DRUG ADDICTS THERAPEUTIC CENTRE ABUJA:

"ARCHITECTURE AS A REHABILITATIVE TOOL"

BY

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D E C L A R A T I O N

I, OLATUNDE MODUPE CINDY declare that this thesis is my authentic research work on DRUG ADDICTS THERAPEUTIC CENTRE, ABUJA under the supervision of Arc. Prof. Tukur H. Saad. All sources of information are acknowledged in the bibliography at the end of the thesis.

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CERTIFICATION
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meets the regulation governing the award of the degree of Master of Science (M.Sc.) in Architecture of Ahmadu Bello University, Zaria and is approved for its contribution to knowledge.

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D E D I C A T I O N

This thesis is lovingly and sincerely dedicated to my mother CHIEF (MRS) A. F. OLATUNDE who taught me to rely on Christ and who instilled in me the zeal for knowledge. Thanks for standing in the gap for me, always.

And also to those millions of hurt, humiliated, harassed and haunted human beings of my generation... who have not yet discovered the push, power and purpose found in the regenerated, redeemed and released disciples of our Lord Jesus Christ.

May you have DOMINION Today.

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ABSTRACT

Drugs have been existing as neighbours to the human society from the time of creation, and man has been consuming them in a controlled way. Abuse came into being when man became reckless with the use of drugs and started taking them for the fun of it. During our generation we are now witnessing the psychological and physical damage of the ecological disturbance of the man-drug co-existence - A.I.Ds, Deaths, Broken homes and violent behaviour, to name a few consequences.

In order to control drug abuse, man must be discouraged from taking up the habit. All the factors that expose people to drugs must be dealt with. This is not just the job of counsellors, religious teachers and agencies that deal with human behaviour. Everyone must join in to prevent drug usage and to save the addicted. This is where Architecture comes in.

Architecture is not an art, it is a natural function. It grows on the soil like animals and plants. It is a function of the social order. It serves as a medium between man and the environment he finds himself. As such, it can be used to minister to a drug addict. Site selection is a very important aspect in proposing for a centre that will deal with trying to rehabilitate drug addicts. A wrong site choice could hinder successful results. Therefore, the site selected at Abuja already possesses a lot of therapeutic

properties - a river for a soothing effect, lots of land for free unhindered movement and undulated slopes for easy manoeuring, and privacy.

In view of these potentials, more natural landscaping was also introduced on the site in the building shapes of all the structures on the site. This is due to the fact that the more we study nature's form-world, the more clearly it becomes evident how rich in inventiveness, nuances and shiftings nature's form-language is. And the more deeply we learn to replize, in nature's realm, expressiveness is "basic".

It is my belief that by the completion of the thesis project, the efforts of the National Drug Law Enforcement Agency and philantrophic organizations towards developing standard care for the rehabilitation of drug abusers in Nigeria would have been further propagated.

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GLOSSARY OF TERMS

1. NARCOTIC:- Kinds of drug producing sleep, often dunting the senses and, in large doses, producing complete insensibility.
2. INTIGATE:- Make less severe, violet or painful.
3. CONTRITE:- Filled with showing deep sorrow for wrong doing.
4. DEBILITATING:- Making a person's constitution's weak.
5. PALPABLE:- Something that can be felt or touched clear to the mind.
6. CONSENSUS:- General agreement of opinion the practice of basing policies on what will gain wide support.
7. FOETAL:- Fetal of, related to, or in the stages or condition of a foetus.
8. PARAPHERNALIA:- Numerous small possesions, tools, instrument especially concerning somebody's hobby or technical work.
9. PRECURSOR:- Person or thing coming before as a sign of what is to follow.
10. ALKALINE:- Various substances that form chemical salts when combined with acids - opposite of acids.
11. INSOMNIA:- Inability to sleep, want to sleep.
12. SCHIZOPHRENIA:- Type of mental disorder marked by lack of connection between thoughts, feeling and action.
13. EUPHORIA:- State of well being and pleasant excitment.
14. AMNESIA:- Part, partial or total loss of memory.
15. APOTHECARY:- Old use, but still in Scotland; person who prepares and sells medicine and medical goods.
16. PULMONARY:- In connection with the lungs.
17. TOURNIQUET:- Anything, especially a band of cloth with a small tightly packed mass of cloth underneath, twisted tightly round a limb to stop bleeding.

THE TWELVE STEPS OF ALCOHOLICS ANONYMOUS

1. We admitted we were powerless over alcohol- that our lives had become unmanagable.
2. Come to believe that a power greater than ourselves could restore us to sanity.
3. Made a decision to turn our will over to the care of God as we understand him.
4. Make a searching and fearless moral inventory of ourselves.
5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.
6. Were entirely ready to have God remove all these defects of character.
7. Humbly ask him to remove our short comings.
8. Made a list of all persons we had harmed, and become willing to make amends to them all.
9. Made direct amends to such people wherever possible, except when to do so would injure them or others.
10. Continued to take personal inventory and when we were wrong promptly admitted it.
11. Sought through prayer and meditation to improve our conscious contact with God as we understand him, praying only for knowledge of his will for us and the power to carry that out.
12. Having had a spiritual awakening as the result of these steps, we tried to carry his message to alcoholics and to practice these principles in all our affairs.

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CHAPTER ONE

I N T R O D U C T I O N

1.1: Preamble

According to the New College edition of the American Heritage Dictionary of English Language; A drug is any chemical agent or substance that affects the function of living things and, a drug addict is person who is a habitual taker of (non-medical) drugs.

Drug taking is almost a universal phenomenon. People have always used drugs to alter their state of consciousness, eagerly seeking out whatever naturally occuring substance can be used as drugs and wherever possible, deliberately cultivating them.

Each part of the earth that is capable of producing drugs has been used for this purpose. Europe is covered by vines; the cannabis plant flourishes in Asia and Africa; the opium poppy grows in the middle East and Asia; in the British Isle we get - the hop (English narcotic). In America, we have plantations of Cocaplants, Tobacco and Cactuses containing mercaline; and throughout the world we have mushrooms containing hallucinogenic drugs. The only people with no traditional drug are the Eskimos who live in a land too bleak and uncompromising to produce intoxicants.

Treatment for drug addiction and abuse can not be thought of in a simple medical model of acute illness. The 'symptoms' of this chronic disorder and thus, the interventions that as a result may mitigate the symptoms range well beyond the physical, psychological, or psychiatric to include often profound social, legal and economic problems.

The process of rehabilitation has been thwarted by the societal attitude towards a contrite drug addict. For a total and successful rehabilitation programme to be put in place, most neuro-psychiatrists insist that society start seeing addicts as sick people who deserve sympathy and normal healthcare.

1.2: PROBLEM STATEMENT

While it may be true that drugs are used to sub-due suffering, the widespread misuse of drugs has become detrimental to the individual; it is so bad that they have now created new social problems. Such abuse and misuse have also led to wide spread illicit trafficking in drugs with debilitating consequences to human life.

The war on drugs is a truly global conflict tqught on battle fields as far flung as the Andean Highlands, the Hinds Kush, and the streets of Africa. There is no issue short of war which has a more direct bearing on the well-being of the people.

In Nigeria today, the problem is assuming alarming proportions, the use of our future leaders young Nigerians as carriers and vendors of drug as well as Nigeria as a transit base by drug peddlers of five continents have led to greater abuse (Olukosi 1994). Experience has shown that a nation of drug vendors and peddlers soon transform into one that consumes drugs.

The ominous effect of drugs on the Nigerian society caused the Federal Government of Nigeria to promulgate decree-48 of 1987 establishing the Nigerian Drug Law Enforcement Agency (NDLEA) as a co-ordinating body to tackle

malade associated with drug abuse and trafficking (Olukosi, 1994). Not to mention the numerous non-governmental organizations springing up all around the country campaigning against drug use and trafficking within the society.

According to a recent survey conducted by the Data unit of the NDLEA, 45 per cent of Nigerians reported that either they, someone in their family or close friend have used illegal drugs. Of this number, 28 per cent are occassional users, while 29 percent are addicts (NDLEA, 1992). Clearly, drugs are not a problem just for some minority groups or the poor. They affect all Nigerians regardless of social, ethnic, racial and economic background.

It is pertinent to add that, the drug situation in Nigeria is such that the former United States Ambassador to Nigerian Mr. Lannon Walker in 1984 on page 5 of March 28, 1984 New Nigerian Newspaper captured it thus,

> "the growing incidence of drug use by Nigerians in Nigeria shows that Nigerians are increasing their use of cocain, heroine, cannabis and other illicit substances at an exponential rate. Here lies the hydra-headed nature of drug problems in Nigeria and the dilemma of successive Nigerian Governments".

The energy and money devoted for much of this decade to combating drug abuse and trafficking is impressive. Yet, those most concerned about drugs have complained about frustration in achieving consensus against drug use due to its growing rate of consumption and availability on the street.

One thing is certain, society needs a facility having a formal/structured arrangement' for drug treatment and recovery within an allocated budget for such a service.

1.3: MOTIVATION

Drug addiction and other drug-related problems have no doubt assumed alarming proportions in the contemporary Nigerian Society.

The psychosocial motive, physical and economic consequences of drug abuse have become palpable within the society robbing many youths of life and preventing many more from fulfilling their hopes and aspirations, it has torn apart many families and corrupted the nation's values. These ravaging effects have not spared any social class.

Nigerian nationals who have at any point in time had genuine reasons to travel abroad are known to have been subjected to dehumanizing treatment at various foreign immigration points for being percieved as drug couries.

To stem drug trafficking and possession of illegal drugs law percieved as severe have been made but, despite the execution by firing squad in 1984 of three convicted drug dealers, the trend still remains upwards. Long jail-terms have also been handed to both convicted drug users and runners, to no avail. On completion of their prison terms, it is discovered that majority of these convicts go back to the practice.

From my observation, drugs induce hallucinations and also alter reality for a person. They distort a person's awareness and perception and induce the addict to believing that he has extra-ordinary abilities, therefore, it is not very easy to give up. Again, the bane of decisively keeping an addict off drugs lies in the fact that planning and rehabilitation in Nigeria have never been well articulated.

A top official of Neuro-Psychiatric Hospital, Aro, speaking under anonymity in 'African Model' volume 2, number 2 of June 1991, admits that, "not much progress is made towards checking drug addiction, nor are there any gains being recorded as a large percentage of discharged drug patients relapse and get readmitted for another long bout of treatment".

I feel that it is absolutely inexcusable that when a contrite patient has stayed about 20 months in a rehabilitation centre, usually without a visit from relations, he now goes out into society and is denied a job. Let us be reasonable, of course he will go back to drug usage. For rehabilitation to be achievable, frustration, hunger, deprivation and unemployment should be addressed by all sectors of the society. Since society provides the drugs on the streets of Nigeria, society has a role to play in the rehabilitation of ex-drug addicts.

1.4: JUSTIFICATION OF WORK/STUDY

The abuse of, and trafficking in illegal drugs has gradually built-up such that the toll it takes on the National psyche is devastating; both in terms of the loss in vast youth strength and the embarrassment to which Nigerians have been subjected to abroad.

Multi-dimensional efforts have been made to effectively stamp-out trafficking in illegal drugs and drug possession. But suprisingly, drug related problems still persist in the country.

Another issue of concern is that drug addicts who manage to gain the attention of health experts, after being treated still relapse and return to start undergoing treatment all over again.

For rehabilitation to be achievable, the researchers vision is to introduce a therapeutic centre which will be aimed at a humane intermarriage of: Regeneration (personal Valuer), Restoration (mental health), Rehabilitation (social skills) and Recreation (Educational training).

1.5: STATEMENT OF INTENTIONS

The aims and objectives of a therapeutic centre are not confined to reducing the drug consumption of individuals in treatment alone, but are much broader. They include:-

i. Providing a homely and drug-free environment.
ii. To help assist the patient re-orient/re-direct their focus (personal values).
iii. To help the patient develop educational and vocational skills.
iv. To help to reduce foetal exposure to drugs.
v. To help to improve the patients overall health.
vi. To assist the patient get reintegrated back into the society.
vii. To assist the patient become psychologically independent.

The aims and objectives of this thesis are in conformity with the Federal Capital Territory (FCT) institutional policy objectives statement of intentions.

1.6: ARCHITECTURAL SIGNIFICANCE

This study seeks to contribute architecturally to humanity by providing a unique and functional environment, where natural elements and materials are stimulated through the proper utilization of technology and application

to create a reformative atmosphere.

The researcher seeks to create through the use of architectural elements an environment psychologically conducive to a patient. A humane institutional facility that will embrace and act as a treatment centre, as well as a half-way house, to help reintegrate the patient back into the society.

1.7: SCOPE OF STUDY

For the purpose of this research the researcher will concentrate on a particular group of drugs known as psychoactive drugs. These are any chemical subsance; whether natural or synthetic in origin, which can be used to alter mood, perception or psychological state. They are mostly illegal drugs that can not be bought off the counter such as from chemist shops like Cocaine, Heroin, Marijuana and Amphetamines to mentioned few.

Instances where an addict has a psychiatric problem, he will first be referred to a psychiatric hospital for treatment before being admitted. Residential and non-residential patients will be catered for within a stimulating and relaxed environment.

1.8: RESEARCH METHODOLOGY

The methodology for this research will be comprised of:-

1. Primary Data:- Studies of international rehabilitation centres like;
   i. The Buddist Holy Island, Scotland and the
   ii . Psychiatric Rehabilitation Centre, Johannesburg; studies of drug-addict rehabilitation centre in Nigeria and semi-formal interviews

with their medical personnel and patients. The centres and

iii. The Daughters of Abraham, Abuja

iv. The Drug Addict Rehabilitation Centre at Minna and Abeokuta and Our Lady of Victory Drug and Alcohol Rehabilitation Centre, Jos and interview were conducted with the members of different drug suppression organisation like:-

The N.D.L.E.A, Lagos; African Council on Narcotics (ACON) Jos; Eagleview Production Abuja; Planned Parenthood Federation of Nigeria (Kwara Branch), Ilorin; The Joseph Project Foundation, Ilorin; Christ Against Drug Abuse Ministry (C.A.D.M) Lagos; United States Information Services (USIS) Lagos; University of Ilorin Teaching Hospital, Ilorin; United Nation Information Centre, (UNIC) Lagos; Joseph OHEN Hospital, Lagos; and the Federal Capital Development. Authority (F.C.D.A) Welfare Department Abuja.

ii. Secondary Data:- Studies will be shared on related literature from the following books 1992 Drug data collection manual. The Business of Drugs by Mary Cooper; Living with drug by Michael Gossop; Drugs and Foreign Policy by Rapheal Perl; Drug Wars by Tim Wells; and William Triplett; the Living Bible Drug Crimes and the Justice System by the U.S. Bureau of Justice Encyclopedia Britannica; African Model Journal Volume 3; Architects Journal Volume 54, 67, 89, 90:- Growing up drug free by the U.S Department of Education Seminar Papers compiled by the

Family Support Programme (F.S.P) Kwara State and unpublished Masters of Science Thesis.

This study seeks to contribute a functional environment, where natural element and materials are employed through the proper utilization of technology to create a reformative atmosphere.

CHAPTER TWO

HISTORY OF DRUGS AND DRUG ADDICTION

2.1: DRUG TAKING - A BROAD VIEW

The term "drug taking" conjures up an image of syrings, needles, heroin and all the para-pherinelia of the Junkie drop-out. Its surrounded by all manners of sinister implication which reinforce the view that the use of drugs is a strange, deviant and inexplicable form of behaviour or possibility even a symptom of mental illness.

In trying to put drug taking in a more balanced perspective, I looked at the full spectrum of drugs and discovered that "drug taking" is something almost every one does. People who drink tea and coffee consistently are drug takers. Beer, cigarettes, wine and kolanut are drugs. Just as surely as heroin and cocaine. Infact, Alcohol, the most domestic drug, is a very powerful intoxicant. It can produce a dramatic change in peoples behaviour. And it can cause many different sorts of illness and health damage including cancer and brain damage. Cigarette smoking is also a form of drug taking that kills vast number of people each year than are killed by everyone of the illegal drug.

2.1.1: Psychoactive Drugs

For the purpose of this research will be to concentrate on a particular group of drug known as psychoactive drugs. Substances whether natural or synthetic in origin, which can be used to alter

perception mood or psychological state (Gossop 1992). They are mostly illegal drugs that can not be bought off the counter at Chemist Shops like Marijuana,Cocaine, Heroine and Amphetamines to mention a few.

.2: Growth and Production Process

1. Cocaine

The cocaine and crack sold at neighbourhood outlets originates in condition of poverty perhaps as desperate as those at the retail and peasant farmers cultivate the coca - bush in remote valleys along the Andes mountain range, chiefly in Peru, Bolivia, and Colombia and each producer country occupies a special niche in the initial phase of cocaine production.

The government permits cultivation of up to 18,000 hecters for domestic and medicinal coca production. The bush can yield four harvests a year and live for 15 to 30 years depending on weather conditions and terrian. 1 hecter supports 10,000 - 20,000 plants for a yield of 1,000 to 2,000 kilos per year of leaves (Cooper 1996).

Crude Opium can be dehydrated and concentrated for smoking, the traditional mode of administration in East Asia, or it can be broken down into numerous component ALKALOIDS notabity codeine

and morphine raw opium upon addition of an in expensive chemical like acetic anhychride is transformed to gum or merphine base, and later heroin on dehydration. 10 kilogrammes of opium make 1 kilo of merphine and 1 kilo of heroine (Cooper 1996).

PRODUCTION

The harvested leaves are stamped on with bare feet and then soaked in kerosine or bleach to form a paste about ten percent cocaine, the paste is later transformed to cocaine base upon fermentation, which is 90 percent pure cocaine.

Chemicals used to complete the base to powder transformation of cocaine-according to the Central Intelligence Agency (C.I.A) and Drug Enforcement Agency of the U.S.A in a 1987 report are "precursor" chemicals like ether and acetone.

The typical metric tonne harvest of dry leaves from a one hectre plot yields about 5 kilos of paste or two kilos of finished cocaine powder.

"Crack" named for the crackling sound it makes when smoked, is made by mixing cocaine powder with baking soda (which acts as a catalyst) and water. The mixture is boiled to remove kerosine and other impurities used in breaking down the coca leaves to paste. All it takes is 20 minutes in the micro wave oven to make according to a user.

2. Heroin

The opium poppy that is the source of heroin sold in the world is cultivated in three major area:- South East and South West Asia, and recently Mexico. These three yeilded 1,500 metric tonnes of Opium in 1985 (Cooper 1996).

Crude opium is the dried juice of the poppy (Paprer Somniferum) a plant that is thought to have originated in the Eastern mediterranean and has been grown for centuries in the temperated climate of the middle East and Asia.

3. Marijuana

Its the mostly commonly used illicit drug in the world. In countries like Amsterdam it is not illegal to smoke it.

The marijuana plant (Cannabis sativa), also known as hemp or pot, grows anywhere. Mexico and Colombia are the main source of hemp world wide but, Jamaican hemp is the purest and as such, the best. It is very hard to find and, four times the cost of other types. Hemp is dried cannabis sativa leaves.

4. Designer Drugs

These are Amphetamine, methaqualone, and hydromorphone to name a few. They have become popular alternative to many banned substances in the 1980's. Chemically similar to the drugs they are made to resemble, they closely reproduce the effects of heroin, cocaine and other illegal substance. Although these chemical substitutes also were banned under the

Anti-Drug Abuse acts of 1986, they continue to be a major component of the traffic in dangerous drugs (Cooper, 1996).

2.3: MEDICAL USES AND EFFECTS

Many drugs are potentially dangerous chemical that can cause serious, some times fatal poisoning if used incorrectly; associated with the benefits that have resulted from modern drug.~ Development has been on increase in medical and non-medical uses and abuse of drugs.

Most hospital patients for example receive 4 to 5 drugs during a hospital stay, and large quantities of drugs are also used by private physicians and by individuals for self-medication. Widespread abuse of drugs has been reflected by an increase in the occurence of drug toxicity also referred to as iatrogenic disease. Functional changes produced by a drug on various organs (e.g heart, lungs, kidney) are termed effects.

Six classes of commonlyabused drugs besides substance like alcohol and tobacco are:-

(A) OPIOIDS

This group includes drugs derived from opium (such as morphine and heroine) and its synthetic substitutes (such an methedone).

They are used as pain reliever to suppress coughing; as well as for relief from diarreah. They induce a state of

psychological indifferent. Heroine came into existence in 1898 in St. Mary's Hospital London to counteract the addictive effect of morphine, introduced in 1803 (Gossop 1992). In 1843 Alexandra wooden invented the hypodermic needle to aid in drug administration to patients. It is the most common means of heroine intake (Gossop 1993).

Their symptoms of withdawal are anxiety, kicking of legs, insomnia; nausea; sweating; cramps; vomiting; diarreah ; fever; goose-pimples and tremois.

B. SEDATIVES (HYPNOTICS)

Principal drugs abused in this class are the harbiturates, which have been used since the early 1900s to relieve anxiety and induce sleep. They are also used to treat epilepsy. Wides drugs in this class include the benzodiazepines which are marked under such names as valium and librium. They produce severe dependence like alcoholic dependence.

Their symptoms of withdrawal are shaking; Insomnia; Anxiety; Convulsion; and Delirum. A sudden withdrawal could lead to death.

C. STIMULANTS

Commonly abused stimulants are cocaine and drugs of the amphetamine family. They are used medically to produce anesthesia for surgery of the nose, throat, teeth, to constrict blood vessels, and reduce bleeding during surgery.

Amphetamines introduced in the 1930's for treatment of colds and hay fever were found to affect the nervous system. Amphetamines (Nicknamed "Speed") produce heightened allertness, elevate moods, decrease fatigue and need for sleep, and they make the user very talkative. Long use causes acute schizophrenia.

Symptoms of withdrawal of both types of drugs are abnormal moods, anxiety, irritability fatigue, excessive sleeping, general slowing of metal capabilities, and decreased physical strength.

D. DHALLUCINOGENS

Not often used medically, due to its potency, except in treatment of dying patients, alcoholics, drug addicts and the mentally ill. Widely abused hallucinogens in the 90's include Lysergic Acid Diethylamide (L.S.D), masculine derived from the pegote cactus, and Phencyclidine (Nicknamed "angle dust").

L.S.D discovered in 1943 by Dr. Albert Hofmann at Sandoz Laboratories Switzerland is the most potent drug known to man. Other drugs are measured in milligram, L.S.D is measured in micrograms (million th of a gram). It produces a feeling of detachment, euphoria, intensified vision, and a crossing of senses (colour are heard e.t.c.). P.C.P or angle dust by contrast produces a sense of detachment and reduced sensitivity to pain, accompanied by acute Schizophrenia.

Symptoms of withdrawal are destructive behaviour, Amnesia and in some cases the patient goes into a coma.

E. CANNABIS SATIVA

Marijuana, harshish, pot weed, tea, grass dope and ganja are a few of the different names for preparations of this plant. In 1606, Louis Herbert, an apothecary introduced its cultivation to North America for fibre used to produce sails and ribbing for ship (U.S bear of Justice 1992). Nowadays, it is smoked to induce relaxation and increase heart rate, percieved slowing of time, and heightened hearing, taste touch and smell. It is used medically to treat alcoholism, seizine, pain and nausea produced by anti-cancer medication and glaucoma.

Symptoms of withdrawal are irritability sleeplessness, and sweating. Long term effects are short term memory, and damage to pulmonary functions. Its presently the most abused drug due to its accessibility.

F. INHALANTS

In this class are substance not usually considered drugs-such as glue, gasoline; and aerosols like nasal spray. These so called harmless drugs cause lapse in conciousness, depression of the central nervous system, the user to loss control, headaches, nausea and drowsness, impaired vision and lack of reflex and judgement control.

no industry that can generate the employment and income - as estimated $500 million a year - that coca production does (Gossop, 1992). Most cocao are sold to the Colombians who dominate the downstream activities of the cocaine industry.

Compared with Peru and Bolivia, Colombia is an economic success story. As profitable as cocao cultivation and processing is, they pale in comparism with the profit-making potential of exporting cocaine powder. It is this stage that is dominated by a group of between five and ten Colombian organisations, the biggest of which is the "Medellion Cartel", named after the countries second largest city, there it is based. The only other organization powerful enough to warrant the title of Cartel is based in Cali, Colombias third largest city. Together, the Cartels control about 90 percent of the worlds cocaine business (Cooper, 1996).

By some accounts, the highly organized drug mafia that exists in Columbia today over its success largely due to the dreams of one man, Carlor Enrique Lender Rivar. While serving time in the United States of America for smuggling, he is said to have kid out his plan to consolidate Columbia's fragmented cocaine exporting business. After his release in the mid /0's, Lehder began collaboration with Jorge Luis Ochoa Verques, a leader in

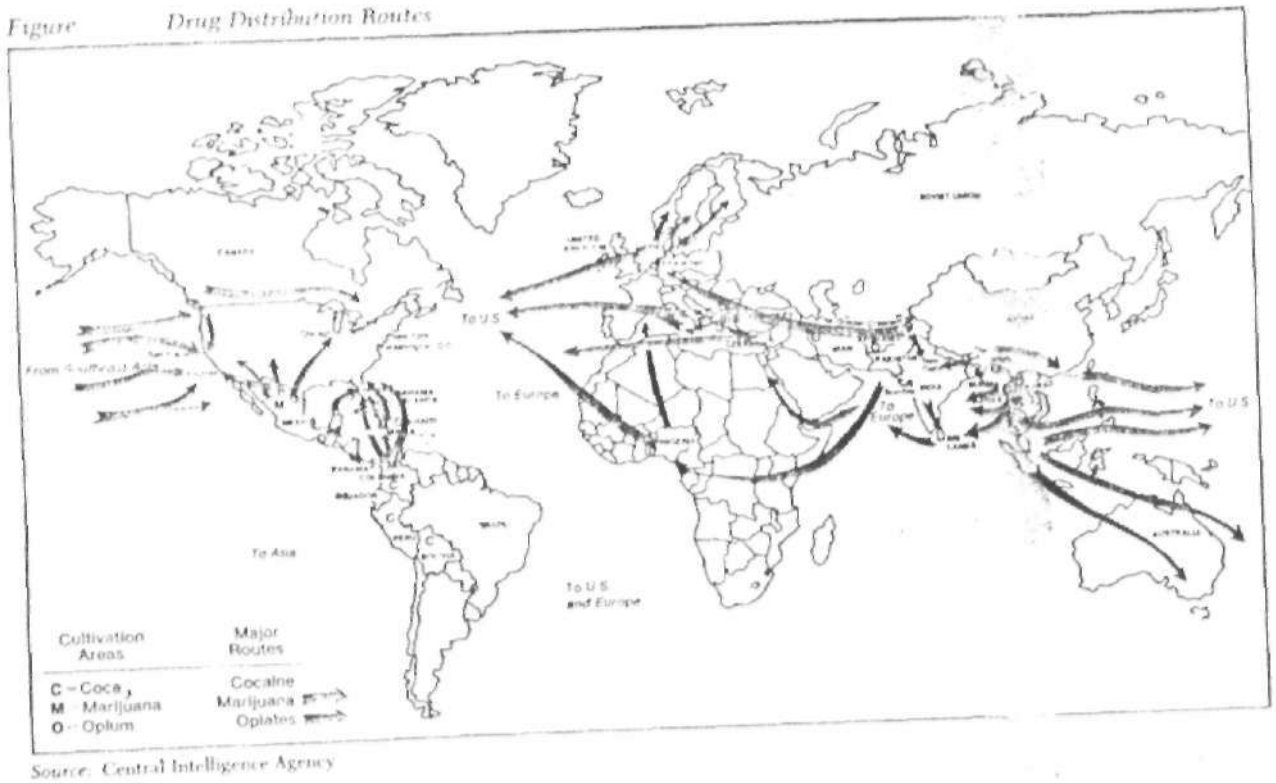
the existing cocaine - smuggling operations headquartered in Medellin (Perl, 1994). The Colombians dominate the market because they came out of a tradition that is quite exceptional for Latin American culture; they are modernizers and tremendously good businessmen who come out of an entrepreneurial tradition.

South America grosses about $4 billion per year, of which $3 billion is accounted for by Colombia alone. Medellin Cartel controls 80 percent of the Colombian Industry with an earning of $2.4 billion (Perl, 1994). Drug Lords use Mexico, Jamaica, Lagos, Bahamas, Cuba, Haiti, and recently Riode Jenero in Brazil to transport drugs worldwide.

2. Heroin

Mexico today is the worlds largest single source of heroine. Mexican peasants began opium cultivation in the1920's to satisfy the demands of Chinese opium smokers who had settled there. But in the mid 1970's the industry took off to fill a vacuum left in the United States market by the ban on Turkey in 1972, not to produce opium and delimination of the heroin distribution network known as the, "French Connection". Cultivation is centred in States like Durango, Sinaloa and just south of the Texas and New Mexico boarder-Chihuahua. In South West Asia - producers Iran, Afghanastan and Pakistan produce about 1,000-2,000 metric tonnes per year according to Interpol.

Figure *Drug Distribution Routes*



Source: Central Intelligence Agency

Table *Population Estimates of Lifetime and Current Recreational Drug Use, 1988* (population in thousands)

	12-17 years (pop. 20,250)				18-25 years (pop. 29,688)				26+ years (pop. 148,409)				Total (pop. 198,347)			
	Ever used	%	*Current user*	%	*Ever used*	%	*Current user*	%	*Ever used*	%	*Current user*	%	*Ever used*	%	*Current user*	%
Marijuana & Hashish	17	3,516	6	1,296	56	16,741	16	4,594	31	45,491	4	5,727	33	65,748	6	11,616
Hallucinogens	3	704	1	168	14	4,093	2	569	7	9,810	*	*	7	14,607	*	*
Inhalants	9	1,774	2	410	12	3,707	2	514	4	5,781	*	*	6	11,262	1	1,223
Cocaine	3	683	1	225	20	5,858	5	1,323	10	14,631	1	1,378	11	21,171	2	2,923
Crack	1	188	*	*	3	1,000	1	249	*	*	*	*	1	2,483	*	484
Heroin	1	118	*	*	*	*	*	*	1	1,686	*	*	1	1,907	*	*
Stimulants	4	852	1	245	11	3,396	2	718	7	9,850	1	791	7	14,068	1	1,755
Sedatives	2	475	1	123	6	1,633	1	265	3	4,867	*	*	4	6,975	*	*
Tranquilizers	2	433	*	*	8	2,319	1	307	5	6,750	1	922	5	9,482	1	1,374
Analgesics	4	840	1	182	9	2,798	1	440	5	6,619	*	*	5	10,257	1	1,151
Alcohol	50	10,161	25	5,097	90	26,805	65	19,392	93	131,510	55	81,356	85	168,498	53	105,845
Cigarettes	42	8,564	12	2,589	75	22,251	35	10,447	80	118,191	30	44,284	75	149,005	29	57,321
Smokeless tobacco	15	3,021	4	722	24	6,971	6	1,855	13	19,175	3	4,491	15	29,467	4	7,073

Note: Ever used: used at least once in a person's lifetime. Current user: used at least once in the thirty days prior to the survey.
* Amounts of less than 5% are not listed.

Source: U.S. Department of Health and Human Services, National Institute on Drug Abuse, August 1989.

These countries export to the United States, Western Europe and Africa. These three producer countries are referred to as the 'Golden Crest' (Wells and Triplett, 1992).

Egypt is the greatest African consumer of Heroin. Its government has launched a drive against drug use and imposed death sentence on traffickers. Nigerians control the heroin market in Africa- because they possess the advantage of widespread expatriate communities in the main heroin trade routes. Nigerian couriers have become famous for using body cavities as a means of concealments. By this means each smuggler can carry as much as 800 grammes of finished heroin to initial transit points in Africa, mainly Lagos, Nigeria; Abidjan, Ivory Coast; and Accra, Ghana (Wells and Triplett, 1992).

From here the heroin is carried to markets in Western Europe and North America. The lure of enormous profit makes it easy for Nigerian traffickers to find couriers among their countrymen, whose standard of living has suffered due to declining oil exports and mounting indebtness to foreign creditors. Per capital income in Nigeria stood at $370 in 1987 about half of what it was in 1984 (Wells and Triplett, 1992). At $2,500 a kilo for the good stuff, it's easy money, "sundaraling of the International police (Interpol) in Nigeria notes". It you are willing to take the heroin from Karach airport to Europe or Ameria, you are a millionaire. Nigerians do not

mind getting caught".

The South West Asia heroin industry knows no religious or political boundries. Not only is the narcotic cultivated and processed in areas heavily populated by muslims, whose faith strongly condemns drug use, but it travels through the Soviet Union and other Eastern block countries, whose government have long depicted drug addiction as a curse of the capitalist world alone. Both Bulgaria and Czechoslovakia serve as transit points.

2.4.1: TREATIES

Global efforts to curb illegal traffick in dangerous drugs are front-page news and television features in most lands. Nations patrol their borders with ships and inspect visitors who are suspected of carrying contrabands.

Agreements between nations and overall supervision of control treaties by the United Nations are the subject of efforts of thousands of government officials all around the world.

The 1931 United Kingdom - United States extradition treaty was extended to include Nigeria in 1985. In 1989 the United States and Nigeria signed a mutual legal assistance treaty. March 1, 1993, the Nigerian Airways and the United States customs entered into an air carrier agreement which is used to deter, smugglers from using the Nigerian airways as courier aircrafts. Nigeria was party to the

1961 United Nations single convention treaty, and 1972 convention on psychotropic substances.

The United Kingdom, Germany and the Netherlands have programmes with the Federal Military Government on counter narcotic issues. Nigeria also hosted the United Nations African Regional Heads of National Drug Law Enforcement Agencies (HONLEA) meeting in May 1993.

Under a bilateral agreement signed in 1990, the United States government provided the NDLEA with radios and automobiles. In September 1993, the United States government and the Federal Military Government signed an agreement for additional assistance to expand NDLEA's support capabilities. United States Information Services (U.S.I.S) sponsored an anti narcotic training team to participate in a drug workshop in the United States, and produced four world network satellite conferences on drug reserves (NDLEA, 1997). Still the problem continues to increase.

2.5: SUMMARY

The United States is the worlds leading retail market for drugs. One third of all worldwide homocides involve drugs. The drug trade started because the "blacks" were getting involved in the liquor business and threathening to run the Italians out of business in the 50's. So the Italians flooded the place with drugs, the blacks got

addicted and the competition between them subsided.

Nigeria is a major transit country for Asia heroin and the focal point for most of West Africas heroin trafficking organization. The NDLEA has made a number of arrests, but they focus almost exclusively on the drug couriers, rather than the leaders of drug groups. Corruption, I am sad to admit remains an obstacle to effective counter narcotic efforts. The government is seriously concerned about increasing domestic drug abuse as can be seen from the 'watchdog' approach of Maj. General Bamayi, the Chairman of NDLEA.

While legal mechanisms are in place to combat what appears to be extensive money laundering (a side effect of drug trafficking), there has been no significant attempt at enforcement of these laws. Nigeria is party to the 1988 United Nations Convention on "drug trafficking and addiction", but she has not yet made an effective effort to achieve the various treaties objectives and goals.

CHAPTER THREE

ORIGIN OF THE THERAPEUTIC CENTRE

3.1: DRUG USE

It has been called a scourge, the most daunting social problem of the twentieth century, even an instrument of genocide aimed against minority communities. Whatever their merits, these and other definitions of drug abuse apply to an activity whose dynamics are determined by the basic economic law of supply and demand.

In June 1971, Richard Nixon became the first American President to declare "War on drugs" (Wells and Triplett, 1992). His heavily publicized initiative war, he said, was "designed to mount a frontal assault on our Number One Public Enemy". Throughout the two decades that have followed President Nixons declaration, the drug war has become a staple of contemporary political rhetoric, as successive series of administrations have launched high touted antidrug campaigns. President Clinton joined his predecessors in echoing Nixons claim that the drug epidemic is "Public Enemy Number One", in 1994 (Cooper, 1996).

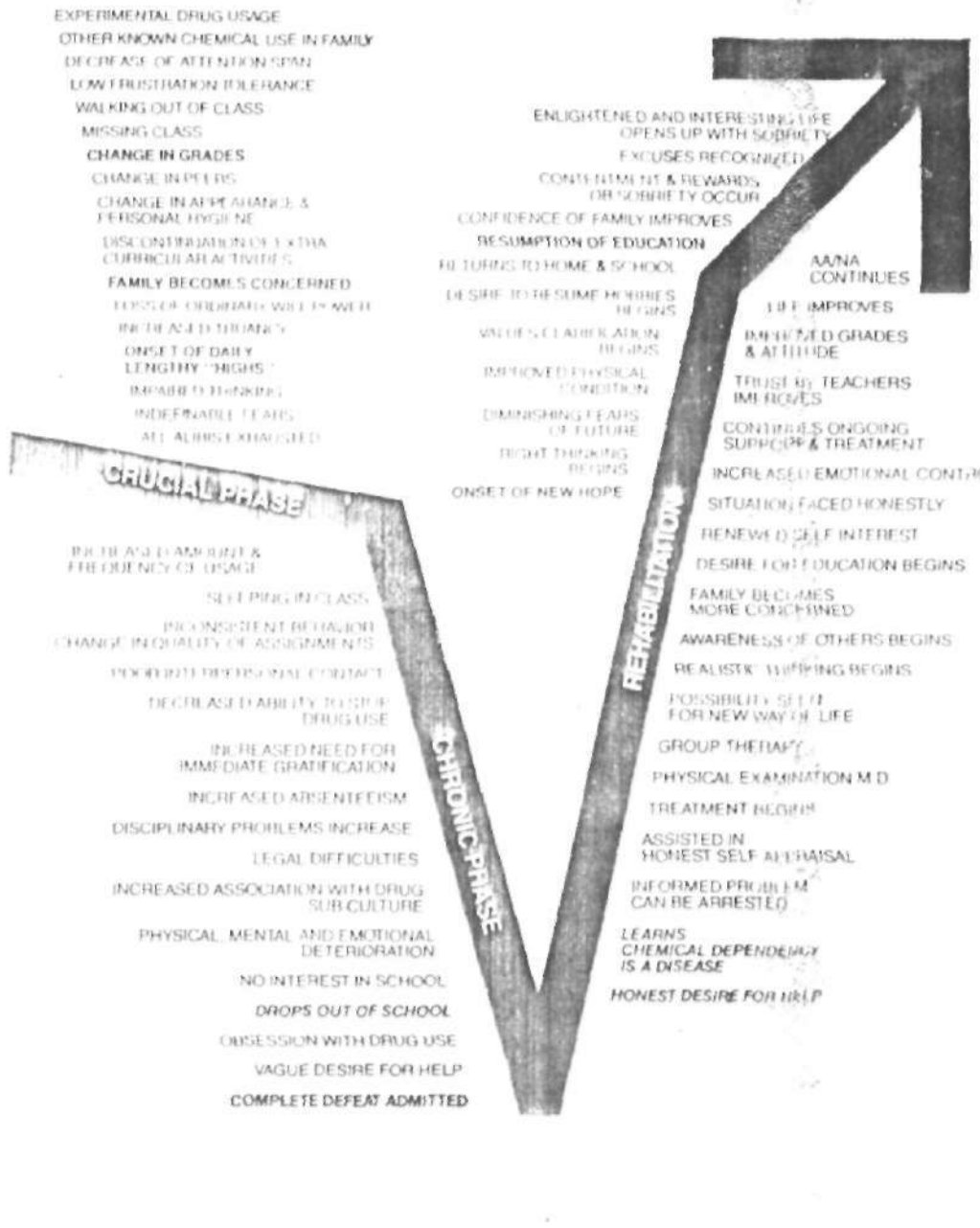
The number of drug addicts living in our cities and towns has increased at an alarming rate and policy officials routinely estimate that over 50 percent of all criminal activity is directly related to substance abuse in Nigeria. Today, the government claims

that 37 percent of the total population of Nigeria (108 million) have used illicit drugs at some point in their lives (NDLEA, 1997). For those under the age of 35 years, the numbers are even more dramatic; it is estimated that a staggering 63 percent of all Nigerians born after 1982 have experimented with illegal drugs. The rise in addiction rates has been coupled with a steady rise in violent crimes and drug-related fatalities.

In the 90's the violent crimes most commonly associated with substance abuse (murder, robbery and aggravated assault) have risen at a per capital rate of 67 percent, while arrests for violation of Nigerian narcotic laws are up by a full 100 percent (NDLEA, 1997). If present trends continue, every citizen living in Nigeria has a fifty-fifty chance of becoming the victim of a drug-related crime at some point in the late 90's.

Nigeria's school children are introduced to illegal drugs at suprisingly young ages, and amidst their peers they are forced to come to terms with the excitment of temptation, the powerful yearning for acceptance, and the beckoning of fun and laughter that "recreational" experimentation calls forth. Whatever the motive, an undeniable fact of contemporary Nigerian society is that drug and alcohol use per meates every social and economic stratum of our national life. Illicit drugs are not confined to the ghetto or the school yard; but

The Path of Chemical Dependency in Adolescence



are commonly found in corporate offices and urban homes.

3.1.1: FACTORS THAT LEAD TO DRUG USE

According to a 1990 Medical General Associated Press Poll taken by the NDLEA in Lagos and Kano, the people who are more likely to see the drug problem increase in the next 10 years are:-

i. Women (due to pressure)
ii. People with low income (below ₦36,000/year)
iii. Children/Adolescents
iv. Blacks and Hispanics sojourneying away from home

There are many reasons why people continue to use drugs, like;

i. Peer pressure
ii. For performance enhancement
iii. Curiousity
iv. Social pressure
v. Influence of role models and so on.

Chief among these are ignorance of the facts about addiction and the potency of drugs, and the complacency about the danger of drugs. Unfortunately, all too often we see signs of complacency about the dangers of drug use:

i. diminished attention to the drug problem by the national media;

ii. the glamorization and legitimization of drug use in the entertainment industry;

iii. the condoning of professional athletes who are habitual drug users;

iv. avoidance of the issue by parents and other adults; calls for drug legalization and, the marketing of products to young people that legitimize and elevate the use of alcohol, tobacco and illicit drugs.

3.2: ADDICTION

Debbie, 20 years old and unemployed slumped on a tattered sofa in the living room of her boyfriends flat at Ketu in Lagos. Beside her lay a belt, looped through the suckle for use as a tourniquet. She bore the signs of drug addiction - a three inch long track on her inside right arm below the elbow. She also admitted to smoking cocaine and marijuana, fitting the profile of todays multiple-drug abuser, the POLY ADDICT.

Drug Dependence or Addiction is a chronic, relapsing disorder requiring specialized treatment. Breaking the cycle of dependence is difficult at best, and hard core drug users often suffer extreme physical, psychological,

emotional, economic and social pain. In many ways they are isolated from society. Their addiction affects not only them but also their family, friends and the larger community.

"We who do not use drugs can not understand why people can not just stop", says a doctor at Aro Psychiatric Hospital who treats recovering addicts. "After you've lost your job, home and family, why can't you just stop". Unfortunately, drug addiction is a progressive disease that frequently evolves in an insidious manner.

"I was addicted to cocaine for 5 years before I even realized it", says a recent law school graduate. "I was going to a psychiatrist because I had all these problems. I wasn't getting along with my parents, I was irritable and prone to outbursts of anger, I was drinking too much and doing irrational things. My psychiatrist and I would talk about all sorts of things, but I never once mentioned cocaine to her. That's because it didn't seem significant. Cocaine was one of the few things in life that would actually make me feel better. So how could that be part of the problem?".

In making the transition from recreational use to drug abuse, most addicts go through prolonged periods of denial, where they struggle to maintain the appearance of a normal life. "I would go to work completely stoned, explains one addict, " and I would work

hard. I was always a high-level performer. Infact, I realize part of my being able to function like that helped me in denial. My feeling was, how can I be an addict when I can keep my job and keep on functioning?".

The truth is, most addicts would like to quit, but cannot The addict knows their life is falling apart, but he (she) refuses to admit it. Cocaine or heroin has become an obsession, and the addict just can not see - or refuses to see - that his behaviour has become distorted and bizarre.

Baseball's Darrell Porter was booked (Ebony, 1995). When Darrell recieved his first contract of $77,500 to play ball for the Milwaukee Brewers in the U.S he thought he had it all. But he nearly lost it all. First, it was the pressure to prove himself to the winner takes all atmosphere of professional athletics. Then it was peer pressure, the need to belong in a cold, competitive, and impersonal world. Lonely and scared, he sat down one night with co-team - mates and had a beer. Later he had more. Then it become a habit. Then someone gave him a pill-an upper. Then he took a pill to come down from the upper. Then another upper, then another downers, then some cocaine at a party....

His marriage went first, then paranoia set in. One night Darrell Porter woke up in a holiday Inn bathroom stall with blood all over him.

He had beaten someone up and could not remember it. His baseball career took a down slide. Then he had an encounter with God. He asked for his forgiveness and help. That gave him the strength to confess publicly his problem and seek professional help. Today, Darrell is off his habit, free and playing ball better than ever.

3.2.1: DRUG TESTS

Drug tests are not too effective (especially by urine) says Dr. Adeoye of Christ Against Drug Abuse Ministry (CADEM). To detect drug in urine depends on the amount taken, frequency of use, and sensitivity of the urinalysis test used. The larger the dose taken; the longer the body takes to process it, and the longer it is detectable in urine.

A positive test result only indicates that a particular substance is present in the test subject's body tissue. It does not indicate abuse or addiction; recency, frequency or amount of use; or impairment. Different drugs take different lengths of time to pass through the body.

Cocaine for example, clears from the body fairly quickly and is detectable in urine for 2-3 days after ingestion.

Marijuana (single dose) - 3 days

Marijuana (Moderate use - 4 times/week) - 5 days

Marijuana (heavy smoker) - 10 days

Marijuana (chronic smoker) - 21-27 days

Opiates (Heroine, morphine, codine) - 48 hours

Amphetamines and Metamphetimines - 48 hours

Benzodiazephines (valium, librium) - 3 days

Data was gotten from American Medical Association Council of Scientific Affairs, 1987 report.

3.3: TREATMENT FOR ABUSE

Drug abuse treatment is the process of breaking an individuals dependence on illicit drugs (e.g. heroine, cocaine) or ilicit drugs (e.g. alcohol and prescription medication) (Cooper, 1996). Although the term "drug abuse treatment" implies a single entity, infact it is a complex and variable network of services tailored to meet the multiple needs of individuals. Drug abuse treatment can take place in hospitals, long-term residential treatment programmes; wake-in clinics; psychotherapists officer; and church basements. The choice of setting and type of treatment depend on such factors as history of drug use and previous drug treatment, the addictive drug, social needs, criminal records, economic status and personal characteristics.

Most treatment programmes in therapeutic centres provide a combination of services. Drug own selling, education, pharmaco-theraphy, psychotheraphy, vocational services, urine testing, relapse prevention and, social and community support. There

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services vary from programme to programme.

VARIANCES

1. SETTINGS:- The place where treatment occurs:-

A) Non-residential or outpatient

i. The client receives treatment services at a particular place, but resides and spends most of his/her time elsewhere.

ii. Most treatment clients are in non-residential settings.

iii. Some programmes have more than 1,000 clients at a time.

B) Residential

i. The client receives treatment services and lives at the treatment facility, which can be a traditional hospital or a facility sych as a group home or halfway house.

ii. Treatment-related activities normally occupy most of the individuals time, such activities normally consist of traditional psychotherapeutic services but may also include activities such as job training, skills training, or sharing in cleaning and cooking tasks for the facility.

iii. Typically, residential programmes are relatively small; frequently they house less than 50 residents, while some have as fever 5 or 7 residentss.

2 MODALITIES - The primary manners of treatment

A) DETOXIFICATION

i. A programme of planned drug dependence withdrawal which may or may not include medication to assist in withdrawal.

B) THERAPEUTIC INTERVENTION

i. Characterized by wide variability due to differences in ownership, sponsor organization, type of services provided, service intensity, staffing and diagnostic treatment approacher.

ii. Typically includes some form of counselling as well as ancillary services.

C) PHARMACOLOGIC ASSISTANCE

i. Characterized by use of sterilizing medicating such as methadone for heroine users.

ii. Includes treatment using drug antagonists - medications that neutralize the effect of the addicting substance.

D) SUPPORT GROUPS

i. Individuals with problems of substance abuse and dependence come together to help each other become and remain drug free.

ii. Most are modelled on the 12 steps of Alcoholic Anonymous; major groups include Narcotic Anonymous and cocaine Anonymous.

iii. They are not traditional treatment modalities, in that there is no paid staff or prescribed regiment of treatment and services. Medicine is often times a very primitive science. This is particularly true when we talk about drug addiction and how it

operates on the brain. Because knowledge is limited, treatment tends to be primitive. In most cases, the best that can be done is to put a patient in a counselling environment there he (she) can begin to talk about the problem. The medical side of the disease can not be dealt with except on a very short-term basis.

3.4 DRUG ADDICT REHABILITATION CENTRES

Rehabilitation according to Websters Dictionary of Contemporary English, means to put back in good condition, in its simplest definition. There are quite alot of types of rehabilitation centres like physiotheraphy and religious centres to name a few. A drug addict rehabilitation centre simply stated, is a center or institution where a drug user can go to for treatment, to enable he(she) to drop the bad habit. In Western countries, drug addiction is taken very seriously and almost all States have facilities for the treatment of these 'sick' people. It is only within the last decade that African countries have begun to see the need for such facilities to be provided. In 1989, of the 6,170 drug treatment units in the United States of America, 65 percent were private non-profit, 17 percent were private but profit oriented, 16 percent were State of Local Government owned and 2 percent Federal owned (Wells and Triplert, 1992).

3.5 NIGERIAN DRUG ADDICT REABILITATION CENTRES.

According to Mrs. Adetula, Director Drug control unit, NDLEA in Nigeria, we have five government owned drug rehabilitation centres (NDLEA, 1997). These centres are maintained and sustained financially by the United Nations Drug Control Programme (UNDCP). They are:-

1. Yaba Psychiatric Hospital - Drug Ward, Lagos
2. Usalu Psychiatric Hospital - Drug Ward, Benin
3. DRUG ADDICT REHABILITATION CENTRE, MAIDUGURI
4. " " " " , MINNA
5. Neuropsychiatric Ward of Aro Hospital, Abeokuta.

In Nigeria, we currently have about 15 Rehabilitation Centres for drug addicts, 10 of them situated at Lagos. The NDLEA operates more as advisory body than as a rehabilitation centre. (NDLEA, 1997). According to Mrs. Adetule , Director Drug Reduction, NDLEA.

When a family member comes to the NDLEA to state that, there is a drug user in his (her) house, the NDLEA sends an official over to verify the claim and interview the user themselves. Unlesss the user realizes that he(she) needs help, they can not be helped. Once they indicate the need for assistance, the officer then finds out from the people close to them, whether they would advice treatment to be close by (Lagos) or elsewhere, and they will also asertain their financial capacity. Letters will now be drafted by the NDLEA to drug rehabilitation centres to find out if they can accomodate the patients. If there is room, the patient is referred there for the necessary duration of about 12 to 20 months. The NDLEA follows up on the patient for the next two years after they are discharged.

Treatment in almost all the centres is based on guidiance by professional counsellors, group therapies, formal and informal discussions, reality theraphy sessions, meditation and, attendance of alcoholic/ narcotic anonymous (A.A/N.A) meeting designed to restore them to healthy

and productive lives in the society. Briefly, treatment is based on changing attitudes and beliefs in the patient. And weekly evaluations are done on each patient.

3.6: DEDUCTIONS

I feel that the process of rehabilitation and even habitation has been thwarted by the social attitude towards a contrite drug addict. Since the lives of addicts seem to revolve around drugs, coupled with the fact that habits die hard, an adequate treatment devoid of the right re-orientation process could cause a serious relapse in a drug addict.

Investigations show that the question of a conclusive rehabilitation of ex-drug addicts could be quite an ardous task to accomplish in the sense that government's well intentioned approach to the general issue of drug problems is mono-dimensional. A source disclosed that the Federal Governments' campaign against the vice is such that, emphasis is placed on supply reduction, a method which seeks to check the influx of these abusive substances.

This system I gathered, only highlights the criminal aspect of trafficking and consumption, thus further punishing the culpits. But in the history of treatment for drug abuse worldwide, I learnt that this method has never worked. Experts feel that setting up draconian legislations have not really worked, and they suggest the

introduction of more humane approaches. Rather than go one narrow way, such dimensions as medical, sociological, psychological and religious should be tried.

Although, I agree that prevention should be more paramount in the drug campaign programme in order to avoid the congenital pessimism associated with drug treatment outlook, I strongly feel that a recovering drug addict could relapse if denied care and concern. A very critical factor in terms of the treatment of drug addicts is employment. The addict who has a stable job to go back to stands a better chance than the unemployed addict. The addict who is coming from an able and supportive family is also at an advantage.

Before I conclude I would like to briefly touch on the vast resources spent every year on drug control, that could be helping to feed low-income earners or that could be used to improve the lives of the disabled and so on.

3.6.1: ACCUMULATED DRUG COSTS

Each year substantial resources are used in an attempt to control illegal drugs use and deal with its consequences. In addition resources that otherwise may have been used for legitimate purposes are used to produce and distribute illegal drugs. All the resources used because of illegal drugs have associated costs.

1. Preventing drug crimes through education and treatment, protecting personal and company property through tighter security measures, enforcing drug laws, and adjucating and punishing drug law violators.
2. Public and private health care, such as that used to care for drug users, children exposed to drugs before and after birth, victims of drug related work place and traffic accidents, and victims of drug related crimes.
3. Lost physical resources, such as property damaged or destroyed as a result of drug-related work place or traffic accidents, or drug crime, and unsafe use of hazardous chemicals by drug producers like kerosine.
4. Legitimate industrial production, such as agriculture and manufacturing land, labour and equipment diverted to the production and distribution of illegal drugs.
5. Lost labour productivity, such as the absenteism and lower and lower productivity of those using, or affected by someone else's use of illegal drugs, or those not participating in the labour force because of incarceration from drug crime victimization, or death from drug related or traffic accidents.

6. Diminished quality of life caused by illegal drug use, such as pain and suffering of families, friends and crime victims, urban neighbourhood decay, and disruption in schools and at work.

3.7: THE DRUG ADDICTS THERAPEUTIC CENTRE

A therapeutic centre is quite similar to a rehabilitation centre. They differs only on the fact that they are residential treatment programmes which view drug use as symptomatic of the users personality and social problems. (Wells and Triplett, 1992). The centre is expected to provide a safe and secure environment where recovering drug users not only remain drug free but can also develop the social, educational economic, family and occupational skills necessary to function in a modern society.

The specific features of individual therapeutic centres vary because the way a drug affects the person who takes it depends as much upon the psychological character of the individual (his personality, how he believes the drug will affect him, his emotional state, e.t.c) as upon the chemical property of the drug itself. But they typically use individual and group counselling, plus psychotheraphy.

A drug user generally stays in the residential environment for 6-12 months before gradually re-entering the outside community

over another 6-12 months, prior to graduation. The centre usually has the following units: a clinic, a central administration, residential units, recreational areas and vocational units or workshops.

CHAPTER FOUR

ARCHITECTURE AND REHABILITATION

4.1: DEFINITION OF ARCHITECTURE

Architecture is universally defined as the art and technique of designing buildings. Vitruvius defined "architecture as a building that incorporated utilities, firmness and delight". This definition recognizes that architecture embraces functional, technological and aesthetic requirement; it must have utilitarian qualities, firmness (structural stability and sound construction) and delight (have an attractive appearance).

All but the simplest culture have evolved characteristic forms of architecture and more complex societies command a great variety of styles, techniques and purposes that shape their buildings. Architecture is an important part of man's environment and he creates it himself. Buildings not only provide an immediate solution for mans needs but they also reflect his culture, and aspirations. In most cultures, buildings last more than one generation and therefore, the architecture of one generation will affect the next. As W.R. Lethaby stated, "architecture is building which is made to carry a story and convey a message" (Laurie, 1975).

4.2: ARCHITECTURE AND ENVIRONMENTAL MODIFICATION

There are two ways of characterizing environment:

i. The Objective Environment - This includes all identifiable physical and social factors.

ii. The psychological environment which consists of those aspects of the objective environment which a person comes into contact with and which affects his perceptions and responses.

It is obvious that the objective environment would include as a *prime physical factor, the total structured-space environment.* These architectural spaces constitute a major element in the psychological environmnt also, since they exert a profound effect on the emotional well being of the people experiencing them. There is a continous reaction on the part of the individual to the enclosed space in which he finds himself to such phenomena as size, scale, proportion, openings, closures, lights, colours e.t.c. Long and seemingly endless corridors, for example are disturbing to both mentally and emotionally *ill people. As John Pawson said during the launching of his new Calvin* Klein store in Manhattan, "one of the greatest luxuries of a building is the chance to walk unimpeded around bare walls. (Time mag., 1990). Endless corridors encourage a sort of distortion of perception which often encourages anxiety. Ambiguous spaces where size, shape and purposes are not clearly defined produce feelings of insecurity, and even panic.

Architecture is concerned with the controlling and creation of meaningful space. Space affects one and can control one's spirit. To a large extent, the pleasure which one derives from architecture springs in reality from space. Space can not be visually percieved; one sees only objects in space, or structural members that enclose the space, but its effect is upon the emotion, and can not be rationalised, measured or depicted. Every building has two types of space; its internal space and its external or urban space, defined by that building and others around it.

A person can guage and describe accurately enough the effectiveness of an architectural construction in terms of its structural soundness, its provision for warmth, ventilation, sanitation, light and other physical factors. One can criticize its components in terms of proportion, textures, colour and other aesthetic considerations. But beyond all of these there is an overall effect which is exerted upon one's consciousness by architectural spaces and which is highly significant in determining an individuals comfort or stress.

4.3: ARCHITECTURE AND THE SOCIAL ENVIRONMENT

The architect who designs a house, builds it, designs a site plan, decides which direction the house will face and how close it will be to other houses, will be deciding the pattern of social life among the occupants of this house to a great extent. There is a role played by

structured space in conditioning inter-personal and family relationships, and it is within the context of these relationships that the seeds of general alienation or ill health often take root in the individuals personality.

Beyond these direct influences, there is a subtle but pervasive role which the spatial environment plays in the area of status. The individuals self-esteem may be affected by the spatial character of the structures and urban areas where he occupies or frequents. His evaluation of these spatial conditions will affect his sense of his status in the eyes of others and this in turn will influence his self-esteem.

4.4: STRUCTURED SPACE AND PERSONALITY

There is a dynamically reciprocal relationship between structured space and the psychological state of individuals. This reciprocity occurs not only in socio-cultural areas but also in the physical environment. As the development of an individual from birth to maturity is the result of inter-actions with his surroundings, so culture is the product of prolonged and cumulative interaction with the environment.

An important aspect of this interaction lies in the area of perception; the impact which a space has upon an individual experiencing it will be conditioned in different ways by that individuals

psychological state and his prior experiences. The appearance of structures like walls, floors, and ceilings, and the materials of which they are constructed will depend on the percievers experience of space presently or in the past.

Perception as defined by Ittelson (1968), "is that part of the process of living by which each one of us from his own particular view creates for himself, the world within which he has his own life experiences and through which he strives to gain his satisfaction". The built environment is as subject to distortion and interpretation by human perception as any other element of our environment. It has no fixed character, indeed no real existence except in relation to people and their personalities. It is worth stressing that personality can not be viewed as an isolated element in the human system, but rather as dynamically related to the physical being of individuals, and to the world around them.

Despite individual differences and cultural variations, there exists unity in every human being. This means, we are alike, similar in emotions, responses e.t.c, and as such are subject to conditioning. When some kinds of organisms respond to similar situations, similar outcomes can be expected. Architecture truly concieved is nothing less than the conscious and careful determination of our whole structured environment and its social implications has a tremendous effect on

shaping the individuals personality. The fulfilment or frustration of the individuals needs, the impact of early life experiences, and the standard or relations within the structured environment helps to determine the individuals health condition.

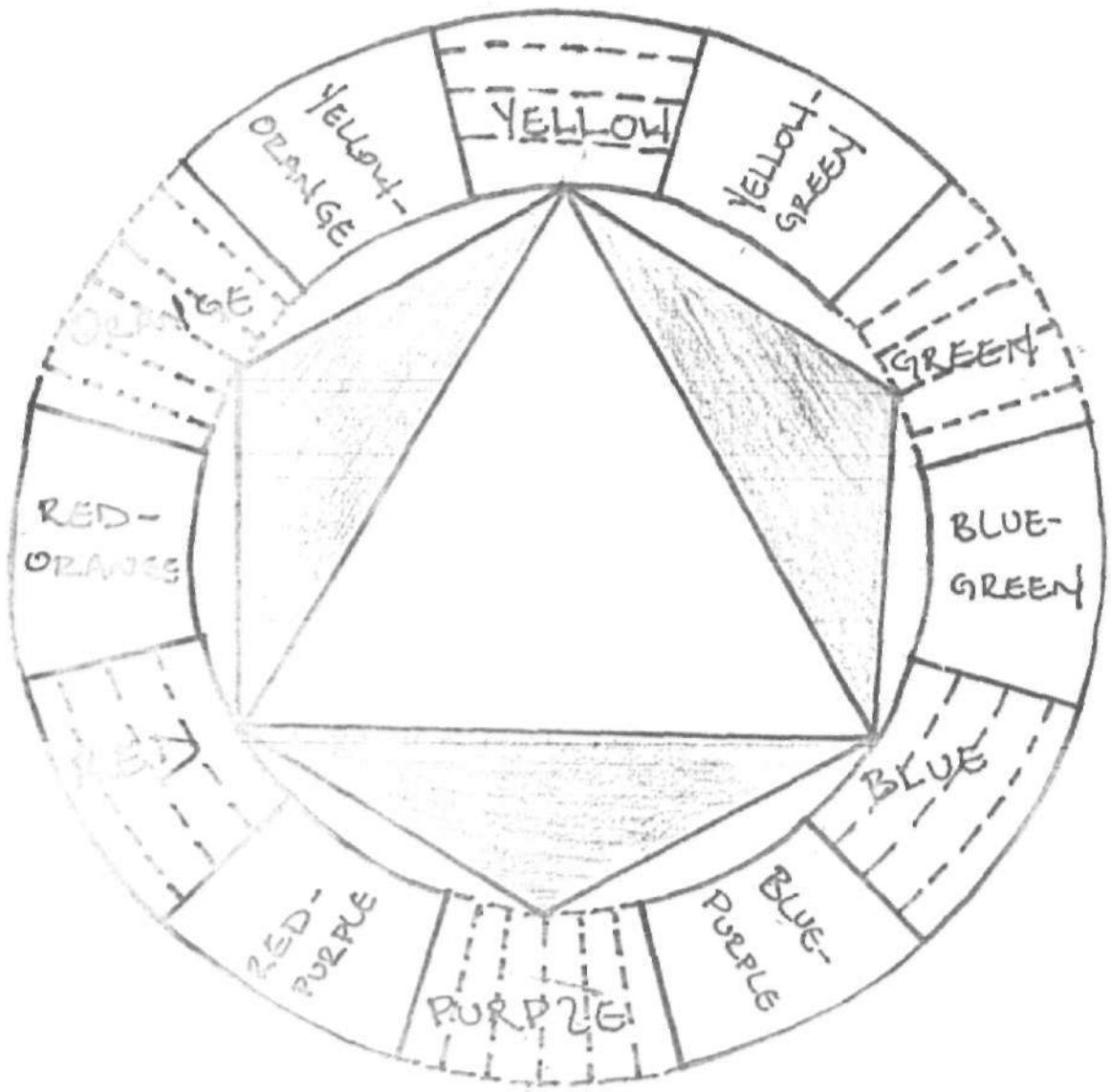
4.5: ARCHITECTURE AS A REHABILITATIVE TOOL

Architecture plays a vital role in all professions, not only in providing a conducive physical environment within which the practice of such professions are carried out but also in arresting the psychological environment which affects the perception and response of the people concerned. Architecture as a rehabilitative tool is centred on the psychology of the structured environment as a therapeutic tool. Architectural spaces constitute a major element of the psychological which exerts a profound effect on the emotional well-being of the people who experience them. The social and therapeutic inter-action of people within such spaces also exerts an effect on each individuals self-esteem.

4.5.1: COLOUR AS A THERAPEUTIC MEDIUM

If we wish to understand colour and to know why it is better to choose some colours rather than others for a particular use, we would do well to learn something of the nature and language of colour. The psychologist shows how a person is affected by the colours he sees and how colours are affected by one another.

The Colour Wheel



- Primary Colours
- Secondary Colours
- Intermediate Colours

Colour is simply the decomposition of whitelight, which is composed of the seven colours in the spectrum: red, orange, yellow, green, blue, indigo and violet. (Uzoagba, 1985). Colour may be divided into six classes:

i) Primary colours: There are three primary colours, red (R), yellow (Y) and blue (B). They are so called because they are the only pigments that can not be obtained by mixing other colours.

ii) Secondary colours: When two primary colours are mixed in equal proportion, a different hue results. This hue is called a secondary or binary colour: orange, green and violet.

R + Y = orange

R + B = violet (or purple)

Y + B = Green

iii) Intermediate colours:- When a primary and a neighbouring secondary colour are mixed, an intermediate hue results. It is usually half-way between the two colours in appearance. The six intermediate hues are: yellow-green, blue-gree, blue-purple, red-purple, red-orange and yellow-orange.

iv) Tertiary Colours:- The mixture of two secondary colours is a tertiary colour. Tertiary yellow is smoky yellow; tertiary blue is slate blue and tertiary red is brick red.

v) Complementary Colours:- Any mixture of two primary colours is a complementary of the third. For example blue and yellow mix to give green; therefore, the third primary coloured is complementary to green.

vi) Harmonious Colours:- These are colours that go well together. Colours that lie side by side in the colour wheel can be combined harmoniously because of the basic colours they share. For instance, yellow is the common colour of green and orange. It is important for any artist or designer to have a knowledge of the fundamentals of colour harmony. There are two general laws of harmony:

a) the colours must be related to one another in some definite way

b) one colour must dominate; equal competition between colours in a design or painting must be avoided.

Combinations of complementary, or near complementary, colours are often considered to produce more satisfying colour schemes than the relationship of hues that appear next to one another in the colour wheel.

Colours in themselves exercise an influence upon our emotions. Many of these emotions are the result of the direct action of colours on the nerves of the eyes. Colour can create moods and feelings similar to those induced by fine music.

i) White:- Gives a feeling of lightness, purity and gaiety.

ii) Black:- Spreads gloom. A symbol of mourning and depth.

iii) Blue:- Cool and soothing. For example, we rest and sleep more easily in a room painted blue than in a room painted green, yellow or red. Blue can be a symbol of live. Dark blue can be depressing while light blue gives an impression of delicacy.

iv) Red:- A warm colour. A bright red suggests gaiety and a dark red suggest friendliness. Red is also exciting and aggressive. Perhaps, that is why red is generally used as a danger signal.

v) Yellow:- The warmest and brightest of all colours. It is stimulating and hints of sunlight, moments of joy and light-heartedness. It can also be a symbol of hope.

vi) Green:- Reflects the in-between moments of stimulation and depression. It is the most emotional neutral colour of all. Thus it is cool and restful. Green can be regarded as a symbol of growth and life.

vii) Orange:- Suggests sunlight and anger.

viii) Grey:- It is a neutral colour.

ix) Violet:- It is the least pleasant colour of all. It has an emotional quality of depressed excitement or anger, which is unhealthy.

x) Purple:- It is a "royal" hue, that is best for depicting qualities of stateliness.

4.5.2: LANDSCAPE AS A THERAPEUTIC TOOL

"Nothing is of greater importance", said Sir John Soane during the 12th of the Royal Academy lectures he delivered in 1809, to the professional character of the architect"than a thorough knowledge of construction, and of the nature and quality of the different descriptions." (RIBA 1984).

Twenty years ago, Sir Geoffrey Jellicoe asserted that, "the world is moving into a phase where landscape design may well be recognized as the most comprehensive of the arts". (RIBA 1989) Unfortunately, landscape design is still usually regarded as a picture or pretty view, something added after the "serious" design decisions have been made as projects are "landscaped" to become acceptable to the planning authorities. Change is essential to the status quo and architecture thrives on change. Great landscapists of our time are Carlo Scarpa, Brion Tomb, Alvar Aalto, Richard Burton and Frank Lolyd Wright to name a few.

Landscape and phychology go hand in hand. Among several distinct types of psycho-events are two of particular interest. "Sensing" and "feeling". Sensings are mental data about people and places derived from our innate faculties. Some are factual, such as a sense of time, rythum or direction; others are critical, such as a sense of beauty, occasion and formality. Feelings are emotional responses to places and people, such as pleasure, melancholy, or awe. They can result from sensings, or come directly from perception.

Along with "eventuality", the other concept is "sensationism" a method of analysing places by using the senses, with the "read-out" expressed in meanings, feelings, values, and so forth. It starts from the premise, that place can be regarded as a complex cipher (system), which is interpreted or decoded by people in different ways (the "meaning" part). These messages lead in turn to intellectual and emotional responses, depending on individual psychological properties (the "feeling" part).

With observation and patience, relationships can be established between certain sights, scenes, signs and symbols belonging to place, and feelings belonging to people. Given an understanding of these relationships, the designer can determine the character of a particular place and the kind of feeling it evokes in people. The media are the physical properties of place-plants, shapes, components, colour, noise; the ways in which they communicate include association, allusion and connotation.

Landscape philosophy will always cover a wide spectrum of opinion and design expression. Its practitioners are developing a sense of identity based in some cases on intuitive aesthetic and inventiveness (the art side), and in other cases on hard information and rational pragmatism (the science side). The beauty and usefulness of "sensationism" is that it belongs to both sides. It indeed is an essential part of future landscape. All landscape which has been subject to human occupation contain the ghosts of previous cultures as well as the aspirations of their current occupants.

CHAPTER FIVE

5.0: CASE STUDIES

In order to successfully design for the staff and patients that will reside at the drug addicts therapeutic centre; it is necessary to study similar existing centres. It is worth mentioning here that most of the drug addicts rehabilitation centres in this country are not up to international standards. I visited quite a few Institutions for rehabilitation and I would like to comment on some of them before we proceed with the three selected case studies.

A) The Daughters of Abraham Foundation, Abuja

It is a non-profit making organization aimed at the restoration of the dignity of Humanhood. Its President and Founder is Mrs. Julie Useni the wife of Lt. General Jeremiah Useni. It is presently situated at its temporary site at Adetokunbo Ademola Way in Wuse phase II.

The foundation believes in the total salvation of the prostitute through a 4-point programme of regeneration, restoration, rehabilitation and recreation. It's permanent site is at Jabi, when completed it will have a general administration block; a faith clinic; medical clinic; vocational clinic; and educational clinic. The day to day activities of the foundation are coordinated by Evangelist Margaret Baryo. At the time of this write-up the foundation had 16 staff on its payroll and 80 daughters.

B) The Joseph Project Foundation, Oro, Kwara State

It is also a non-profit making organization aimed at the resettlement of ex-convicts and destitutes to respectable and productive life through having an ideal relationship with God and; learning and acquiring proficiency in trade. It is run by Mr. Ade Bodunde.

It is a farming commune situated at Oro, in Kwara State. It has the following units: a chapel building, residential buildings, office buildings, classroom, clinic and sizeable farmland.

465779

C) Christ Against Drug Abuse Ministry (CADAM)

It is a non-profit making organization run by Redeemed Christian Church of God, Acme Parish, Ikeja. Of all the centres visited this one was the most like a home and their method of treatment was uniquely different from the rest.

Situated at Ekpe about 50 kilometers outside Lagos it is a self-contained village. A well organized and landscaped institution. The Programme Development Officer is Mr. Samuel Davies. Their motto is "Gods Love to the Hopeless". They believe the war on drugs is a spiritual and not a physical one and unless the addict realizes that in his own strength he can't win the battle he will never win. So getting right with God is the first step used by the Alcoholics Anonymous, the most successful rehabilitation

tool in the world so far.

Before we go into our case studies I would like to briefly mention something about prisons. Some people at the NDLEA believe that drugs addicts should be locked up in prisons and the keys thrown away but from research I have found that this will not solve a thing. The following quotation by Theodore Ziegler a drug treatment administrator sums it up very nicely:

> "Prisons are not the answer to addiction. We have one treatment facility called Raymar. It is a nice place-individual rooms, a complete staff, video cassette recorders, stereo, movies, and a great look. I should have it so nice in my own home. We have prisoners brought to us in chairs; they have been remanded for treatment. They've been told that they have to stay for at least 90 days. In the lst week a lot of them elect to go back to prison because there you do not have to change anything about your life. If your stay at Raymar,, the staff are going to make you bath, brush your teeth, launder your clothes, examine your life and make you talk about what is wrong and confront it". (Gossop, 1992).

5.1: Psychiatric Rehabilitation Centre, Parktown, Johannesburg, South Africa: Architect Jo Neoro Architects, South Africa

Introduction

About 10 years ago, Walberton Manor, a typical Edwardian Parktown Villa built in 1908 was bought by the Talisman foundation, a private welfare organization providing residential and day care services for people suffering from mental illness.

Aim:

The foundation aims to bridge the gap between illness and re-integration into the community.

Programme:

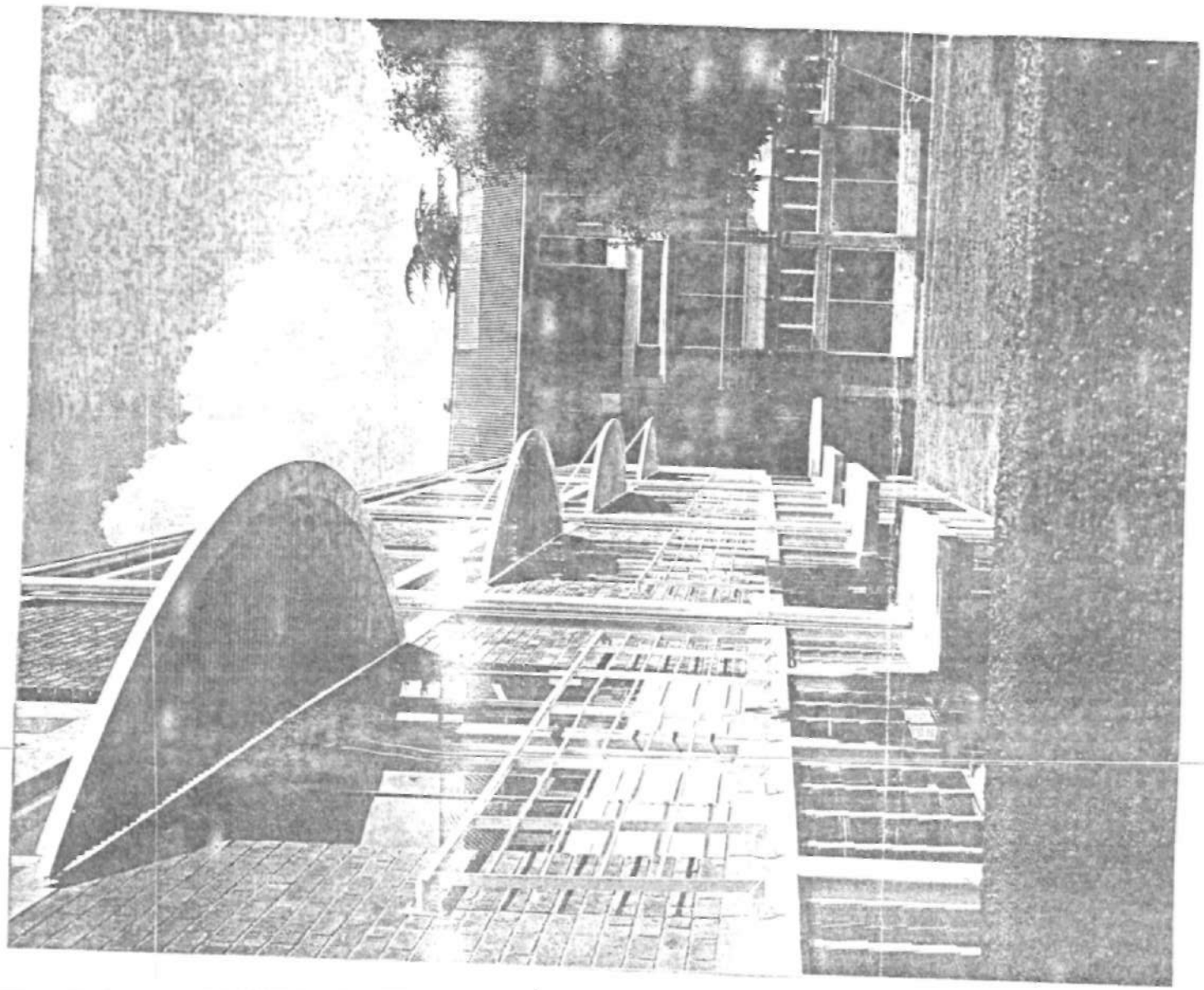
The programme includes six individual departments-intended to encourage the skills required for independent living-together with workshops, and officer for the centre's therapists and nursing staff.

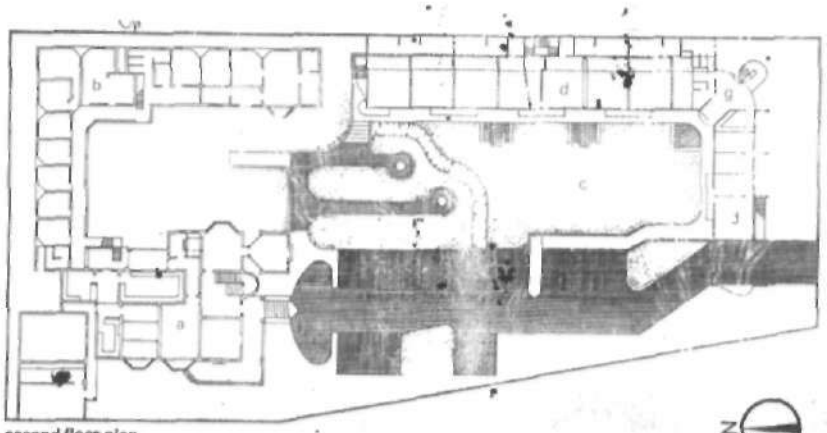
Structure:

It is comprised of three-storey block mirroring an L-shaped administrative block. It encloses an enlarged central courtyard which has a pleasant quad-like scale and forms a defining street edge to the South. The two wings of the L-shaped plan are hinged around a circular core and entrance lobby. The upper storeys are divided into well proportioned flats, with offices, theraphy rooms and workshops on the ground level.

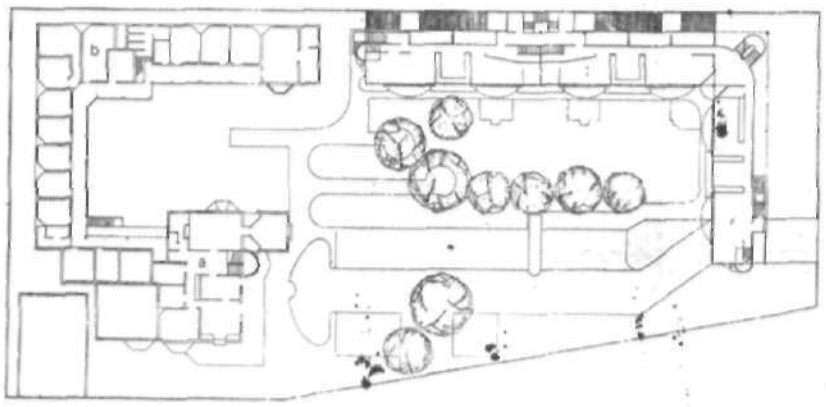
Merits:

1. The windows are deliberately generous-sunlight has a beneficially therapeutic effect on the residents and being able to see out helps calm fears of classtrophobia.
2. The exposed concrete frame of the top storeys is infilled with brick and the lower storey is rendered a Barragenesque blood red, an appropriate choice, since Johannesburg's scorching heat is similar to Mexicos altitudinous intensity.
3. The structures are legibly and simply expressed, making them demystified and more accessible.

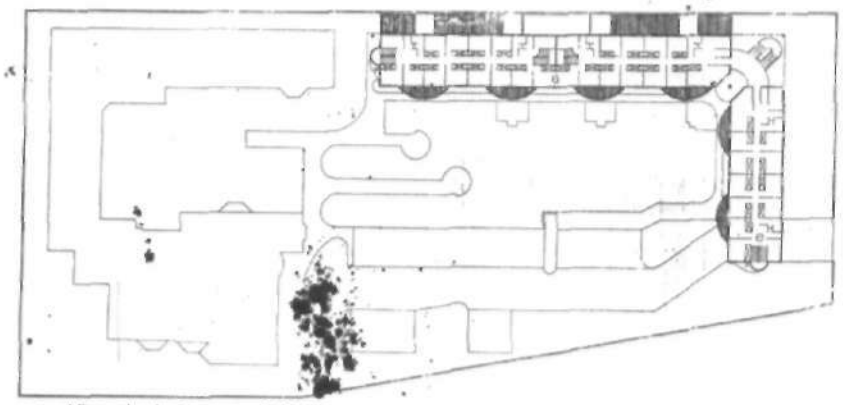




second floor plan



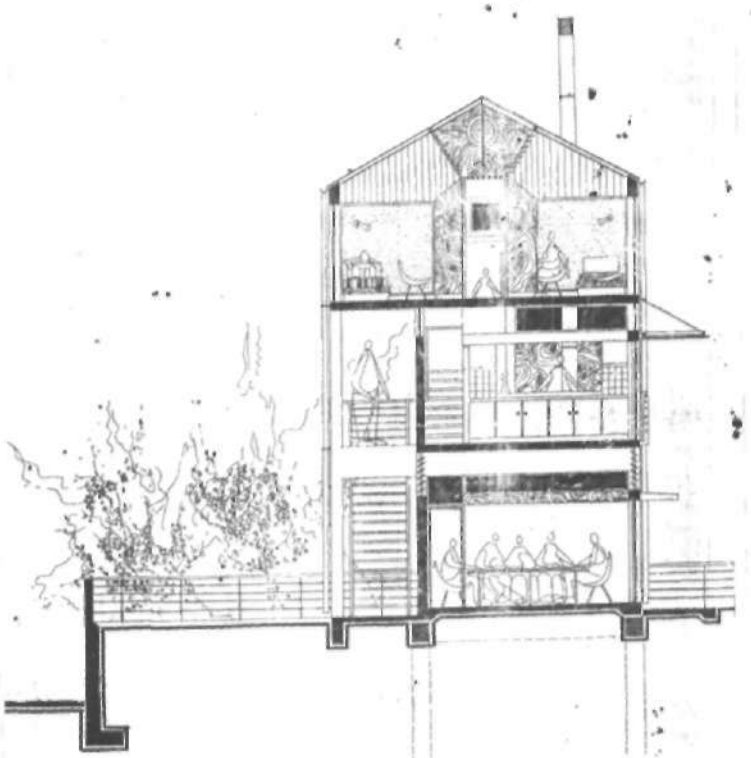
first floor plan



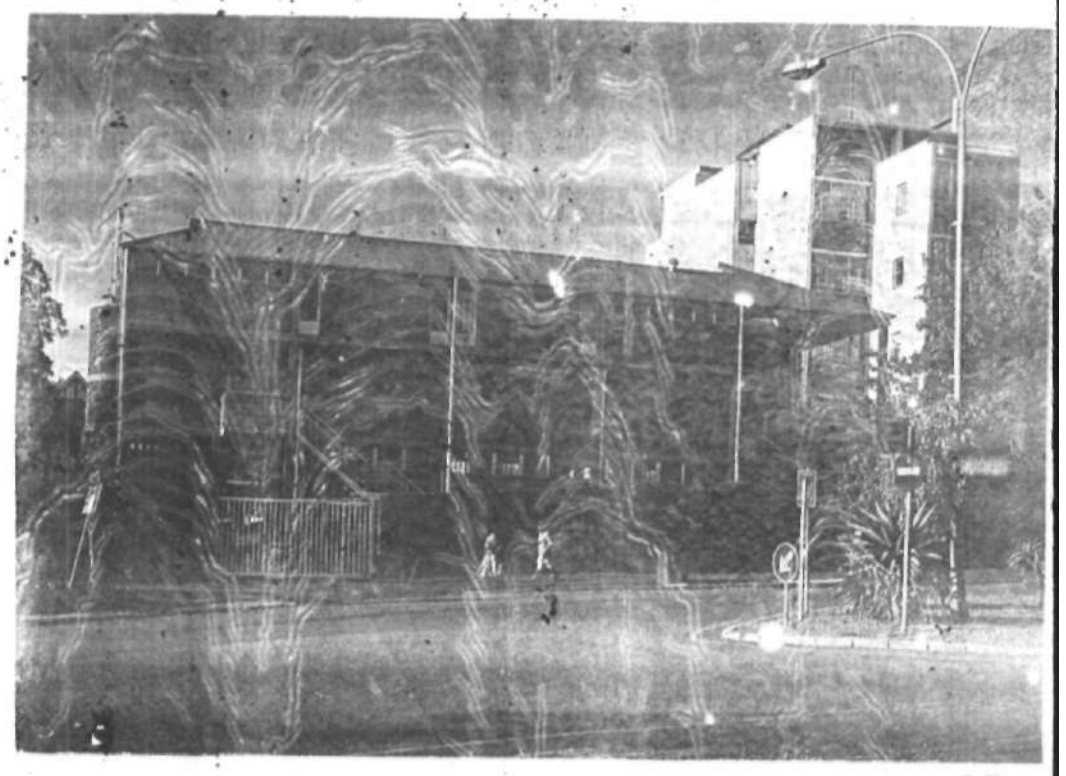
ground floor plan (scale approx 1:1000)



b existing annexe
c courtyard
d offices and workshops
e individual flats
f communal areas
g main entrance



cross section



4. While not excluding the outside world to the point of being monastic, the courtyard forms a tranquil inner realm, striking in appropriate balance between the building's public and private dimensions.
5. Well landscaped courtyards.

Demerits

1. There is no space for horizontal expansion since the land is banked by roads on two sides. Vertical expansion gives an unstable minded person the feeling of alienation.
2. No security measures whatsoever to protect the patients from themselves.

Conclusion:

Both literally and metaphorically, it is a half-way house- but it is also a beautifully replized example of Architecture's therapeutic potential.

The two case studies chosen in Nigeria are situated in the Northern parts of the country to indicate that a lot of works still needs to be done concerning rehabilitation in this part of the country.

5.2: Our Lady of Victory Drug and Alcohol, Rehabilitation Centre, Jos, Plateau

Introduction:

Opened in 1987 the centre is located near Sabon Gidakana village, 4 kilometres off Bukuru on the Jos-Akwanga highway

(23 kilometers to Jos town). It is a farm house leased from the Tin Mining Corporation of Nigeria. It is out in the scenic picturesque and wind-swept plains of the Jos Plateau.

Aim:

Its one aim is to save the lives of the millions of men and women ensnared by the terrible but subtle epidemic that is our own equivalent of the Aids virus. (Drugs and alcohol).

Programme:

Treatment is based on a method developed by Hazeldon Centre in City Centre, Minnesota, U.S.A. Under this system, patients undergo guidiance of professional counsellors, group therapies, meditation and reality therapy sessions designed to restore them to health and enable them to resume meaningful and productive lives in the society.

Staff:

The centre overseer is Reverend Father Jack Yaley a former alcoholic himself. It is manned by a full-time and 5 part-time trained counsellors and other supporting staff.

Cost:

It is a non-profit making organization sustained by charity. However, to help subsides treatment cost, patients pay a meagre sum of 30 Naira per day covering accomodation, feeding and treatment. A non-refundable deposit of 1,000.00 is also paid upon admission.

Structure:

It is a 14 bed inpatient treatment centre and only 3 females are admitted at once. Facilities include indoor/outdoor games, and a library for group and individual use. It is comprised of all facilities under one roof.

Merits

1. The place is slightly landscaped, very serene and quiet; conducive for the sober meditation and introspective self-research and analysis essential for treatment.
2. Being a farm house it gives a homely air, not to mention the vast surrounding greenlands.

Demerits

1. It was not designed to be used as a rehabilitation centre, offices and other facilities are inadequate in number.
2. Only very few patients can be accomodated at once and only three female patients. It is grossly inadequate, accomodation wise.
3. No security measures whatsoever to protect the patients from themselves.
4. It is a conventional brick farm house building.

Conclusion:

The methods of treatment are very effective. Landscaping is natural due to the environment it is surrounded by. It also

has plenty of space for recreation and to help prevent claustrophosia.

5.3: DRUG ADDICTS REHABILITATION CENTRE, MINNA, NIGER STATE

Introduction:

Commissioned on the 3rd of March, 1990. The centre, a project of the Association of Lady Pharmacists in Minna is one of the most extensive rehabilitation centres in Nigeria. It is sponsored and run by the United Nations Drug Rehabilitation Control (UNDRC), the State Govenment (Niger), Association of Lady Pharmacists Nigeria (ALPS) and philantrophic donations.

Aims:

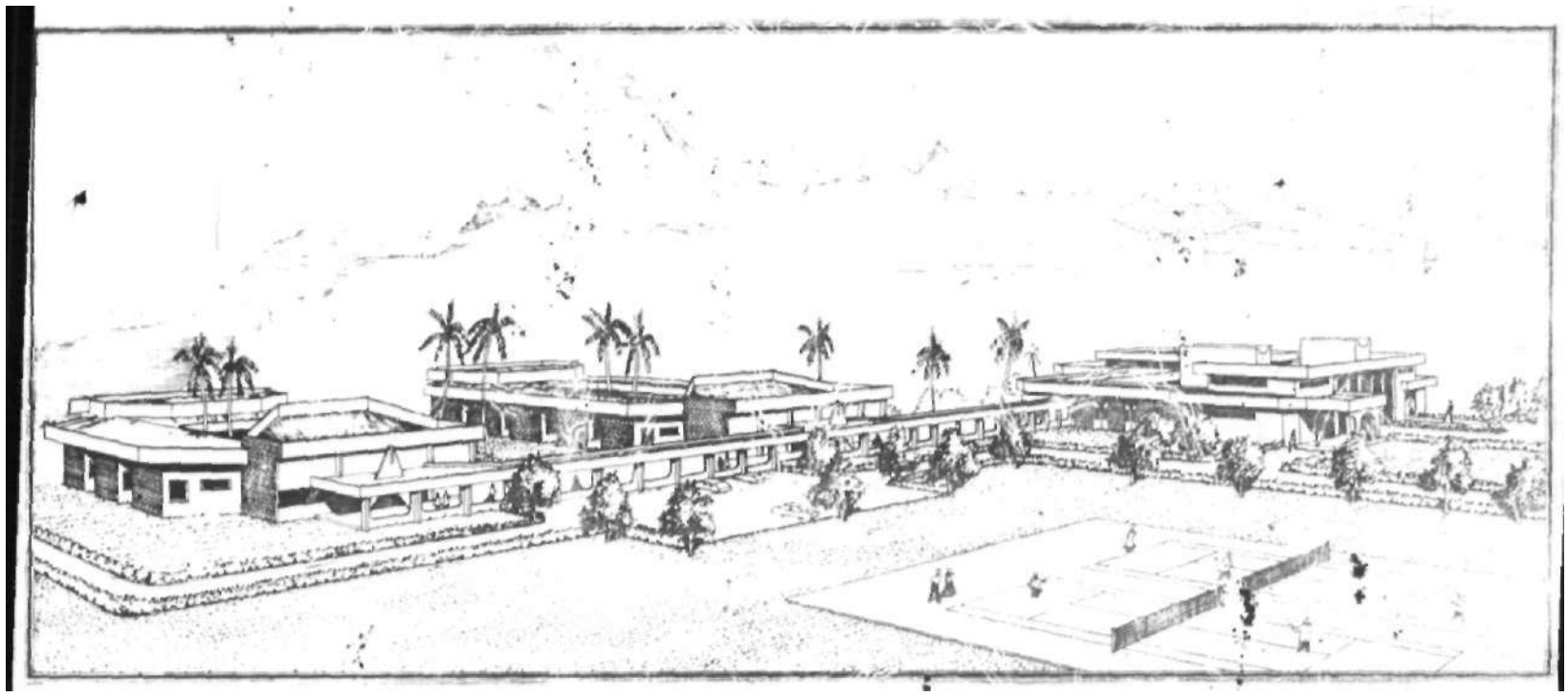
ALPS aims to assist mankind in the fight against drug misuse, and abuse by public enlightenment campaign, education and counselling throughout the States of the Federation.

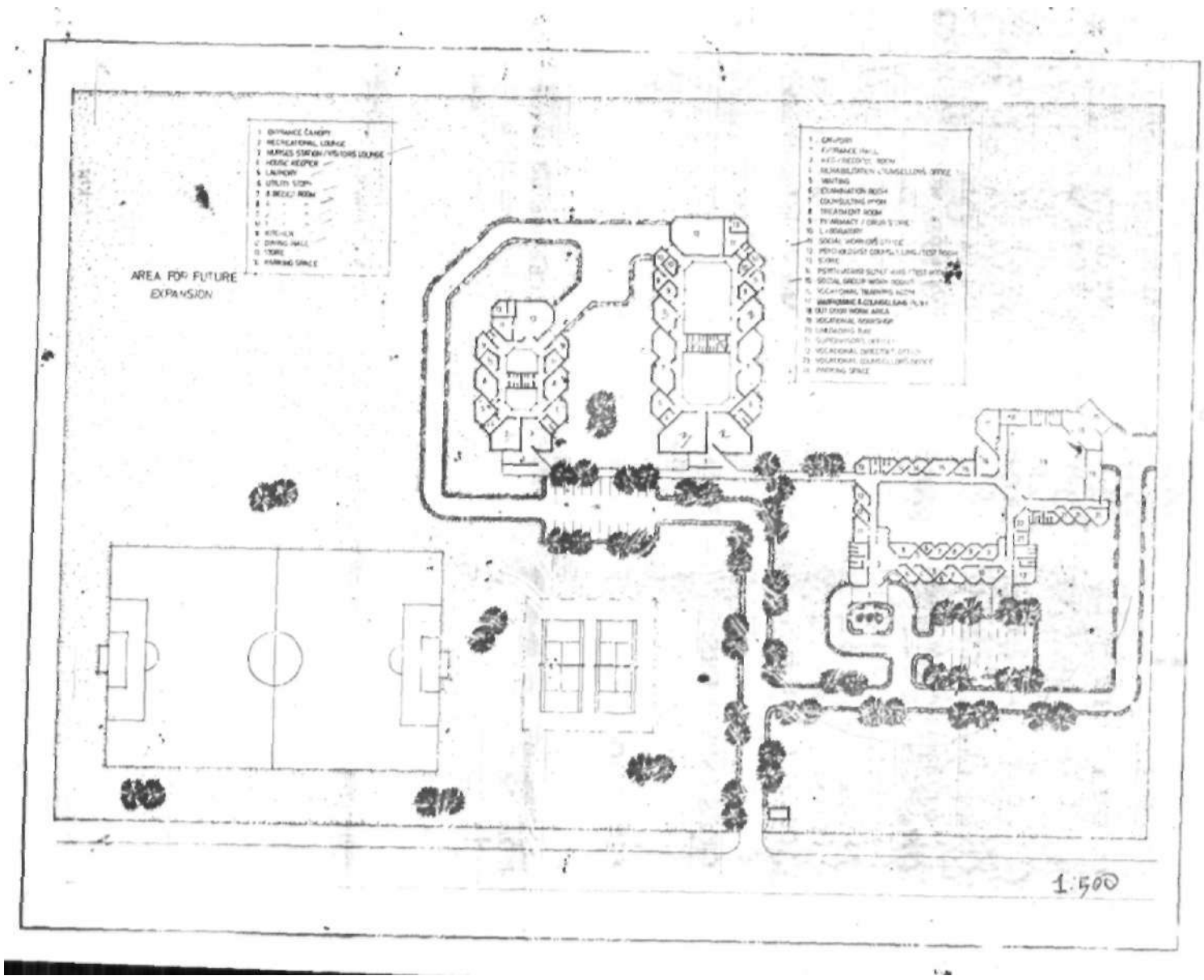
Programme:

The programme includes drug counselling education, pharmacotheraphy, psychotheraphy, vocational services, urine testing, relapse prevention and, social and community support. Housekeepers and nurses reside within the premises.

Structure:

The centre is composed of broadly, four units. The central administrative block, the male and female hostels, the vocational areas and the outside recreational areas.




AREA FOR FUTURE
EXPANSION
1:500

The buildings are sandcrete block walls painted white with sloping roofs covered by parapets. The different units have very appealing and unique forms.

Merits:

1. The site is very vast and facilities are well grouped.
2. Unique form concepts for each individual unit and large internal courtyards that are multipurpose.
3. Provision of adequate external recreational areas like a football pitch and lawn tennis courts.
4. Very secure.

Demerits

1. It is run like a cross between a prison and a hospital. Patients are made to feel like inmates.
2. Vehicular and pedestrian movement are not properly seperated.
3. Site not well landscaped. No introduction of flowers for landscaping, only green shrubs that give the environment a monotonous look.

Conclusion:

A very interesting centre, design wise. It is an architectural challenge to produce a centre that is more functional and inter-married with its sight.

CHAPTER SIX

SURVEY OF STUDY AREA AND SITE

6.1: STUDY AREA

6.1.1: ORIGIN OF ABUJA

The geopolitical entity known as Abuja came into existence by decree No.6 of February 5th, 1976. Until the creation of this new Federal Capital Territory (FCT), Lagos had remained the capital of Nigeria. Since the amalgamation in 1914. With time, the increased tempo of economic activities and the influx of people into Lagos were not matched with corresponding increase in the level of infrastructural activities and services. Thus, the city was over-burdened and it's facilities were stretched to breaking points.

In 1975, the Federal Military Government under the Late General Murtala Mohammed set up a panel under the Chairmanship of Justice Akinola Aguda, to examine the issue of relocation of the Federal Capital. The panel submitted its report, recommending Abuja for being among other things, centrally located with easy accessibility from all parts of the country by road, rail and air.

The name, "Abuja" is derived from the most important settlement within the territory, known today as Suleja. Abuja was grafted from Niger, Kwara and Plateau States. It has a total land area of 8,000km^2.

6.1.2: POPULATION AND PEOPLE OF ABUJA

Prior to the creation of the Federal Capital, the area which now constitutes Abuja was sparsely populated. The population was put at 109,000 in 1963 and 125,000 in 1977.

However, since 1980 when physical development of the city and other parts of the territory commenced, Abuja has experienced considerable increase in its population. Results of the national population census conducted in march, 1992 put the population of Abuja at 378,671. The rapid growth will continue in the foreseable future, having regard to the on-going programme of moving the seat of government from Lagos to Abuja.

The significant indigenous ethnic groups consists of the Gwari, Gade, Koro and Gwandara. But with the influx of immigrants from different parts of the country and beyond the structure, ethnic composition and socio-economic characteristics of the population of Abuja have been affected tremendously.

6.1.3: GEOGRAPHY

Abuja lies between longitude $7^{o}.45$ and latitudes $8^{o}.25$ north. It lies just north of the alluvial plains formed by the confluence of rivers Benue and Niger. It is within the hot and humid low land of Benue/Niger trough.

There are four major rivers that flow through or are adjacent the territory into Benue/Niger trough. The first is River Kaduna; it is the largest and lies to West and North of the territory. It's watershed drains most of the territory into the Niger. The second is Gwarara River; which passes through the territory along the western edge into the Niger. East of the territory, lies the Okwa River; while between river Kaduna and FCT is the Jatau river.

An extension of the Jos Plateau, known as Jama'a Plateau continues into the middle of the territory.

6.1.4: CLIMATIC DATA

A) RAINFALL

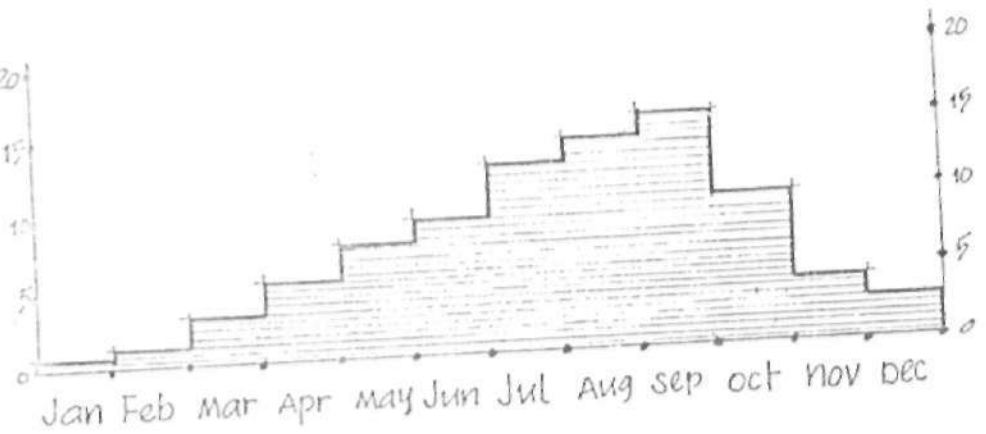
Rainfall is between the month of April and October. Mean monthly distribution shows a concentration of rainfall in the month of July, August and September.

Squall lines which also occur is a seasonal characteristics of the rainy season. It brings dark clouds, accompanied by strong winds, thunder and lightening and followed by torrential rainfall. This phenomenon often causes property damage.

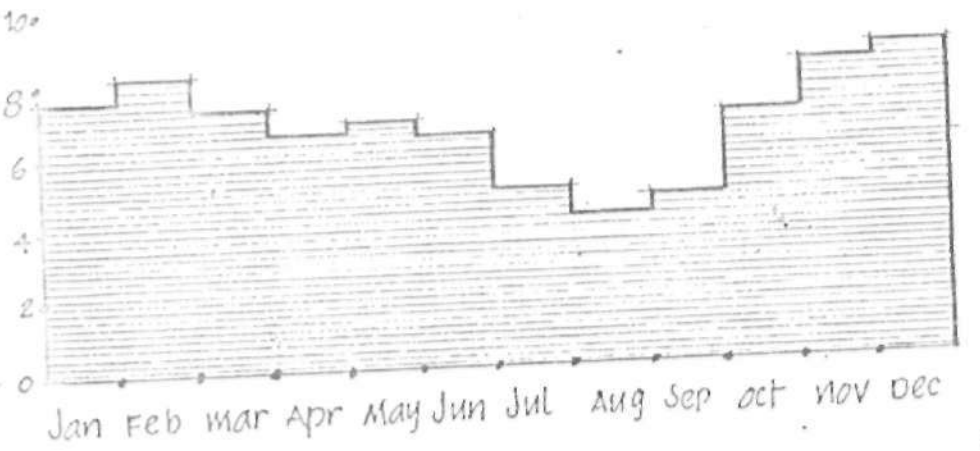
B) WINDS

Two air masses affect the F.C.T., the first is Tropical Maritime Air Mass, it is asociated with the South-West monsoon

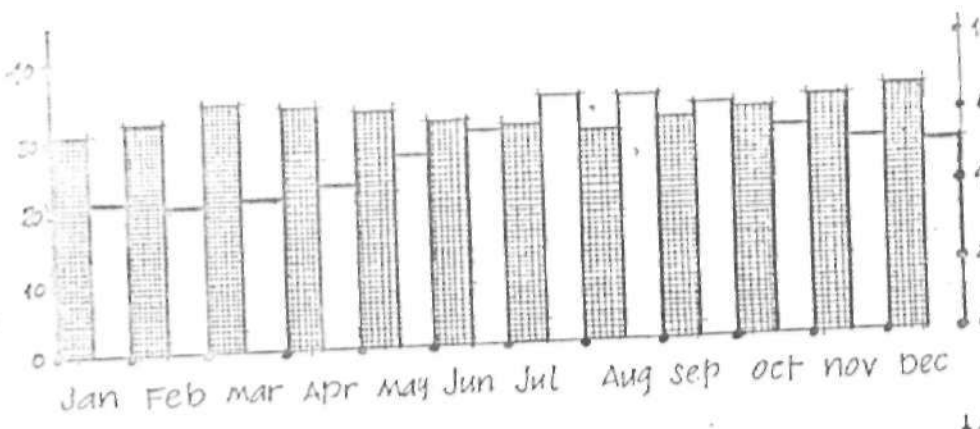
i Average monthly rainfall [mm]



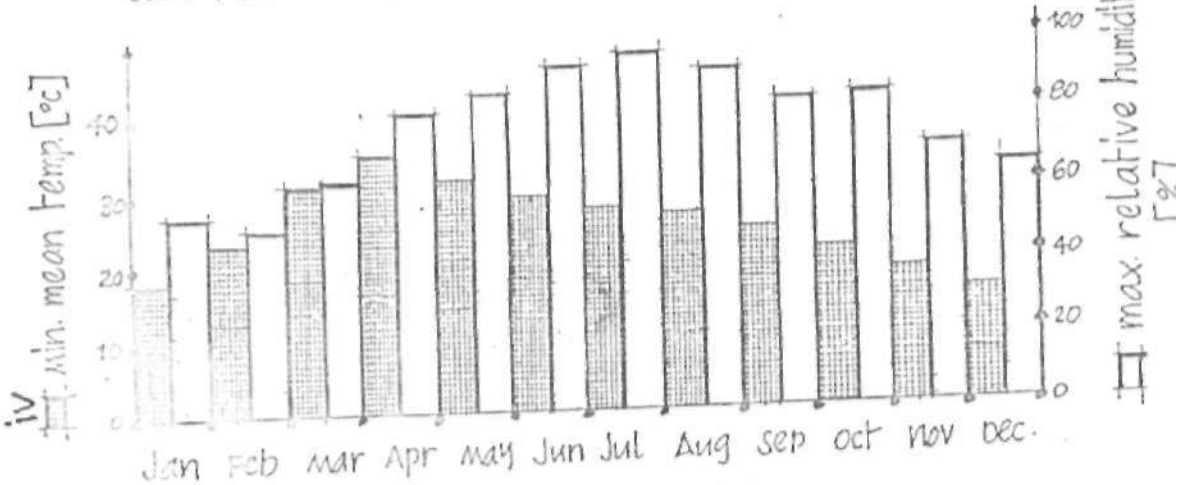
ii mean monthly sunshine duration [hrs]



iii max. mean temp [°c] — min. relative humidity [%]



iv min. mean temp [°c] — max. relative humidity [%]



AFUA CLIMATIC DATA.

winds. It is warm, moist and brings rain. The second is tropical continental air mass. This is developed over the Sahara. It is hot, dry and dusty, causing dry season from November to March. It is associated with the North-West trade winds, which brings about the dry season.

The intensity and duration of each type of wind over a particular place vary due to the interface of these two air masses.

C) SUNSHINE

The city is exposed to 2500 hours of Sunshine annually. This figure is highest in the months of November to April, when the monthly variation increases to over 2750 hours. During rainy season, when there is cloud cover, sunshine hours value decreases; it is lowest in August.

Averagely, a minimum of seven hours Sunshine is experienced each day.

D) TEMPERATURE/HUMIDITY

Abuja records it's highest temperature in the dry season when there is no cloud formation. For such a period, diurnal temperature difference of up to $17^{o}C$ is recorded when the sky is clear. During rainy season, temperature is low due to thick cloud formation. For this period diurnal temperature are also low, not exceeding $70^{o}C$ in the month of July and August. Relative

humidity falls in the afternoon to as low as 20%, during dry seasons; this causes desiccating effects. During wet seasons, relative humidity goes up as high as 95% causing heat-trap.

6.1.5: SITE EXISTING LAND USE PATTERN

The immediate situation of the site consists of two distinct land use features; peasant farm land characterize about 60% of the site environment. The remaining 40% consists of total bush area that is probably used for grazing of cattle by herdsmen.

6.1.6: TOWN PLANNING REGULATIONS IN ABUJA

1) Harmony of building with the site and surrounding environment.
2) Accessability in terms of (a) traffic (b) Parking (c) Pedestrian movement.
3) Proper and effective landscaping
4) The design project should take into account the existing building in the area with respect to linkage with the following network:
   (a) Water in collaboration with the water supply grid.
   (b) Electricity in consultation with NEPA supply grid.
   (c) Drainage of rainwater and waste water complying with laid down guidelines and proceedures.
5) Fire Security for the area involved.

6) Proper zoning in compliance with planning authorities or the Federal Capital Development Authorities.

7) Good building orientation - for minimum glare and wind problem.

8) The design project must have good regional character depending on the type and nature of the building.

9) The Federal Capital Development Authority must approve of all the parameters prior to the design and construction of any project.

The above must all be strictly adhered to.

6.2: THE SITE

6.2.1: SITE SELECTION CRITERIA

The selection of site for a drug addict therapeutic centre should be based on the following parameters:

a) LOCATION: The choice of location of the site should be in relation to the following:

- ZONING: The site should be within an area reserved for institutional facilities. It should be far from industrial zones to avoid polution by harmful industrial smokes, fumes and soots.
- EASE OF ACCESS: To and from site, to allow for smooth traffic flow. The site should also be within easy reach to attract high number of patrons.

- adequate space for expansion.
- adequate space for parking.

b) TOPOGRAPHY/GEOLOGY

The terrain of the site should be gentle with relatively uniform slope, so that courtyards and fields do not significantly slope or require costly cut-offs and fill-ins.

The geological masses should be such that can be easily excavated.

c) SOIL

The soil should be able to support weight of heavy structures. It should have moderate to high degree of permeability to prevent water logging. The soil should have a minimum of 25cm topsoil layer to support turf.

d) HYDROLOGY

The water table should be at least 70cm to support plant life.

e) ECOLOGY

The site should have adequate vegetation cover for landscaping and to create micro climates.

f) CLIMATE

The micro-climate should be conducive for rehabilitative activities.

6.2.2: SITE JUSTIFICATION

The site chosen for the Drug Addicts Therapeutic Centre by the Federal Capital Development Authorities has the following potentials, all of which agree with the criteria for the selection of therapeutic centre site. These potentials are:

- It is located within an Institutional/Residential area. The site is large enough to accomodate all the anticipated centres facilities, parking requirements as well as enough room for expansion.
- It is strategically located to attract patients.
- It is relatively flat and therefore suitable for a Drug Addicts Therapeutic Centre.
- It offers parkland savannah vegetation cover and it has predominantly alluvial soils for landscaping and sustainance of turf.
- The site is underlain mainly by igneous and metaphoric rocks which can support heavy structures.
- It is not close to any industrial zone and therefore it is safe from environmental hazards.
- It offers good view for leisure.

However, the site has the disadvantage of being close to a major express way. But this problem can be easily resolved.

6.2.3: SITE ANALYSIS

i) Introduction

The site proposed for the Drug Addicts Therapeutic Centre is located on the North-Western bank of Jabi river. This river is dammed at the bottom. It is located within the phase II development of the city and will be retained as a recreational facility, as well as a source of water, for irrigation for the parks and gardens that would be developed in phase II.

It is centrally located and has perfect links with the central areas of phase I and phase III.

ii) Geology and Topography

The site is underlain mainly by crystalline, igneous and metamorphic rocks. The main geological formations of the site are fine-to-medium grained, biotite granite and magmatite.

The terrain is steep, with relatively uniform slopes encasing a knoll which helps to reduce flooding to a minimum.

iii) Soils

Alluvial soils majorly of laterite dominate the whole site and occupy about 75%. Alluvial soils which consist of weathered debris accumulates at the foot of the slope.

iv) Vegetation

The vegetation of the site is predominantly park and shrub savannah with trees and shrubs in different proportions. Tarminalia, Avicennoides, Andropogrum Tectorum is a common grass species found all over the site.

v) Services

A) Electricity: At present an 11 kilovolts power-line passes along the B12 Parkway on the sites Northern axis and 32 kilovolt lines exist alongside the adjacent Ring Road I. Electricity will be tapped from the 11 kilovolts power lines for our site.

B) Water Supply: There is a 600mm mains from the Sardauna of Plateaus housing estate along the B12 parkway. Water will be tapped from this water mains. Water can also be tapped directly from the Jaji river banking the site.

C) Drainage Network: The site is drained by Jaji river. As such the designed drainage system proposed for the site will be sub-divided into the following parts:

i) Tertiary Collectors: These will take off from the various units of the centre.

ii) Secondary Collectors: These will collect water from the unit areas and it will be laid along roads and footpaths.

iii) Primary Collectors: There will be box channels, they will receive water from the secondary collectors.

iv) Main collectors: These shall be opened channels, lined or unlined, and will generally flow the route of the existing river.

v) Sewage Network: There are two sewage mains of 600mm diameter each on the western and northern sides of the site. They both drain to a sewage treatment plant of daily capacity of 425,000m^3.

vi) Traffic Flow: The rate of traffic flow is high on the collector road passing in front of the site, because it links the B12 parkway to the residential area close to the site. Therefore a street will be introduced within the site to control vehicular traffic flow from the collector road.

vii) Micro-Climatic Effects:

a) Rainfall:- heavy concentration of rainfall from July to September shows a need for adequate drainage system to handle the large volume of storm water.

b) Winds:- North-West trade winds bring dust particles which settle as fine deposits on horizontal surfaces. Plant screens should be used to filter off the dust laden winds. Due to the proximity of the site to the B12 parkway and the collector road, adequate greenbelts should be used to buffer noise pollution.

River breezes from the Jaji river will create a different climatic zone by creating a cooler macroclimate.

c) Sunshine:- Since the sun moves in a East-West direction, the longer axis of the building should be oriented in this direction. The sports facilities however should be oriented North-South to protect players from the sun's glare.

d) Temperature/Humidity:- Maximum mean temperature is over $30^{o}C$ for 8 months in a year and maximum relative humidity over 70% for the same period. As such adequate ventilation should be given paramount importance; cross ventilation should be provided as much as possible.

CHAPTER SEVEN

7.0: DESIGN PARAMETERS

7.1: PLANNING AND DESIGN BRIEF

It has become necessary to build a Drug Addicts Therapeutic Centre in Abuja following 50 reported cases of persons found in different States of abuse and addiction this year by officials of the Social Welfare Unit of the Rehabilitation section of the F.C.D.A.

The proposed centre is aimed at the treatment through vocational and occupational theraphy of drug addicts. It should provide a symbolic focus for Nigeria's National Policy of excellence in medical treatment. It should also provide comfortable facilities and high standard medication of national and international standards.

The scope of the proposed Admission Unit of the Therapeutic Centre includes the following:-

ADMISSION UNIT

A) Medical Area

i) Reception unit

ii) Waiting Area

iii) Consultation Room - Executive desk, chair, bookshelf and film illuminator. Two visitors chairs and a wheel chair space.

iv) Examination Room - Examination table, examination light, instrument and supply cabinet, a chair, sterilization unit.

v) Treatment Room - Treatment cubicles with curtains all around, treatment table.

vi) Laboratory - Pressure sterilizer, sink, plaster cart, work counter, storage cabinet, small x-ray machine and blood bank.

These areas must be accessible to all other areas and be well integrated with the administrative units.

B) Social Adjustment Area

i) Psychiatrists Services are:

1) Screening to diagnose emotional problems.

2) Conduct staff consultations on how the problems should be managed in relation to the patients total rehabilitation program.

ii) Psychologists Services are:

1) Psychological evaluation accomplished by means of various psychological testing procedures and interviews which evaluate the patients intelligence and personality.

2) Interpretation of findings to members of staff.

3) Counselling (theraphy) on either individual or group basis, usually carried out with the psychiatrist and social service staff.

iii) Social Workers Services are:-

1) Social study and evaluation including the collection of relevant information from the patient, his family and other agencies, and the appraisal of such information with respect to the patients rehabilitation potential.

2) Social case work where the social worker works with the patient to improve attitudes towards self-support and motivation towards treatment.

3) Social group work including the correction of abnormal living patterns by using planned group activities, recreational in nature but therapeutic in value. It may include hobby activities, group discussions, or adult education activities.

7.1.1: Schedule of Accomodation

A: ADMISSION UNIT

	Functions	No. of Units	C	L.R	Floor Area of Each (m^2)	Total Floor Area (m^2)
1.	Entrance lobby	1	25	20	15	15
2.	Reception	1	12	10	15	15
3.	Waiting Area	1	25	20	15	15
4.	Records unit	1	20	25	17.5	17.5
5.	Pharmacy	1	25	15	17.5	17.5

C= Case studies

L.R= Literature review

	Functions	No. of Units	C	L.R	Floor Area of Each (m^2)	Total Floor Area (m^2)
6.	Psychiatrist Screening	1	10.5	12	17.5	17.5
7.	Psychiatrists Testing	1	10.5	12	17.5	17.5
8.	Psychologists Testing	1	10.5	12	17.5	17.5
9.	Psychologist Councelling	1	10.5	12	17.5	17.5
10.	Social Workers Office	1	20	15	17.5	17.5
11.	Drug Education Office	1	15	15	17.5	17.5
12.	Examination Room	1	10.5	12	15.75	15.75
13.	Consultation Room	1	10.5	12	15.75	15.75
14.	Treatment Room	1	10.5	12	15.75	15.75
15.	Drug Store	1	20	15	10.50	10.50
16.	Lab	1	30	20	15.75	15.75
17.	Psychologist Councelling	1	10.5	12	15.75	15.75
18.	Psychologist Testing	1	10.5	12	15.75	15.75
19.	Treatment	1	10.5	12	10.50	15.50

C = Case studies

L.R = Literature review

	Functions	No. of Units	C	L.R	Floor Area of Each (m^2)	Total Floor Area (m^2)
20.	Psychiatrist Testing	1	10.5	12	15.75	15.75
21.	Pyschiatrist Screening	1	10.5	12	15.75	15.75
22.	Consulting Room	1	10.5	12	15.75	15.75
23.	Examination Room	1	10.5	12	10.50	10.50
24.	Conference Room	1	30	25	24.5	24.50
25.	Director's Office	1	20	25	15.75	15.75
26.	Secretary	1	9	12	12.25	12.25
27.	Account Office	1	15	20	15.75	15.75
28.	Toilets	3	13	9	9	27
	Total Gross Area		426.5	m^2		
B.	REHABILITATION UNIT					
1.	Kitchen store	1	12	9	9	9
2.	Kitchen	1	25	21	21	21
3.	Outdoor cooking	1	12	15	12	12
4.	Dinning Hall	1	80	100	108	108
5.	Classes	8	25	30	25	200
6.	Library	1	50	40	45	45
7.	Multi-use Auditorium	1	50	40	45	45

C = Case Studies

L.R. = Literature review

Functions	No. of Units	C	L.R	Floor Area of Each (m^2)	Total Floor Area (m^2)
8. Vocational Workshop	2	60	70	54	108
9. Central Store	1	35	48	60	60
10. Clinic	1	60	55	132	132
11. Toilets	2	15	18	25	50
Total Gross Area		790		m^2	
C. SHOPS					
1. Core	1	20	30	39.25	39.25
2. Serve counter	1	124	15.8	17.27	17.27
3. Sit-out area	1	158	179	208.81	208.81
Total Gross Area				$265.33m^2$	
D. MOSQUE					
1. Entrance lobby	1	15	12	12	12
2. Toilet	4	15	18	12	12
3. Ablution room	1	9	9	6	6
4. Prayer hall	1	150	120	120	120
Total Gross Area	$150m^2$				

C = Case Studies

L.R.= Literature review

Functions	No. of Units	C	L.R	Floor Area of Each(m^2)	Total Floor Area (m^2)
E. CHAPEL					
1. Entrance lobby	1	20	17.5	15	15
2. Pastors Office	1	12	9	9	9
3. Toilet	3	5	9	3	9
4. Chaplins office	1	12	9	9	9
5. Store	1	6	12.5	9	9
6. Podium	1	12	17.5	15	15
7. Auditorium	1	250	227	216	216
Total Gross Area	282m^2				
F. HOSTEL A					
1. Room of 2	6	13.5	16	14	84
2. Toilet	3	3	4.5	3	9
3. Shower	3	3	4.5	3	9
4. Laundry	1	13.5	12	14	14
5. Nurses Room	1	9	9	10.5	10.5
6. Security Room	1	9	10.5	10.5	10.5
7. Common Room	1	30	25	28	28
8. Corridor	1	-	-	68	68
9. Back verander	6	6	8	8	48
TOTAL GROSS AREA	281 x 4 = 1124m^2				

C = Case Studies

L.R = Literature review

Functions	No. of Units	C	L.R	Floor Area of Each (m^2)	Total Floor Area (m^2)
G. HOSTEL B					
1. Room of 1	6	9	12	10.5	63
2. Toilet	2	3	4.5	3	6
3. Shower	2	3	4.5	3	6
4. Laundry	1	100	9	10.5	10.5
5. Nurses Room	1	9	9	10.5	10.5
6. Security Room	1	9	10.5	10.5	10.5
7. Common Room	1	25	20	21	21
8. Corridor	1	-	-	50	50
9. Back Verander	6	4.5	6	6	36
Total Gross Area	213.6				
H. GENERATOR HOUSE					
1. Generator Room	1	30	25	25	25
2. Fuel Room	1	15	10	15	15
Total Gross Area	$40m^2$				

C = Case Studies

L.R = Literature Review

Functions	No. of Units	C	L.R	Floor Area of Each (m^2)	Total Floor Area (m^2)
I. SECURITY OFFICE					
1. Room	1	10.5	10.5	10.00	10.00
2. Toilet	1	2.25	4	2.25	2.25
Total Gross Area	$12.25m^2$				
J. LAWN TENNIS PITCH					
1. Pitch	2	3.36	3.36	336	672
2. Walkway	1	-	-	772	772
Total Gross Area	$1444m^2$				
K. FOOTBALL PITCH					
1. Pitch	1	1008	1008	1008	$1008m^2$
L. LOADING/OFF LOADING BAY					
1. Bay	2	90	100	108	$216m^2$
M. PARKING LOT					
1. Parking space	44	16.5	16.5	16.5	7.50
2. Road in front	1	-	-	456	456
Total Gross Area		$1206m^2$			

C = Case Studies

L.R. = Literature Review

7.1.2: ZONING OF THE SITE

The site was zoned according to three criteria: Accessibility, noise and security.

Zone A: This part of the site is easily accessible due to its proximity to the road. It is rather noisy due to passing traffic and not very secure. It is suitable for public activities like parking, recreation and administration.

ZoneB: This part of the site is relatively accesible, it is exposed to medium noise and, it is fairly secure. It is quite suitable for semi-public activities like vocational training and group discussions.

Zone C: This part of the site is rather secluded due to the fact that it is behind a knoll, and maximum security can be easily achieved. It is suitable for private activities like accomodation, and group theraphy or meditation.

7.1.3: DESIGN PHILOSOPHY

An analogy may be made that, one must know and understand alphabets before words can be formed and a vocabulary developed, one must understand the rules of grammar and syntax before sentences can be constructed, one must understand the principles of composition before essays, novels and the likes can be written.

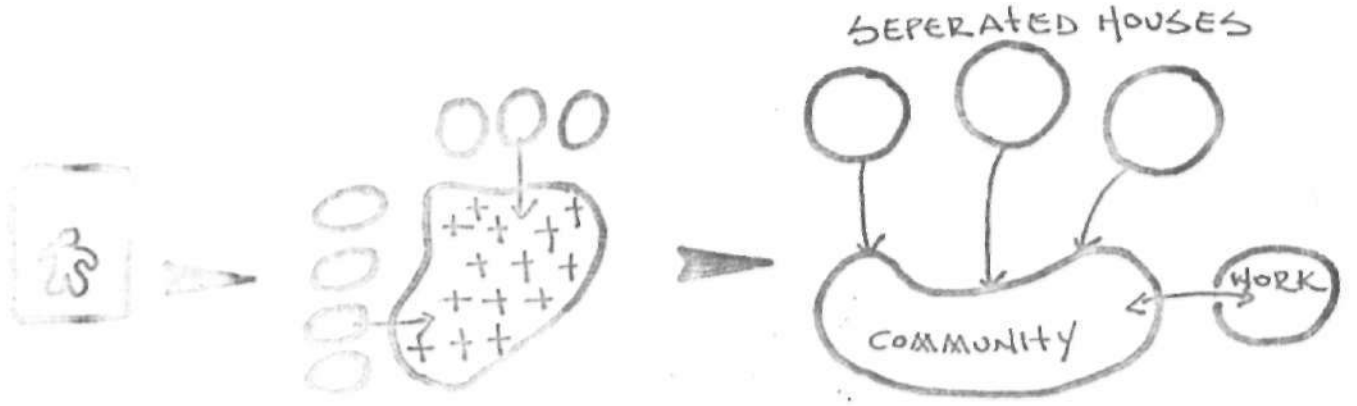
It is therefore useful to recognize the basis elements of architecture, understand how they can be manipulated in the development of a design concept and realize their visual implication in the implementation of a design goal.

The design layout is planned to enable the individual patient to feel that he or she has a sense of place in the largeness of the centre. This process extends through a transitional stage - the housing unit - into the larger scale of the centres community as shown in the enclosed diagrams.

The separated and identifiable individual's house is fundamental to the Therapeutic Centres design philosophy. The house becomes the symbol with which the patient consciously or unconsciously relates and registers as a separate element within the overall design of the centre.

This approach gives management more flexibility since all housing units do not need to be run in the same way and it complements the

A

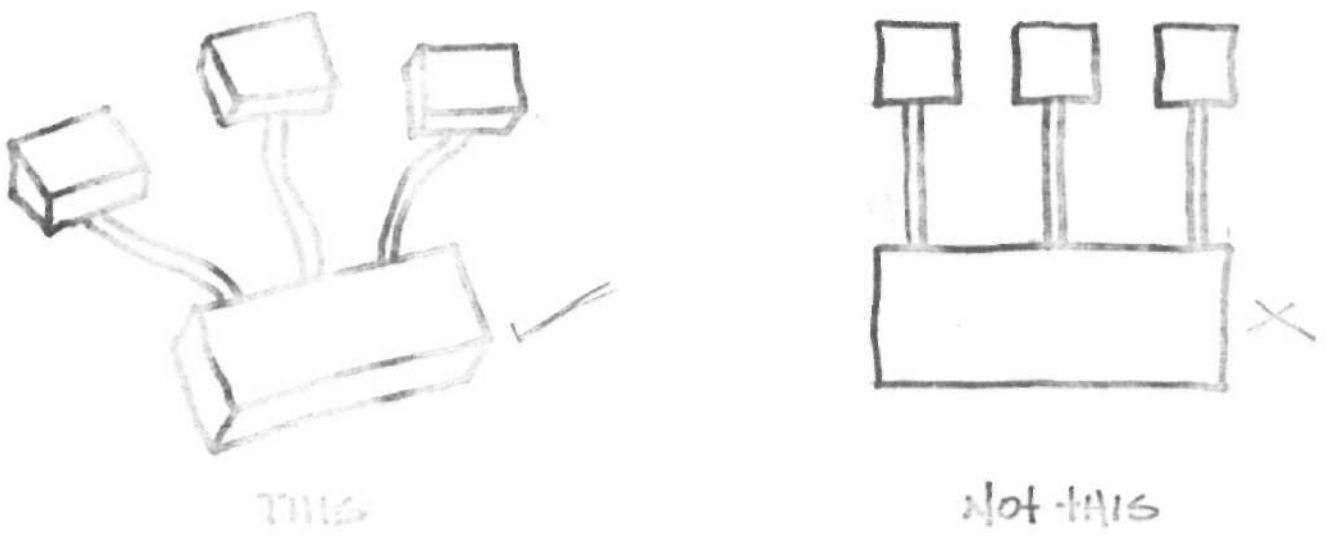


(1) The individual room

(2) The individual house with 10 to 50 patients

(3) The total centre of 100 to 200 patients

B



THIS

NOT THIS

CONCEPT DEVELOPMENT

therapeutic centres system of small, dedicated management teams- an integrated design and management philosophy.

7.2: SPECIAL DESIGN CONSIDERATIONS

A) GROUP CLASSIFICATION:

Within the centre, the patients are assigned to physically separated housing units according to five groups of classification:

1. Hostile, aggressive, psychopathic — Victimisers
2. Manipulative agitators
3. 'Situational normal'
4. Inadequate, dependent — Victim prone
5. Neurotic, anxious

The patients have separate house units but are normally arranged along the following lines:

groups (1) + (2) - group (3) - groups (4) + (5)

This method insulates those who wish to be helped and live in peace from those who do not - it tends to reduce the problem of inter-patient conflict and produces centres safer for the patients and easier for staff to operate. There tends to be more social/ rehabilitation workers with groups 1 and 2; more correctional/ security staff with groups 4 and 5; and less staff generally with group 3.

B) CENTRAL FACILITIES:

Patients are prohibited from visiting other houses but are brought together and allowed to mingle in the central facilities (church, mosque, shop, rehabilitation unit). The central facilities are consciously designed as the business and community focus of the centre.

7.2.1: PRINCIPLES OF DESIGN

I arrived at a set of overall design principles which are reflected in the centres I studied. The main points are as follows:

Living Conditions: I accept that a completely 'normal' environment can not be achieved in a centre designed for the purpose of theraphy, but I am concerned with reducing as far as possible the stress that comes with loss of freedom - I tried to avoid such features as grey and white walls and long corridors that send a message of de-humanisation to patients and staff.

My approach is to design a campus-like institution with an open atmosphere and with as much freedom of movement as possible. Furnishings and decorations

are attractive, and selected to reduce noise levels. Facilities like laundry, television and showers are provided in the housing units.

Size and Location: The days of large centres are over. For new centres 100 to 200 should be the maximum population, with patients grouped in housing units of 10 to 50 people. Centres should be located near communities from which patients are drawn and sited reasonably near to urban areas.

Staff and Management: The design of the centre will encourage informal contact between patients and staff, be organized around small management teams and planned to enable staff to oversee and control in an unobtrusive manner and without confrontation. Patients who are difficult and who do not behave are placed in more restrictive accomodation.

7.2.2: LANDSCAPING

"In Spengler's most moving passage, where he identifies the "landscape" as the base of "culture", he says that ..... man ... is so held to it by myriad fibres, that without it

life, soul, and thought are inconcievable" Stanley White (Simonds, 61 pg. 10).

The Planned Landscape

The natural landscape is a repose of equilibrium. It has its own cohesive, harmonious order in which all forms are an expression of topography, climate, natural growth, and the forces of nature.

We are all familiar with landscape areas in which there is a man-made or artificially produced harmony of all the parts. We subconsciously sense in the landscape certain qualities of fitness, order and harmony that appeal to us.

Landscapping on the site is based on two elements.

(i) Major Landscape Elements - These are form, features, and forces that we can not alter, like the water table, seasonal temperature, contours, and so on. The planning of the centre has seen shaped to create the fullest possible harmony with these elements.

(ii) Minor Landscape Elements - These elements are trees, stream and so on that can be modified. The river banking the site has been preserved from change. An orchard has been introduced at the left of the site to create a park. Stone footpaths were introduced to blend with the natural contours of the site and sculptors were introduced at strategic locations.

> "Therefore, let us build houses that restore to man the life-giving, life-enhancing elements of nature. This means an architecture that begins with the nature of the site. Which means taking the first step toward assuring a worthy architecture, for in the rightness of a house on the land we sense a fitness we call beauty". F.L. Wright (Simond, 61 pg.49).

7.2.3: CIRCULATION PRINCIPLES

Circulation within the centre is over outdoor footpaths with free movement limited to certain prescribed times. Circulation is brought together in front of the central facilities in a so-called "Rehabilitation street".

i) ENTRANCES- Due to the proximity of the site to the express way, a road has to be created within the site for easy circulation. According to Abuja legislation points of ingress/egress on the site must be at least 50 kilometers from existing nodes-so I gave space of 65 kilometers before my ingress/egress points. These are mainly two types of access-vehicular and pedestrian, so openings were created by a gate to facilitate easy access and exit.

ii) VEHICULAR AND PEDESTRIAN MOVEMENT - As much as possible seperation of vehicular and pedestrian movement was created, and crossing of the two was almost totally eliminated.

a) Vehicular Movement

1- Turning radius -density of traffic and manuvering contemplation were taken into account.

2- Bend negotiation was also considered.

3- Drop off point - shelter from elements was considered

- space for cars to park when visited by dignitaries.

4- Loading and offloading bays - were provided for the kitchen/dining area and the clinic (for emergencies).

7.2.4: SAFETY AND SECURITY

i) Security on site - security posts were introduced near the points of ingress and egress to control flow into and out of the site. And a fence was provided to keep out tresspassers.

ii) Security and control measures- The Nigerian Drug Law Enforcement Agency (NDLEA) permits recourse in emergencies to security and control measures like fire arms, gas and restraint devices. It must be stressed however that these measures are normally very much in the background, and that reliance for the smooth running and maintenance of control in the centre will be based on humane factors, such as management relationships, counselling programmes, and classification and grouping-systems.

iii) Bars were introduced at the windows of the individual rooms to keep out intruders and to keep in patients. The house corridors also were screened to keep patients under surveillance at all times.

CHAPTER EIGHT

8.0: CONCLUSION AND RECOMMENDATIONS

8.1: PROJECT APPRAISAL

A relaxed atmosphere coupled with a clear sense of purpose and commitment was tried to be achieved. These were brought about by a combination of factors, including a refined system of classification and separation, successful operation of the unit management system, and the physical design of the houses themselves. The atmosphere thus created helps to foster a sense of personal safety among both staff and patients, while at the same time reducing the stresses and tensions of confinement.

Creating an atmosphere conducive to personal safety was achieved by concentrating patients who share similar behavioural characteristics into small distinct and individually managed groups, thus separating potential trouble makers from those who were prepared to respond and conform. The physical design has also had an important part to play, by providing for example opened areas to the North, which are easily supervised by patrolling security men; by including an orchard (park) at the extreme north of the site; by eliminating long corridors which experience shows may lead to claustrophobia.

A number of design features which serve to reduce the tensions and pressures normally associated with confinement were eliminated.

These include:- Colourful and attractive decorations and furnishings were delibrately introduced into the living and ancillary units. Large windows provide light and airy interiors, while high ceilings and wide circulation areas helped to avoid any impression of restriction. A number of other regime and management factors also helped to contribute to a stable and successful atmosphere, and thereby reduce the problem of control. These include long hours out of houses with good access to a range of vocational jobs, educational recreational activities, generous visiting provision, and the low visible presense of security staff.

8.2: MANAGEMENT SYSTEM

The centre operates a policy of decentralized and dedicated management teams within each of the separate units in the centre. The teams are staffed with motivated and well trained people who have an ability to mix and communicate with the aim of breaking down psychological barriers and becoming familiar with patients' worries and problems at the lowest level.

The team usually consists of one shift correctional officer and one nurse, both trained in security and control duties for the houses. The team is co-located in the housing units with the intension of reducing any feelings of 'us' and 'them' that could arise if staff and patients were accomodated separately.

In the Rehabilitation Unit, the team usually consists of a social worker, a vocational director and a rehabilitation officer. The admission units team consists of psychiatrists, counsellors, social workers, and psychologists. The conclusion to be drawn from this is that - a clear management philosophy is fundamental to the smooth and effective operation of a therapeutic centre.

8.3: FINANCE AND COST

The centre is to be the pet project of Lieutenant General Jeremiah Useni, Minister of the Federal Capital Territory, Abuja. As such, it will be financed 50% by him. The Federal Capital Development Authority will handle 10% of the cost, the United Nations Development Programme (UNDP) will handle 20% and the United States Information Centre (USIS) will also take care of 10% of the cost. The remaining 10% should be realized during the Commissioning of the Centre sometime in the near future.

The cost of running the Centre will be financed by philantrophic donations from well meaning people. No amount is too small. Proper treatment should not be denied a contrite drug addict just because he can not pay for it.

The centre will cater for four groups of patients according to psychological evaluation.

a) Out patients

b) 6-12 weeks - drug abusers

c) 6-12 months - drug abusers/addicts

d) 2 years - drug addicts

8.4: CONSTRAINTS AND LIMITATIONS

Due to the shady and secretive nature of the drug industry, collection of data was quite difficult. Some people were quite edgy when approached and a lot of patients preferred to be interviewed without reference to their names.

The NDLEA for reasons of security were not of too much help in data collection because they have an oath of secrecy concerning patients and records. Most of their data are also not up to date, except in very few cases, organized record keeping of surveys and so on, terminated in 1992. No reason was found for this.

Most Centres to protect the privacy of their patients refused to let them be interviewed.

Due to the above factors, I would like to say, I tried my hardest to present the drug problem as accurate as it is in Nigeria. Some of the statistics might not be 100% reliable due to the method of data collection (middlemen) at times. But I guarantee that the drug problem is a real epidemic of the 20th Century in Nigeria.

8.5: CONCLUSION AND RECOMMENDATIONS

A) Conclusion

The architectural contribution to the designing of a Therapeutic Centre is manifested in the provision of "a site controlled structural space". Architectural spaces constitute a major element of the psychological environment which exerts a profound effect on the emotional well being of the people who experience them. The social and therapeutic inter-action of people within such spaces also exerts an effect on each individuals self-esteem.

All these call for a careful architectural design that would encourage these desired aspects and reduce stresses. The design has to reflect the characteristics of the architectural features of the site which can be easily associated with the neighbouring community, not forgetting the possible changes likely to occur with time. Familiar features produce a more friendly environment to the individual, than a monotonous set-up which occassionally produces psychological stresses.

It is hoped that this centre will constitute the ideal structured space for effective drug abuse treatment and re-enforce the usefulness of the therapeutic system to the medical practice. The problems encountered on discharge from orthordox drug rehabilitation centres will be minimized.

B) Recommendations

Evaluating the effectiveness of treatment is difficult because the full recovery from all drug problems after a single treatment episode is an unrealistic goal for most people. Among the factors that must be considered in program evaluation are:-

1) drug abuse is a chronic, relapsing condition
2) long-term provision of treatment may be necessary to maintain its effects.
3) treatment can improve many dimensions of behaviour; including health, employment, education and fulfilling family responsibilities, as well as reducing drug use.

Realistically, no one believes better medication alone will solve the drug problem. Infact, one of the most hopeful messages coming out of current research is that the biochemical abnormalities associated with addiction can be reversed through learning. For that reason, all sorts of psychosocial interventions, ranging from psychotheraphy to self help recovery programes such as Narcotics Anonymous (N.A), can and do help. Cognitive theraphy, which seeks to supply people with coping skills (exercising after work instead of going to a bar, for instance), appear to hold particular promise.

In the late 20th - Century world, where drugs of abuse are being used on an unprecedented scale, the mounting evidence that treatment works could not be more welcome. Ironically, the biggest barrier to making care for drug addicts available is the perception that efforts to treat addiction are wasted. Yet treatment for drug abuse has a failure

rate no different from that for most chronic diseases. Close to half of recovering addicts fail to maintain complete abstinence after a year - about the same proportion of patients with diabetes and hypertensions who fail to comply with their diet, exercise and medication regimens. "What doctors who treat drug abuse should strive for", says Alan Olagunju, drug abuse Counsellor at Aro Neuro psychiatric hospital, Abeokuta, "is not necessarily a cure but long-term care that controls the progress of the disease and alleviates its worst symptoms. The occassional relapse is normal and just an indication that more treatment is needed".

I would like to conclude on the note that; everyone must accept the responsibility to teach that drugs are illegal and deadly. They may land you in jail; they may cost you your life. We must renew our commitment to the drug prevention strategies that deter first-time drug use and stop the progression from alcohol and tobacco use to marijuana and harder drugs.

I ask the Federal Government to be a bi-partisan partner and provide the resources needed to get the job done. I challenge State and Local Governments to focus on drug abuse as a top priority. I ask the media, advertising and entertainment industries to educate our youths and all Nigerians, about the dangers of drug use. Finally, I invite every Nigerian - every parent, teacher, law enforcement officer, faith leader, young person and community leader-to join the national campaign to save our heritage.

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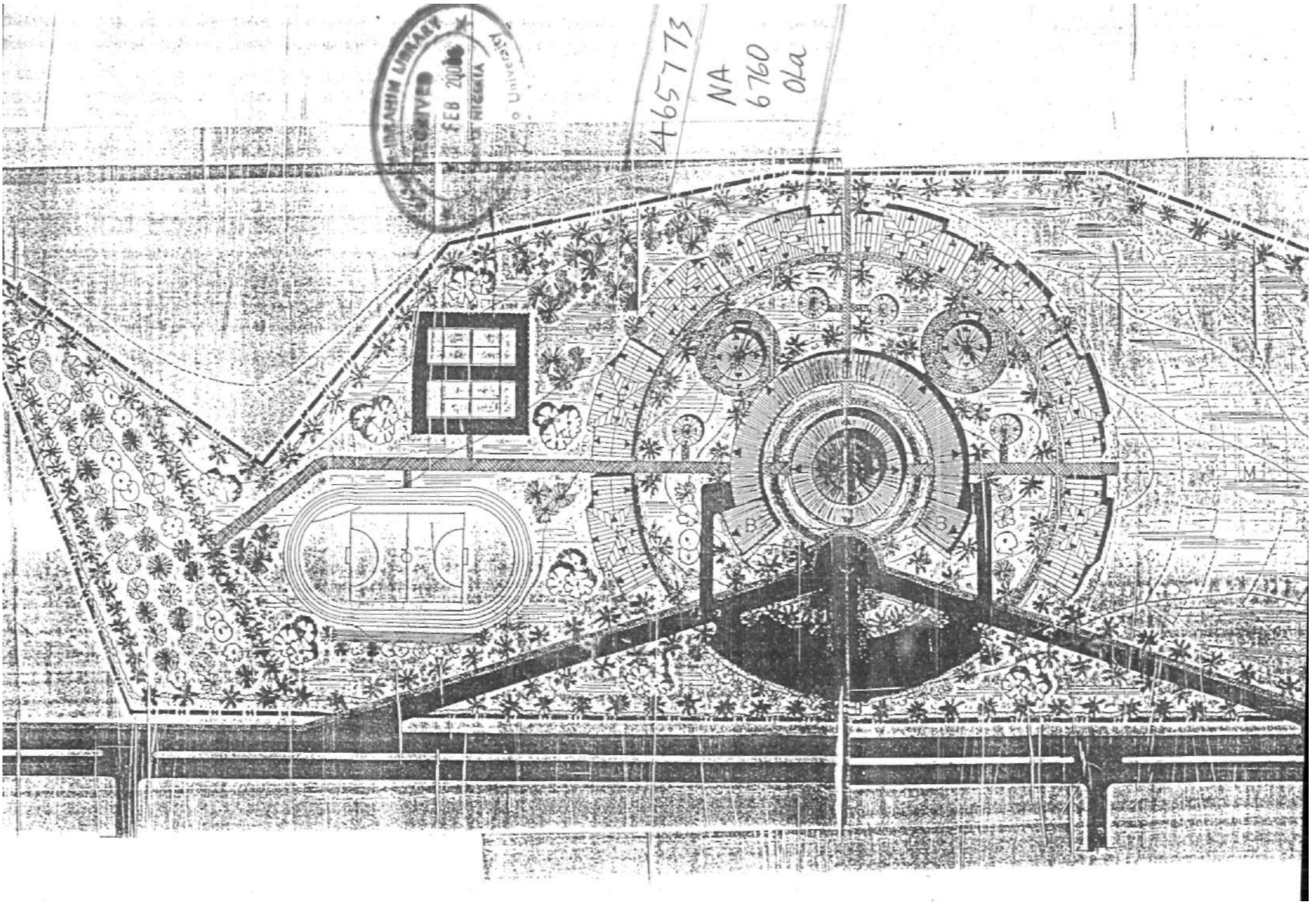
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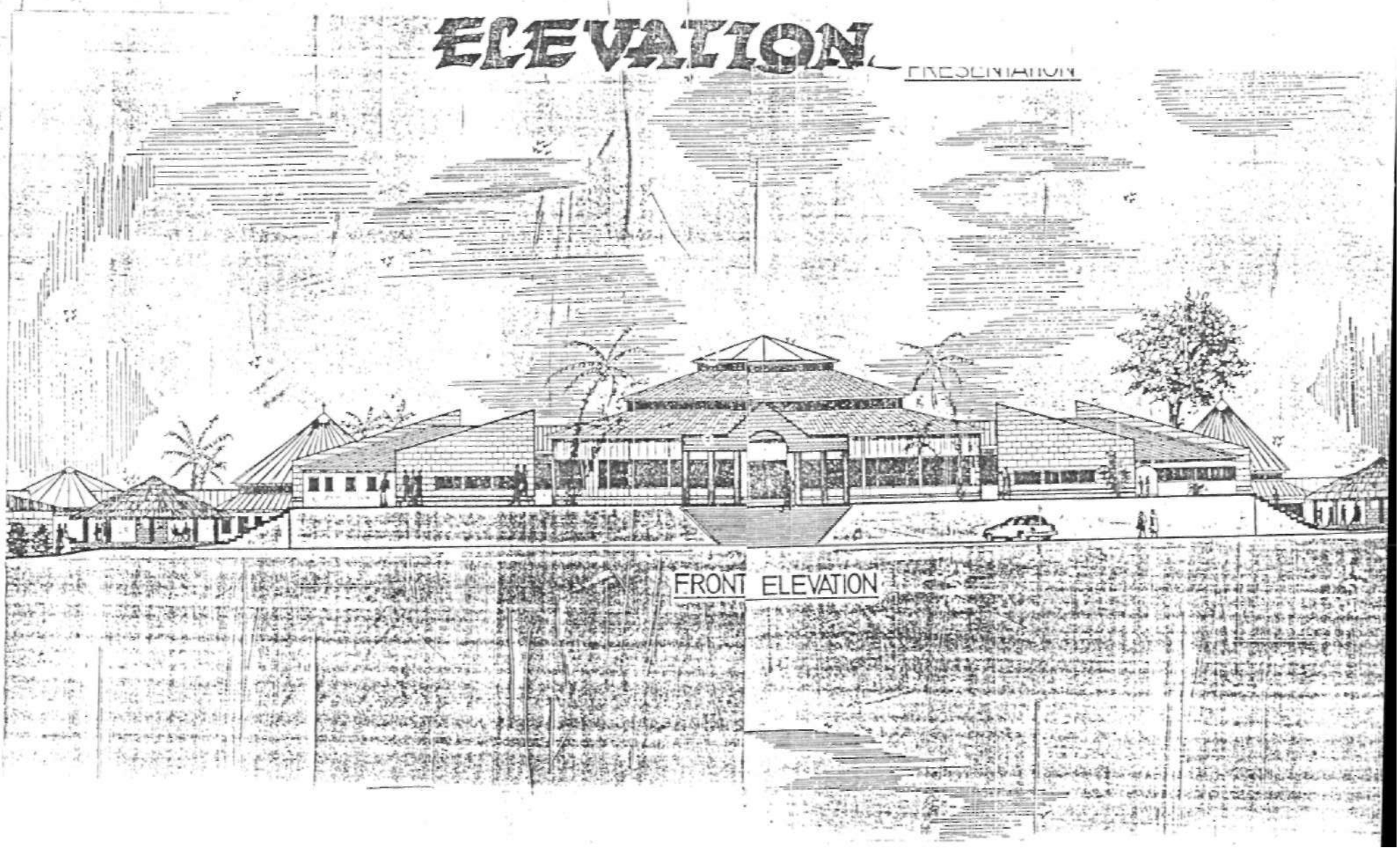
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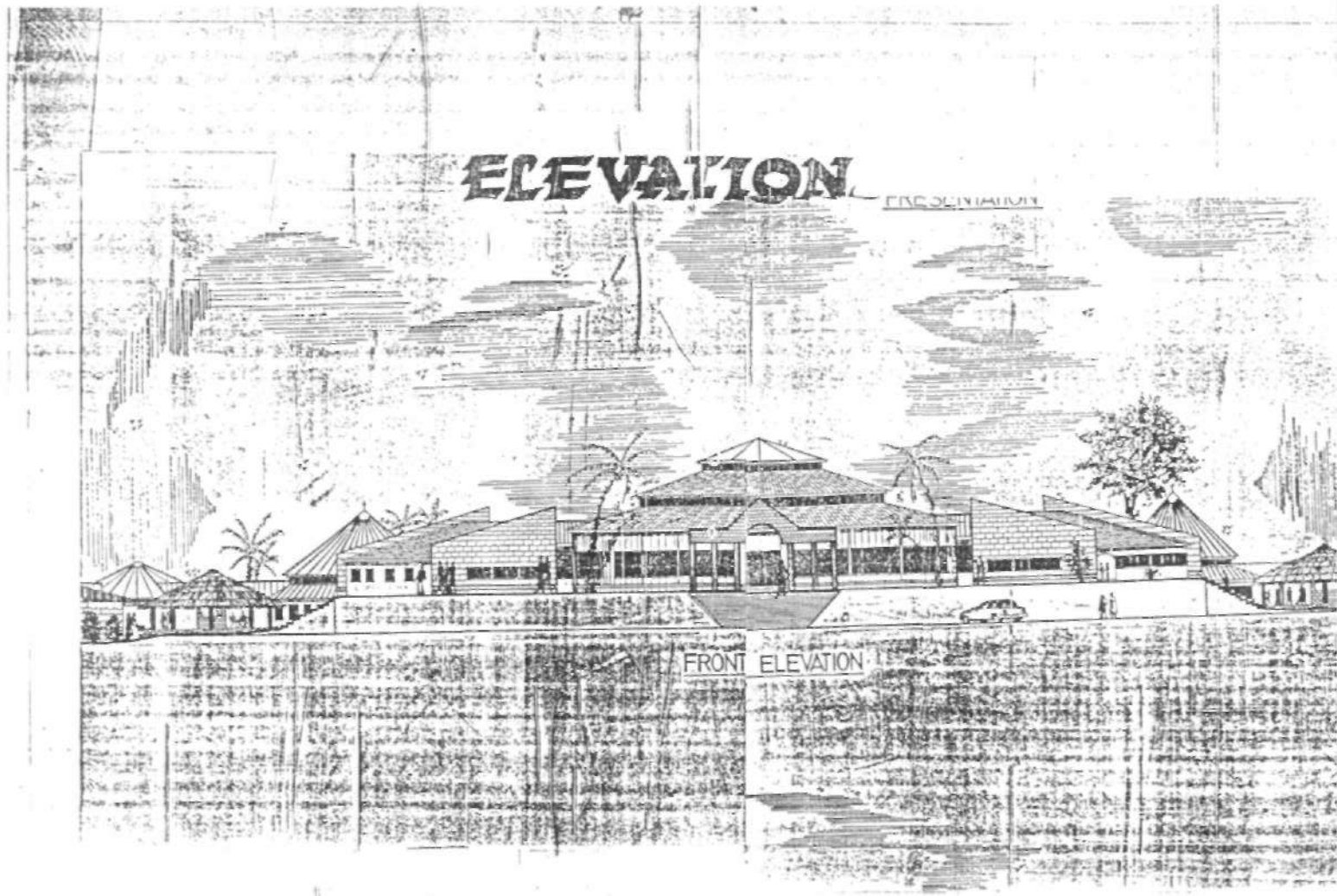


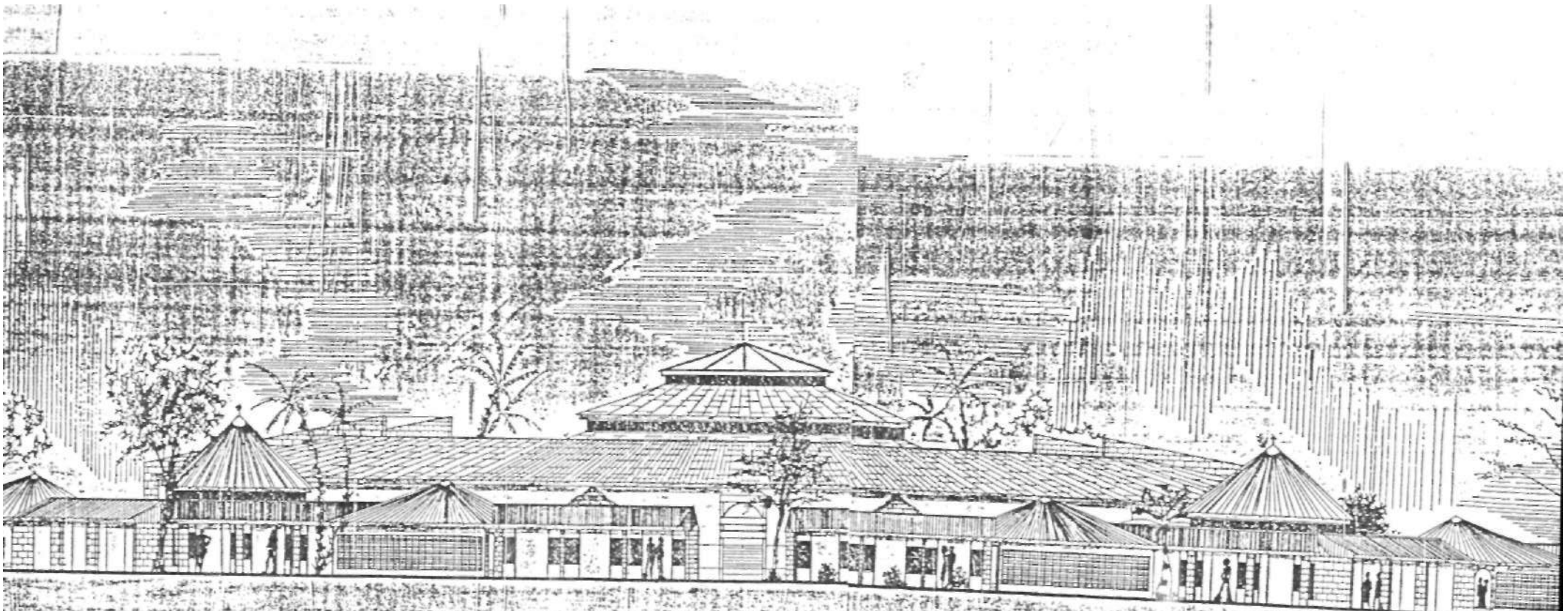
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PRESENTATION



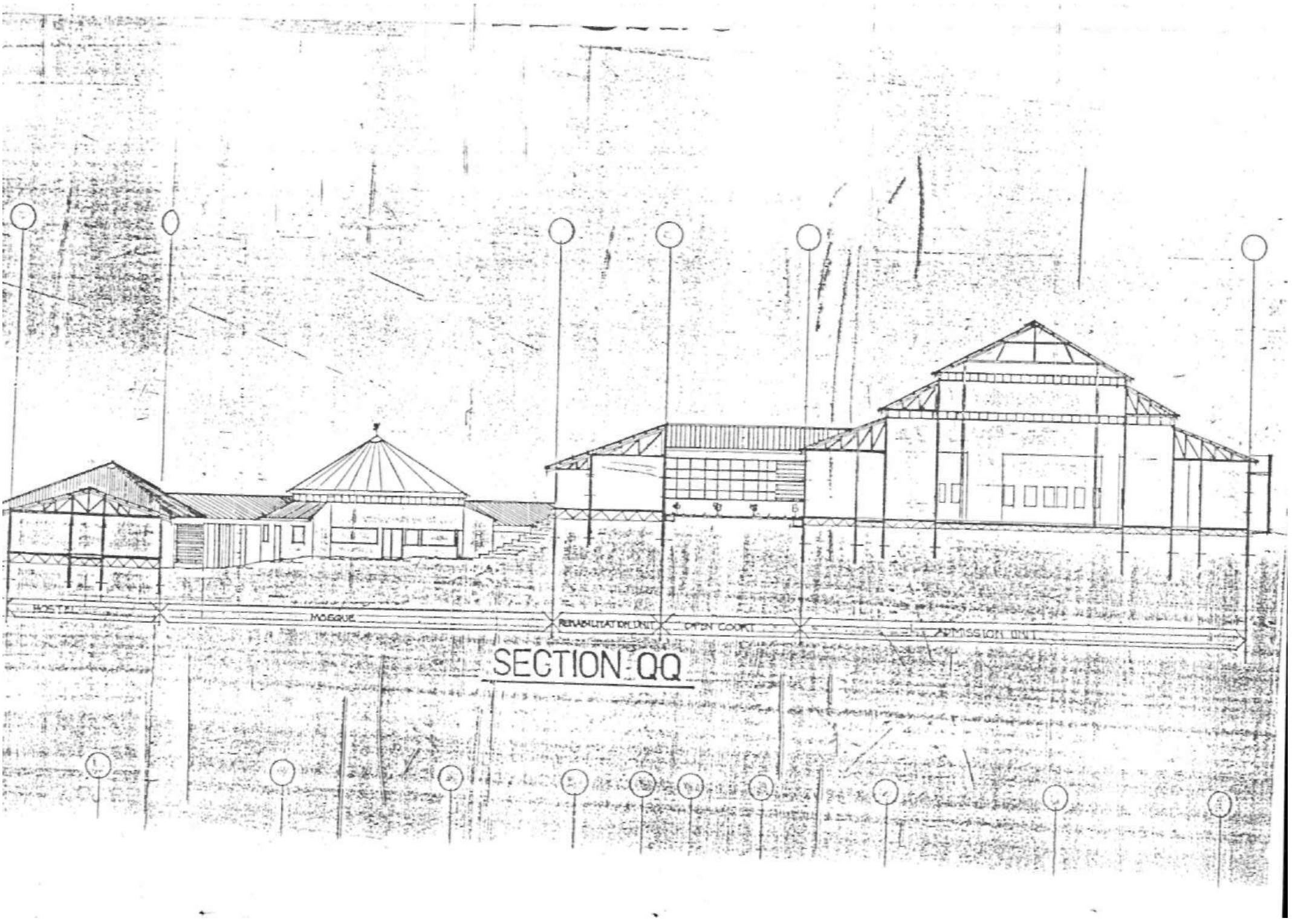
FRONT ELEVATION


ELEVATION
PRESENTATION
FRONT ELEVATION

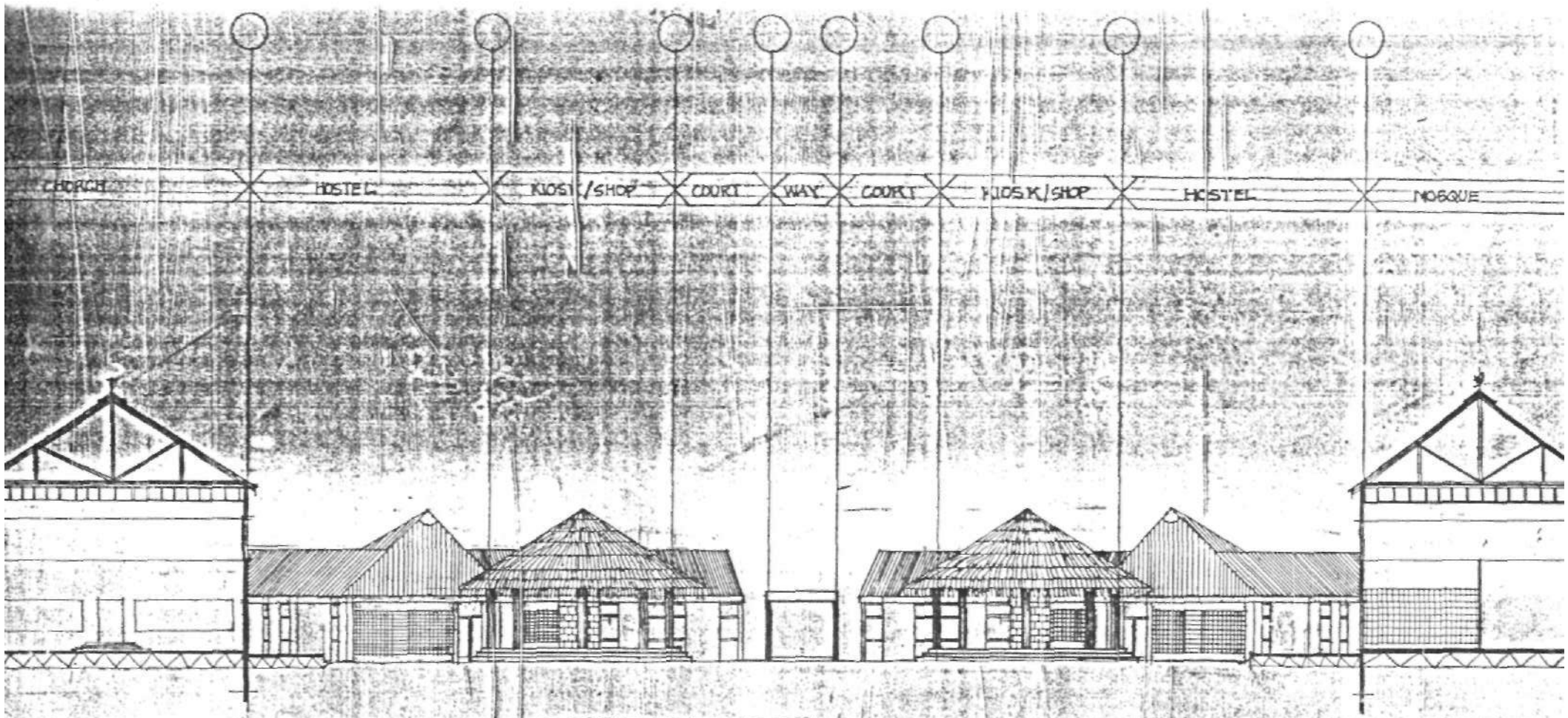


BACK ELEVATION

ADDICTS THERAPEUTIC CENTRE ABUJA

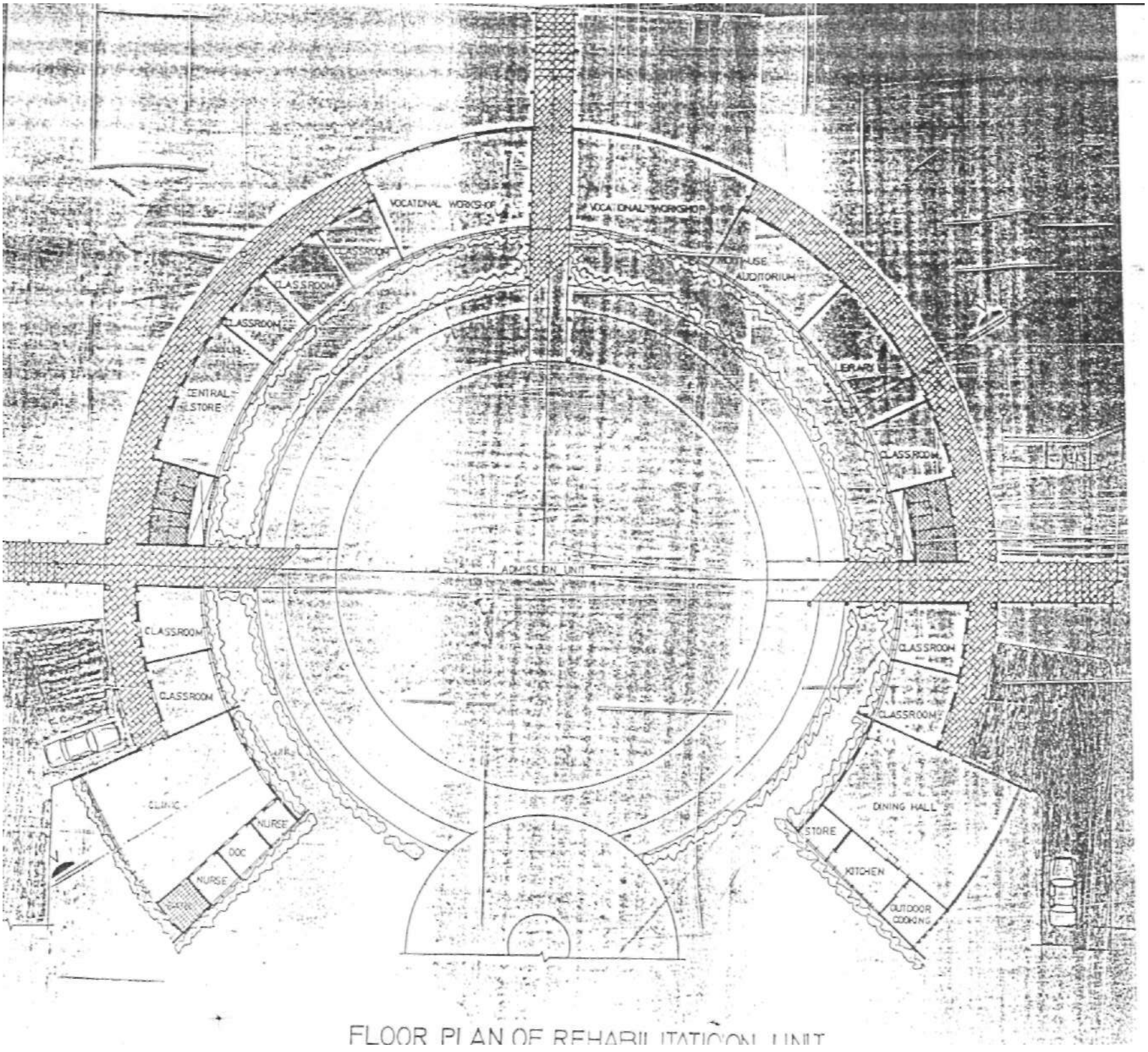

HOSTEL
MOSQUE
REHABILITATION UNIT
OPEN COURT
ADMISSION UNIT

SECTION QQ

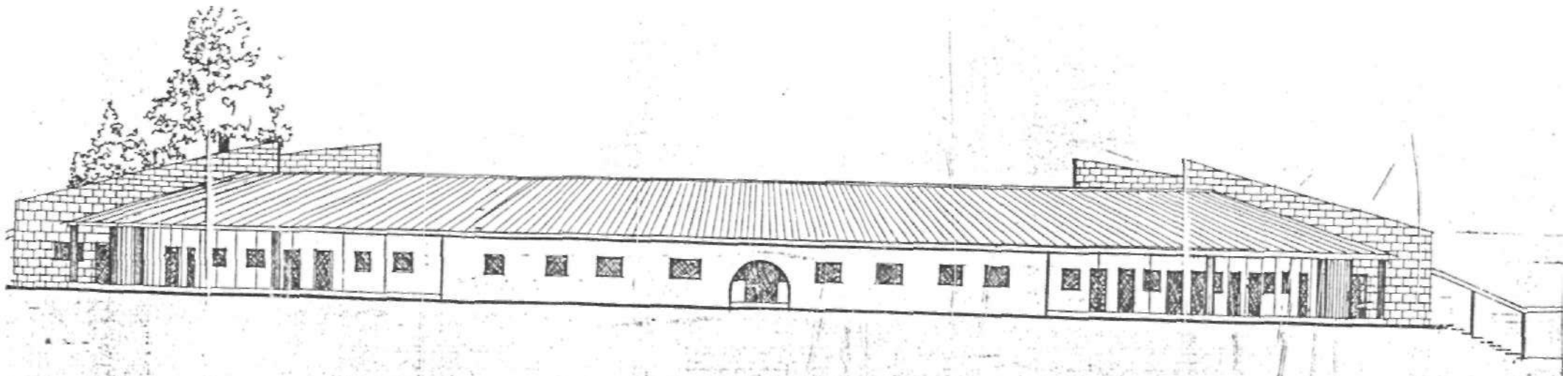


SECTION Z-Z

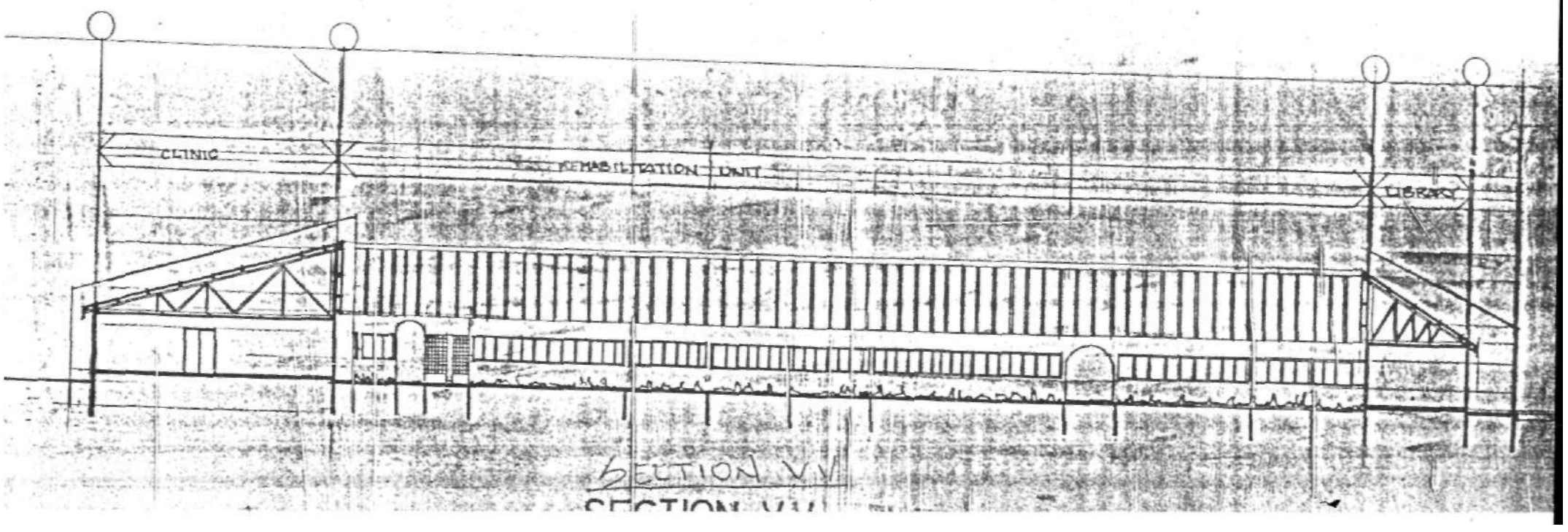
ODICTS THERAPEUTIC CENTRE



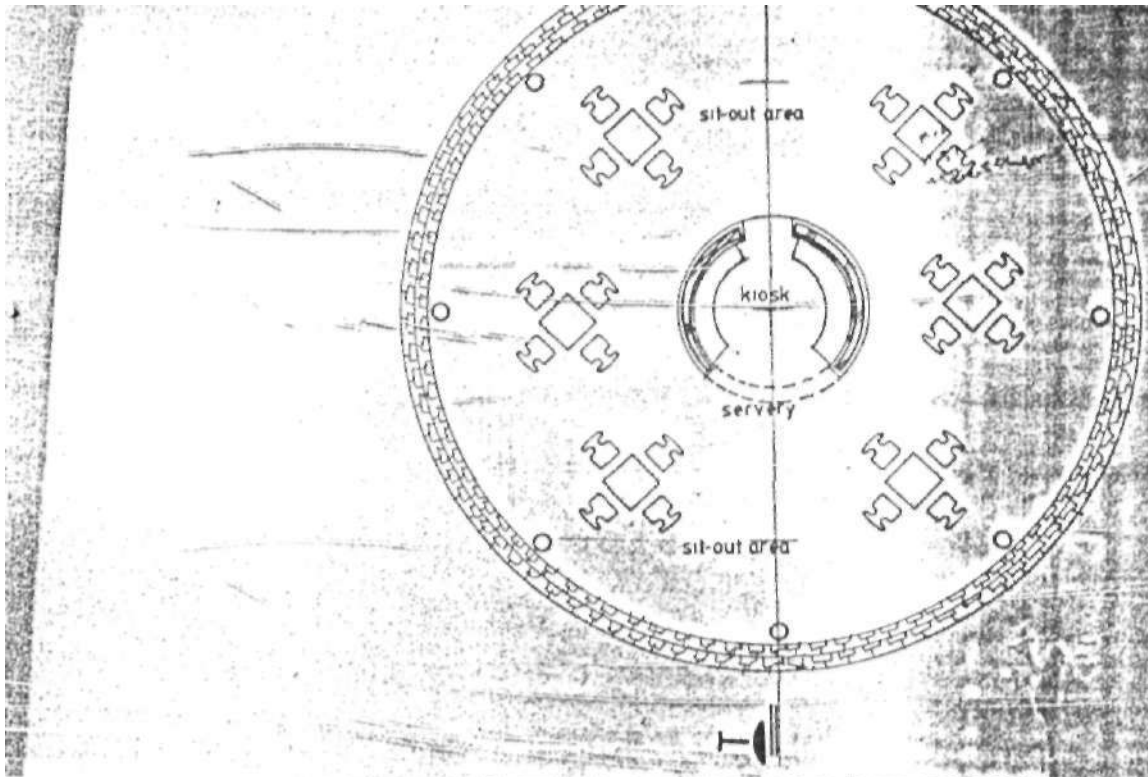
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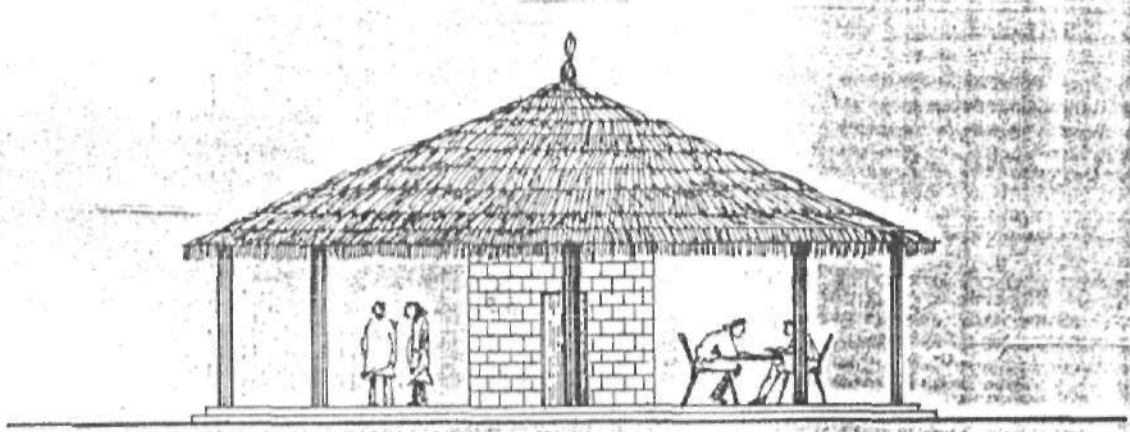
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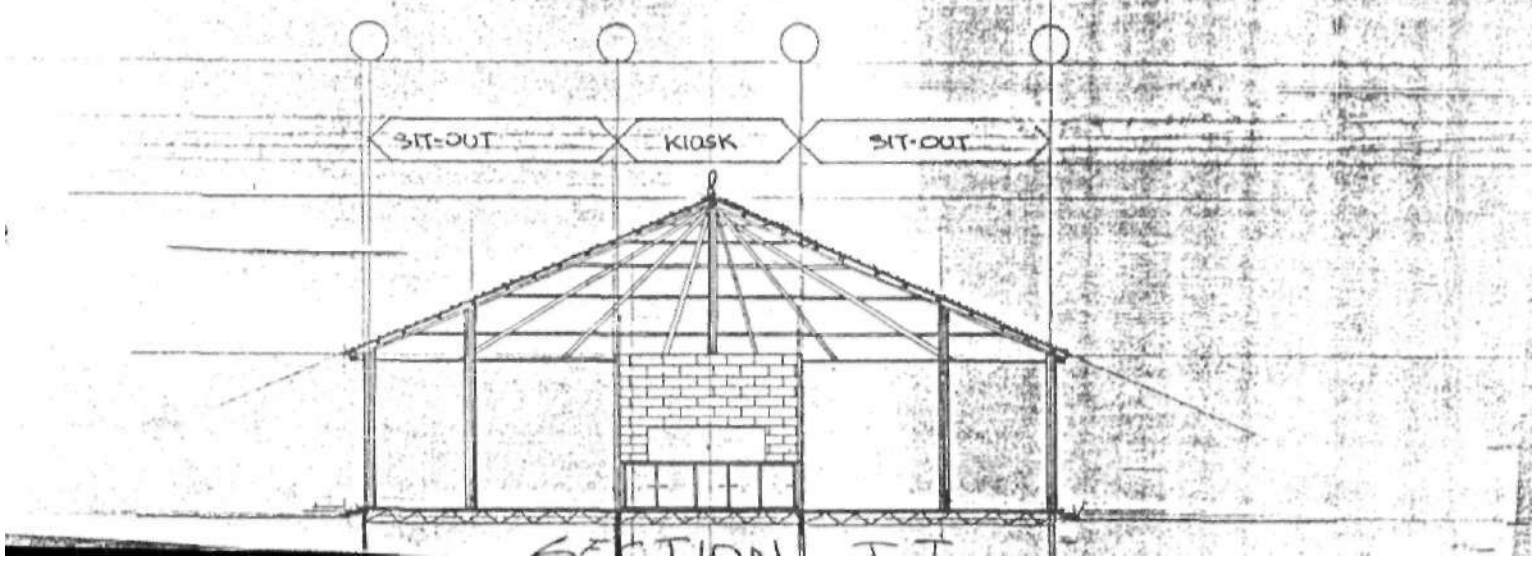
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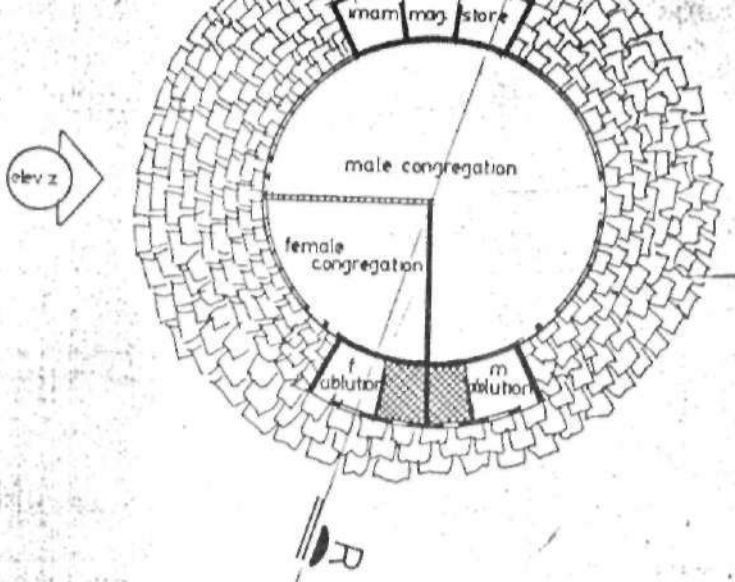


FLOOR PLAN OF SHOP 1:100

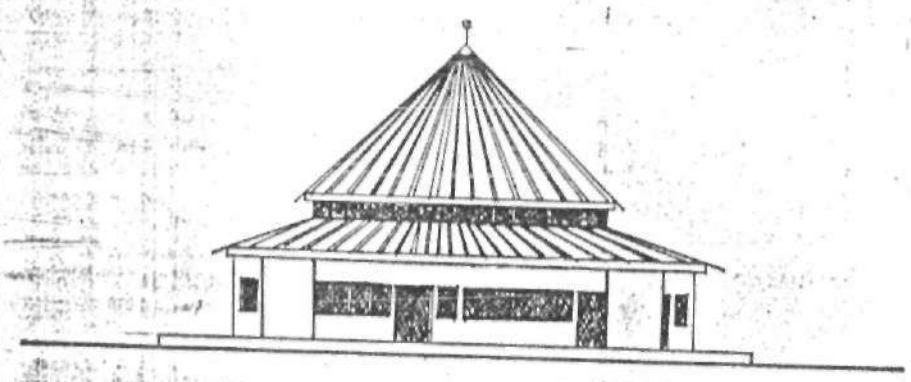


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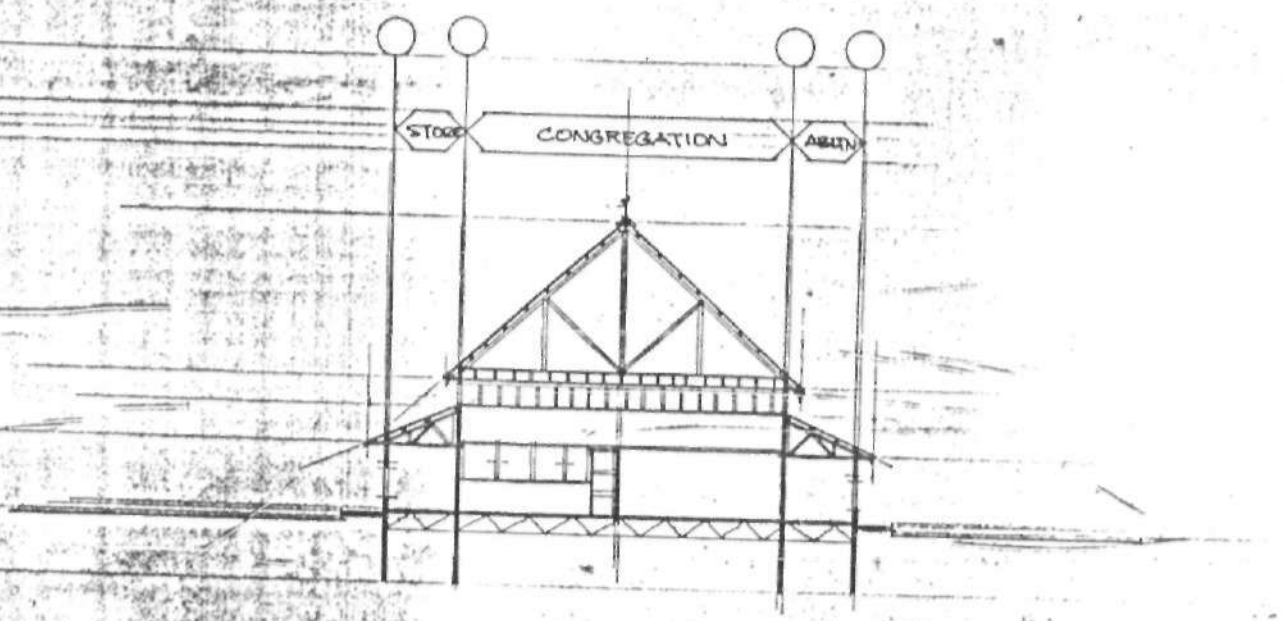




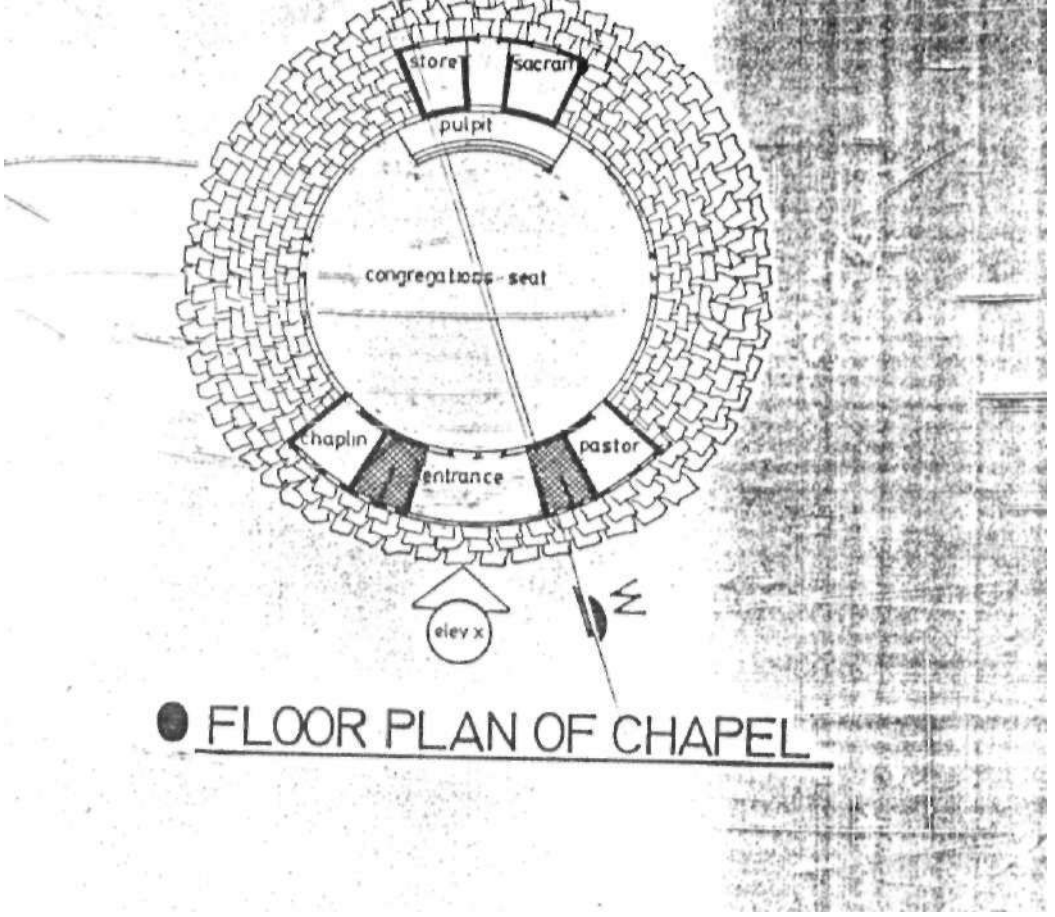
FLOOR PLAN OF MOSQUE



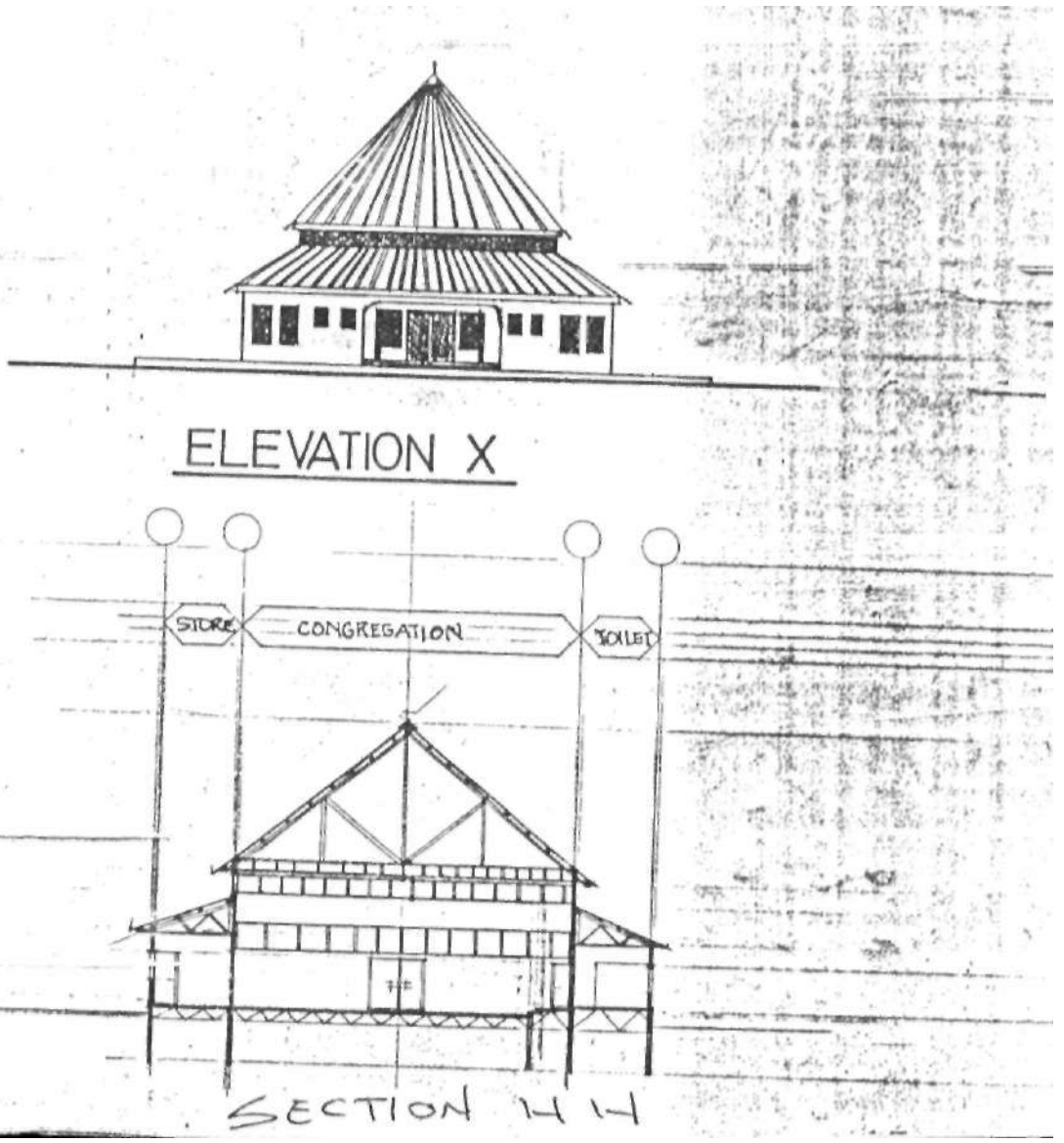
ELEVATION Z



SECTION RR



FLOOR PLAN OF CHAPEL



ELEVATION X

SECTION H-H