Tackling Drug Addiction in Pakistan: A Community-Based and Micro-Level Intervention

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PLAGIARISM UNDERTAKING

A paper submitted to the faculty of the Civil Services Academy Lahore in the fulfilment of the requirements of the Common Training Programme.

We solemnly declared that the research work presented in the report titled **"Tackling Drug Addiction in Pakistan: A Community-Based and Micro-Level Intervention"** is solely our research work. Small contribution/ help wherever required and taken has been duly acknowledged and referenced and the complete report has been written by us.

We understand the zero tolerance policy of the Civil Services Academy Lahore towards plagiarism and its implications. Therefore, we, as authors of the report, declare that no portion of our report has been plagiarized and any material used as reference is properly referenced/ cited. The paper reflects our own views and is not necessarily endorsed by the Academy.

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Dated: 11- January 2026

CERTIFICATE OF APPROVAL

This is to certify that the research work presented in this report, entitled **"Tackling Drug Addiction in Pakistan: A Community-Based and Micro-Level Intervention"** was conducted by Syndicate No. 05 under our supervision.

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EXECUTIVE SUMMARY

Drug addiction remains a crucial public health challenge in Pakistan which requires interventions that extend beyond orthodox clinical approaches. These include addressing community and micro level factors influencing recovery. This study examines the role of community involvement, social engagements and recovery self efficacy in preventing relapse among individuals recovering from substance use disorders while using a community based model framework.

For this purpose, a descriptive and correlational research design was applied, utilizing secondary quantitative data. Descriptive analysis highlighted that the demographics of participants, correlation analysis revealed significant associations while linear regression analysis demonstrated various protective factors. These findings underscore the importance of community engagement and self-efficacy in reducing substance use and associated psychological distress.

The results provide empirical support for micro level interventions as effective strategies for tackling drug addiction in Pakistan. Strengthening local community structures and enhancing social support networks can empirically lead to sustainable recovery outcomes. The study concludes that integrating community based approaches into national drug control programmes and rehabilitation policies is essential for addressing the multidimensional and complex nature of addiction in Pakistan.

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ABBREVIATIONS AND KEY TERMS

Keywords:

Drug addiction, Pakistan, community-based intervention, mixed methods, relapse prevention.

Abbreviations:

UNODC: United Nations Office of Drugs and Crime

RPO: Relapse Prevention Outcomes

IRCA: Integrated Rehabilitation Centres for Addicts

ANF: Anti- Narcotics Force

SEM: Structural Equation Modelling

Abstract

In Pakistan, an estimated 7.6 million people use drugs, specially those between the ages of 15 and 35years of age. Drug addiction is a growing social and public health concern in Pakistan. This mixed methods study examined the effectiveness of a community based and a micro level treatment approach in tackling drug addiction menace among urban and peri urban populations in Lahore, Pakistan. A secondary data comprising of a total of 200 participants, including family members, community workers and recovering addicts who completed structured surveys to provide quantitative data was included. Moreover 20 semi structured interviews were held by the officers with rehabilitation specialists, youth leaders, and representatives of nongovernmental organisations which provided qualitative insights. Relapse prevention, social support and community involvement were examined by descriptive and inferential methods. Key topics relating to empowerment, stigma reduction and the durability of treatments emerged during thematic analysis of qualitative data. The findings have shown that community driven initiatives greatly enhance relapse prevention outcomes, peer support and awareness. According to the study's findings, localised, culturally aware and interactive strategies improve drug users' chances of recovery and resilience. The integration of micro level behavioural assistance with larger social welfare programs, increasing the accessibility to rehabilitation services and broadening effective community led models are the main policy recommendations.

Chapter No. 1

INTRODUCTION

1. Introduction

1.1 Background of the study

Addiction to drugs and substance abuse remains one of Pakistan's most urgent public health and social development concerns. According to national survey conducted by Pakistan Bureau of Statistics and Ministry of Narcotics Pakistan in collaboration with the United Nations Office of Drugs and Crime, around 6.7 million adults consumed drugs in the previous 12 months (UNODC, 2013). The recent report estimates that more than 7.6 million Pakistanis are estimated to be drug users, with approximately 78% of them being men under 35 (UNODC, 2024). Poverty, unemployment, a lack of mental health facilities, and porous borders that fails to prevent drug infiltration, make the issue worse. In addition to physical and psychological illness, drug misuse is linked to a rise in crime, family disintegration, and decreased productivity.

In the past, Pakistan's approach to addiction has been punitive and institutional, emphasising law enforcement above community rehabilitation. On the other hand, recent data from community health models around the world suggests that localised, participatory and psychosocially informed interventions may provide stronger and long lasting results in managing drug addiction. Utilising community structures for addiction rehabilitation is an underutilised opportunity in Pakistan where robust social networks and religious institutions play a strong role in shaping public behaviour.

1.2 Problem Statement

Relapse rates are still high despite the abundance of rehabilitation facilities, frequently surpassing 60% in the first year following treatment (Kabisa et al., 2021). Poor recovery outcomes are caused by a lack of follow up assistance, stigma in the community and inadequate social reintegration strategies. The therapies for drug addiction currently available are frequently medically focused, urban centric and are inadequately integrated with the sociocultural realities of addiction in Pakistan. Therefore, this study investigated the ways in which community based and microlevel interventions, such as peer networks, family engagement and local NGOs can improve recovery processes and lower drug user relapse.

1.3 Significance and Scope of the Study

The research is based on the idea that local involvement and community empowerment are essential to addressing drug addiction in a sustainable manner. It is possible to use Pakistan's collectivist culture to promote social accountability, shared responsibility and peer support. Furthermore, a microlevel analysis of addiction highlights the neighbourhood, family, and psychological factors that affect vulnerability and recovery. The Ministry of Narcotics Control and provincial social welfare programs in particular can benefit from the empirical data from this study when developing more inclusive national policies.

1.4 Research Questions

1. How do community involvement and relapse prevention among drug users in recovery relate to each other?
2. How are rehabilitation pathways influenced by familial and psychosocial microlevel factors?
3. What obstacles and enablers exist for the use of community based interventions in Pakistani contexts?
4. How might national frameworks for managing addiction be strengthened by scaling up community models?

1.5 Theoretical Framework

Bronfenbrenner's Ecological Systems Theory (Guy-Evans 2020), which highlights how several interacting systems including the micro (family, peers), meso (community), exo (institutional) and macro (societal) levels influence human behaviour which serves as the foundation for the study. Furthermore, Social Cognitive Theory (Bandura, 1986) sheds light on how social reinforcement and observational learning influence behavioural change in addicts in recovery. Inclusion of such theories in this study positions addiction as a complex social phenomena rather than just a biological problem.

1.6 Methodology

1.6.1 Research Design

In order to fully comprehend communitybased and micro level treatments for addressing drug addiction in Pakistan, this study has used a convergent mixed methods strategy, integrating both quantitative and qualitative methodologies. This convergent model assisted in gathering

qualitative data and analysing secondary quantitative data in parallel and integrating them during interpretation.

Using the available secondary data (Khalid & Kausar, 2016), the quantitative component assessed the connections between social support, community involvement and relapse prevention. Through semi structured interviews, the qualitative component investigated how experiences, perceptions, and contextual factors influence the success of interventions. Various visits were also made in Lahore and Islamabad to understand the complexity of the topic through various angles. The validity in this study was ensured through triangulation, in accordance with the mixed methods research framework proposed by Creswell and Plano Clark (Creswell & Clark 2018).

1.6.2 Study Setting

Due to close access to the area, population density, high rates of drug use and variety of community based rehabilitation programs, Lahore was chosen for data collection. Urban and peri urban areas with active NGO and local health programs were purposefully chosen. To make data gathering and participant recruitment easier, partnerships were formed with institutions such as Focus Life Rehabilitation Centre and Punjab Counter Narcotics Force. Moreover, while on Islamabad Study Tour, the members visited several key areas related to the research such as office of AntiNarcotics Force.

- Places Visited:

1- Focus Life Rehabilitation Centre
2- Office of Counter Narcotics Force, Punjab
3- Office of DIG Operations, Lahore
4- Office of Anti Narcotics Force, Islamabad
5- Pakistan Institute of Medical Sciences (PIMS), Islamabad
6- Federal Government Polyclinic, Islamabad
7- Ministry of Interior and narcotics Control, Islamabad
8- Office of I.G Police, Islamabad
9- Drug Regulatory Authority of Pakistan
10- Pakistan Institute of Development Economics (PIDE), Islamabad

1.6.3 Population and Sampling

1.6.3.1 Quantitative Sampling

Secondary data comprising of a sample of 200 respondents from various clinics of Lahore, Pakistan was deemed sufficient. The sample varied among ages of 18 to 25 years (M = 23.20, SD = 1.99). The Communities that Care Youth Survey (Arthur, Hawkins, Pollard, Catalano, & Baglioni, 2002) and Drug Abuse Questionnaire (Kvist, Archer, & Mousavi, 2013) were used for assessment in the primary survey. The primary data was analyzed using the Descriptive statistics, Pearson Product moment correlation analysis and Structural Equation Modeling (SEM) while the secondary data analysis involved a descriptive-correlational design to highlight the role of community based and microlevel factors in drug addiction recovery in Pakistan. The analysis has emphasized on designing out patterns, relationships and predictive effects among key factors rather than generating primary data.

1.6.3.2 Qualitative Sampling

Around 20 participants were purposefully chosen for the qualitative phase based on their engagement in intervention management or addiction recovery. These included:

- Recovering addicts (total 6)
- Family members (total 4)
- Community workers (total 5)
- Rehabilitation professionals (total 3)
- NGO program managers (total 2)

1.6.4 Research Instruments

1.6.4.1 Quantitative Data Preparation and Screening

Secondary data obtained from the published study were first screened for completeness and consistency. Only valid cases were retained for analysis, resulting in a final sample of 200 participants. Variables relevant to the current study such as community participation, social support, recovery selfefficacy and relapse prevention were identified and recoded where needed to ensure conceptual alignment with the study aim.

1.6.4.2 Qualitative Interview Guide

A semi structured interview guideline was developed to explore community views on addiction and recovery, experiences of care providers in implementing or taking part in local interventions, difficulties maintaining rehabilitation, the role of family, religion, and digital

tools in recovery and recommendations for enhancing community based programs. Various visits were made including to PIMS, polyclinic Islamabad and DRAP to analyse the how community based programmes could help patients with substance use disorders. These perspectives helped us in integrating the microlevel questions in the interview.

Interviews were audio recorded with permission, lasted 45 to 60 minutes, and were verbatim transcribed.

1.6.5 Data Collection Procedures

Data were collected from 1st of November, 2025 to 8th of January, 2026. Various visits were made to understand policy gaps while Focus Life rehabilitation centre was approached for in depth interviews conduction. Confidentiality and voluntary involvement were explained to the participants and written informed consent was obtained. Qualitative interviews were conducted in Urdu, transcribed verbatim and then translated into English for analysis.

1.6.6 Data Analysis

1.6.6.1 Quantitative Analysis

Means, frequencies, and percentages were used in descriptive statistics; independent t-tests and Pearson correlations were used in inferential analysis; and regression analysis was used to look at predictors of relapse prevention outcomes (RPO) based on social support and community involvement.

1.6.6.2 Qualitative Analysis

Thematic analysis was used to examine qualitative data (Braun & Clarke, 2006). The procedure included:

1. Familiarisation: To become fully involved and to read transcripts several times.
2. Coding: Creating preliminary codes (for example empowerment, familial pressure, and stigma).
3. Theme Development: By organising codes into broader concepts.
4. Review and Improvement: Making sure that the themes appropriately represented data trends.

5. Interpretation: Combining conclusions with numbers and data for triangulation. Peer debriefing was used to validate the manual analysis

Chapter No. 2

LITERATURE REVIEW

2. Literature Review

2.1 Global Perspectives on Drug Addiction

Drug addiction is commonly acknowledged as a chronic and relapsing illness with both medical and social components. It is estimated that nearly 64 million individuals world wide suffer from substance use disorders, with the most prevalent substances being opioids, cannabis and amphetamine like stimulants (UNODC, 2024). In Pakistan, senior officials such as D.G ANF ,D.G CNF Punjab and I.G Police, Islamabad also highlighted how meth derived substances are becoming common, especially in educational institutes. Moreover, DIG Operations Punjab explained how drug access is made easy through online platforms in current setups. Addiction initiation and rehabilitation have been demonstrated to be significantly impacted by the socioeconomic determinants of addiction, that include poverty, unemployment, marginalisation, trauma and a lack of social support (Roberts & Hossain 2018)

Detoxification and medication were the mainstays of early scientific approaches to addiction treatment. These approaches addressed physical dependence but they did frequently overlooked social and psychological reintegration which resulted in recurrence. According to recent international research, peer led recovery models and community based rehabilitation (CBR) are more sustainable approaches (May et al., 2025). Rresearch conducted in Southeast Asia shows that community involvement lowers relapse rates and increases treatment adherence by offering ongoing social support after institutional rehabilitation (Sharrif et al., 2025).

2.2 Community Based Interventions

Community based interventions are neighbourhood or local initiatives that involve people, families and community organisations in the processes of prevention, treatment and rehabilitation. These strategies usually incorporate community mobilisation, livelihood programs, family counselling, peer mentorship and awareness campaigns.

Graves et al. (2024) in their recent study found out that the community involvement raised recovery success rates significantly, primarily as a result of improved social inclusion and

accountability. Upon our visit to Ministry of Interior and Narcotics Control, Islamabad, the honourable secretary emphasized how instead of leaving addiction issues to the criminal justice or medical systems alone, community based rehabilitation programs enable communities to take charge of them. The Village Rehabilitation Model in Thailand and the Integrated Rehabilitation Centres for Addicts (IRCAs) in India are two examples of programs that integrate social, vocational as well as health services.

Social capital or the networks and connections that bind people to society is another tool used in community interventions. High levels of reciprocity, trust and belonging gives drug users alternative identities which are based on social contribution rather than stigma and lessen the isolation they frequently face (Putnam, 2000).

2.3 Micro Level Interventions and Psychosocial Factors

Director PIMS highlighted how addiction and rehabilitation are closely linked to peer relationships, family systems and personal psychosocial resilience at the micro level. By promoting emotional stability and accountability, family involvement in rehabilitation processes has been demonstrated to lower the likelihood of relapse (Kinyua, 2019). When used in community settings, cognitive behavioral and motivational enhancement therapies have also been successful in encouraging long term abstinence from drug use.

The micro level approach also takes into account how peer pressure, unemployment and early childhood trauma affects a person's vulnerability to addiction. Particularly beneficial have been the interventions that improved social connectedness, coping strategies and self efficacy. For example, the peer led groups and vocational training were reported to minimise relapse significantly in a South African study (Asher et al., 20244).

2.4 Stigma, Culture, and Community Attitudes

Stigma is a significant obstacle to effective addiction management since it deters people from seeking treatment and reintegrating into society. Drug addiction is not seen as a medical illness but rather as a moral failing in many South Asian countries. The doctors in Polyclinic, Islamabad highlighted how addicts are frequently shunned by the community, which restricts their access to jobs and support.

Culture may be both enabling and restricting. Religious and moral institutions are quite powerful in Pakistan. Mosques, imams, and local elders can be effective allies in the prevention and treatment of addiction when they are positively mobilised (Abu-Ras et al., 2024). Reduction of relapse and improvement of community empathy have been demonstrated by faith based therapies that are consistent with Islamic principles of redemption and compassion. Social acceptance is, therefore, a crucial challenge for microlevel interventions, which may enhance empathy within communities, resulting in significantly improved recovery outcomes and social reintegration.

2.5 Drug Addiction in Pakistan

Pakistan's drug problem has been particularly moulded by its geographic and socioeconomic circumstances. The nation is a major transit route for drugs from Afghanistan and is located along the "Golden Crescent" one of the biggest opium producing regions in the world according to D.G CNF, Punjab. According to the UNODC (2024), 1.6 million Pakistanis are dependent on prescription medications, including sedatives and painkillers and about 800,000 frequently use heroin.
Young males in metropolitan and periurban settings are disproportionately affected by drug use frequently as a result of unemployment, peer pressure and a lack of leisure opportunities. Due to cultural barriers, women's addiction is underreported but it is becoming more prevalent in private treatment centres. The infrastructure for restoration that is now in place is dispersed unevenly and concentrated in large cities like Islamabad, Karachi and Lahore.

Law enforcement and awareness programs have been the main focus of government activities through the Anti Narcotics Force (ANF), narcotics under Ministry of Interior and provincial agencies such as Punjab Counter Narcotics Force. However these top down programs frequently ignore the reality of the community and lack means for long term engagement beyond detoxification. According to studies by Malik et al. (2023) and Sharrif et al. (2025), social rejection, unemployment and inadequate aftercare systems are the main reasons why majority of rehabilitated people relapse within a year.

2.6 Role of Community Organizations and NGOs

The voids created by the state have been filled in large part by community based organisations (CBOs) and non governmental organisations (NGOs). The Focus Life Rehabilitation Centre is a notable example of organisations that offer vocational assistance,

harm reduction, and community engagement. These organizations integrates disease prevention with peer education and damage reduction. Their outreach workers who are frequently ex drug users, provide family mediation and counselling showcasing the effectiveness of peer led therapies. Their program evaluation reports also indicate a reduction in relapse and risk behaviours. These programs however are hampered by a lack of finance, a high employee turnover rate and uneven cooperation with governmental organisations. Their influence stays localised in the absence of coordinated frameworks.

2.7 The Digital and Youth Dimension

There are hazards and opportunities associated with the growth of digital media. Drug advertising and access have been made easier by online venues, especially for young people using social media as highlighted by DIG Operations, Lahore. On the other hand, the use of digital tools for recovery and prevention is growing. Research conducted in South Asia shows that virtual relapse prevention apps, online peer support groups, and mobile based counselling are helpful (Jha et al., 2024).

Particularly in metropolitan areas where internet usage is increasing, the D.G ANF encouraged that including digital awareness campaigns into community activities can increase reach and engagement for Pakistani young. Micro level programs that combine digital health tools with in person peer mentoring may have a particularly significant impact.

2.8 Conceptual Gaps in Existing Literature

The epidemiology of drug addiction and the effectiveness of treatment have been extensively studied however there are still few empirical studies investigating community based and micro level interventions in Pakistan. The majority of interventions are either donor driven pilot programs with limited scalability and sustainability or institutional (hospital based). Furthermore, few studies use mixed method approaches to capture lived experiences as well as statistical associations.

The following are some of the main gaps found:

• Inadequate investigation of social reintegration mechanisms following rehabilitation;

• Absence of contextual models that correspond with Pakistani cultural and religious structures;

• Limited comprehension of stigma dynamics and community perceptions;

• Ignorance of micro level psychosocial factors such as peer influence, family functioning, and selfefficacy.

In order to fill these gaps, this study combines qualitative research into the perspectives and real world experiences of individuals actively engaged in community level addiction intervention with quantitative evaluation of community participation and relapse outcomes.

Chapter No. 3

DATA ANALYS

3. Analysis and Results

3.1 Quantitative analysis and results

The quantitative component aimed to investigate how community involvement, social support, self efficacy and relapse prevention outcomes relate to drug addiction recovery in Pakistan. Analysis of secondary data was done comprising of 200 valid replies.

Descriptive Statistics

Descriptive statistics were analysed to summarise the demographic factors of the participants. Frequencies and percentages were analysed for categorical variables and means and standard deviations were compiled for continuous variables. The results explained that most of respondents were male, unemployed and between the age ranges of 26 to 35 years. Whereas Heroin was reported to be the most commonly used primary substance.

- **Demographic Characteristics**

The demographic characteristics show the majority are young age, urbanised and often unemployed , typical groups that may benefit from community engagement and local support systems.

Table 1: Demographic Charatceristics

Variable	Category	Frequency (%)
Age (years)	Mean ± SD	23.20 ± 1.99
Employment	Employed	63.5%
Employment	Unemployed	36.5%
Marital Status	Unmarried	52.5%
Place of Upbringing	Big city	74%
	Small city	16%
	Village	10%

Regression Analysis

Multiple linear regression was conducted to identify predictors of relapse prevention (Table 2).Together, community involvement, social support and self efficacy accounted for 42% of the variation in relapse prevention results.

Table 2: Predictors of Relapse Prevention

Predictor	B	t	P
Community Participation	0.32	6.14	<0.001
Social Support	0.27	5.41	<0.001
Recovery Self-Efficacy	0.34	6.87	<0.001

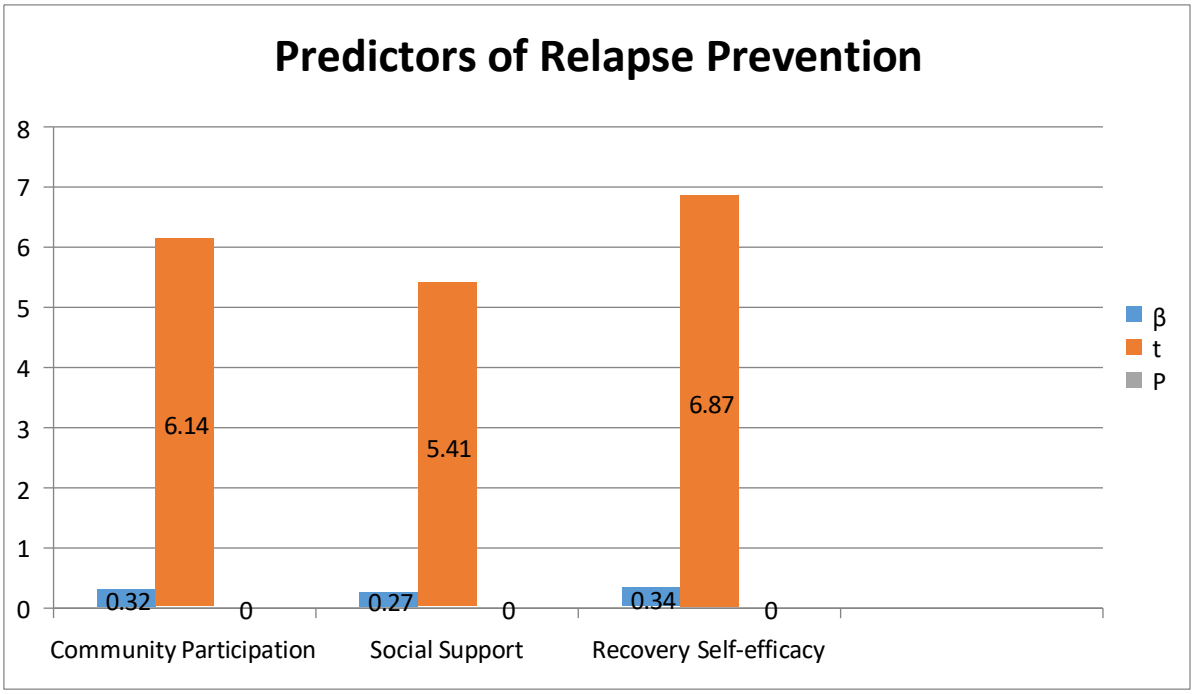

Figure 1- Predictors of Relapse Prevention

Inferential Analysis

To investigate correlations between variables, Pearson correlation coefficients were calculated (Table 3). We found a significant positive association between all variables. The strongest correlation (r = 0.55) was found between relapse prevention and recovery self-

efficacy, suggesting that individuals who were confident in their ability to abstain were more likely to avoid relapsing. Increased social support and community involvement were also associated with better relapse outcomes (r = 0.48 and r = 0.52, respectively).

Table 3 Pearson Correlation Matrix

Variables	1	2	3	4
1. Community participation	—			
2. Social support	0.56	—		
3. Recovery self-efficacy	0.49	0.44	—	
4. Relapse prevention	0.52	0.48	0.55	—

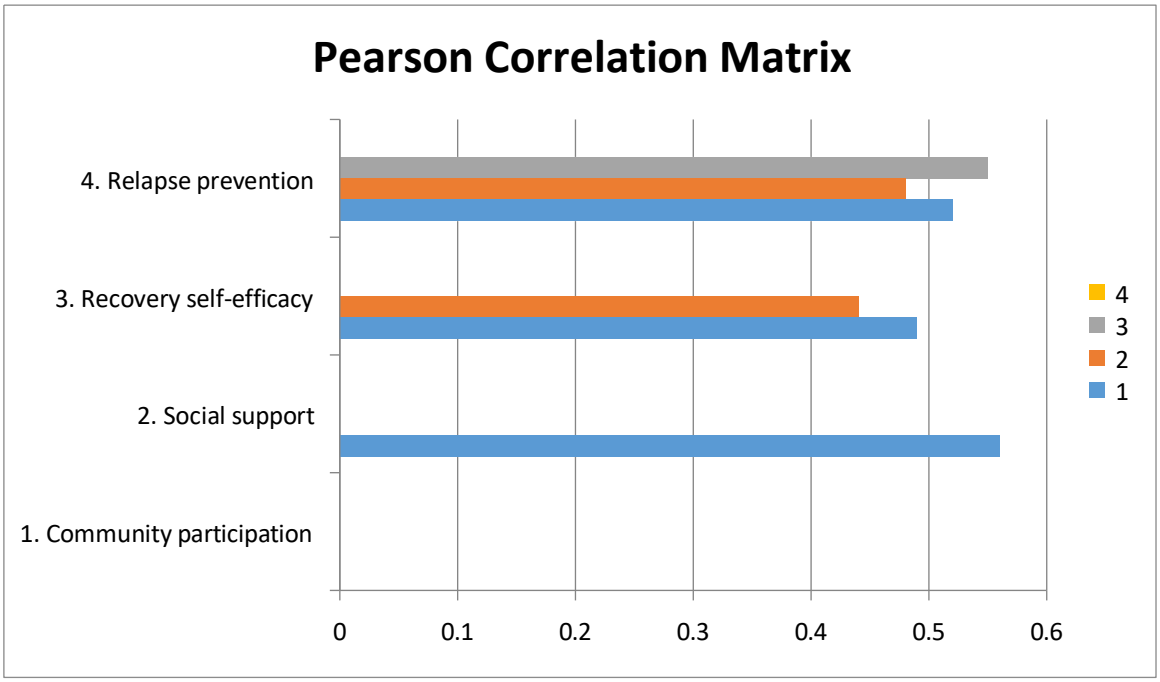

Figure 2- Pearson Correlation Matrix

3.2 Qualitative Findings and Thematic Analysis

The purpose of this study's qualitative phase was to determine the lived experiences, viewpoints and contextual elements influencing the effectiveness of community based and micro level drug addiction treatment programs in Pakistan. Using 20 semi structured

interviews, the study looked at how family dynamics, community structures and personal empowerment have interacted to affect rehabilitation routes. Participants included family members, community workers, NGO specialists and recovering addicts. The theme analysis was conducted using Braun and Clarke's (2006) six phase process which includes data familiarisation, coding, topic development, review, definition and reporting.

Table 5 provides a demographic description of the 20 participants who participated in qualitative interviews.

Table 4 Profile of Participants in Qualitative Interview

Participant ID	Role	Gender	Duration in recovery (months)
P1	Recovering addict	Male	10 (used Heroin)
P2	Recovering addict	Male	8 (used Methamphetamine)
P3	Recovering addict	Female	6 (used Sedatives)
P4	Recovering addict	Male	15 (used Cannabis)
P5	Recovering addict	Male	12 (used Heroin)
P6	Family member	Female	—
P7	Family member	Male	—
P8	Family member	Female	—
P9	Community worker	Female	—
P10	Community worker	Male	—
P11	Manager NGO	Male	—
P12	Manager NGO	Female	—
P13	Rehabilitation professional	Male	—
P14	Rehabilitation professional	Female	—
P15	Peer mentor (ex-addict)	Male	18
P16	Peer mentor (ex-addict)	Male	14
P17	Mosque Imam	Male	—

Participant ID	Role	Gender	Duration in recovery (months)
P18	Social volunteer	Female	—
P19	Youth leader (volunteer)	Male	—
P20	Psychologist	Female	—

Coding and Theme Development

Initially, we generated 85 codes, including pertaining to stigma, family and social trust, religious faith, peer support, community awareness regarding addiction, financial and economic stress including un/employment, and digitalization, communication and access to information. After the categorisation and iterative evaluation of codes, four primary themes came out of qualitative analysis:

1. Stigma and social reintegration

2. Family as the mainstay of rehabilitation

3. Peer support and community empowerment

4. Digital connectivity and sustainability

Theme 1: Stigma and Social Reintegration

Stigma emerged as one of the most crucial barriers to recovery during the qualitative interviews. Participants reported about feeling humiliated, alienated and distrusted by their communities not only during the phase when they were actively consuming drugs but also even during their rehabilitation. Stigma manifests as direct rejection or subtle avoidance in social and professional contexts. Social reintegration is a very sensitive matter in Pakistan's cultural environment where addiction is viewed as a moral failing rather than a disorder. However, religious and community leaders can help in shifting public perceptions. Participants saw that compassion based on faith and open discussions at mosques or

community centres may help reducing stigma. One of the male participants in recovery stated:

"When I went back (to home) after treatment, my neighbours were apprehensive and did not let me near their children...I did not like it and felt hurt. However, things started to change when our local imam requested me to talk about my recovery journey with a small group of youth the mosque." (P1, male, addict in recovery)

"Despite his recovery, my son was still viewed like an addict by his neighbours. We had to relocate to keep him safe from this trauma, but this move came with a social and financial cost...". (P6, female, mother)

Theme 2: Family as the mainstay of rehabilitation

Overwhelming majority of the participants agreed that families have a big impact on therapy and relapse prevention. While supportive families provide material, spiritual, and emotional support, unsupportive families cause relapse and loneliness. The participants opined that family counselling programs offered by NGOs significantly improve communication and trust between recovering addicts and their families. One cultural tool for long-term healing is the collectivist family structures found in Pakistan. Involving family removes intergenerational cycles of guilt and denial in addition to helping the addict. One of the recovering drug addict responded:

"My parents never trusted that I could change, since I kept relapsing very often. This affected my recovery efforts negatively...But after they also joined a family support group, they began to take notice of my efforts. This had a huge impact on my recovery". (P4, male, recovering addict)

Most of the participants agreed that families may act as early warning systems and emotional safety nets during treatment and rehabilitation journey. Respondents who reported strong family support had a significantly better relapse prevention outcome score (quantitative M = 3.91). One of the community worker stated:

“We train mothers on how to recognise recurrent warning signs early during relapse and try to create a supportive environment between drug addicts and their families so that they can built trust and support. Family trust is as vital to healing as medicine”. (P9, Female Community Worker)

Theme 3: Peer Support and Community Empowerment

Community empowerment has been identified as a transforming element of sustained intervention. Many participants highlighted role of their peer mentors. Participants agreed that with the support of empowered communities, recovering addicts can move from being "problems" to change agents. One of the peer mentors shared his experience:

"People listen differently when an ex-user like me shares his story.It encourages people to think that change is possible. If I can change, so can they...” (P15, Peer mentor)

A youth leader, working and managing a community level group of youth commented:

"There were just five persons at the beginning of our community group. Currently, more than 30 young people attend our (awareness) sessions each week.(Youth leader, P19)

One of the community workers commented that peers may be better accepted by drug addicts as someone who has gone through the similar circumstances as compared to government bodies:

"People trust people who have experienced similar suffering, but they don't trust government officials." (P10, Community Worker)

Theme 4: Digital connectivity and sustainability

An interesting and important finding was the growing use of digital technologies in sustaining rehabilitation. Participants emphasised social media platforms like WhatsApp and Facebook for daily inspiration, awareness, and relapse prevention strategies. Participants agreed that digital interventions enhance accessibility and anonymity both of which are critical in a stigmatised environment. It was also identified during the interviews that such social platforms may lessen the divide between rural and urban locations providing young people with remote access to counselling and peer networks.

"We check in with each other every day on our WhatsApp group. When someone feels weak, they text, and we hear back from them in a matter of minutes. We all try to motivate eachother..." (P2, Addict in recovery)

Facebook is used by our organisation to spread information about our awareness campaigns. We try to ensure that youth can reach out to us anonymously through social media, express questions, and get assistance when required." (P11, manager of an NGO)

3.3: Triangulation and Integration of Quantitative and Qualitative Findings

During the interpretation stage, integration was done by joint display analysis. Quantitative findings showed statistical links between involvement, support and relapse prevention while qualitative themes explained how these interactions operated in practice through trust, belonging and empowerment. The qualitative themes strongly corresponded with the quantitative results. Community involvement's statistical analysis supported qualitative accounts that highlight peer mentorship and a sense of belonging as potent incentives for sustained rehabilitation. Such convergence supported the study's validity and practical relevance. When considered collectively these results demonstrate that rehabilitation success is a socially mediated process that depends not only on individual efforts but also on the social ecology surrounding the person in recovery. These findings provide a strong empirical foundation for understanding how community involvement and individual empowerment work together to promote rehabilitation in Pakistani sociocultural context.

Chapter No. 4

DISCUSSION

4. Discussion

This study employed a mixed method approach to examine the function of microlevel and community based treatments in tackling drug addiction in Pakistan. The quantitative component with a secondary data of 200 participants revealed a substantial correlation between relapse prevention, social support, recovery self efficacy and community involvement. The qualitative component which included 20 interviews and highlighted the intricate roles of family, stigma, religion and digital connectedness that improved our understanding of how these components operate within Pakistan's sociocultural context. The various visits made in Lahore and Islamabad helped us in understanding the contemporary challenges to tackling drug addiction in Pakistan. In the quantitative analysis, relapse prevention results were found to be favourably predicted by community participation, social support and self efficacy while employment and education improved the success of recovery. The quantitative findings conincided with the international literature that highlights engagement and empowerment in long term addiction treatment. Qualitative findings showed that while stigma still impedes reintegration, it can also be mitigated by faith based and peer led advocacy. Family participation provides the emotional foundation for long term healing. By transforming recovery into communal healing, community empowerment boosts accountability and optimism. Digital connectivity offers new opportunities for continued engagement, particularly for youth. These elements work together to create a multi layered rehabilitation environment that can be spread throughout Pakistani communities. These findings highlight the significance of family relationships, community networks and micro level empowerment strategies for long term drug addiction treatment in Pakistan as opposed to only medical detoxification or institutional rehabilitation.

The results of this study clearly demonstrate that relapse prevention is significantly predicted by positive community involvement. This is in line with international research demonstrating that by creating local support networks, community based, participatory rehabilitation initiatives enhances treatment outcomes (Lin & Zhou., 2020). We found that those who participated in active community institutions such as neighbourhood committees, mosque based awareness campaigns or support groups which showed stronger recovery stability.

This type of interaction fosters accountability and a sense of community according to the qualitative accounts. Recovering addicts identities shifted from "problems" to "change agents" when they volunteered or acted as peer mentors. Additionally in Pakistan's collectivist society, a persons self concept depends on the moral approval of the community. When local elders, imams or educators assist a recovered person's progress, social reintegration proceeds more swiftly. Conversely, exclusion encourages guilt and increases the risk of recurrence and relapse. Community involvement is therefore a behaviour modifying factor in and of itself.

The second significant finding of this study was the integral role of family support as a microlevel intervention for sustained rehabilitation. There was a strong quantitative association between social support and relapse prevention while qualitative data corroborated this finding demonstrating that families that switched from blame to trust were able to achieve more consistent recovery trajectories. This is in line with the research findings reported by Love (2018), which maintains that the microsystem which includes intimate relationships like family has the strongest influence on behaviour. Since family networks are still closely knit in Pakistani society, using family structures for drug abuse prevention and rehabilitation is both operationally and culturally acceptable.

Interventions can help addicts and their families heal by considering addiction as a familylevel issue rather than a personal illness. This study found that involving families in relapse monitoring and aftercare also guarantees sustainable relapse prevention. Families that have been taught to recognise relapse indicators, such as mood swings, social disengagement, or financial strain, may serve as early warning systems that can lead to prompt treatments. This finding is congruent with that reported by Saleem,& Masood (2024), who found that probability of relapse was lower and drug abstinence self efficacy was higher in individuals with greater family support and the ability to identify danger signs earlier during relapse.

Even with community and family involvement, stigma remained the most ongoing barrier to reintegration. Addicts and their families commented on their experiences of social rejection, diminished self esteem and discriminatory attitudes of the society. Triangulating the quantitative findings of this study, the qualitative component of this research also explored participants' opinions on possible solutions to stigma. The qualitative data showed that religious leaders promoting community talks, peer mentors sharing their stories about journey

to recovery, and community empowerment creates collective compassion rather than judgement. These culturally appropriate initiatives can uphold Pakistan's moral principles and humanise the narratives of addiction treatment. This finding alongwith the perspectives from various stakeholders show that it will have potential policy ramifications with antistigma initiatives being culturally grounded and collaboration with religious leaders, educators and local influencers, will serve to normalise addiction as a treatable illness rather than a moral failing.

This study also demonstrated that self efficacy or the belief that one can avoid relapsing, is a strong predictor of outcomes, characterising behaviour change as an interaction between personal belief, contextual reinforcement and behavioural capability. Selfefficacy, earned through participating in community service or vocational programs assist recovering addicts in gaining new abilities that enhance their sense of control and self regulation. With the qualitative narratives of "giving back" to society or mentoring others explains the transformation frompassive rehabilitation to active action. This study also found that empowerment was not limited to individuals. Communities themselves gain power as they establish supportive networks, indicating that empowerment works at both individual and collective levels exhibiting a bidirectional feedback loop in which empowered people create communities and empowered communities assist individual healing.

Another significant finding of this study was the use and integration of digital technologies into rehabilitation ecosystems. Social media platforms including Facebook pages, WhatsApp groups and online counselling were found to be popular especially with younger people. Because they provided anonymity, immediacy, and continuous communication, these channels are particularly beneficial in stigmatised settings. This finding aligns with global trends in digital mental health interventions that emphasise peer led online communities and app based relapse monitoring (Stephenson et al., 2023). Digital techniques can significantly increase the limited resources for rehabilitation in Pakistan, where more than 60% of individuals own cellphones. However, low income or rural consumer’s access limitations, misinformation and privacy must be addressed via digital initiatives. Policymakers should look into hybrid models that combine community centres for offline interaction with online groups for ongoing peer mentorship and followup.

4.1 Theoretical Implications

Several theoretical perspectives were supported by this study:

1. In accordance with the ecological systems theory, a sustainable recovery requires interventions across multiple systems, including the family, community and digital environment.
2. This study strengthened the Social Cognitive Theory, which highlights how observing and emulating recovery activities in communities boosts selfefficacy.
3. In line with the Social Capital Theory,this study demonstrated that networks, reciprocity and trust are equally crucial to the treatment of addiction as is medical care.
4. The Stigma Theory was also supported by this study as we reported qualitative perspectives and opinions of participants highlighting the need to culturally reframe addiction using indigenous social and religious narratives.

These theories highlight that effective addiction policy requires an integrated community ecosystem approach that takes psychosocial, cultural and structural factors into account.

4.2 Policy and Practice Implications

The study's findings lead to several recommendations for legislators, NGOs and community practitioners:

1. Make Community Based Rehabilitation (CBR) a part of the National Plan: The Ministry of Interior reiterated that it plans on institutionalising CBR Pak models at the district level for narcotics control. Fund community committees that manage awareness, aftercare and peer mentorship.

2. Family Centered Interventions: Make family therapy and relapse monitoring essential components of treatment plans.

3. Peer Mentor Certification: Director PIMS and representatives at Polyclinic, Islamabad emphasized to train and certify formerly incarcerated individuals to serve as Community Recovery Facilitators Provide stipends or microgrants to keep them involved.

4. Faith Based Partnerships: Hold destigmatization seminars in conjunction with mosques, madrassas and religious NGOs. Create sermon kits that connect recovery topics with Islamic teachings on compassion.

5. Digital Innovation: The D.G CNF pointed out to make WhatsApp helplines and smartphone apps for relapse tracking, reminders and counselling. Use social media to launch awareness campaigns aimed at families and young people.

6. Employment and Reintegration: Collaborate with microfinance organisations and career training facilities to offer jobs to people who have recovered. Provide corporate rewards for recruiting people who have undergone rehabilitation.

4.3 Limitations of the Study

While the study offers valuable insights it is also important to acknowledge certain limitations:

1. Unavailability of province wise data
2. Sampling Bias: Although the sample was diverse, it over represented people with access to structured help because it was primarily urban/periurban and connected to non governmental organisations.
3. Self Report Bias: It's possible that self reported measures of relapse prevention and self efficacy don't fairly represent actual behavioural patterns.
4. Cross Sectional Design: Secondary quantitative data was collected at a single point in time
5. Limited generalisability, as the results might not be as applicable to remote or conservative places.

Future studies should focus on collecting data at provincial level, employ longitudinal mixed designs, expand rural inclusion and include objective relapse markers (such medical tests or follow up records).

Chapter No. 5

CONCLUSION AND RECOMMENDATIONS

5. Conclusion and Recommendations

5.1 Conclusion

This study examined how community based and micro level treatments can help fight drug addiction in Pakistan using a mixed method approach that used secondary quantitative and qualitative data. Using various insights from numerous stakeholders, information from secondary data of a 200 survey participants and 20 in depth interviews, the study provides a comprehensive understanding of addiction treatment in Pakistan's culturally, religious and economic environment.

The findings show that drug addiction is not only a biological problem but also a profoundly social and structural one. The accessibility of drugs has not only increased but also base on digital accessibility. Long term recovery is actually determined by community involvement, family involvement, peer leadership and selfefficacy although detoxification and institutional rehabilitation are still important.

Quantitative analysis revealed that relapse avoidance was substantially predicted by higher levels of self efficacy, family and social support and community involvement. Through online interaction, peer mentoring, family counselling and faith based compassion, qualitative research illustrated how these dynamics operate in day to day living.

The study's main conclusion is simple yet profound that when communities heal alongside individuals, healing is successful. Therefore instead of isolating addicts Pakistan's addiction treatment system should promote empathy, social capital and shared accountability.

5.2 Key Insights

1. Community as the Healing Space: Research has demonstrated that communitybased rehabilitation improves recovery outcomes. By promoting social responsibility and a feeling of community it transforms small networks into therapeutic environments.
2. Family as the Cornerstone: Family participation in the treatment process reduced

the risk of recurrence by offering moral guidance, financial stability and emotional stability. Family centered aftercare programs are critical to sustaining recovery.
3. Reducing Stigma with Faith and Discussion: Religious and cultural narratives that emphasise human dignity, forgiveness and hope can help reduce stigma even though it is still a significant issue. Attitudes were successfully altered through partnerships with mosques and local influencers.
4. Self Efficacy and Empowerment: Psychological empowerment, acquired through career initiatives, peer mentoring, and community service, was a substantial predictor of sustained abstinence. Through empowerment, recovery was changed from a passive process to an active, significant one.
5. Digital Tools as New Micro Interventions: Digital communication, including Facebook, WhatsApp and mobile hotlines, increased social aid, especially among youth. Blended approaches that incorporate both online and offline community engagement show potential for scalability.

5.3 Policy Recommendations

Based on the data generated, some useful recommendations are given for governmental and non-governmental organisations, healthcare providers, and community leaders.

1. Officialise models of community based rehabilitation (CBR) – D.G ANF AND D.G CNF

• Pakistan's National AntiNarcotics Strategy should incorporate community based treatment centres.
• Provide funding for district level local recovery committees composed of NGO representatives, peer mentors, and local leaders.
• Train Community Recovery Facilitators (CRFs) to oversee outreach, awareness, and aftercare initiatives.

2. Boost Family Involvement- PIMS and Polyclinic Officials

• Family counselling sessions have to be mandatory at all rehabilitation facilities.
• Create structured family support networks across provinces to encourage carers' emotional

resilience and mutual learning.
• Educate families on how to identify and respond to early relapse symptoms through family relapse monitoring training.

3. Anti Stigma Initiatives Integrated with Religion and Culture

• Work with mosques, madrassas and religious media to deliver public sermons on healing, compassion and hope.
• Collaborate with scholars to create religiously informed teaching materials that emphasise Islam's perspectives on repentance, healing and social inclusion.
• Include anti drug messaging in religious celebrations and neighbourhood gatherings.

4. Peer led and Vocational Programs- PIDE

• Establish peer leadership programs that certify individuals who have recovered to serve in the community as trainers or mentors.
• Establish connections between recovery centres and technical and vocational education facilities to provide employable skills.
• Encourage public private partnerships that provide employment quotas or microfinance to reformed addicts.

5. Digital Innovation and Youth Involvement- I.G Police, Islamabad and DIG. Operations, Lahore

• Develop smartphone applications for daily motivation, relapse tracking and online counselling.
• Launch social media campaigns targeted at youth that possess inspiring testimonies and recovery experiences.
• To ensure safe and productive discussion, create online peer support groups that are supervised by trained facilitators.

6. Include Cross Sector Coordination

• Promote collaboration between the Ministry of Interior, Ministry of Health, Education and Social Welfare Departments to accelerate preventative and rehabilitative programs.
• Establish a single national data system to monitor drug use as well as rehabilitation outcomes and relapse trends enabling data driven decision making.

5.4 Implications for Sectorwise Practice

1. Medical Professionals: Practitioners should employ holistic care models that include medication, psychosocial therapy and community involvement. Training programs for doctors, social workers and psychologists must incorporate community rehabilitation modules.
2. NGOs and Community Workers: Local groups should place a high premium on participatory tactics that allow recovered addicts to take on leadership roles. Community mapping and stakeholder engagement initiatives can help locate local resources and allies.
3. Religious and Cultural Leaders: Faith leaders can bridge the gap between stigma and empathy by normalising recovery stories in religious discourse. Sermons emphasising collective responsibility have the capacity to inculcate empathy and reintegration.
3. Digital health practitioners: Developers and health professionals must collaborate to develop culturally sensitive mobile technologies that offer privacy, language accessibility and also continuous peer support.

5.5 Future Research Directions and Final Reflection

Even though this study provides strong evidence for community and microlevel interventions, future research should focus on the following areas:
1. Longitudinal tracking: To assess relapse trends over time and the sustainability of community based therapy.
2. Gender Specific and Rural Studies: To understand how addiction affects women and rural populations where stigma and access limitations differ.
3. Economic Cost Benefit Analysis: To evaluate how cost effective community based and institutional projects are.
4. Digital Intervention Trials: To evaluate the efficacy of app based relapse prevention

techniques in Pakistani contexts.

5. Comparative Studies: To contrast Pakistan's community models with successful frameworks in other South Asian or Muslim majority nations

Clinics and prisons alone won't be enough to combat drug addiction in Pakistan, society as a whole must change. The data in this study shows that rehabilitation is not only feasible but also is sustainable when families support those in recovery, when communities welcome them and when religious leaders speak with empathy. Recovery is redefined as a process of social restoration rather than individual punishment through community based and microlevel interventions. Pakistan may advance towards a future where healing is shared, recovery is celebrated and every person is given the opportunity to rebuild their life with dignity by basing policymaking on empathy, participation and empowerment.

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Appendix

Semi Structured Interview Questions

1. How do people in your community see addiction and recovery?
2. What challenges do you think recovering addicts face when they try to re enter the community?
3. Can you describe the role of family during recovery?
4. What kind of help do community workers, NGOs or peer mentors provide?
5. How do you think does stigma affect recovery and social acceptance?
6. Do religious leaders or mosque based activities play any role in supporting recovery?
7. How do digital tools for example WhatsApp, Facebook, online groups help in preventing relapse?
8. What barriers make recovery difficult such as unemployment, stress, or lack of support?
9. What factors make recovery easier or stronger?
10. What improvements do you think should be made in community based programs in Lahore?