Developing a coordinated response to drug abuse in Pakistan

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Abstract
This paper describes moves towards the coordination of efforts to respond to the worsening drug abuse situation in Pakistan which affects all segments of society. The efforts reported seek to rectify inconsistencies in treatment policy resulting in unsatisfactory outcomes. Examples of collaborative strategies with encouraging results need further underpinning and expansion. There is, however, a lack of realization at the policy level of the need to effect changes in treatment formulated on a consistent and evidence-based approach. Policy has therefore been reviewed and proposals made for a comprehensive treatment strategy in line with international best practices to deal with this problem effectively and efficiently. Establishment of an addiction study centre at university level to continue professional and academic development is suggested.

Keywords: Coordinated treatment, drug abuse, Pakistan, policy

Introduction
Substance abuse is not a new phenomenon in Pakistan. People have long been abusing drugs for various reasons such as pleasure and recreation, social and religious customs, medical needs, personal necessities and psychological problems (Smith, 1984). The most commonly abused drugs are cannabis (hashish), bhang, psychotropic drugs, alcohol, opium and heroin and glue (sniffing) (Khalily, 2001). Some, like cannabis, opium and alcohol, have been used in Pakistan traditionally, but the problem became worse in the early 1980s with the introduction of heroin into the international market including Pakistan (Khalily, 2001). This has affected the social fabric of Pakistani society in every walk of life (Ahmed & Shafi, 1990). At the same time, dealing with this issue has been putting a tremendous demand on the health system. This paper draws attention to the gravity of the drug abuse problem in Pakistan and reviews the treatment response in the context of policy as an important aspect of demand reduction. It puts the drug problem in the milieu of major public health issues to cope with the emerging challenges. Suggestions are made for a comprehensive treatment policy that is practical, relevant to Pakistani culture, and in line with the international best practices with a good chance of success.
History of drug usage in Pakistan

The first national survey conducted by the Pakistan Narcotics Control Board (1986) reported 1.3 million regular drug abusers in Pakistan. Further breakdown of the data indicated that 3.4% of adult males regularly used hashish and that 1.3% were opium addicts. Another survey conducted by the Pakistan Narcotics Control Board (1988) revealed that the number of drug users had increased and reached 2.24 million in a short span of time with tremendous changes in the pattern of use. Despite all efforts to abate the problem, the illicit use of drugs has increased day by day and reached an alarming number of addicts estimated at 3.01 million (Narcotics Control Division, 1993). The figures showed an increase of 0.76 million since 1988. They further indicated that 1.52 million people used heroin as the first choice of drug and .89 million charas (hashish). It is estimated that currently there are four million addicts in Pakistan, many of whom inject their drugs. The current figures show that there are 156,500 injectable drug users in Pakistan. Many addicts aged 16 to 30 years live on the streets (Anti Narcotics Force Islamabad, 2006–07). In addition to the social and familial consequences of drug misuse, it is now a public health issue.

Changing modes of administration also create new challenges. In Pakistan, traditionally, the popular mode was smoking or snorting (Pakistan Narcotics Control Board, 1988), but the latest figures show that the number of injectable drug users is increasing, especially in the urban areas but also throughout the country (Anti Narcotics Force, 2006–07). Subsequently, the risk of contracting and spreading hepatitis (Mohammed & Suzanne, 2008) and HIV infection (Currant & Hardy, 1988) has increased. The problem is now highly complex presenting a range of challenges demanding multifaceted strategies (Abbott & Chase, 2008). Two main strategies have been adopted in Pakistan; supply reduction mostly by the law enforcement agencies to minimize the easy availability of illicit drugs (Anti-Narcotics Force Islamabad, 1995); and demand reduction where treatment is one of the core approaches.

Drug treatment approaches

Different organizations in Pakistan, including public health facilities, non-governmental and some private sector organizations, are providing treatment for addicts. The public facilities are mostly located in psychiatric units of teaching and districts headquarter hospitals. These facilities are available all over the country including the tribal areas (United Nation Office for Drug Control and Crime, 2000). They provide detoxification, which is mostly symptomatic treatment, plus general counselling in a few centres. There is no uniform treatment policy which is mostly influenced by the training background of the psychiatrists (United Nations Office for Drug Control and Crime, 2000). The disease model (Jellinek, 1960) has prevailed in all treatment facilities, which provide two-week detox programmes in 10–20-bed units. There is no formal training (European Monitoring Centre for Drugs and Drug Addiction, 2003) or third-level degree programme in addiction treatment in the whole country although the United Nations Office for Drug Control and Crime (2005) has trained personnel from government and non-governmental organizations for this purpose through various projects.

Some non-governmental organizations run addiction treatment centres, but few have staff trained in this field (European Monitoring Centre for Drugs and Drug Addiction, 2003), provide community-based detoxification, outpatient counselling or are involved in harm reduction activities. Most are dependent on foreign donors with little financial support from the government. A few private clinics provide institutionalized detoxification for those clients who can afford to pay for treatment. Again, the disease model is dominant.
Nevertheless there is a collaborative effort among governmental departments and non-governmental organizations.

**Collaborative strategies**

Some government agencies run detoxification programmes and outpatient clinics collaboratively, for instance, the Health Department, the Social Welfare Department, and the Anti Narcotics Force. In addition to this inter-departmental collaboration, there are some programs run as public-private partnerships. Two non-governmental organizations are involved prominently, Nai Zindagi Lahore (1990) and Dost Foundation Peshawar (1992) which follow the psychosocial model and run different projects in collaboration with different departments of the Pakistan government. Some of their projects are being sponsored by foreign-donor agencies, for instance UNODCCP (United Nations Office for Drug Control and Crime Prevention) and from the European Union, the USA, the UK and GTZ (German Technical Cooperation). These organizations are innovative and flexible in their approach towards treatment policy in comparison with the governmental organizations and have been attempting to deal with the emerging challenges in the context of public health problems. They have introduced street-based harm reduction strategies, residential programs, community detoxification (Nai Zindagi Lahore, 1990; Dost Foundation, 1992) and socio-economic rehabilitation. They also run training and public awareness programmes in collaboration with different departments of the government of Pakistan and with international organizations. Keeping in mind the socio-cultural background, the Dost Foundation (1992) has a separate program for women and children and a residential program for a significant number (United Nations Office for Drug Control and Crime, 2000) of addicts in the prisons. Some other NGOs in Karachi, Quita, and Ralwalpindi work in collaboration with governmental and foreign-donor organizations, but their activities are sporadic and confined to one city. The NGOs are independent in their policy formulation and decision-making. They can introduce innovation and make changes in their treatment policy although this freedom is sometimes influenced by the sponsoring agency.

There is a pressing need to monitor and to evaluate the outcome of these collaborative efforts (European Monitoring Centre for Drugs and Drug Addiction, 2003) in order to widen such activities all over the country and extend treatment services (McLellan, Arndt, Metzger, Woody, & O'Brien, 1993). This may loosen up the existing treatment system and suggests the possibility of an extended and consistent collaborative approach to strengthen and further enhance the existing public-private partnership.

**Effective treatment strategy**

An effective treatment policy expedites the recovery process and leads to a productive life. It includes detoxification under medical supervision followed by treatments that include medication and behavioral therapies (Bickel et al., 1997) and a relapse-prevention plan. Medically assisted withdrawal is not a treatment in itself, but a step forward in the treatment processes. Easing withdrawal during detoxification may diminish cravings and help to reestablish normal brain function (Horspool et al., 2008). While the main objective of the treatment is to enable an individual to attain lasting abstinence, the immediate goals will be to reduce drug use, minimize the physical and social harm and improve the individual’s ability to function (National Institute on Drug Abuse, 1999).

The best treatment plan then provides a combination of therapies and other services to meet the needs of the clients. The following presentation from the National Institute on
Drug Abuse (NIDA, 1999) shows components of an integrated treatment plan, which could be considered in treatment policy formulation keeping in mind cultural and infrastructure considerations (Figure 1).

Some efforts have been made by the Drug Abuse Prevention Resource Center in Islamabad (DAPRC), and more recently a Model Treatment Center (Anti-Narcotics Force, 2006–7) established near Islamabad to replicate its model in the country, but limited to a few yearly public awareness seminars and walks on “Narcotics Day”.

There is, however, no academic, professional or third-level course in Pakistan at university level to study these problems profoundly and to work out treatment solutions compatible with the culture (Heath, 2001) and in line with international standards (Edwards, 2000). A center of excellence is needed to provide diploma, masters and doctorate-level courses to study addiction in depth in the context of culture, to sensitize the policy makers, and to carry on continuous professional development for those working in the health and medical, law and justice, labour and social welfare and environmental departments, and non-governmental organizations.

**Conclusion**

Addiction frequently changes its form creating new challenges for the people working in this field (Anti Narcotics Force Islamabad, 2006–7). In response, people working in the addiction field need to be flexible and innovative (Edwards, 2000) in policy and practice rather than stick to the old treatment model of unproven worth. Continuous collaboration is needed between governmental departments with governmental and non-governmental organizations to formulate a consistent treatment policy, keeping in mind the current challenges and treatment of proven efficacy.
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References


