criteria
- To describe the views of treatment providers, patients and their families about the efficiency of the treatment approaches
- To identify shortcomings in the provision of treatment services to heroin addicts, including the training of relevant personnel and other resource requirements (human, financial, material etc.)
- To make concrete recommendations regarding problems to be addressed in future treatment and rehabilitation programmes

B. Methodology

This study utilised a "Rapid Assessment Methodology" and was conducted through open-ended, semi-structured interviews and focus group discussions. The primary participants included thirty personnel involved in service delivery in the twelve government-run institutions, including three jails and eight non-governmental and private institutions providing drug treatment and rehabilitation services. These facilities were located in Quetta, Karachi, Lahore, Faisalabad, Peshawar, and Rawalpindi/Islamabad.

Similarly, three focus-group discussions were held with eighteen clients who were currently undergoing drug treatment in Quetta, Karachi and Faisalabad. These discussions were undertaken in order to identify the clients expectations and perceptions of treatment and recovery. All interviews and discussions were recorded and the essence of the discussions held has been incorporated into the relevant sections of this study.

II. OVERVIEW OF DRUG TREATMENT PROGRAMMES IN PAKISTAN

A. Background

Drug treatment programmes in Pakistan formally began following the proclamation of Hadd (Religious Injunctions) in 1979, which resulted in scores of opium addicts who could not get their daily dosage of opium, coming to government hospitals for "help". Most of the hospital staff, at that time, did not have the necessary training to deal with such cases. In most cases, the onus of treating these people fell on the departments of psychiatry in these hospitals. With the emergence of a heroin epidemic in the 1980s, there was again a demand for treatment services to which government agencies, hospitals, NGOs and private organisations responded by establishing treatment facilities. Detoxification procedures for drug withdrawal however, became the most common form of treatment during this period as a response to the increasing number of heroin addicts seeking treatment from an overburdened system.

Since 1982, the UN, through the UNFDAC and the UNDCP, has sought to assist in efforts to promote institutional and capacity building for the delivery of drug treatment and rehabilitation services. The UNFDAC helped to establish drug treatment facilities at selected location in Pakistan during the period 1982 through 1988. The UNDCP-funded Integrated Drug Demand Reduction Project made efforts during the 1990s to improve the service delivery of treatment programmes.

B. UNFDAC-Funded Treatment Facilities

The UNFDAC provided the first financial and technical support in the 1980s by establishing 32 model drug treatment centres in the country. The majority of these were situated in government teaching hospitals (within the departments of psychiatry), but some were within NGO-run facilities. The financial support included assistance for the salaries of the staff involved in the treatment, for the cost of medicines, and for other operational costs related to the running of the treatment centres. Material support included provision of vehicles for transporting clients to treatment or for their follow-up, and the purchase of TLC (Thin Layer Chromatography) equipment for drug testing, beds etc. Technical support was provided in the form of training for physicians in treatment procedures.

The UNFDAC project introduced a " National Case Monitoring System" which looked at the profile of patients presenting themselves for treatment at the supported centres. Every month the drug treatment centres being financed in the project recorded information about every patient coming for treatment which provided social, demographic and drug use data. These data were then compiled, analyzed and published. In addition, the Pakistan Narcotics Control Board (PNCB) published a booklet entitled "Guidelines for Heroin Detoxification". As the name suggests, this publication provided broad guidelines to primary health care physicians regarding detoxification of people with heroin dependence.

At the end of the project the responsibility for running the treatment facilities was handed over to the Provincial Health Departments under whose administrative control fell all the government-run facilities. Over the years, due primarily to financial constraints, and a lack of political will and

support, most of the treatment facilities became dysfunctional and, in many cases, the equipment procured under the programme eventually was placed into storage.

C. Integrated Drug Demand Reduction Project

The second important effort to improve the service delivery of treatment programmes was undertaken as a part of the Integrated Drug Demand Reduction Project (IDDRP) supported by UNDCP. During its implementation the project developed materials and provided training to service providers with the objective of improving service delivery of treatment programmes beyond short-term medical intervention. The concepts introduced focused on social rehabilitation and reintegration of drug dependent persons and included assessments of drug-related problems, counseling, relapse prevention and aftercare. In all, as a result of 23 workshops, 630 health workers, psychologists, social workers, paramedics and NGO workers were trained in the application of these concepts. Unfortunately, only a few NGOs had the capacity and will to implement these concepts and apply them in their delivery of treatment services. The majority of treatment facilities, especially those in the government sector, failed to utilize the acquired knowledge and skills for rehabilitation for drug addicts.

Similarly, in the absence of any inpatient rehabilitation, the project introduced a community-based treatment approach through the support of community intervention teams (CITs). The CITs were established, funded and monitored by the project. Teams consisting of two members from an NGO, were trained in rehabilitation and community development concepts, and worked in a defined geographical area. These teams have proven a good model for the provision of effective community-based rehabilitation. During this period, concepts of community involvement and linkage of community resources for social integration of drug dependent persons were also introduced through the CITs. Following the termination of IDDRP, most of the NGOs could not sustain either the level of activities or the required services, and therefore ceased to function. As a result, these efforts have produced insignificant changes in the delivery of treatment services in Pakistan.

III. ASSESSMENT OF THE TREATMENT MODALITIES IN SELECTED INSTITUTIONS

A. BALUCHISTAN

Quetta

Bolan Medical College

The drug abuse treatment centre at the Department of Psychiatry, Bolan Medical College, has been operational since 1979 and is one of the first centres designated for drug abuse treatment in Pakistan. The staff consists of three consultant psychiatrists. three medical officers, two house officers, six staff nurses and three paramedics. The total bed capacity allocated for drug treatment is ten. The drug treatment regime is 10-15 days, however many clients opt to leave prior to completion of treatment. The monthly turnover of clients is around 50 with most of the clients coming from lower- and middle-income groups from in Quetta, and a small number from Afghanistan and Iran.

Heroin is the main drug for which clients seek treatment. Detoxification treatment and the management of acute withdrawal symptoms are the principal interventions provided. The mode of detoxification is mainly symptomatic and includes the use of drugs for treatment of underlying psychiatric illnesses. The regimen includes use of a potent antidepressant such as Amitryptline upto 100 mg as a single dose at bed time, and 50 mg administered in two doses during the day. If available, a non-addictive, potent analgesic such as Diclofenic acid is given twice a day to which sometimes Paracetamol is also added. Valium, Baralgin, Novalgin and Chlorpheniramine are also administered. During the acute phase, which may last for 35 days, supportive therapy is given to control diarrhea, nausea and vomiting, lacrimation etc.

Currently, the department offers no services for social reintegration or vocational rehabilitation to its clients. The relapse rate of clients is almost 100% in a period ranging from 3 days to 6 months after discharge from treatment. During the period of IDDRP support, the department had developed good linkage with community-based organizations and was offering services such as counseling, family interventions, community-based follow-up etc. Unfortunately, the department could not sustain these services in the absence of financial support.

District Jail

At any given time there are approximately 250 drug addicts residing in the district jail in Quetta. These inmates are in custody on a variety of charges and constitute nearly 20% of the total jail population. At the present time, drugs are widely and easily available in the jail and as a result intervention efforts are largely ineffective.

Symptomatic treatment of withdrawal symptoms, similar to that available at the Bolan Medical College, is the only intervention available for these drug addicts.

Milo Trust

Milo Shaheed Trust is a community-based drug treatment and rehabilitation programme which began providing services in 1990. The trust has been supported by a number of international donor organizations including OXFAM, CRS, IDDRP, EU etc. The total bed capacity of the centre is 25,

with 5 beds in each room. The monthly turnover of clients varies from season to season, however an average of 30 drug addicts are admitted for treatment in a month. The addicts who seek treatment come from the Hazara community and other ethnic groups in Quetta, as well as from other parts of the province and from Afghanistan and Iran. Most of the addicts seeking treatment are from the middle or lower income groups. Over the last eight years, 6 female drug addicts have also been treated here. Whereas sometimes the local addicts are put on a waiting list prior to admission for treatment, those coming from other areas are often admitted without delay.

Milo Trust does not adhere to a particular model of treatment. They believe in adopting whatever treatment modality they believe will suit the requirements of their clients. The Trust has adopted components from different programmes that they have had opportunity to become aware of or in which they have received training. The trust has maintained a complete record of the 2699 clients that have been in treatment over the 8 years of operation. This information is used for looking at relapse rates, for developing social and demographic profiles of clients, for demonstrating the programme's performance and for other reasons.

There are 19 paid workers in the centre. These include the coordinator, one psychologist, one doctor, three male and one female social workers, three dispensers, a physical instructor and a teacher along with support staff.

Treatment

The duration of the residential programme is one month, and up to 95% of the patients complete the mandatory four weeks stay. The range of services provided include:

- Detoxification: Treatment is mainly symptomatic: analgesics for pains, anti-emetics for nausea and vomiting, glucose infusion for dehydration, tranquillisers and sedatives such as diazepam for aggressive patients. Depending on patient's condition the duration of detoxification is most often 7-10 days. Some patients may not require medication for withdrawal.
- Counseling: Individual, group and family counseling is undertaken as supportive therapy for addicts undergoing withdrawal.
- Physical training: gymnasium and weight training
- Group teaching: lectures and role-plays on addiction and the social, economic, and spiritual impact of drug addiction
- Self-Help groups: Meetings of Narcotics Anonymous are available to clients. Eighteen local recovering addicts have been attending the Narcotics Anonymous meetings for the previous 6 months.
- Aftercare and follow up: Follow-up care is for those who reside in Quetta. The frequency of visits is twice in a month for a period of 6 months. For the other clients follow-up letters are sent to them or their families and those not responding after a few letters are considered relapsed. Audio cassettes are given to families about their role and support to the addict during recovery and social reintegration. Approximately 30% of the clients come in regularly for aftercare.
- The services provided by the Trust are free of charge. Only a nominal amount of Rs. 60 per day per client is charged for meals.

The Trust has developed a network of 5 NGOs in the city who identify and refer clients for treatment as well as facilitate follow up of the clients in their respective communities.

Effectiveness

The effectiveness of the interventions is gauged by the fact that out of 2113 clients, 690 (i.e., 32%) have remained drug free for periods up to 12 months or more. The probable reasons for the relative effectiveness of the programme are:

- discipline and firmness in implementation of programme's interventions
- trained staff
- ongoing contact with addicts and their families
- linkage with other organizations in the community
- opportunities to receive training and visit abroad and learn from other international programmes.
- good local and international donors' support for the programme.

Focus Group Discussion at Milo Trust

Four recovering addicts currently in treatment at Milo Trust for Heroin dependence participated in a focus group discussion. Two participants were undergoing repeat treatment. Two had been brought by family members while the other two had themselves sought treatment. Their reasons for coming to Milo were the discipline and restrictions as well as other programme interventions which they thought helped in their recovery. They all believed that the actual treatment and the recovery process began outside the treatment setting.

Regarding questions about how they could maintain their recovery, the respondents felt that:

- One needs to have a firm commitment to recovery, needs to work and improve upon this resolve in remaining drug free during treatment.
- An extended period in the treatment programme helps one to recuperate physically and mentally as well as to develop the resolve to deal with problems and remain drug free.
- If problems such as sleeplessness, appetite-loss and others (sexual problems for some) were addressed then there was less chance of relapse for an individual.
- A close contact with the treatment programme and aftercare, for at least 1 year helps to prevent relapse.
- If one remains busy, and/or is gainfully employed, and is given responsibilities there is a better chance they will remain drug free.
- Strict adherence to religion helps in recovery and prevention of relapse.

B. SINDH

Karachi

Lyari General Hospital, Department of Psychiatry

Background

The Drug Abuse Treatment Centre at the Lyari General Hospital was one of the earliest centres established with the support of UNFDAC. The department has three full-time psychiatrists, two social workers and other support staff. Currently, the department does not offer in patient treatment services to drug addicts as, firstly it is difficult to accommodate drug addicts in the same setting with other psychiatric patients, and secondly the department has no allocation for drugs to use during detoxification. Nonetheless, there is a monthly turnover of approximately 100 patients seeking drug treatment on an outpatient basis.

Treatment

Patients are admitted only for outpatient treatment only, and are usually only monitored for one day. Many are prescribed medication to be administered at home under the supervision of a family member. The regimen for detoxification includes the use of antipsychotic drugs such as Chlorpromazine (50 - 300 mg in daily divided doses), potent analgesics, tranquilizers such as diazepam or Benzodiazepine, and other medicines as supportive therapy to deal with symptoms such as diarrhea, nausea and vomiting, dehydration, etc.

Prior to beginning the process of detoxification, the patient is assessed for his motivation and the doctors confer with the patient's families explaining to them the process of withdrawal and their role in supporting the patient during this phase. No other services are provided by the department.

Jinnah Post Graduate Medical College

Background

The Drug Abuse Treatment Centre at the Department of Psychiatry, Jinnah Post Graduate Medical College, was established in 1981. The turnover of patients seeking drug treatment is 10-20 per week. As the modalities for drug treatment are biologically determined, the services offered to these patients are primarily for detoxification on an outpatient basis.

Treatment

Patients are evaluated for motivation and readiness on an outpatient basis during 2 or 3 visits prior to commencement of treatment. Because the majority of drug addicts have an underlying or associated psychoactive disease (e.g., manic-depressive illness) or psychotic behavior, no stereotype modality is applied to the patient and treatment is developed accordingly. A weekly family session is provided for those seeking drug treatment. The family session provides a platform for free communication between the patient, the family and the doctors to discuss issues regarding drug use, recovery and each side's role in the process. On an average, 20 or more patients attend each meeting. The number of times a patient attends the family sessions ranges

between 5 and 6. After that, it is assumed that either he has stabilized, lost faith in the facility, has gone elsewhere for treatment or has relapsed.

Pakistan Society

Background

Pakistan Society is an NGO-run drug treatment facility established in 1985. The current turnover of patients is approximately 150 per month as inpatients and a similar number of patients seek treatment on an outpatient basis. Nearly all of the patients seeking treatment are doing so for heroin dependence. Most are from low income groups and reside in Karachi. Over the years a small number women have also sought treatment in the centre. The total bed capacity of the centre is 50. Twenty full-time staff members provide services. Of these, two are counselors and eight paramedics, the rest are support staff. Recovering addicts also work as honorary staff members in the centre.

Treatment Services

1. Group counselling with drug addicts at Pakistan Society—an NGO at Karachi

Detoxification of clients on an outpatient basis is a service that has recently been established. There is no definite criteria for selecting a person for outpatient detoxification. The success of this service is low; only 35% of patients ever complete the detoxification process. Currently, in patient detoxification for a period of ten days is the only other intervention offered by the centre. In patient detoxification consists of symptomatic treatment of withdrawal symptoms using non-narcotic analgesics such as Mefenemic acid or Brufen, hypnotics such as Mogadon or tranquillisers such as Ativan, along with other supportive therapy.

Until recently, a one-year modified treatment programme modeled after the Therapeutic Community, with the philosophy of making clients take responsibility for their recovery, was being offered at the centre as the primary drug treatment and rehabilitation programme. Due to constraints of financial resources, the services offered and the programme had to be curtailed.

The structured, one-year programme, consisting of four stages, takes clients through various phases of behavioral change, increased responsibility in their recovery and major issues of life. The interventions designed consist of lectures; individual, group and family counseling and therapy; morning meetings; adherence to strict discipline etc.

Reintegration in the community is gradual for the clients. Selling and marketing a daily newspaper in the community is one way by which some clients learn to reintegrate within main stream community life. The newspaper is compiled, edited and printed by the staff, some of whom are recovering addicts in the program, and consists of, besides the normal requirements of a tabloid, messages of drug prevention and the impact of drug dependence on the individual, family and the society. Selling this newspaper helps the recovering addicts learn skills of relating within the community beyond the treatment centre's and their partners' support.

Aftercare consists of attending a weekly meeting. For follow-up the client is asked to return every week for a 24-hour monitoring period. After eight to twelve weeks this period is extended to 24 hours every ten days. Gradually the interval between monitoring visits is extended.

In a six-month period, 40% of clients come every week for check-ups, while within a twelve-month period this percentage is reduced to less than 10%. The centre charges between 2000 and 6000 Rupees as fee for detoxification from about 60% of the clients. For those staying longer the charges are approximately 2,000 Rupees per month.

Focus Group Discussion at Pakistan Society

A focus group discussion was held with 6 clients who were in treatment at Pakistan Society. Except for one who had the problem of alcohol dependence, all the clients had come for treatment of heroin dependence. All were chronic poly-drug users. For one member of the discussion group, the period of active addiction was twenty-five years. Except for one, all had undergone multiple treatments either at Pakistan Society or other places. For most it was their families who had brought them to this centre for treatment.

Their reasons for continuing in the treatment or for coming in for aftercare were:

- provision of good counseling
- realization after being in the treatment of one's fault, and therefore the need to be abstinent from drugs.
- a caring attitude of the staff, with no torture or beating.
- the programme helped realize value of life and the reasons for quitting drug use.
- the programme helped them to change behavior and to adopt a healthy routine of daily living.
- the programme continued to build one's resolve in being drug free.

Other issues of discussion on treatment and recovery were:

- Most addicts are brought by force into treatment, but the programme makes them realize that they have to quit and it has to be their own willingness and resolve.
- Certain changes are made in the addict's behavior and he learns to live sober, when that happens he can sort out his own problems in the outside world and remain drug free.
- If the addict has the strength to get his drugs despite difficulties and problems, he can also solve other problems if put on the right track.
- The programme is a learning ground such as a school or college; what one learns here helps him to live a better life outside.
- Confidence and resolve are not built up by just remaining inside a treatment facility. One has to learn to face what is in the outside world and gradually learn to live normal life.
- If one has spent so many years in addiction he needs to spend at least an equal number of months in recovery.
- Addicts are rejected people and need to learn to adjust in life with patience and the knowledge that nothing will be all right for them in the outside world.
- In recovery, half of the efforts are those of the therapist and half are those of the addict.

C. NORTH WEST FRONTIER PROVINCE

Peshawar

Khyber Teaching Hospital and Lady Reading Hospitals

Background

The drug treatment programmes began in the two hospitals in 1980 when, as a result of ban on opium, there was an influx of opium addicts presenting themselves for treatment. Currently, the turnover of clients is around 20 to 25 per month in each hospital. The bed capacity of each hospital is ten beds. Most of the people seeking treatment belong to the lower or lower-middle class, and are primarily seeking treatment for opiate dependence including dependence on heroin. Other drugs for which clients seek treatment are alcohol and psychotropic substances.

The Department of Psychiatry, through its linkage with volunteers, voluntary organizations and by networking with philanthropists in Peshawar, generates funds to provide drug treatment and medical services to clients, especially those with tuberculosis. Fifty rupees is a standard hospital admission fee charged to the patients seeking treatment, but those who are unable to pay are still provided services.

Community-based treatment with a strong aftercare component is the basic philosophy followed for treatment. However, there is no absolute model employed. Rather, all interventions are designed according to the circumstances and needs of the individual and the community. For example, a person may not achieve a drug-free state but may fulfill other criteria or parameters of being functional.

Treatment

The treatment regime consists of in patient detoxification for ten days, motivational counseling, outpatient aftercare and self-help groups. The average stay for patients in the hospital is two weeks, which may be extended to three weeks. The detoxification is mainly symptomatic and consists of the administration of Naltrexone or Clonidine, initially as an antidote and then as an antagonist, and Valium or Diazepam. As a rule, parenteral administration of drugs is avoided as much as possible. Counseling is provided along with other supportive therapies to the clients.

An Addiction Severity Index is used as a tool for developing a treatment plan for each client. If the family is present or the need arises, they are provided counseling as well. Senior recovering addicts who visit the centre are also helpful in counseling and in generally helping clients on their pathway to recovery. For vocational rehabilitation and occupational skills training of clients, the programme staff utilize resources within the community that they identify through networking and linkages with other organizations.

Follow-up and Success

Usually up to 30% of the clients relapse within the first three months. At the end of one year, 30-40% of clients continue coming for aftercare, whereas at the end of two years this number is reduced to 25-30%. The criteria for success that the programme looks at is that the person should be relatively drug-free, crime-free and gainfully employed over a given period.

District Jail

Background

Currently, there are 300 drug addicted inmates in Peshawar Jail. These constitute almost 40% of the total jail population. Most of these addicts are incarcerated for charges of drug use, and some for possession of small quantities of drugs. Most of the drug addicts are those whose families, after being frustrated by their behaviour and their addiction, have arranged for them to be incarcerated. The period of incarceration may vary from 6 months to one year. On an average, each drug addict has been in jail three times.

Currently the three hundred addicts are kept in one barrack which normally accommodates eighty people. Some inmates who may not necessarily be drug addicts are also sent here as punishment for misbehavior. There is a hospital within the jail premises but, as a routine, it does not provide medical intervention as it has no provision for medicines for detoxification. Only those addicts are treated whose condition is deteriorating or who are experiencing severe withdrawal symptoms.

Treatment

Since July 1998, the Dost Foundation has established a programme using the 12-step modality in the jail. The programme staff consist of a counselor, health technicians and recovering addicts who have been trained in counseling techniques. The team visits the jail on a daily basis and conduct an open Narcotics Anonymous meeting with all those who are present and interested in joining the meeting. After this those who are further interested in joining the formal programme get their names registered. The counselor or the other staff talk to each of these addicts for their motivation and reasons for coming in the programme.

About 30 of the inmates who fulfill the programme's criteria are taken in for a 1-month programme. Since the programme staff are allowed to remain within the jail premises from 08:30 to 1:00 PM, this is the time for which they can effectively provide any intervention or remain in touch with the inmates. This time is spent in an open space outside the main barracks. Three to four days a week, the daily programme begins with the morning meeting, followed by lunch break. After lunch there is a 45 minute lecture on various aspects of addiction, thirty minutes of individual counseling, and. lastly, group discussion about various topics. For a new group the programme staff fill forms for each client in the first few days of the programme. At the time of this study, there are three recovering addicts who are in their fourth month with the programme.

For follow-up of those inmates who have completed 1-month program, the programme staff are trained in the broad principles of counseling. Four inmates who are non-addict inmates serving life imprisonment, act as counselors and provide support to these inmates, and report on the inmates progress or regression.

Although the programme is-running with the collaboration of jail authorities, the jail staff are skeptical about the programme. The programme staff are considered to be interfering in the jail routine. In addition, the jail staff believe that nothing can be done for these addicts except through force and strict disciplining.

Horizon

Background

Horizon was established in 1986 as an NGO offering drug treatment and rehabilitation services. Currently, besides the drug treatment services, the organization offers training and research services in the field of drug demand reduction. Horizon has a ten bed facility for drug treatment. The organization offers community-based follow-up, rehabilitation, and aftercare programme primarily utilizing the services of volunteers and senior recovered addicts. Horizon works in close collaboration with the government-run facilities at the Khyber Teaching Hospital and the Lady Reading Hospital, and follows the same treatment regimen applied there.

Dost Foundation

2. A view of Dost Welfare Foundation Building in Peshawar

Background

The Dost Foundation is a not-for-profit NGO established in August, 1992. Currently, the organization is involved in prevention, drug treatment and rehabilitation, and programmes for street addicts. The Dost Foundation has had good liaison and support from international organizations and local donors and philanthropists. The organization's staff were trained by Nai Zindagi in running a 12-step programme. While the bed capacity of the Centre is 30 beds, the average turnover is around 25 patients in a given month.

The staffing in the programme consists of four psychologists, three medical doctors, two recovering addicts who work as counselors, and other support and office staff. For those who are able to pay, the programme charges between 50 and 200 Rupees per day.

Day Care Centre

The bulk of clients in the programme are referred from the day care centre that the Dost Foundation is running for street addicts in Peshawar. The philosophy of intervention with street addicts is based on the maxim " rehabilitation even before detoxification" where addicts are given time to restore some of their physical strength, health and hygiene, bring a level of manageability to their lives and establish contact with their families before they are formally inducted into the treatment programme.

One recovering addict and two medical technicians-cum-counselors visit the street scene in Peshawar 6 days a week. The team gathers together addicts and talks to them about their health and other immediate concerns of survival on the streets, and gradually brings them to the point of considering to quit drug use and admitting themselves for treatment. The message for these addicts is that their first step towards demonstrating a desire to quit is to come to the Day Care Centre on a daily basis. Once the addict has been coming to the centre fairly regularly, and has established contact with his family, he or she is formally accepted for admission and treatment into the residential programme.

In the Day Care Centre, addicts may come in to bathe themselves, wash their clothes, have tea and bread, get first aid or medical treatment for minor ailments and/or attend the Narcotics Anonymous meeting held there. All of these activities are carried out on a fixed schedule. On the average, 20 to 25 people, some of them recovering addicts and some actively using drugs, come to the day care centre each day. From among them, active drug users, who have been demonstrating some changes in their behavior in terms of manageability and have established contacts with their family, are referred for treatment into the residential programme at Dost. The number of such referrals does not exceed ten in a month.

Residential Programme

Detoxification

Every month ten addicts from the street, along with some direct admittees, are taken into the residential treatment programme. This programme consists of a 15-day detoxification period followed by primary rehabilitation for another 15 days. The main drugs used for detoxification include Diazepam, a non-narcotic analgesic such as Panadol, an antihistamine such as Phenargan, along with supportive therapy for diarrhea, vomiting etc. The purpose of the medication is to stabilize the client during the acute phase of withdrawal from drugs. Frequent baths, showers and dips in the outside pool have also been found to be beneficial to clients in easing their withdrawal symptoms. Counseling for clients is another intervention found to be useful during the withdrawal phase.

Primary rehabilitation

Out of the ten clients admitted for detoxification, five are discharged from the residential programme. These, if willing, go to the Day Care Centre to continue their programme on an outpatient basis. The remaining five are then taken into the primary rehabilitation programme. The emphasis during this phase is on behavior modification through lectures, sharing groups, counseling and taking small responsibilities within the premises.

Secondary Rehabilitation

The next phase of treatment is secondary rehabilitation, consisting primarily of vocational rehabilitation. During this period, the clients work as security guards, counselors to those who are undergoing withdrawal and group leaders, or they work as support staff in the centre or participate in the street or jail programmes. Some of these residents are also taken up as full-time staff in the programme. Reintegration into the community is gradual. During this phase, the client may go, on a weekend, to his home and back. The frequency of visits is gradually increased until the client is completely ready and confident to spend full time at his home.

Families Programme

The programme for families is another programme component at Dost Foundation. Starting from the tenth day of detoxification, the families of the addicts begin visiting the centre every week. During this time, families are given lectures about addiction, co-dependence and counseling and have the opportunity to share among each other as a family unit or within the larger group of parents and families.

Successfulness of the Programme

One factor for the program's relative success is the number of recovering addicts who continue to be active participants in the Narcotics Anonymous meetings. Some of these recovering addicts have been able to start Narcotics Anonymous meetings on their own at four different locations outside Peshawar, thereby extending the program's network.

Some possible reasons for the success of the programme are:

- The provision of a wide range of services to the clients; e.g.., withdrawal treatment, rehabilitation, in patient services, outpatient day care, street programme, self-help groups etc.
- Well-qualified staff who were trained in addiction rehabilitation at the beginning of the programme
- Adaptability and flexibility within the program according to clients' needs.
- Good linkage with other programmes and financial support from donor agencies as well as a network of local donors.
- Commitment by staff and management to continue the program despite difficult circumstances. For example, the street program continued for 3 years before it could obtain sufficient funding for its operations.
- Multi disciplinary staff who have had exposure to various programmes and components of drug treatment and rehabilitation both nationally and internationally.

D. PUNJAB

Faisalabad

District Headquarters Hospital

Background

The Drug Abuse Treatment Centre was established in the District Headquarters Hospital in 1982 with the assistance of UNFDAC. While the turnover of clients seeking drug treatment varies by seasons, it averages approximately 30-35 per month. Since this is a government hospital based facility most of the clients coming here belong to lower socioeconomic groups from Faisalabad city and the surrounding area. All the clients treated at the facility have been males.

The Drug Treatment Centre is a 50-bed indoor independent unit. It has a staffing of two social welfare officers, two clinical psychologists, one statistics assistant, ten staff nurses and two medical officers trained in psychiatry. At the time of admission, the clinical psychologists evaluate the patient for motivation, social background etc. The social welfare officers primarily provide follow-up services to the clients.

Treatment

Symptomatic treatment during the acute phase of withdrawal is the main intervention provided. The philosophy of treatment is that since drug dependence is a chronically relapsing disorder, the effort is to help an addict overcome his withdrawal symptoms with relative ease and comfort and to physically restore the patient's health. The regimen for detoxification is tailor-made according to the needs of the clients and his tolerance to drugs. Tranquillisers, anxiolytics, hypnotics, analgesics, antihistamines and antidiarrheals, along with supportive therapy, are used for 3-10 days of detoxification. The clinical psychologist briefly counsel clients during this period. No other interventions or services are provided to the patients during their 10 to 15 day stay in the hospital.

Previously, social workers and clinical psychologists used to visit the patients and clients' home as follow-up once every month for 1 year. The follow-up consisted of checking with the client if he had relapsed or not and discussing any problems or difficulties he faced in the preceding month. This has been stopped due to budgetary constraints faced by the department.

St. Paul Detoxification Centre

Background

The St. Paul Detoxification Centre was established in March, 1990. The Centre is run under the supervision of the Diocese of Faisalabad with funding from Caritas Germany. The facility provides an indoor treatment programme, has a bed capacity of 10 with a turnover of ten to twelve clients per month seeking drug treatment services. Most of the clients coming here belong to the lower or lower-middle classes, and come for treatment of dependence of Opiates (opium, morphine, buprenorphine etc.). During the previous 2 years approximately 50% of the clients being admitted have been injecting drug users.

The staffing of the centre beside the Director, consists of one doctor, two psychologists

(one male and one female), three social workers, one male attendant, three dispensers, watchmen, cook etc. The director and one doctor were initially trained as Addiction Counselors by Nai Zindagi in 1992, and as a result have incorporated the twelve step programme of Narcotics Anonymous as the main modality for treatment. One psychologist has also been trained in hypnotherapy, which he uses as an additional tool in treatment. The main emphasis or philosophy of treatment is that the individual needs to change his lifestyle, behaviours and attitude, in order to recover from drug dependence.

The programme works on an open-door policy meaning the client may leave at any time he wishes; however, any final decision is taken after consultation with the family. Between 70% and 80% of the clients leave the programme after 25 to 30 days of treatment. The Centre charges 75 Rupees per day from the clients, totaling 3,000 Rupees for the forty days' stay.

Treatment

As a preliminary to admission the patient is checked for his motivation and honest desire to quit drug use. A client must visit two or three times before he may eventually be admitted for treatment. Medical examination is an essential part of admission, as many patients have been found to be afflicted with tuberculosis. Such cases are then referred for anti-tuberculosis treatment before being admitted for drug treatment.

The process of detoxification lasts for 10 to 15 days. Use of injections is avoided to the maximum. Some of the drugs used in the process are: major tranquillisers (e.g., Largectil), minor tranquillisers (e.g., Benzodiazepines), antihistamines, expectorants, narcotic analgesics (e.g., Distalgesic and Darvin) and multivitamins. Psychologists also assure the clients during the process of detoxification.

The programme uses interventions for social rehabilitation in treatment. Some of these are:

- A series of forty lectures on various aspects of drug dependence, including its impact on their lives, shame, anger, grief, dry-drunk syndrome etc.
- Group discussions, sharing of life stories, 12-steps work, relapse prevention training etc.
- Daily individual counseling.
- Weekly Narcotics Anonymous meetings at another site with residents and other recovering addicts.
- Lectures and therapy for families about their role in recovery. (Family involvement has hitherto not been a very strong component of the programme.)
- Assistance in job placement for those who may request it.

Follow-up for local and some nearby clients is undertaken for up to 2 years. The rehabilitation assistants visit every week for the first three months, fortnightly for the next three months, and once a month for the remaining period. Approximately ten to fifteen people recovering addicts attend the weekly Narcotics Anonymous meeting.

The success of the programme can be gauged by the fact that 30% to 40% of the clients remain drug free over a 2-year period. Some possible reasons for this success rate are the staffs' spirit, dedication and commitment to their work, and the use of the Narcotics Anonymous programme.

Focus Group Discussion with Clients of St. Paul's

A focus group discussion was held with eight clients who were in treatment at St. Paul Detoxification Centre. Of these clients, two were primarily dependent on morphine (injecting users), two on Buprenorphine (injecting users), two on heroin, one on opium and one on heroin and Buprenorphine. All of these clients were poly drug users. Except for one client whose period of drug use was less than 1 year, all the other drug addicts were using drugs for the past 6 to 12 years. Three of the clients had come for the first time for treatment, one for the second time, while the other four had multiple treatments from various places.

Most of the clients cited the following two reasons for their coming to treatment:

- to become a good person.
- to spend a good life without drugs do something for the family, good work, serve parents etc.

Their reasons for coming to St. Paul's in particular were:

- the treatment provided was good.
- there was good discipline, timetables and routines to be followed and restrictions were tight so that there were no chances of getting or using drugs there.
- the lectures given by psychologists were good and helped one remember things, e.g., how one starts, how one can relapse, how to anticipate high-risk situations and save oneself from falling prey to drug use again.
- the behaviour of the staff was very supportive and encouraging

On the question of how one can keep away from drugs in the outside world the responses given were:

- keep away from the drug society (drug-using friends)
- learn how to deal with problems
- the label of drug addiction will remain, but we need not worry about it and must focus our minds on our recovery
- Willpower
- control the desire to use, delay taking action when there is desire

On what could the treatment programme do to help them remain drug free, the clients responded:

- The mind needs to be prepared to keep away from drug using company and environments.
- The lectures help them remember their actions and behaviour and prepare them to not repeat the same mistakes.
- The attraction of drugs is so great that they forget everything they have learnt in the programme.
- They look for excuses to use drugs. They need to be honest with themselves.
- They needed to remember their powerlessness over their addictions.
- If they have used drugs for long periods, how can one expect them to be normal in a few days or months. They needed a long period to regain their strength, and reform their mind and behaviour in order to be the new person.
- Their craving, sleeplessness, restlessness and sexual problems would continue. They needed to learn to deal with these problems.

Rawalpindi

Fauji Foundation Hospital

Background

Fauji Foundation is an army veterans' hospital and essentially a tertiary referral centre where patients are sent from surrounding towns and areas by the smaller hospitals, dispensaries and mobile dispensaries run by the Fauji Foundation. Its Department of Psychiatry has a 10-bed facility for drug treatment. The staffing consist of male and female nursing staff, four nursing assistants, two clinical psychologists, two medical officers and the consultant psychiatrist who has been involved in drug treatment and rehabilitation for the last 15 years in various capacities. The turnover of clients varies from 30 to 50 per month.

Most of the clients are poly drug users with heroin as the main drug for which they seek treatment. Those who are coming from the periphery of the city are generally new patients while those coming from the inner city are mostly relapsing cases. The patients who are finally admitted to the hospital for drug treatment usually have secondary complications of a psychiatric or physical nature. Those who do not manifest any secondary complications are seen on an outpatient basis.

Treatment

The philosophy of detoxification is that it is a medical phenomenon and is a very small component of a much bigger problem. The purpose of detoxification is to make the person comfortable during the process of withdrawal while his body is becoming free of the chemical substance. The modality depends on the drug of use as well as the use of a single drug or poly drugs. In the majority of cases, the drugs required for detoxification are:

- combinations of analgesics
- hypnotics such as Temazepam or a long-acting Benzodiazepine
- an antihistamine with a long-acting phenomenon such as Retard Avil
- anti-depressants with a sedative component such as Prothiadine to cover high anxiety and restlessness during withdrawal
- Intravenous fluids for dehydration
- Multivitamins, anti-diarrheal and anti-emetics as supportive therapy

During detoxification, when the patient is conscious, he is inducted into therapy programmes run with the assistance of psychologists. When acute withdrawal has settled down the drugs are gradually weaned off. Some doctors may use major tranquillisers or anti-psychotics during withdrawal. These may have their own potential side-effects or the patients may develop lethal or even fatal complications (for instance, extra pyramidal symptoms, centralized muscle rigidity or respiratory depression) if they are not given in proper dosage or without anti-parkinsonism drugs.

The total treatment plan must be developed supported with the full assessment of the patient's psychological and social aspects. These aspects are identified by a clinical psychologist with additional help from family members. The clinical psychologist charts out a plan at the time of

admission. He takes two histories, one from the patient and one from the family, and then identifies areas that are highly sensitive to the patient. This is especially important if the patient is coming after a relapse.

The patient is offered psychotherapy in the form of group or individual therapy. Then they are referred to an outpatient rehabilitation service. At present the department does not have a follow-up plan as the staff are overworked with the regular psychiatric services at the hospital and commitments. Currently, the department has a liaison with Nai Zindagi (NZ) programme to offer rehabilitation, aftercare and follow-up services to the discharged clients. NZ is also referring their clients who have secondary drug dependence associated with some underlying psychiatric illness for initial psychiatric assessment and then for detoxification services to the Consultant Psychiatrist.

The department has no contact with the clients once they leave the facility unless they relapse and are brought back, or if they develop some secondary psychiatric problems such as schizophrenia or drug-induced psychosis.

Effectiveness of Interventions

At this stage, based on clinical experience, one can safely deduce that there is more than 50% relapse over a period of 6 months. The individuals who have higher stresses often relapse within the first 3 months, and those who have some kind of social support such as family often relapse after 6 months or more.

Institute of Psychiatry and Behavioral Sciences

Background

The drug treatment programme at the Institute of Psychiatry and Behavioural Sciences, located at Rawalpindi General Hospital and affiliated with Rawalpindi Medical College, began in 1980 in response to an influx of patients following the ban on opium use. This was one of the centres that had been supported by UNFDAC funding for the establishment of drug treatment centres in the country. The institute is a WHO collaboration centre and provides training in psychiatry and behavioural sciences to undergraduate, graduate and postgraduate level students both from within the country as well as from abroad. The institute was one of those centres that initially used standardized “opium” tablets supplied by the Excise Department and used as a gradual withdrawal and replacement therapy for persons with problems of opiate dependence. The institute has a full-fledged teaching faculty of highly reputable psychiatrists. Currently, the Institute of Psychiatry is providing inpatient drug treatment services for 4 to 5 days to a limited number of clients.

The Institute's staff believe that the current focus of programmes is on management of acute withdrawal with little or no emphasis on rehabilitation components. Therefore, they feel the need to develop these services but are restrained by lack of support, primarily financial, from the concerned quarters.

Central Prison

Background

Currently, there are approximately 1,000 (22%) drug addicts out of a total jail population of 4,500 in the Adiala jail. Most of these come from Rawalpindi and the surrounding areas and are in custody on charges of use of drugs. A few of these inmates are booked under charges of possession of drugs. Until 1996, a programme supported by the Integrated Drug Demand Reduction Project was implemented by the staff of the Prisoners Aid Society and the Rawalpindi Society for Anti Narcotics. Due to lack of support from concerned quarters this programme was halted.

Treatment

Currently the only service provided is for detoxification of those addicts who are undergoing acute withdrawal syndrome. The treatment regimen consists of a major tranquillizer such as Largectil, or Serenase or Kemadrin. For some addicts who have been using high doses of heroin, or are overly aggressive, these drugs may even be given in combination.

For those who have not been on high doses of heroin, the other medicines used are diazepam or Phenargan. Symptomatic management of diarrhea, and vomiting is handled by antidiarrheal drugs and infusions for dehydration. Since most of the addicts either have tuberculosis or other respiratory tract infections, medicines to treat these are also given.

The medication continues on a reduced dosage for approximately 3 to 4 weeks. After the first week the addicts are shifted to their designated barracks. Within a month's period the addicts are sent to their normal barracks. During their stay in the drugs barrack the inmates are exposed to information about the ill-effects of drug use and its impact on their lives.

As far as the medical treatment is concerned, 99% of addicts are ultimately treated. As long as the addicts are incarcerated in the jail, they do not use drugs. The moment they are released their relapse rate becomes high.

New Imran Drug Treatment Centre

Background

The New Imran Drug Treatment Centre is a private, not-for-profit organisation working in Rawalpindi since 1989. It has a bed capacity of between 27 and 30 beds, but up to 35 patients can be accommodated in times of need. The average turnover of clients is 25 per month. Most of the clients coming to Imran Centre belong to the lower and lower-middle classes. Nearly 98% are addicted to heroin. The majority of clients are those who have been using drugs for at least 6 to 7 years. Very few clients are those who have just begun using drugs.

The staffing of Imran Centre consists of two medical doctors, four qualified dispensers, three inpatient recovering addicts who work as volunteers, and other support staff. The charges for four weeks of treatment is 4,000 Rupees but hardly anyone is able to pay this whole amount and, therefore, the centre staff readily accept whatever amount the clients are able to pay.

Treatment

During the 4-week programme the main intervention provided is medical detoxification. While other services for treatment and rehabilitation are provided they are limited in nature and scope. The programme personnel believe in a "closed-door with lock and key" policy.

Detoxification is basically symptomatic in nature and consists of the use of analgesics, minor tranquillisers and other supportive therapy for dehydration, nausea and vomiting. The medication is continued for approximately 1 week after which the clients become totally drug free.

Other interventions or services provided include morning meetings and group and individual counseling. Some 60% of the clients actually complete the stipulated treatment period. The motivation for those who stay for the entire duration or longer is that since they have relapsed so many times they want to improve themselves physically. Also, for a considerable number of clients, pressure from their families for them to stay is considerable.

Follow-up is limited in nature. The programme staff try to contact their clients once every 3 months by mail but very few actually respond. Some 25% either contact themselves or respond by mail.

The programme cannot state the effectiveness of its intervention as it does not have resources to physically follow-up the clients.

Lahore

Government Mental Hospital, Drug Addiction Unit

Background

The drug addiction unit of Government Mental Hospital was established in 1987 when an influx of heroin addicts seeking treatment started in the early and mid eighties. The unit has a twenty-five bed capacity, and generally allows 15 days of treatment and stay to the patients. Most of the patients themselves demand discharge from the hospital after between 7 and 10 days of treatment. The monthly turnover of admissions for drug treatment range between 75 and 100 patients.

The primary staffing of the unit consists of an in charge psychiatrist, four nursing staff, guard and other support staff. Since each psychiatrist from other hospital units is allocated five beds in the unit, these are also involved on a daily basis in the treatment of patients.

Most of the patients seeking admission come from Lahore and its surrounding cities, some may even come from far off places and other provinces, and belong to the low socio economic group. They seek treatment for primarily heroin addiction but most are poly drug users.

Treatment

The drug addicts who come for treatment are seen in the outpatient department and then referred to the drug addiction unit for admission. The regimen for detoxification consists of antipsychotic drugs, anxiolytics, analgesics, antidiarrheal drugs on a needs basis and Phenargan

as an antihistamine. While the antipsychotics drugs are gradually reduced, the patients are generally advised to continue use of anxiolytics and analgesics for 3 to 6 months. The dosage is adjusted on a weekly basis according to symptoms and need of the client in the out patient department. These drugs are thought to be necessary to help relieve symptoms such as insomnia or general restlessness which may continue for months for some of the patients.

As follow-up the patients are required to visit the out door or out patient department of the concerned unit which had initially admitted them. The purpose is to check on their health and adjust their dosage of medicine prescribed to them at the time of discharge. Less than 5% of patients continue coming for follow-up after the first month. Those who come, reportedly come to get extra, free psychotropic drugs to augment their usual drug of addiction.

Readmission of relapse cases is approximately 90%. Although there are two social workers on the hospital staff, their case load is such that they cannot effectively follow-up many of these patients.

Mayo Hospital, King Edward Medical College, Department of Psychiatry

Background

Drug treatment at the Department of Psychiatry, Mayo Hospital, King Edward Medical College was established in 1988 as part of the UNFDAC supported model drug treatment centres at teaching and district headquarters' hospitals in the country. The Psychiatry Department's staffing consists of a full Professor, one associate professor, three assistant professors, two registrars, seven medical officer, eight house officers, two social workers, three psychologists and nursing and other support staff. One assistant professor is in charge of the drug abuse treatment centre.

Currently, the monthly turnover of clients at the centre is approximately 30 whereas, in 1990, it was more than 200 patients per month seeking treatment for drug dependence. Most of the clients seeking treatment belong to lower socioeconomic groups, and are admitted primarily for heroin dependence. A sizable number of patients with Bezodiazepine dependence also come in to the out patient department.

Treatment

The department offers treatment both at the in patient and out patient department. In the out patient department, the patient may be asked to gradually come off drugs and may help to facilitate his home detoxification with the support of family members. The in patient department has 12 to 15 beds allocated for treatment of drug dependence.

The duration of stay for treatment at the centre is 2 weeks during which the main intervention is medical detoxification. Some of the medicines used for detoxification include: neuroleptics to induce sleep, Benzodiazepam if the patient is restless or aggressive, analgesics, Maxolon and an antihistamine for nausea and vomiting, anti diarrheal drugs and other supportive therapy for diarrhea, dehydration etc. The medication continues until the last day of stay in the hospital, and most clients are also advised to continue medication at home.

Other interventions or services provided during the 2 weeks stay include daily individual

counseling to patients by a psychologist and group counseling sessions held by the social worker to help the patients understand their addiction and to tell them that detoxification is just a small step in the whole process of recovery. Indoor games are used so that the patients can remain busy and involved. For those family members that may come to visit the patient, the social worker or psychologist may intervene to help them look at their relationship with the patient and explore ways to improve them.

Nai Zindagi

3. A view of Nai Zindagi Drug Rehabilitation Center at Angoori

Background

Nai Zindagi, was established in 1990 as a total-abstinence based, 12-step, residential programme with twelve clients. Now, Nai Zindagi has a residential capacity of forty-eight clients in two facilities: one in Lahore and the other in Angori, near Islamabad. Usually, the programme at both the facilities has up to thirty-five clients at any given time, with an average monthly turnover of thirty clients per month.

Previously, the programme relied on the services of ex-drug users as counselors. Now, the programme tries to encourage non-drug users to become counselors. The staff at the Angori facility consist of a doctor who is a recovering addict, a treatment supervisor and an assistant treatment supervisor, a cook and other support staff. The Lahore centre's staff include a treatment supervisor who is also a doctor, an assistant supervisor who is a recovering addict, two counselors and other support staff.

Philosophy and Model for Treatment

The focus of the treatment programme is not so much on abstinence from drug use, as it is on enabling the person take small steps to improve his condition. In certain cases this may be a permanent improvement, and in other instances this may be a temporary change. For instance, if an injection drug user on the street, after coming in contact with the outreach worker, is no longer sharing needles that is a temporary improvement for that person. If the same person decides to come in for detoxification and is medically off drugs, this may yet be another improvement either a temporary or a permanent improvement in that person's life.

4. A picturesque view of Nai Zindagi Rehabilitation Centre at Angoori

For rehabilitation, the philosophy is to explore new areas or avenues to improve the client's present situation regarding family, job and other social responsibilities. The entire process of recovery treatment and rehabilitation is broken down into steps that appear to be achievable, making the person's progress observable or tangible for the client as well as for others concerned with the client's life.

The programme does not follow a specific model, instead it is entirely needs-based. The programme has taken different concepts from different models.

For two years the programme was also run as a therapeutic community but this was not a fruitful experience in terms of cost effectiveness. Each client was kept for 12 months with the recovery rate at that time being approximately 97%. The cost per client was 6,000 Rupees per month. The total turnover of clients during this period was not more than 24 clients per year and there was pressure to do more for more people. Now, approximately 15 clients are released per month from each facility. The level of recovery is much more practical in this instance with 45 to 50% of clients continuing their recovery.

Program Components

Outreach Services

The earlier “reception services” of the programme have now become “outreach services” . The programme staff working on the streets help street addicts by providing them with basic social and medical services. Those needing specialized medical services are assisted in obtaining these services. This contact is maintained for 4 to 6 weeks, helping the addict to stabilize, understanding his problems, contacting families, continuing medical assistance, providing clothes etc. Eventually, those addicts who show progress and willingness are selected and brought in to the residential programme.

Detoxification

Detoxification is primarily symptomatic, with no heavy dosage of any medicines

administered. Most of the drugs used are Brufen and Paracetamol as analgesics and Valium as a tranquilliser, along with other supportive therapy. At the fifth or sixth day of detoxification the person is free from most withdrawal symptoms. Detoxification is managed by senior recovering addicts. The time is also taken to help the client write his life story, employment history, financial situation and liabilities etc. At this stage the client is sent on a one week leave from the programme. Approximately 25% of the clients released do not come back for rehabilitation. Sometimes, the client decides to come back to the programme. When this happens, the returning addict has to complete a written assignment about why he returned to the programme and what was different this time around in the outside world. Those returning addicts who had used drugs while on leave are not given any medicines since they often experience only mild withdrawals.

Rehabilitation

Rehabilitation lasts for 6 weeks during which the client works further on his life story. The counselors work with the client on family issues, the client's personality and vocational issues. Other interventions during this period focus on the person developing inventories of his past deeds or wrongs, attendance at recovery groups, lectures on addictions and recovery, therapeutic duties etc. A client gets only one chance to enter into rehabilitation, so a person who has relapsed after graduating from the programme is not permitted readmission.

Vocational rehabilitation, which is variable and depends on the person's needs and aptitude, begins on the seventh week. The client is helped to select an area from the different vocational training sections the programme offers, e.g., carpentry, leather works, brass works, construction and wrought iron works etc. During the 3-month training period the person is given a stipend of 3,000 Rupees. Later the client is assessed in terms of his work and vocational skills and ability to turn out an acceptable quality of work. The person may be promoted to a full-time worker or encouraged to try and set up something on his own.

For most of the clients, especially those who do not require vocational rehabilitation, aftercare is non-residential. They may work 5 days and come into the programme for 2 days to review their progress in life.

Family Involvement

There is now a strong family component as an integral part of the programme. Currently 80 to 85% of the clients are coming from the street. When the outreach workers first come in contact with the drug addict, they record the addict's home or family address and send a letter to his family. Some 15 to 20% of family members thus contacted respond and contact the programme asking about the whereabouts or condition of their family member. When the same person comes in for detoxification, another letter is sent to inform the family that their family member is in detoxification.

During rehabilitation, the client goes home every weekend. Upon his return he is supposed to bring back his family. Some 75% of the family members return every Sunday for the families' programme. At the programme's seventh week, when the client is going into aftercare, the counselor tries to identify a family member, a key member, who will act as the family counselor, and will manage the aftercare programme for the client and other family members.

Experiences with Narcotics Anonymous

Previously, a main focus of the programme was Narcotics Anonymous meetings. In two years, it was found that Narcotics Anonymous meetings had become ineffectual and there was little perceptible progress in promoting non-use of drugs. Therefore, the approach was changed and a more methodical aftercare programme was developed.

Effectiveness of Programme

The programme's success rate is estimated at 45 to 50%. Approximately 65%, however, have moved forward in their lives, have jobs and are at least looking after themselves and their expenses.

Some possible reasons cited for the relative success of the Nai Zindagi programme are:

- The programme breaks the process of treatment into small, achievable and tangible steps
- Staff have regular contact with the client, and tailor interventions to their needs so that they themselves may see the progress achieved and the scope for further work
- There is flexibility in the programme but there is firmness as well. A client may go through detoxification any number of times but has a single chance in rehabilitation.
- Various tools taken from different programmes that seem to work have been integrated into the programme.
- Constant experimenting and programme review helps to maintain a high level of treatment.
- Good support from donor agencies and ability to market their programme.

Sadaqat Clinic

Background

Sadaqat Clinic is a privately-run drug treatment facility established in 1982 with in patient treatment facilities in four cities. The director of the clinic, Dr. Sadaqat Ali refused to divulge any information regarding the clinic's bed capacity, staffing or turnover of clients or other specific information on the programme's intervention except to discuss the broader concepts of treatment modality they were using. According to Dr. Sadaqat " there is no need to conduct any research or assessment. The only need is that people work and before that they may learn the work. There is no formal teaching or training programme on drug dependence at the undergraduate, graduate or post graduate level. We ourselves sought knowledge and tried implementing the programme."

Program Model

Sadaqat Clinic uses the Minnesota Model which was introduced by the Hazelden Foundation in Minnesota, USA. Essentially using the principles of self-help and Narcotics Anonymous , the programme looks at addiction as a disease, and "the patient requires some sort of help of a higher power in order to maintain or achieve sobriety". The model also aims at changing the person's drug behaviour by creating new social relationships.

The interventions provided during the 90-day programme include helping clients write their life stories and assess problems in various areas of the client's life. Treatment work focuses on the person's denial and tries to help him to accept his powerlessness over this addiction and to recognize the unmanageability in his life. Individual and group counseling, lectures on addiction,

psychological manifestation of drug-using behaviour in terms of guilt, shame, anger etc., and opportunities to the client to begin changing his behaviour and life are all part of the treatment programme.

The two areas in which the programme has not been very successful are the continuation of Narcotics Anonymous meetings by the clients who graduate from the programme, and involvement of the families of clients. The main reasons cited by Dr. Sadaqat Ali for this is that professionals, especially psychiatrists, and others who are considered authorities in the field of drug dependence treatment, have not endorsed the philosophy of the 12-step programmes and the model.

IV. IDENTIFICATION AND ANALYSIS OF MAJOR ISSUES

A. Institutional Capacity

Government Institutions

Drug Treatment Centres

Most of the drug treatment facilities in the public sector are situated within the departments of Psychiatry in teaching or district headquarters hospitals. Most of these institutions, being hospital based and having a case load of psychiatric patients, may not necessarily provide long-term in patient drug treatment services. The staff within these facilities are trained in psychiatry and, therefore, view addictive behaviours from that perspective. As an example, statements were heard from psychiatrists such as, "most of these patients have co-morbidity (underlying psychiatric illness) as the main cause of their addiction" or "drug addiction is a chronically relapsing disorder". These perceptions may limit the scope and nature of interventions a therapist will be providing to his and her clients. With a few exceptions all the government-run drug treatment facilities visited during the study either provided no in patient treatment or their interventions were limited to management of acute withdrawal symptoms.

The facilities affiliated with teaching hospitals, especially those of reorientation and training, do offer opportunities to provide ongoing institution-based training to service providers within the government and private sector in the areas of drug dependence treatment and rehabilitation. Similarly, personnel within these institutions, if trained in research methodologies especially qualitative and rapid assessment methodologies can undertake operational research in the areas of prevention, intervention and treatment and rehabilitation.

Prisons

The largest number of drug addicts to be found in any institution are in prisons throughout the country. They constitute somewhere between 20% and 40% of the total jail population. These large numbers are perceived to be a burden on the prison systems as they limit the space and resources to deal with other criminals in the criminal justice system. Most of the addicts are rounded up by police in their special drives to "clean up" and for the "record to look good" In some cases the families of addicts, after having tried and failed different treatment attempts, arrange for them to be incarcerated. Most of these addicts languish in the jails for prolonged periods, sometimes getting drugs within the prison system. They receive extremely limited services or intervention during this period that may help them look at and change their drug using behaviour. After their release from prison most tend to go back to using drugs.

The prisons do not have personnel who have either the orientation or training in such aspects of "correctional measures" required for the drug addicts. Currently, except for Peshawar jail, there are no programmes or services available in other prisons for treatment and rehabilitation of drug addicts.

NGOs

More than half of the organisations providing drug treatment services in Pakistan are located either in the private sector, or are working as not-for-profit organisations or as NGOs.

These organisations have differing levels of development and capacity in terms of providing drug treatment services. NGOs seem to be more receptive to learning new concepts and applying them in their service delivery. This is evident from the fact that most NGOs visited during this study, and in other assessments, were providing a range of services beyond medical interventions to their clients. However, many NGOs need training in concepts such as social and vocational rehabilitation.

Most of the NGOs are dependent on donors for their programme funding. As a result, their programme priorities tend to shift according to the areas in which funding is available. Regulation and monitoring of NGOs' activities by a coordinating and regulatory body has been an issue of long debate in the country.

B. Sustainability and Continuity

One major issue that organisations providing drug treatment and rehabilitation services in Pakistan face is the sustainability and continuation of their programmes. The momentum of their activities and the nature of services they provide have been waxing and waning by the amount of funding available. This is evident from assessing the impact of the past two major projects focusing on drug treatment programmes. For the NGOs this is a major issue since many do not have the orientation or the expertise to run their organisations as a business, or to apply careful financial management.

C. Coordination and Cooperation Mechanism

The Narcotics Control Division (NCD) and Anti Narcotics Force (ANF) have the mandate to deal with drug demand reduction issues as well as law enforcement and supply reduction initiatives. The NCD operates at the Federal level only, whereas the ANF is essentially a federal government organisation but has regional directorates in the provincial capitals. The delivery of health care is a provincial responsibility as are social welfare and education. There is an apparent absence of channels of communication, coordination and cooperation within the organisations at the policy-making level at the federal or provincial level, and at the operational level at the provincial or district level.

Organisations, whether NGOs or private drug treatment facilities, are more or less operating in isolation. Organisations have their own modus operandi and philosophies that may not necessarily be shared by others, and are often not forthcoming in sharing their programme experiences, resources or expertise. In the past years, some efforts at creating a coordination and cooperating mechanism between organisations were undertaken but did not achieve the desired results.

D. Political Commitment

A major issue with regard to the nature and quality of services which drug treatment programmes are offering, especially in the public sector, is the political commitment to address these issues. Given the overall state of health care delivery in the public sector and the pressing need for its improvement, drug treatment does not fall within the priority list of health care issues. Another reason why drug treatment and rehabilitation, especially the latter, does not get attention stems from a lack of understanding of its mechanisms, purposes and desired outcomes.

E. Community Involvement

The staff and service providers in all organisations affirm the need and importance for community involvement and community-based programmes. All agree on the essential involvement of social institutions such as family and religion in the treatment process, and community-based aftercare.

Notwithstanding this need, there is an apparent ignorance or lack of clarity about concepts, methods and approaches with regard to this issue. For instance, the involvement of family by many is seen as a way of keeping watch over the drug user after his release from treatment. Program staff do not necessarily comprehend the need for the family to understand addiction, the process of recovery and their roles in this process. For religious programmes, the focus is often on sermonizing and preaching by religious scholars which does not seem to effectively awaken the spirituality of the drug user.

Rehabilitation within the community is seen largely within the context of vocational rehabilitation. That, too, is often limited to teaching vocational skills such as carpentry, carpet weaving, etc., and is not necessarily based on the needs and aptitude of the client.

F. Lack of Research & Availability of Reliable Data

Most of the programmes maintain some basic records, usually consisting of the medical history and basic demographic data about their clients. Beyond this, very few programmes maintain data on outcome of interventions or on the overall recovery of their clients.

G. Successful Programmes

Some possible reasons for the relative success of some of the programmes highlighted during the study were:

- The commitment of programme leadership towards the programme, their facilitation of learning of new concepts, and their giving programme direction to apply and adapt these concepts.
- Opportunities for ongoing training as well initial training of programme staff in treatment and rehabilitation concepts.
- Regular financial support from donors as well as community support for the programme.
- A multi-disciplinary team providing the continuum of care needed for drug treatment and rehabilitation.
- Programme components addressing needs of the client with orientation towards community-based aftercare and rehabilitation.

V. STRATEGIES FOR FUTURE PROGRAMMING

Some broad strategies that could be adopted for future programmes are:

- Develop strategies for advocacy of demand reduction programmes, especially of treatment and rehabilitation, focusing on community-based approaches and development of the political will and commitment to address these issues.
- Create bodies at national, provincial and district levels to coordinate drug treatment services at their respective levels.
- Develop a core group of professionals from the public and private sector to look at various modalities, and to develop a generic training programme incorporating these modalities and approaches to drug treatment with special emphasis on community-based intervention, services and programmes for social reintegration and rehabilitation.
- Develop broad, general protocols for community-based drug treatment programmes that interested organisations can adopt and adapt.
- Develop demonstration projects at selected settings, demonstrating the principles and approaches for the selected modalities. An important component, besides training, needs to be operational research looking at the effectiveness of interventions and services provided.
- Provide assistance to organisations to develop their capacity for service delivery in terms of developing programme objectives and training of personnel in issues related to service delivery of particular components, financial and human resource development and management, linkages with community resources and organisations etc. Part of this assistance may take the form of financial support, materials and equipment to facilitate programme development and service delivery.
- Utilizing the general concepts of therapeutic communities, self-help groups and linkages with community organisations for aftercare, develop drug treatment and rehabilitation programmes at selected prisons in the country.

VI. OBJECTIVES, OUTPUTS AND ACTIVITIES FUTURE PROGRAMMES

Objective

To improve the service delivery of drug treatment programmes in Pakistan with special emphasis on organisations in the public and private sector (NGOs) in order to provide low cost community-based interventions for drug treatment and rehabilitation.

Output 1: Advocacy and Coordination

Advocacy and coordination of drug demand reduction programme with special emphasis on treatment and rehabilitation.

Activity 1: Develop Advocacy Strategies

Develop strategies for advocacy of demand reduction programmes especially for treatment and rehabilitation focusing on community-based approaches and to develop the political will and commitment to address these issues. Through one-day seminars and workshops, different decision makers in developing policy and provision of services both from the public and private sector should be brought to review existing components of programme delivery, desired or expected outcomes, and gaps in the service delivery. Part of the workshops' strategy should be to help organisations see the gaps and needs for improved service delivery of drug treatment and rehabilitation programmes. These seminars should be held at the national and provincial levels.

Activity 2: Develop Coordination Mechanisms

As envisaged in the National Drug Control Master-plan, another outcome of the national and provincial seminars and workshops should be the creation of multidisciplinary groups to develop coordination mechanisms for service delivery of drug treatment programmes at the national, provincial and district levels. The existing District Narcotics Control Committees, with a little modification in their composition and a shift in their current emphasis towards drug demand reduction and treatment and rehabilitation, may perform these functions at the district level. As they do currently, the district level body may meet once every month. The provincial body may meet every quarter and the national body once every 6 months to look at coordination mechanisms, issues, gaps, and improved service delivery of drug treatment and rehabilitation programmes.

Output 2: Institution-based Training & Mainstreaming

Provide institution-based training to service providers and mainstream organisations to address and provide services for drug treatment and rehabilitation.

Activity 1: Develop Core Group of Professionals

Develop a core group of professionals from related disciplines from the public and private sector to look at various modalities especially those addressing community-based approaches and modalities for drug treatment and rehabilitation. The core group should consist of professors of psychiatry, psychology, social work and sociology from selected teaching institutions, and representatives of established private sector programmes and NGOs.

Activity 2 : Develop Training Modules and Develop Protocols

The core group should then develop generic training modules addressing modalities and approaches for interventions and services for community-based drug treatment, social reintegration and rehabilitation programmes. The core group may look at the training modules developed by the Integrated Drug Demand Reduction Project and modules developed for Asian Regional Training Program on Addiction Rehabilitation (a joint project of UNDCP, ILO and Government of Malaysia). Besides the training modules, the core group should undertake development of broad, general protocols for community-based drug treatment programmes that it can recommend for implementation, monitoring and evaluation of these programmes. The national, provincial and local level coordination bodies can use these protocols.

Activity 3: Institute Multidisciplinary Training

Facilities within the teaching hospitals, university departments of psychology and social work, and NGOs having the institutional capacity will be supported to run training courses on treatment and rehabilitation concepts for interested individuals, service providers from the government and NGO-run facilities. The university departments can issue certificates and diplomas for undergraduate, graduate and postgraduate level studies in addictive behaviours and treatment of drug dependence. A special emphasis should be to develop a cadre of service providers whose expertise may be utilized for implementation of current programmes. The organisations and personnel trained under the IDDRP's training programme, and especially those of CITs, can be considered for involvement in the project. An important built-in component of these demonstration projects will be operational research to look at programme effectiveness.

Activity 4: Develop Demonstration Projects

Based on the training modules and protocols, the project should develop demonstration projects at selected places, preferably one in each province, which will act as training sites demonstrating the principles and approaches for the selected modalities. One such modality is linkage of a local NGO with a government-run treatment facility. The NGO may identify and refer patients for detoxification to the government hospital, whereas the government hospital may refer patients for follow-up and non-residential, community-based aftercare to the NGO. The overall responsibility for coordinating and monitoring of these projects should lie with the District Anti Narcotics Committees.

Activity 5: Develop Capacities for Programme Development, Implementation and Management

Provide assistance to organisations, based on their needs, to develop their capacity for service delivery in terms of developing programme objectives and orientation, training of personnel in issues related to service delivery of particular components (e.g., assessment, counseling, vocational rehabilitation, organisations, financial and human resource development and management, linkages with community resources and organisations, etc.). Part of this assistance may take the form of financial support, materials and equipment to facilitate programme development and service delivery. Additionally, provide opportunities in the form of annual seminars at the national and provincial levels for the supported organisations to share their

experiences and review progress in programme delivery.

Activity 6: Develop Programmes for Drug Dependent Prison Inmates

Utilizing the general concepts of therapeutic communities, self-help groups and linkages with community organisations for aftercare and social reintegration, develop drug treatment and rehabilitation programmes at selected prisons in the country. An important aspect of these programmes should be that the prison authorities take the lead in implementing them with the assistance of outside organisations having the capacity to implement them. The aim will be to develop personnel within jails who can continue provision of these services and programmes. After reviewing the relative success of these interventions, programmes may be replicated in other prisons and jails. The current programme in Peshawar jail, being run by the Dost Foundation, and an earlier programme run at Adiala Jail by Prisoners Aid Society with the assistance of IDDRP, may be reviewed when developing programme interventions.

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TREATMENT OF DRUG DEPENDENCE

Because of the fact that drug use has biological, social, psychological and spiritual aspects, treatment of drug dependence must address all these aspects. Interventions for treatment and rehabilitation, therefore, occur in different phases. These phases are identified below.

Acute intervention: Detoxification (to deal with the withdrawal symptoms as a result of the cessation of drug use).

Rehabilitation has two components:

Social Rehabilitation

Assessment: Screening and basic assessment of the major areas of an individual's life. These areas include medical, employment and support status; drug misuse; legal status; family and social relationships; psychological and leisure time utilization. Assessment is a collaborative effort between the client and counselor to identify the client's perceptions and the severity of the problems arising due to or resulting in drug use, and to develop plans to deal with these problems.

Counseling: Efforts to facilitate self understanding of the individual to realize his or her strengths and weaknesses, and to take better decisions regarding his or her life. Counseling includes that of the individual, group and family.

Relapse Prevention Training: Assessment of high-risk situations one may face in recovery. Developing plans and providing opportunities to practice new (drug free) behaviour.

Education: Educate family, friends and the recovering addict in addiction, recovery and their roles and responsibilities in recovery.

Vocational Rehabilitation

Assessment: Assessment of the educational, vocational skills, employment status and job pattern and history of the individual.

Tolerance: Job conditioning tolerance for job performance, work habits, responding and relating to supervisors and co workers, etc.

Skills Training: This may include skills related to finding job, preparing resumes and curriculum vitae, giving interviews, improving one's educational standards or employability in terms of vocational skills. Vocational skills training need to be based on the aptitude of the individual and market of a particular vocation in the community.

Selective Job Placement: Based on community linkage and market assessment (availability of jobs) and the aptitude of the individual. This may also include how to apply and look for jobs.

Maintenance:

Recognition of the gains in treatment, continuation of recovery with the aim of a drug-free lifestyle.

Aftercare: Providing ongoing support for recovery, addressing outstanding issues not dealt with during treatment, or new issues arising as a result of reintegration.

Two aspects of aftercare are:

Counseling: Related to current issues and situations

Self-help Groups: providing a supportive environment to continue recovery.

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