



A Critical Evaluation of the National Drug and Alcohol Rehabilitation Programme in Saudi Arabia

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❖ Abstract:

the national drug and alcohol rehabilitation programme in Saudi Arabia seems to have had only modest success. The reasons for this are multiple and arise from the many obstacles, traditional, religious and broadly cultural, that stand in the way of significant progress. It seems evident that, despite the efforts and resources it has expended, there has been only limited commitment on the part of the government in terms of pragmatic response to developments and changing conditions. While significant funding and expertise have gone into providing facilities for the recovery of sufferers, this has not been matched by wider measures to implement programmes of education and instruction to drive attitude change among the wider population. In addition, it is clearly essential in the field of healthcare programs that close monitoring and evaluation is critical in obtaining the best results, if only because it helps to ensure that the targeted group or groups are reached. Such monitoring and evaluation seems to have been in short supply and therefore incapable of being acted on effectively via provision of necessary structures to ensure that the outcomes are aligned with the goals. Given that the Saudi Ministry of Health plans to extend its rehabilitation programme by adding 14 more hospitals to its current 3, it will need to address the



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above shortcomings in order both to move forward with the country's rehabilitation programme and, above all, to prevent a worsening of the problems associated with drug and alcohol dependency.

❖ **Introduction**

Drug abuse, including alcohol, is an epidemic disease whose effects are not usually limited to the individual but extend to their family and society at large. The steady upsurge of drug taking from one year to the next, especially among the young, is widely documented, (Bennett, 2000; Clark, Pollock, Bukstein, Mezzich, Bromberger & Donovan, 1997; Fitzgerald, Hough, Joseph & Qureshi, 2013;). Drug-related problems also cause huge waste of resources, both human and financial (McLellan, Lewis, O'Brien & Kleber, 2000; World Health Organisation, 2003; 2006). This applies not just to countries of the advanced Western world where the problem is known to be rife but also to countries such as Saudi Arabia where, for various reasons, one might not expect to find the problem.

Alcohol and drug use are categorically forbidden by Islam, and since addictive behaviours are socially stigmatizing in Muslim countries, where they exist they tend to be concealed by those involved (Al-Qaradawi, 1999; Valentine, Holloway, & Jayne, 2010). This can in turn have the effect of interfering with the representativeness of population screening methods, and consequently the reported incidence rates of substance abuse. In general, in fact, addiction research is lacking in the Arab world despite known and increasing substance use and the literature is small and largely descriptive in nature. Nevertheless, there is now enough evidence from studies carried out to alert Arab and Muslim communities to the realities and the magnitude of the drug problem in Middle Eastern countries (Al Arabi, Al Hamedi, Salas & Wanigaratne, 2013; Al-Krenawi & Graham, 1997; Al-Krenawi, Graham & Shwail, 2002; Al-Marri & Oei, 2009; Bilal, Makhawi, Al-Fayez & Shaltout, 1990; Stylianou, 2004).



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Against this background this essay seeks to provide an evaluation of the National Alcohol and Drug Rehabilitation Programme in Saudi Arabia which began as far back as 1985 but has gathered momentum in more recent years. It provides a background to and description of the programme and its rationale looking at specific aspects of it and how these may be contributing to its success or failure. It then goes on to discuss how the Saudi government is succeeding, or otherwise, in obtaining the engagement of the public in the programme and how important that may be in ensuring its effective delivery.

❖ **The Rehabilitation Programme**

Traditionally in Saudi Arabia convicted drunkenness has been punished by flogging in public. In the mid 1980s, as part of the rehabilitation programme then initiated, a new judicial ruling concerning alcohol and drugs was brought in. While imposing even harsher punishments than hitherto, ranging from fines and/or short term imprisonment for first-time drug dealers and retailers to life-imprisonment or even the death penalty for smugglers and importers, for drug or alcohol sufferers it ensured secure, confidential and free treatment of substance-use problems in the Al Amal hospital in the city of Riyadh with all facilities for treatment available under one roof. This also had the goal of eliminating the social burdens associated with substance misuse. The hospital programme was organized to provide care in a number of different units tailored to suit the patients' needs as they progressed in treatment and has since been established in three specialised hospitals in Saudi Arabia (Elakad & Kobeisy, 2013). In Riyadh there is a total bed capacity of 428 with all treatment protocols carried out by multidisciplinary professionals. All admittance and treatment furthermore is vouched as confidential by law under strict data protection regulations to ensure anonymity of patients, with any information leaked potentially resulting in prison sentence (Saudi Home Office, 2014).

The first of the units mentioned above is for assessment and detoxification and has had three functions. Firstly it undertakes comprehensive preliminary assessment of the patient by a multidisciplinary team to identify areas of strength and weakness that can form the basis of an



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individualized treatment plan. Secondly it provides patients with effective and safe management of withdrawal manifestations according to the approved hospital policy for detoxification relying mainly on objective rather than subjective manifestations (Abdel-Mawgoud, 1994). Thirdly, it seeks to focus therapeutic interventions within the disease concept of addiction and confrontation of denial.

The second unit centres on early, short-term rehabilitation. On completion of assessments and safe detoxification and as the patient starts to acknowledge the illness, they move to this unit, whose main function is to restructure the patient's life in a drug-free environment. The unit relies on the principles of the CENAPS model in which the patient is seen as someone who has been using substance for so long that their body only feels normal in the presence of the substance. Through its highly structured drug-free environment, the patient begins to feel normal and to enjoy activities in the absence of the substance.

The third unit, the convalescent one, involves trying to rebuild the patient's health and ability to function in everyday activity, which could involve physiotherapy, counselling and training in health living.

The fourth unit seeks to provide patients with continued care. As patients progress in the short-term rehabilitation unit, they are gradually introduced and exposed to a less structured, longer-term rehabilitation in the continued care unit. Its main function is to help them re-settle in their environment and focuses on the concept of relapse prevention through helping the patient to develop viable and effective alternatives to their addictive behavior as proposed, for example, by Marlatt & Gordon (1985). Therapeutic interventions rely on a cognitive behavioral psychotherapy approach using as its main techniques coping skills training and improving self image and confidence, as well as the handling of craving. The movement of patients from one unit to the next is based on their ability to grasp the concepts of treatment through a gradual exposure process and the treatment team spirit of care and protection.



The fifth unit is for aftercare where addicts return to the hospital for morning sessions. This stage takes 6 to 18 weeks. There is also a halfway home for patients who are rejected by their families or those who do not have a home. They are hosted for up to 6 years until they can find job or the relations with their relatives improve.

Additional units which may be appropriate for some patients are: (a) for dual diagnosis dealing with health conditions which may accompany the addiction (e.g. mental health, AIDS, hepatitis, liver failure); (b) tailored specifically to women's needs (e.g. religious requirements, privacy, pregnancy) and run by highly-qualified and trained women; (c) designed specifically for adolescents where their needs may be considered different from older patients; (d) for security, where for example, the addict is admitted through the police and they may have a criminal case pending. Apart from this last unit, treatment in all other units is entirely voluntary (Saudi Gazette, 2014).

More broadly, in the context of all these units, a number of complementary treatment modalities are made available to patients, as considered appropriate. These include:

- 1 continued use of some quantity of the offending substance where indicated by the patient's physical and psychiatric needs, especially in the detoxification phase;
- 2 community meetings, with daily group activity attended by all patients and staff addressing day-to-day problems in the unit;
- 3 group therapy sessions that utilise group dynamics to induce changes in attitude and behaviour as well as emotional changes;
- 4 individual psychotherapy sessions as part of an individual's treatment plan;
- 5 educational activity consisting mainly of a daily session covering a range of topics related to better understanding of the addiction;
- 6 recovery groups where special group therapy sessions focus on relapse prevention issues;



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7 family therapy whereby, when possible, sessions with family members are used to restore or develop a functional and healthy family system;

8 religious and spiritual groups, given that religious and spiritual awareness are held to assume an important role in patients' recovery, with religious counsellors conducting group sessions and encouraging patients to renew and continue their religious activities via such means as daily prayers and the availability of religious literature;

9 activity therapy, which seeks to assist patients in developing a drug-free lifestyle through involvement in structured and unstructured activities such as art and physical education;

10 biofeedback, cranial electrotherapy stimulation and auricular acupuncture, all non-pharmacological measures used to attempt to reduce patients' suffering, especially the in early stages of treatment, and train them to control their anxieties (Brumbaugh, 1993);

11 self-help groups with step counselling and regular AA/NA meetings conducted for both inpatients and outpatients by chemical dependency counsellors and AA/NA volunteers.

❖ **Success or failure?**

There are anecdotal indications that the treatment regime for alcohol and drug dependent patients in the Al Amal hospitals has, since it was established, had a significant impact in terms of rehabilitating those who have undergone the treatment. There may therefore have been a marked change in patient attitude and a good recovery rate with little evidence of later return to addiction officially if generically reported. However, this remains to be proved evidentially, since as pointed out in a recent article, there are still no reliable studies evaluating drug prevention or treatment programmes in Saudi Arabia, or indeed in any of the Arabic countries (Al Gaferi, Osman, Matheson, Wanigaratne & Bond, 2013). But even if some change may have been achieved in the area of patient attitude, the questions still arises what effect the programme has had on public attitudes to drug and alcohol dependency, given that wide public knowledge of and confidence in such a programme is inevitably a crucial factor in its success.



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One way of approaching this may be by looking at the information available on alcohol and drug use in the country over the last 25-30 years. If we first go back to a 20-year old study, we find that, among 740 students questioned about substance abuse, knowledge and awareness about the risks of drug addiction was extremely limited and it was their religion, Islam, which was stated as playing a major role in the prevention of substance addiction (Al-Subaie & Al-Hajjaj, 1995). Since then however, studies undertaken suggest that, despite a far wider knowledge about drug addiction having developed, especially among young people, the prevalence rates of alcohol and substance misuse in Saudi Arabia and in the whole region have increased rapidly (Al-Harathi & Al-Adawi, 2002; Al-Marri & Oei, 2009; United Nations, 2011). Reasons given for this include unprecedented rapid social and economic development in the Gulf region together with influence of other cultures (Berry, 2008), geographical proximity to opiate producing countries such as Afghanistan, the young age of the population and the social changes and stresses associated with it.

A number of paradoxes arise from the situation that prevails. Firstly when the rehabilitation programme was first initiated, the new approach being adopted was not enough to counter decades of the issues being ignored or swept under the carpet. So the myths, misinformation and misunderstandings regarding addicted patients continued to lead to stigmatisation and to the prevention of open discussion of important issues. This in turn further contributed to denial and neglect on the part of society and fear and suffering for the dependent and their families. Further, the emphasis in this programme on toughness of laws for certain offences (supplying, importing, etc.), and indeed the fact that Islamic Sharia rules forbid consumption of alcohol or other addictive substances increased people's fear of being seen to have anything to do with drug issues and created the danger of scapegoating drug-addicted individuals for a range of social problems, rather than seeing that they or their families might need rescuing from an addictive disorder. This is a pathology that has continued until the present day, at least among certain sections of the population. At the same time, however, as social and economic developments have continued at a rapid rate with increased opening to the wider world, the overall mentality is



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that chemically dependent individuals have come less and less to be considered criminals than was the case in the past. More than anything else - and this is perhaps the major paradox - it is the actual increase in drug use and not any government action or Ministry of Health programme) that over the last two decades has created a form of awareness. Recent research on the characteristics of addicted patients highlights this paradoxical aspect and suggests the need to consider its positive as well as its negative aspects (AlMarri & Oei, 2009; Valentine et al, 2010).

With regard to the pathology of fear and denial among families in Saudi Arabia, it is clear that the continuation of this is closely associated both with the veto on alcohol and drugs by Islam and a concern that one's reputation or name might be besmirched by any association at all with alcohol or drugs, or indeed with mental health difficulties generally. This runs extremely deep, to the extent that many families, if they can afford it, prefer to access medical help for drug or mental problems in their family outside of Saudi Arabia. The question that raises itself therefore is whether the Saudi government, notwithstanding the country's religious culture, has the will and the ability to educate and inform Saudi society in as impartial and objective a way as possible on these issues. If the old cultural practices surrounding them continue, this can only slow down, if not negate, the objectives of any alcohol or drug rehabilitation programme. Looking at this from the health perspective, there is a manifest need for the government to raise the alarm about the continuity of certain cultural practices that clearly encourage delay in people seeking help for addiction with the risk of the development of further complexities. However, to a significant degree, the government hampers itself in this area by the relative paucity of official data it produces regarding drug and alcohol use and so by limiting any awareness there may be of the extent of substance abuse in the country. What limited statistics there are coming from the Saudi Ministry of Health show a substantial increase in specialised psychiatric hospitals, outpatient visits and inpatient admissions in 2011 compared to 2007 (Ministry of Health (Saudi Arabia), 2011). Some of this increase could be due to problems related to alcohol and substance abuse, but in the absence of any clear breakdown, the magnitude of substance abuse remains uncertain.



What is clear however is that, in order to widen the reach and positive effect of its rehabilitation programme, the Saudi government needs to incorporate into it some significant sensitization of its citizenry. It needs to broaden of the scope of the programme so that it not only focuses on the encouragement of people to seek medical help from available hospitals and rails about the dangers of drugs to the rest of the population but also embarks on educational programmes (other than religious) that could prevent people, especially young people, going down the road of alcohol or drugs. This could – probably should – take the form of a sustained information and publicity campaign to educate the Saudi public in the effects of alcohol and drugs (mainly hashish and heroin) and in particular explain why it is undesirable that alcohol and drug dependency should be an ongoing feature of Saudi society. Above all the government needs to be not just reactive in responding to what is clearly a growing problem but proactive by having specific policy goals and offering preventive mechanisms to reduce the cases of alcohol and drug abuse. More than anything the programme is likely to be most effective if supportive policy structures such as the development of effective systems of monitoring and evaluation of the progress of its progress are developed. When such mechanisms are put in place, it then becomes easier for the programme to record progress and to develop and promote policies that can enhance the level of the public reception and understanding of the programme. There have in recent years been many areas of Saudi healthcare which have seen radical improvement. leading the authors of a report on this to point out that ‘health services in Saudi Arabia have increased and improved significantly during recent decades’ and ‘as a consequence, the health of the Saudi population has improved markedly’ (Almalki, Fitzgerald & Clark, 2011: 785, 792). Incorporation of the steps suggested above in the larger health care policy in the country could boost the pace at which the broader goals of the drug and alcohol rehabilitation programme are realized.

It should also be noted that the other challenge with regard to the status of the programme, given the norms and culture of the society, is the level at which people are willing to accept the



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existence of the problem within the family and try to seek help from the facilities available. Islam plays a key role in the lives of Saudi families and the involvement of religious leaders in the implementation of the programme is likely to result in better outcomes. The involvement of those religious stakeholders requires the creation of consensus between healthcare experts and religious leaders in order to promote a common understanding that enhances the level at which the programme gains acceptance and a following from the broader public (Atighetchi, 2007).

❖ **Conclusion**

Overall the national drug and alcohol rehabilitation programme in Saudi Arabia seems to have had only modest success. The reasons for this are multiple and arise from the many obstacles, traditional, religious and broadly cultural, that stand in the way of significant progress. It seems evident that, despite the efforts and resources it has expended, there has been only limited commitment on the part of the government in terms of pragmatic response to developments and changing conditions. While significant funding and expertise have gone into providing facilities for the recovery of sufferers, this has not been matched by wider measures to implement programmes of education and instruction to drive attitude change among the wider population. In addition, it is clearly essential in the field of healthcare programs that close monitoring and evaluation is critical in obtaining the best results, if only because it helps to ensure that the targeted group or groups are reached. Such monitoring and evaluation seems to have been in short supply and therefore incapable of being acted on effectively via provision of necessary structures to ensure that the outcomes are aligned with the goals. Given that the Saudi Ministry



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