WHAT IS IRAN DOING ABOUT DRUG ABUSE

Iradj Siassi, M.D.*

* Professor of Clinical Psychiatry,
University of Pittsburgh, USA
and
Deputy to Minister of Health & Welfare
for Mental Health, Iran

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As in other countries a clear estimate of the present prevalence of opium addiction in Iran is impossible to give. However, the latest Ministry of Health & Welfare figures show that the number of legal opium addicts which had reached a peak of more than 180,000 in 1976, has now been reduced to 150,000. These addicts constitute the population of the opium maintenance program in Iran. The conservative estimate that twice as many individuals are dependent on illicit supplies makes opium addiction to-day's most pressing public health problem in Iran. We are acutely aware of the seriousness of this threat to our country and believe that the government has a clear responsibility in meeting this threat head on. In the past few years the Government of Iran has been heavily engaged in coordinating its efforts with international drug control programs and vital steps have been taken in coordination of a multipronged attack on the problem. These included the following measures:

1. A Cabinet level council was established to develop national anti-addiction goals and recommend programs for implementation.
2. Anti-addiction programs were centralized under an independent and more powerful anti-addiction administration.

3. Treatment programs were strengthened to serve as lead agency on national drug problems
4. Efforts were directed towards promoting a new cooperation in anti-addiction efforts between the law-enforcement authorities and the judiciary. This was to ensure that the police would have the full support of the courts against apprehended smugglers and known drug pushers, so that the government's efforts to lower drug supply will not founder on a failure of prosecution.
5. Finally, Ordinance was issued in 1976 for a more stringent distribution of opium to registered addicts in order to minimize the abuse of opium maintenance program. Specifically, the Ordinance (a) prohibited the issuance of new coupons to individuals under sixty years of age; (b) cancelled immediately the opium coupons for all registered addicts under 50 years of age; and (c) placed a maximum ceiling of opium dosage of 5 grams per day for all remaining and registered addicts under 60 years of age.

TREATMENT

Until four years ago, inpatient detoxification was the only treatment service offered to addicts in Iran. The treatment facilities were delapidated, and grossly under-staffed. Years of neglect had taken their toll in pessimism and despair among both addicts and poorly trained treatment staff. In 1974 a critical assessment of the addiction treatment programs was undertaken, and

as a result the responsibility for the treatment and rehabilitation of drug addicts was transferred from the Ministry of Health to the National Iranian Society for Rehabilitation of the Disabled (NISRD). The first steps taken by NISRD were to renovate the facilities and increase the number of available beds. Simultaneously, well-trained and experienced staff were recruited Moreover, intensive on-the-job training was initiated for both the existing staff and newly hired para-professionals.

In addition, plans were made for construction of new treatment centers in Tehran and provicnes.

Table I shows the expansion of the inpatient capacity for the treatment of the drug addicts since the takeover of responsibility by NISRD.

Such improvements, while necessary as the first step, were hardly sufficient as an effective treatment policy. Moreover, the concept of inpatient detoxification had itself come under scrutiny. Some of the problems noted with inpatient detoxification were as follows.

Given that ¼ or ½ of the 2-3 percent of adult population addicted to opium, can in theory at least be considered candidates for inpatient detoxification, the capacity for such intervention did not exist at the time. Outside of the NISRD hospitals devoted to addicts, little or no capacity existed for inpatient detoxification The existing facilities together with facilities projected for the near future could not provide hospitalization

for even five percent of the opium addicts in a given year. Without realistic or positive alternatives, it appeared inevitable that the remaining 95 percent of the addicted population would continue to suffer and to spread their addiction to other members of society. In addition, the effectiveness of inpatient detoxification had never been demonstrated In view of the lack of capacity to hospitalize these individuals, it appeared that outpatient treatment provided the only positive alternative It was uncertain whether massive funding and heroic efforts to create more beds would be either successful or cost-efficient.

With the above considerations in mind, we embarked on a massive program of providing outpatient services to addicts throughout the country. Table II gives a summary of this continuing effort.

The emphasis placed on outpatient treatment in the evolving programs, however, went beyond the above considerations. It was not only expediency that dictated the need for extension of services. Even if there existed the capacity to develop the thousands of inpatient beds required for the treatment of addicts in an inpatient setting (an impossible proposition), we still would have opted for the expansion of outpatient services. Since 1970, the experience with outpatient detoxification has proved not only equal but superior to inpatient services for addicts in countries that produce reliable data on treatment outcome. Outpatient detoxification with its implied freedoms and its emphasis on self-reliance has a great advantage over inpatient services: patients are forced to assume more self-responsibility.

For the majority of patients who are candidates for outpatient treatment as well as the smaller number who need hospitalization, the detoxification phase of the treatment constitutes but a relatively small beginning step

Many addicted individuals, regardless of the causes of their addiction, need special services to help not only with their dependence on opiates but also with their social incompetence and the emotional maladjustment that are frequently corollaries to their addiction. Since addiction is rarely a temporary condition, exclusive reliance on short-term solutions such as inpatient detoxification, not unexpectedly have met with universal failure.[1,2,3] What follows is a brief description of a comprehensive program of services which is (or will become) available to the addicted individuals who seek help from NISRP.

Medical: Diagnostic evaluation are undertaken with prompt attention to any medical needs of the patient concurrent with the detoxification program (irrespective of whether detoxification is carried out in an inpatient or an outpatient setting).

Psychological: Individual and group psychotherapy, occupational therapy, and recreational therapy, as well as education and learning opportunities for the addicts are to be provided. Moreover, since addiction is a chronic disorder, there is a need for practical supportive counseling and advice to families. Therefore, outreach programs to provide counseling or therapy for patients, spouses, or significant others in the patient's life are an integral part of our comprehensive programs.

Vocational Rehabilitation: Preparation of the unemployed or under-employed addict for gainful employment is now a major goal of treatment. For example, Yaftabad Center has the physical capacity for vocational training of more than a hundred individuals at any given time It is backed up by all the vocational rehabilitation facilities of NISRD. The majority of addicts who complete their vocational training at Yaftabad are able to more directly into competitive employment.

There are some criticisms of the new treatment program for the addicts. These criticisms may be viewed in terms of two separate arguments. The thrust of the first criticism is based on a rather naive economic argument which, as will become apparent, is ill-founded when applied to this medical field. These critics abhore the idea of using highly skilled medical staff and personnel for treatment of addicts. They rightcously argue that allocation of scarce health personnel for the treatment of more or less physically healthy individuals sharply conflicts with the order of priorities in the face of so many unmet medical needs. Such arguments, however, ignore the fact that with the successful control of major infectious diseases in Iran, the addiction epidemic looms as our number one public health problem. It is a joke to contend as some of these critics actually do, that addiction will be "contained" by such things as development of strict punitive measures for addicts

When the issues focus specifically on spending for addiction programs, the arguments presented by these critics are a monument to the misapplication of the ill-understood. They go all out for less

expensive modes of addiction treatment. Comprehensive treatment programs are without doubt quite costly On the other hand, patients may be warehoused and kept quiet on sedatives quite inexpensively. Such care, while deceptively inexpensive when viewed solely in terms of the cost of keeping one addicted individual in a hospital per day, is in reality enormously expensive. Inferior medical care is always expensive, largely because it makes for chronicity which impoverishes purse, health and spirit. In the final analysis, these critics fail to understand or notice the negative impact of poor treatment programs on the national anti-addiction effort in particular, and thereby on the quality of life as a whole.

The thrust of the arguments by the second group of critics are directed against the outpatient addiction treatment programs. The excesses of these critics may be explained against the backdrop of mistaken assumptions and beliefs about the superiority of inpatient over outpatient detoxification and treatment. All these stem from the lack of familiarity of these critics with new approaches to treatment of addiction.

The ambulatory detoxification of individuals who have developed a physical dependency is not a new one As early as 1970, Gay et al (4 had treated 450 patients in the Heroin Detoxification Clinic in San Francisco, on an outpatient basis.

It is generally agreed (5,6,7) that withdrawal or detoxification is a necessary step at some point during the treatment of addiction, but rarely if ever, should detoxification in itself be considered an adequate treatment for a drug dependent individual. Viewed as a

step in the social rehabilitation of the drug dependent individual, it would appear that the success or failure of the overall treatment process may have little relationship to whether the detoxification takes place in an inpatient or an outpatient setting. Review of the available literature supports this contention, since there are no reports showing greater success in the long run for patients who are detoxified on an inpatient basis versus those who are detoxified in an outpatient unit It is therefore our position that in the absence of the complicating medical illnesses which may require hospitalization, or the concurrent addiction to generalized CNS depressants whose withdrawal at present is usually carried out in an inpatient setting, the advantages of ambulatory detoxification over the in-hospital technique far outweigh the disadvantages. The major advantages of ambulatory detoxification are its greater acceptability over hospitalization for an overwhelming majority of narcotic dependent individuals, and its significantly lower cost. These advantages, we believe, far outweigh any gains from the admittedly closer observation of the patient and greater control over his continuing drug abuse, which are afforded by an inpatient unit.

The major lesson to be learned from assessment of these criticisms, is that in clinical fields, constructive criticism cannot proceed from a priori commitment to a particular ideological stance or treatment approach. The most important ingredient of criticism here should be research and clinical experience. We are making every effort to ensure that the major policy thrusts of the new anti-addicti program remains directly founded upon our research findings and

clinical experience. More importantly, in order to ensure the success and flexibility of the [illegible] addiction program, a massive basic evaluative research is being implemented in order to monitor side-effects of the new program and correct its unforeseen shortcomings.

In summary, over a relatively short period of time, many important preliminary steps have been taken which have drastically improved the quality and availability of treatment facilities and services. These accomplishments, however, play only a small part in a national anti-addiction program. Such a program must consist of an integrated public policy package aimed at primary prevention, control of drug supply, and treatment and rehabilitation of addicts. Each of these areas is an integral part of the multi-faceted addiction problems. Failure in any one area will adversely affect performance in the remaining areas. Therefore, unless a concerted effort is carried out to coordinate policies and activities in all these inter-related areas, the fate of the new anti-addiction campaign in Iran will not be much different from those in the past.

COMMENT

Modernization, urbanization and affluence of the past decade, has had as one of its undesirable side-effects in Iran the emergence of western patterns of drug abuse such as abuse of alcohol, heroin and psychotropic drugs. Nevertheless, opium addiction has remained by far the most salient and perennially persistent drug problem in Iran.

Contrary to prevalent myth the problem of opium addiction in Iran

does not date back to recorded history, and abuse of opium is not part of Persian cultural heritage. Use of opium did not go beyond medicinal purposes until less than a hundred years ago, when for the first time the abuse of opium for recreational purposes was initiated and encouraged by forces of colonialism and imperialism. Once initiated the abuse spread with alarming speed to the extent that by 1955 out of a population of approximately 20 million people, it was estimated that there were 1.5 million opium abusers, roughly 7% of the population.[8] Although this estimate does not have any scientific underpinnings, nevertheless the problem was of such staggering dimensions that the Iranian parliament took the radical step of outlawing the cultivation of opium poppy, and use of opium completely. Predictably it took two to three years for the law to be fully implemented, but the results were immediate and dramatic. Suddenly, opium became unavailable to the ordinary man and woman in the country, and within a short time large areas of the country became totally free of this scourge. Since no large organized network for smuggling opium into the country existed, only the well-to-do addicts could continue to indulge their habit through the scarce and expensive contraband opiu[m]. With opium in plentiful supply in neighbouring countries, however, it was not long before large organized criminal networks came into existence, and gradually not only opium, but the easier smuggled heroin became available in the illicit market. The law-enforcement and anti-narcotic units found themselves engaged in an uphill and losing battle and the Iranian government became increasingly more alarmed. As the number of addicts began to climb, and the economic and social costs

continued to rise and vehement protests to the offending neighbours went unheeded, the Government as a desperate act of self-protection proposed a new law to the parliament which would allow for registration of addicts and limited cultivation of opium proportionat to the needs of these registered addicts At the time that this law was approved by the Parliament in 1968, the number of opium addicts in the country had climbed to an estimated 400,000 with an additional 12-20 thousand heroin addicts. At the time it was clearly declared by the Iranian government that the law was a temporary one and would only remain in force for so long as the neighbouring countries continued to produce opium, and that production of opium in Iran would cease immediately if the neighbouring countries agreed to a ban on their opium production. The chief supplier of illegal opium to Iran in 1969, Turkey has since switched to the "straw" method of harvesting its opium, thus making its opium unsuitable for recreation purposes, but its share of the illegal opium market has been more than filled by the other two opium producing neighbouring countries of Afghanistan and Pakistan.

The Iranian decision to outlaw production of opium, had salutary and dramatic results, but it also showed that in the absence of regional and international cooperation, a single country is powerless in eradicating this public health problem within its borders. A regional ban on the production of this destructive substance of abuse is urgently needed, but the numerous overtures of the Iranian government and its steadfast urging for such a ban has, so far met with little success. As fellow professionals who have seen at first hand the

destruction and devastation that opiate addiction brings to the individual and his family and have witnessed the havoc it causes in the society, I hope that you will use whatever persuasive powers you have to convince your governments to respond to our loud and persistent pleas from Iran for a regional ban on opium production.

Our friends in Afghanistan and Pakistan must come to realize that we and they are dealing with a serious and hazardous public health problem. Unless they put an end to their illegal trafficking of opium, our efforts in Iran will continue to remain foolishly quixotic.

Table I

Expansion of hospital beds in the last 3 years for treatment of addiction in Iran.

Center	No. of Beds in 1974	No. of Beds at the end of 1977
1. Vanak	120	120 → 80
2. Naftabad	0	500 → 300
3. Rezaieh	60	150
4. Rasht	15	80
5. Sari	30	60
6. Mashed	40	60
7. Isfahan	30	40
8. Tabriz	0	100
9. Karadj	0	500
10. [illegible]ahedan	0	50
Total:	295	1,650 > 1420

Table II

Comparison of Outpatient Slots
between 1974 and at the end of 1977

	Centre	Province	No. of slots in 1974	No. of slots at the end of 1977
1.	Rezaieh	Azarbaijan	0	1,200
2	Tabriz	"	0	1,200
3.	Kermanshah	Kermanshahan	0	1,200
4.	Hamadan	Hamadan	0	2,400
5.	Vanak (Tehran)	Central	0	2,400
6.	Yaftabad (Tehran)	"	0	2,400
7.	Seyed Khandan (Tehran)	"	0	1,200
8.	4th of Aban (Tehran)	"	0	1,200
9.	Ghom	"	0	600
10.	Kashan	"	0	1,200
11.	Semnan	Semnan	0	1,200
12.	Mashed	Khorassan	0	2,400
13.	Kerman	Kerman	0	1,200
14.	Isfahan	Isfahan	0	1,200
15.	Yazd	Yazd	0	1,200
16.	Zahedan	Sistan Baluchistan	0	1,200
17.	Bandar Abbas	Hormozgan	0	1,200
18.	Shiraz	Fars	0	2,400
19.	Ahwaz	Khuzistan	0	1,200
20.	Rasht	Guilan	0	1,200
21.	Sari	Mazandaran	0	1,200
	Total:		0	30,600

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