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FAITH, FAMILY, AND THE STATE: A MULTI-INSTITUTIONAL ANALYSIS OF DRUG REHABILITATION SYSTEMS IN PAKISTAN

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ABSTRACT

Drug addiction is one of the most persistent and under-resourced public health crises in Pakistan. There are an estimated 6.7 million users across the country, with an estimated 1.2 to 2 million people classified as dependent addicts in need of urgent clinical intervention. Sustainable recovery outcomes are disappointingly low despite a formal legal architecture (notably the Control of Narcotic Substances Act 1997) and operational mandate of the Anti-Narcotics Force (ANF)). The study examines the comparative and complementary roles of institutions in the rehabilitation of drug affected in Pakistan with special reference to the city of Lahore. The research pursues four objectives: to map the institutional landscape of addiction treatment and recovery; to evaluate the effectiveness and limitations of state, medical, educational, and civil-society interventions; to examine the largely under-studied contribution of religious and Sufi institutions-mosques, madrassas, and khanqahs-to psychosocial recovery; and to propose an integrated, culturally responsive model of rehabilitation. Methodologically, the study employs a qualitative, document-based interpretive design that integrates a doctrinal and thematic analysis of a primary Urdu-language research corpus with secondary academic, governmental and international literature.. The findings point toward a fragmented rehabilitation scenario in Pakistan: law-enforcement diversion programs are still nascent, government-run model treatment and rehabilitation centers (MTRCs) cater to a tiny fraction of those who need them, NGOs and private centers are unevenly distributed and mainly urban, and faith-based institutions, tho highly trusted by communities, operate almost exclusively outside formal clinical protocols. The study concludes that punitive, purely biomedical, and purely spiritual approaches each fall short in isolation, and that Pakistan would benefit from an integrated model that combines medical detoxification and Medication-Assisted Treatment with evidence-based psychotherapy (cognitive behavioural therapy, motivational interviewing, family therapy) and structured faith-based components such as those piloted in Malaysia's PUSPEN centres and Indonesia's Inabah programme. Institutional collaboration, rather than institutional competition, emerges as the single most important determinant of durable recovery.

Keywords: drug addiction rehabilitation; institutional collaboration; Pakistan; Anti-Narcotics Force; faith-based recovery; family and community support; Sufi khanqahs and addiction recovery

1. INTRODUCTION

1.1 Background and Significance

Substance use has moved from the margins of Pakistani social discourse to the centre of national concern. What was once treated as a localised urban vice affecting a small, stigmatised population is now recognised as a structural social and public-health problem that cuts across class, region, and age group, with a disproportionate and growing impact on adolescents and young adults in a country where roughly six in ten citizens are under the age of thirty (JPMA, 2023). Government statistics suggest that there are about 6.7 million regular drug users in Pakistan, out of which 1.2 to 2 million are dependent addicts who require immediate clinical treatment (Anti-Narcotics Force Pakistan [ANF], 2023; United Nations Office on Drugs and Crime [UNODC], 2013). It is estimated that opioid use alone affects approximately 628,000 people, with heroin accounting for a staggering 77 per cent of opioid dependence (ANF, n.d.-a). These are not abstract statistics. They are a slow erosion of household stability, economic productivity and, from an Islamic ethical perspective, the moral and spiritual fabric that the Qur'an and Hadith repeatedly instruct believers to safeguard.

The size of the problem is overwhelming compared to the ability of the institutions set up to deal with it. There are only three Model Addiction Treatment and Rehabilitation Centers (MATRCs) in the country established by the ANF, which have treated an estimated 14,388 patients free of charge in total since 2005 (ANF, n.d.-b). Since the dependent-addict population is in the low millions, this figure indicates a chronic shortage of institutional capacity. Meanwhile, punitive legal reform has accelerated, with amendments to the Control of Narcotic Substances Act in 2022 that increased sentencing and eliminated parole and remission eligibility for narcotics offences contributing to severe prison overcrowding in Pakistan (National Commission for Human Rights [NCHR], 2025). A more criminalising than rehabilitative system risks conceptualising addiction as a matter of punishment rather than recovery – a framing that, this paper argues, runs counter to the Qur'anic and Prophetic focus on repentance (tawbah), mercy, and gradual moral reform rather than retribution alone.

1.2 The Need for a Multi-Institutional Rehabilitation Framework

Historically, no single institution medical, legal, educational, or religious has been sufficient in itself to bring about lasting recovery from substance dependence. International clinical literature converges on the view that detoxification, pharmacological stabilisation, and psychosocial therapy operate as complementary rather than substitutable components of treatment (World Health Organization [WHO] & UNODC, 2020). At the same time, in a society as religiously and communally embedded as Pakistan's, purely biomedical or secular-clinical models that bypass the family, the mosque, the madrassa, and the khanqah (Sufi lodge) are liable to be experienced as culturally alien, under-attended, or simply inaccessible outside major urban centres. The present study is premised on the argument that rehabilitation in the Pakistani context should be conceived not as the responsibility of any single actor but as a distributed institutional ecosystem-government agencies, healthcare providers, law enforcement, educational institutions, NGOs and the social welfare sector, mosques and madrassas, Sufi khanqahs, and above all the family-each contributing a distinct and, ideally, coordinated function.

1.3 Statement of the Research Problem

Despite the proliferation of anti-narcotics legislation and the existence of scattered treatment infrastructure, Pakistan's rehabilitation outcomes remain poor and its institutional response remains fragmented. Existing interventions, whether government-run, NGO-run or privately-managed, are overwhelmingly focused on physical detoxification and at best generic counselling, with little integration of the faith-based, familial and community-based dimensions of recovery that are demonstrably salient to the population being served. In contrast, religious institutions trusted by the community-mosques, madrassas and khanqahs-operate largely outside formal clinical protocols with no standardised referral pathways to medical or psychological care. The absence of a coordinated, evidence-informed, and culturally congruent institutional model constitutes the central problem this research addresses.

1.4 Research Objectives

- To identify and describe the range of institutions currently engaged in the rehabilitation of drug-affected individuals in Pakistan, including governmental, medical, law-enforcement, educational, non-governmental, religious, and familial actors.
- To critically evaluate the effectiveness, scope, and limitations of each institutional category in producing sustainable recovery outcomes.
- To examine the specific and comparatively neglected role of Islamic religious institutions-mosques, madrassas, and Sufi khanqahs-and of family-based support, in the psychological and spiritual dimensions of rehabilitation.
- To propose a practicable, integrated model of institutional collaboration, drawing on comparative experience from Malaysia and Indonesia, suited to the socio-religious context of Pakistan.

1.5 Significance of the Study

This study contributes to a thin but growing body of Pakistan-specific literature on addiction rehabilitation by explicitly integrating faith-based institutional analysis with the standard governmental-medical-NGO framework that dominates existing policy literature. Most prior Pakistani studies on rehabilitation centres and NGOs (e.g., studies of the Gujranwala division rehabilitation centres, or of Social Welfare Department facilities in Lahore) treat religious and familial institutions as peripheral or anecdotal. Situated alongside the ANF and licensed treatment centers, mosques, madrassas, khanqahs and the family are the primary institutional actors in the rehabilitation ecosystem, providing this research with a more complete map for policymakers, clinicians, religious scholars and social workers, and a more robust empirical basis for designing the referral networks and multidisciplinary treatment teams which Pakistan's own health authorities have identified as a policy priority.

2. LITERATURE REVIEW

2.1 The Global and National Scale of the Problem

International epidemiological data indicate that Pakistan is among the countries in the region with the highest concentration of opioid users (UNODC, 2013). Majid (2025) analysed more than a decade and a half of clinical laboratory data, and found that drug-use patterns in Pakistan have changed and diversified substantially, with implications for the organization and staffing of treatment services. These epidemiological findings are consistent with the findings of JPMA (2023) which states that young population profile in Pakistan (around two thirds of the population is under the age of thirty) results in an estimated 40,000 new young addicts each year. Such a phenomenon emphasises the need for institutional intervention at school, university and family levels, rather than solely in clinical settings.

2.2 Government and Law-Enforcement Institutions

The ANF remains the principal state actor in Pakistan's anti-narcotics architecture, combining interdiction, prosecution, and-to a limited extent-treatment through its Model Addiction Treatment and Rehabilitation Centres. However, official figures on MATRC caseloads (ANF, n.d.-b) reveal a treatment capacity that is orders of magnitude smaller than the estimated dependent-addict population, a gap consistent with findings elsewhere in the literature that Pakistani state rehabilitation infrastructure is chronically under-resourced (Gujranwala division study; ResearchGate, 2023). The 2022 amendments to the Control of Narcotic Substances Act, which tightened sentencing and eliminated parole for narcotics offences, have been linked to worsening prison overcrowding (NCHR, 2025), a development that sits in tension with the international standards jointly published by WHO and UNODC (2020), which explicitly favour treatment-oriented, rights-respecting responses over purely punitive ones. A growing international literature on police diversion-exemplified by programmes such as the Madison Addiction Recovery Initiative and the Police Assisted Addiction and Recovery Initiative (PAARI) in the United States-demonstrates that redirecting low-level offenders toward treatment rather than incarceration reduces recidivism and improves individual outcomes; such models remain largely untested at scale within Pakistan's own law-enforcement institutions.

2.3 Healthcare Institutions and the Clinical Evidence Base

The clinical literature is clear that detoxification is a necessary first stage of recovery but not sufficient. WHO and UNODC's (2020) International Standards for the Treatment of Drug Use Disorders establish detoxification, Medication-Assisted Treatment (MAT) using agents such as methadone and buprenorphine, and psychosocially assisted pharmacological treatment as the evidence-based backbone of opioid dependence care, a position echoed by the U.S. National Institute on Drug Abuse's (2018) research-based treatment principles. A substantial meta-analytic literature supports the efficacy of specific psychosocial interventions: McHugh, Hearon, and Otto (2010) and the subsequent meta-analysis by Magill et al. (2019) both document a moderate but consistent treatment effect for cognitive behavioural therapy (CBT) across substance-use disorders; Lundahl, Kunz, Brownell, Tollefson, and Burke's (2010) synthesis of 119 studies finds a smaller but reliable effect for motivational interviewing; and Baldwin, Christian, Berkeljon, and Shadish's (2012) meta-analysis establishes family therapy modalities as more effective than treatment-as-usual for adolescent substance misuse. These findings collectively suggest that Pakistani healthcare institutions offering only physical detoxification, without structured psychotherapy or family involvement, are implementing a partial rather than a complete evidence-based model.

2.4 Educational Institutions and NGOs

Pakistani campus-based research paints a troubling picture of institutional passivity. Qualitative studies of drug use among students at public-sector universities report that consumption occurs with minimal restriction or institutional consequence, and that universities have not implemented serious preventive or referral mechanisms (LinkedIn/Pulse commentary drawing on Pakistani higher-education studies, 2023). This is echoed by qualitative fieldwork among

rehabilitation workers in Khyber Pakhtunkhwa's Swat district, which identifies chronic understaffing and resource shortages as structural barriers that slow client recovery and burden frontline workers (ResearchGate, 2025). Studies of NGO-run and government-run centres-including a phenomenological study of a Social Welfare Department model rehabilitation centre in Lahore (Khan & Jabeen, 2023) and an evaluative study of rehabilitation centres in Gujranwala division-recommend expanding NGO capacity, integrating anti-drug content into school and madrassa curricula under government oversight, and building coordinated referral networks between community organisations and formal treatment centres. (Al-Sulaity Welfare Organization in Peshawar, DOST Foundation, Islah Rehabilitation Center, Bridge Rehab and Psychiatric Services, among others) A directory of Pakistani NGOs active in this space points to an active but geographically uneven civil-society sector, concentrated in a handful of urban centers and largely dependent on donor funding rather than sustained state support.

2.5 Religious and Sufi Institutions: An Under-Examined Domain

The Islamic theological and jurisprudential literature provides a highly developed conceptual apparatus for dealing with addiction-treating intoxicants (khamr, understood broadly to include any substance that impairs reason) as both a grave sin and a curable spiritual-psychological affliction. Classical scholarship, from al-Ghazali's Ihya' 'Ulum al-Din to Ibn Khaldun's al-Muqaddimah, stresses early moral formation and consistent parental attentiveness as the first line of defence against deviance, a claim that has a striking parallel in contemporary developmental psychology's finding that consistent parental monitoring is associated with lower rates of adolescent substance use (Hawkins et al., 1992). The Qur'an's own approach to intoxicants is a progressive, pedagogically staged process of prohibition, beginning with the recognition of both benefit and harm (Q 2:219), then banning prayer while intoxicated (Q 4:43), and ending with the unambiguous prohibition of khamr and gambling as "the handiwork of Satan" (Q 5:90-91), a process that has been understood by Islamic scholars such as Wahbah al-Zuhayli to be a deliberate methodology of behavioural change rather than a single punitive decree.

Comparative experience from Muslim-majority countries provides concrete evidence that this theological resource can be clinically operationalized. Malaysia's National Anti-Drug Agency (AADK) and its PUSPEN rehabilitation centers combine traditional practices the ritual bath of repentance, structured prayer, dhikr, and Quranic instruction with modern clinical protocols including detoxification, a community therapeutic approach, methadone maintenance therapy, and a modified, faith-integrated form of cognitive behavioral therapy (CBT-B). Indonesia's Inabah program, based on the Suryalaya tradition, has reportedly treated more than 2,700 severely dependent patients with a structured curriculum based on particular verses of the Qur'an and prophetic traditions and has been replicated in Malaysia as Pondok Remaja Inabah. Amin et al. (2017) report measurable therapeutic benefit for Quran-recitation-based spiritual psychotherapy. Isgandarova (2019) conceptualizes muraqabah (Islamic self-observation/meditation) as a variant of mindfulness-based Islamic therapy that may be useful in dealing with cravings.Badri (2001) places these practices within the larger psychospiritual paradigm of Islam, where contemplative practice is a core component of psychological healing. But in the specific context of Pakistan, mosques, madrassas and khanqahs are documented in the primary source analyzed in this study as offering spiritual guidance, support groups and moral instruction, but with almost no formal integration into referral pathways to licensed medical or psychological treatment providers – a gap identified by this study as a significant missed opportunity, considering the established trust these institutions enjoy at the community level.

2.6 Family and Community as the Primary Unit of Recovery

Across both the Islamic textual tradition and contemporary clinical research, the family emerges as the single most consistently cited institution of support. Baldwin et al.'s (2012) meta-analysis of family therapy modalities and a 2023 systematic review by Esteban and colleagues both report that family- and couple-based therapeutic approaches-whether delivered as stand-alone interventions or as part of multimodal programmes-produce measurable benefit for substance-use outcomes. Pakistani survey research corroborates the salience of peer and family environment: a resilience-focused study of recovering addicts in Pakistan found that 76.7 percent of participants reported that their own friends also used substances, underscoring the protective (or, when absent, risk-amplifying) function of the immediate social environment (SZABIST-affiliated study, cited in ResearchGate, 2025). Stigma research further indicates that family members themselves often experience secondary stigmatisation, alienation, and inadequate social support following a loved one's addiction or overdose, which can undermine the family's capacity to serve its supportive function unless it is itself included in counselling and psychoeducation.

2.7 Research Gap

Three gaps recur across the literature reviewed. First, the Pakistani rehabilitation literature is heavily siloed: studies of government centres, NGOs, university-based prevention, and Islamic theological approaches to addiction rarely engage with one another, leaving policymakers without a synthesised, cross-institutional picture. Second, empirical outcome data on faith-based and Sufi-associated interventions in the Pakistani context specifically-as distinct from

the better-documented Malaysian and Indonesian cases-remain scarce, despite the evident cultural salience of these institutions. Third, existing recommendations for referral networks and multidisciplinary teams (combining physicians, clinical counsellors, and religious scholars) remain largely aspirational, with little documented implementation at scale. This study addresses these gaps by synthesising the institutional roles identified in a detailed Urdu-language primary analysis with the wider empirical and theological literature, and by proposing concrete mechanisms-curriculum integration, referral networks, multidisciplinary case teams, and formal ANF–provincial health department linkages-through which the gap between religious trust and clinical capacity might be closed.

3. METHODOLOGY

3.1 Research Design

This study employs a qualitative, interpretive, document-based research design. Given that the central research questions concern the comparative institutional role and theological-clinical rationale for different rehabilitation actors, rather than the measurement of treatment outcomes in a defined patient sample, a qualitative documentary and thematic-analytic approach was judged most appropriate. This design is consistent with established practice in Islamic studies and social-policy research, where doctrinal, textual, and secondary-source analysis is combined to build an interpretive account of an institutional phenomenon.

3.2 Research Approach

The study follows a mixed qualitative approach combining (a) doctrinal analysis of Qur'anic verses, Hadith, and classical and contemporary Islamic jurisprudence relevant to intoxicants and rehabilitation, and (b) thematic content analysis of a detailed primary research document addressing the institutional landscape of drug rehabilitation in Pakistan, triangulated against secondary academic literature, government reports, and international policy standards.

3.3 Data Sources

- A primary Urdu-language research study addressing the role of Islamic teachings, family, mosques, madrassas, khanqahs, law-enforcement, educational institutions, and society in the rehabilitation of drug-affected individuals in Pakistan, with a focus on Lahore.
- Official statistical and policy reports, including publications of the Anti-Narcotics Force Pakistan, the United Nations Office on Drugs and Crime, the World Health Organization, and the National Commission for Human Rights, Pakistan.
- Peer-reviewed academic literature on addiction treatment efficacy (cognitive behavioural therapy, motivational interviewing, family therapy, relapse prevention) and on Pakistan-specific rehabilitation practice.
- Classical and contemporary Islamic jurisprudential and theological sources, including works of al-Ghazali, Ibn Khaldun, Wahbah al-Zuhayli, and contemporary Islamic psychospiritual scholarship.

3.4 Sampling

As a document-based qualitative study, formal probability sampling of human participants was not undertaken. Purposive sampling was instead applied to the selection of literature: sources were included where they directly addressed institutional rehabilitation roles in Pakistan or in comparable Muslim-majority contexts (Malaysia, Indonesia), or where they provided authoritative statistical, legal, or clinical evidence relevant to the Pakistani setting. Sources with no direct bearing on institutional rehabilitation processes were excluded.

3.5 Data Collection Methods

Data collection proceeded in three stages. First, the primary Urdu-language document was read in full and its content-organised by institutional category (law enforcement, education, mosques, madrassas, khanqahs, society, family) and supported by Qur'anic and Hadith citations, official statistics, and comparative Muslim-country case material-was extracted and systematically catalogued. Second, supplementary academic and institutional sources were identified through targeted literature searching to corroborate, contextualise, and where necessary critically qualify the claims found in the primary document. Third, all material was organised thematically according to institutional category to allow direct cross-institutional comparison in the Results section.

3.6 Data Analysis Techniques

Thematic analysis was used to identify recurring institutional roles, mechanisms of intervention, and reported or claimed outcomes across sources. Analysis proceeded inductively at the level of each institution (state/legal, medical, educational, NGO/social-welfare, mosque, madrassa, khanqah, society, family) and then synthetically across institutions, to identify patterns of convergence (e.g., the recurrent emphasis on tawbah/repentance and community

support), divergence (e.g., the contrast between punitive legal reform and rehabilitative jurisprudential reasoning), and gaps (e.g., the absence of formal referral linkages between religious and clinical institutions).

3.7 Ethical Considerations

Since this research used only published documentary and secondary sources that are publicly available, and no direct contact with human participants was involved, no ethical approval for primary-data was required. The study, however, follows the normal ethical standards of academic scholarship: all sources are explicitly acknowledged; religious texts are treated with appropriate sensitivity and in their proper doctrinal context; and no individual identifying information about any addicted person cited in secondary case material is reproduced. Where sensitive or clinical information was present in the primary document these were discussed as general principles rather than specific case identification, in line with standard research ethics practice with vulnerable populations.

4. RESULTS AND FINDINGS

The study reveals seven distinct but interlinked types of institutions engaged to a certain degree in the rehabilitation of drug-affected persons in Pakistan. Each is described below in terms of its main mechanisms of intervention, documented scope and observed limitations.

4.1 Government and Law-Enforcement Institutions

The ANF is the central anti-narcotics authority in Pakistan and involves interdiction and prosecution with a limited treatment role thru three MATRCs which since 2005 have treated some 14,388 patients, a small percentage of the estimated one to two million dependent users in the country and the national need. Findings from the primary document indicate an emerging, though largely unimplemented, interest in diversion-style policing, whereby individuals apprehended for minor drug-related offences would be referred to treatment rather than prosecuted-a model with clear precedent in international programmes such as PAARI and the Madison Addiction Recovery Initiative, and one presented in the source material as consonant with the Islamic principle of favouring reform (islah) and repentance (tawbah) over punishment (ta'zir) alone. Countervailing this reformist impulse, however, is the 2022 tightening of the Control of Narcotic Substances Act, which removed parole and remission for narcotics offences and has contributed to documented prison overcrowding-evidence of an institutional tension between the punitive and rehabilitative functions of the state that has not yet been resolved in policy.

4.2 Healthcare and Clinical Institutions

The clinical dimension of rehabilitation, as documented in both the primary source and the broader literature, proceeds through four recognised stages: detoxification under medical supervision, pharmacological stabilisation (including Medication-Assisted Treatment with methadone or buprenorphine for opioid dependence), structured psychosocial rehabilitation (cognitive behavioural therapy, motivational interviewing, family therapy), and aftercare/relapse-prevention. International standards jointly issued by the WHO and UNODC (2020) endorse this staged model, and meta-analytic evidence supports the efficacy of each of its psychosocial components. However, the primary source and corroborating Pakistani studies indicate that many existing facilities in Pakistan-whether government, NGO, or private-remain concentrated on the detoxification stage, with comparatively underdeveloped psychosocial and aftercare components, and minimal formal integration of the spiritual/religious dimension that the source material identifies as central to patient engagement and relapse prevention in the Pakistani cultural setting.

4.3 Educational Institutions

Schools, colleges, and universities are found to have a threefold potential role: awareness generation through workshops and seminars; psychological support through counselling centres capable of identifying and referring at-risk students; and moral-religious instruction through Islamic studies curricula. In practice, however, Pakistani campus-based research indicates that this potential is substantially unrealised-students are reported to use drugs on university premises with minimal institutional consequence, and few institutions maintain either dedicated counselling infrastructure or formal partnerships with rehabilitation centres, despite recommendations in the literature that curricula be redesigned, under government oversight, to incorporate structured drug-awareness content across science, social-studies, and Islamic-studies subjects.

4.4 Non-Governmental and Social Welfare Organisations

NGOs and social-welfare institutions-including provincially administered model rehabilitation centres and a range of private and charitable organisations such as those identified in NGO directories operating in Lahore and Peshawar-provide detoxification, counselling, psychosocial support, and, in some cases, vocational reintegration services. Evaluative studies of these centres (including phenomenological research on a Lahore-based Social Welfare

Department facility and an assessment of rehabilitation centres in Gujranwala division) document real, if uneven, positive impact, alongside chronic constraints: understaffing, resource limitations, uneven geographic distribution concentrated in major urban centres, and heavy dependence on donor and charitable funding rather than sustained state support Moreover, qualitative research among rehabilitation workers documents secondary strain on frontline staff due to these structural resource constraint.

4.5 Mosques

The main analysis treats mosques as multifunctional recovery-supportive institutions and not merely as places of worship. Their documented contributions include religious sermons (khutbah) and admonitory discourse (wa'z) addressing the prohibition of intoxicants and the virtue of repentance; encouragement of the five daily prayers, congregational worship, and Qur'anic recitation as sources of psychological stability; the informal establishment of community support groups under the supervision of religious leaders (ulama); charitable and financial assistance for treatment costs; and religious-educational programming, including Qur'an classes and Hadith study circles, aimed at moral and spiritual reinforcement. These functions align closely with an Islamic ethic of mutual responsibility, epitomised in the widely cited Hadith likening believers to a single body in which the suffering of one part is felt by the whole.

4.6 Madrassas (Religious Seminaries)

Madrassas are found to perform functions similar to, but institutionally distinct from, mosques: structured residential religious education incorporating regular congregational prayer and Qur'anic recitation as a means of reducing susceptibility to addiction; explicit curricular content on the prohibition of intoxicants; character-formation programmes emphasising self-respect, patience, and moral discipline; and peer-support groups operating under the guidance of religious teachers. As with mosques, however, the source material and supporting literature indicate that madrassas generally lack formal cooperative arrangements with licensed rehabilitation centres, despite policy recommendations-echoed in Pakistani academic literature on educational institutions and drug abuse-that such linkages be formalised and placed under government coordination.

4.7 Sufi Khanqahs

Sufi khanqahs (spiritual lodges) constitute a distinctive institutional category centred on tazkiyat al-nafs (purification of the self) and murshid-led spiritual mentorship. Documented mechanisms include individualised spiritual guidance from a shaykh or murshid toward repentance and closeness to God; structured practices of dhikr (remembrance) and muraqabah (contemplative self-observation), which the international literature-notably Isgandarova's (2019) framing of muraqabah as a form of Islamic mindfulness-based therapy-suggests may plausibly assist craving management; peer support circles among khanqah affiliates; and, in some cases, informal cooperation with rehabilitation centres for financial or counselling support. Comparative evidence from Malaysia's PUSPEN centres and Indonesia's Inabah programme-which formally integrate Sufi-derived practices (the repentance bath, dhikr, Qur'anic curricula) with clinical detoxification, methadone maintenance, and a modified CBT protocol-demonstrates that khanqah-style spiritual methodology can be operationalised within a clinically structured programme at meaningful scale, treating over 2,700 patients in the Indonesian case alone. No equivalent formalised integration was identified in the Pakistani material reviewed.

4.8 Society and Community

At the level of the broader community, the primary source identifies three recovery-relevant functions: the formation of community support groups, often hosted by mosques, madrassas, or local organisations, where affected individuals share experience and receive encouragement; public-awareness campaigns and educational workshops conducted through media, social media, and community gatherings; and the cultivation of a non-judgemental, compassionate societal attitude toward addicted individuals, framed in the source material as an antidote to the stigma and social pressure that is repeatedly identified-both in the Islamic textual tradition and in international stigma research-as a significant barrier to help-seeking and successful reintegration.

4.9 Family

The family is identified across the primary source, the classical Islamic literature, and the contemporary clinical literature as the single most foundational institution of rehabilitation. Its documented functions include emotional support and unconditional acceptance, which counteracts the isolation and shame that frequently accompany addiction; the maintenance of a low-conflict, spiritually structured home environment (regular prayer, Qur'anic recitation, religious discussion) that is associated, in both the doctrinal and the developmental-psychology literature, with reduced substance-use risk; encouragement toward repentance and connection with religious mentors; and practical support, including liaison with treatment centres, financial assistance, and encouragement of constructive

replacement activities. Pakistani survey evidence-notably the finding that over three-quarters of recovering addicts in one study reported that their own peer group also used substances-underscores, by contrast, the risk posed by an unsupportive or substance-normalising family and peer environment, reinforcing the centrality of family-focused intervention (family therapy, family psychoeducation) within any effective institutional model.

5. DISCUSSION

5.1 Effectiveness of Current Institutional Efforts

Taken together, the findings indicate that Pakistan possesses the conceptual and doctrinal resources for a highly effective, culturally congruent rehabilitation model, but lacks the institutional architecture to operationalise them. Clinical institutions understand what evidence-based treatment requires; religious institutions command the community trust and moral authority to motivate sustained behavioural change; educational institutions and the family occupy the earliest and most durable points of preventive contact; and the state possesses the coercive and resource-allocating capacity to scale any of the above. What is largely absent, on the evidence reviewed, is the connective tissue between these actors-formal referral pathways, shared case-management protocols, and cross-trained personnel-without which each institution's efforts remain individually meaningful but collectively insufficient against the scale of the problem.

5.2 Challenges Facing Rehabilitation Institutions in Pakistan

- Capacity deficits: The ANF's three MATRCs and the wider network of NGO and provincial centers serve only a small proportion of the estimated dependent-user population.
- Punitive-rehabilitative policy tension: Recent legislative tightening (the 2022 amendments) has broadened incarceration for narcotics offenses even as international standards and much of the Islamic jurisprudential material reviewed favor treatment-oriented responses.
- Geographic and resource unevenness: NGO and private sector provision is concentrated in major cities like Lahore and Peshawar, leaving rural populations comparatively underserved.
- Institutional silos: mosques, madrassas and khanqahs function in almost total isolation from any formal referral links with licensed medical and psychological providers, despite their tested community reach and trust.
- Workforce strain: qualitative research among frontline rehabilitation workers documents understaffing, resource shortages, and consequent burnout, which in turn slows client recovery.
- Weak preventive infrastructure in education: universities and schools, despite clear potential, generally lack dedicated counselling capacity or curricular integration of drug-awareness content.

5.3 Comparison with Previous Research

These findings are broadly consistent with, and extend, the existing Pakistani literature. Studies of Gujranwala-division and Lahore-based rehabilitation centres similarly identify capacity and funding constraints and recommend expanded NGO empowerment and curricular reform in educational institutions. Qualitative research from Khyber Pakhtunkhwa corroborates the workforce-strain finding identified here. Where this study extends the existing literature is in its explicit treatment of mosques, madrassas, and khanqahs as formal institutional actors rather than incidental cultural background, and in its use of comparative Malaysian and Indonesian evidence to demonstrate that the integration this study recommends is not merely theoretically desirable but has already been operationalised, at meaningful scale, in comparable Muslim-majority settings.

5.4 Social, Psychological, and Policy Implications

Socially, the persistence of stigma-documented both in the Islamic ethical literature's repeated emphasis on mercy and non-judgement and in international bereavement/stigma research-suggests that public-awareness and destigmatisation campaigns should be treated as a rehabilitation intervention in their own right, not merely a preventive add-on. Psychologically, the convergence between Islamic practices such as dhikr and muraqabah and contemporary mindfulness-based relapse-prevention techniques suggests a genuine, empirically plausible complementarity rather than a merely rhetorical one, meriting further Pakistan-specific outcome research. At the level of policy, the study's findings lend support to recommendations already emerging from within Pakistan's own rehabilitation literature and, notably, from the primary source analysed here: that madrassa curricula incorporate a mandatory module on addiction prevention and rehabilitation with formal referral linkages to nearby treatment centres; that religious scholars and community leaders receive structured training in contemporary treatment protocols (detoxification, MAT, CBT) to shift their orientation from stigma to cooperative referral; that multidisciplinary case teams combining physicians or psychiatrists, clinical counsellors, and religious scholars be formally constituted; and that the ANF establish formal data-sharing and referral linkages with provincial health departments.

5.5 Recommendations

- Establish formal referral networks linking mosques, madrassas, and khanqahs to licensed treatment and rehabilitation centres, so that spiritual engagement and clinical care operate as a single care pathway rather than parallel, disconnected tracks.
- Introduce a standardised addiction-prevention and rehabilitation module into madrassa and school curricula, developed and monitored under government oversight, following recommendations already present in the Pakistani policy literature.
- Provide structured training for ulama and community religious leaders in basic addiction science and contemporary treatment protocols, to enable informed, cooperative referral rather than stigmatising rejection.
- Constitute multidisciplinary case-management teams-physician/psychiatrist, clinical counsellor, and religious scholar-for case-by-case treatment planning, particularly in MATRCs and larger NGO facilities.
- Expand government investment in MATRC capacity and support the geographic decentralisation of NGO and private rehabilitation services beyond major urban centres.
- Reconsider the balance between punitive and rehabilitative provisions in narcotics legislation, expanding diversion-to-treatment options for low-level and possession-related offences, consistent with WHO/UNODC international standards.
- Integrate structured family therapy and family psychoeducation as a standard component of rehabilitation programming, given the consistent evidence for the family's protective and therapeutic role.
- Formalise ANF–provincial health department data-sharing and patient-referral mechanisms to improve continuity of care and enable more accurate national needs assessment.

6. CONCLUSION

This study set out to map and evaluate the institutional landscape of drug rehabilitation in Pakistan, with particular attention to the comparatively under-examined role of religious and familial institutions alongside the more conventionally studied governmental, medical, educational, and non-governmental actors. The evidence assembled here indicates that Pakistan is not short of institutional resources or of conceptual and doctrinal frameworks capable of supporting effective rehabilitation; rather, it is short of coordination among them. Government agencies have legal authority and possibly funding capacity; healthcare institutions have clinical expertise; educational institutions have early and repeated access to at-risk youth; NGOs have flexibility and community reach; mosques, madrassas, and khanqahs have moral authority and deep-rooted trust; and the family has the most sustained and intimate influence of all. The Malaysia-Indonesia comparison shows that it is not only aspirational but also feasible to integrate these strands – spiritual, familial and clinical – into one coherent program. Where implemented, this is associated with considerable treatment volume and reported patient benefit..

The study's main contribution is its explicit systematic treatment of Islamic religious institutions as formal partners in a multidisciplinary rehabilitation model, rather than as a background cultural context, and its integration of a robust Urdu-language primary analysis with the wider empirical, clinical, and policy literature on addiction in Pakistan. The single most significant variable differentiating a fragmented system of well-intentioned but isolated efforts from a genuinely effective national rehabilitation infrastructure is institutional collaboration – formal referral pathways between mosques, madrassas, khanqahs, families, schools, NGOs, and licensed medical facilities underpinned by trained personnel and coordinated government oversight. Future research should prioritise empirical, outcome-based evaluation of faith-integrated rehabilitation pilots within the Pakistani context specifically, longitudinal tracking of relapse rates across institutional pathways, and rigorous assessment of the multidisciplinary case-team and referral-network models proposed here, so that policy can move from recommendation to evidence-based implementation.

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