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Substance Abuse Disorders Treatment in El Salvador: Analysis of Policy-Making-Related Failure

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Abstract

Illicit drug use and substance abuse disorders have increased dramatically in developing countries during recent decades. Sadly, treatment for people diagnosed as manifesting and/or attributed with substance abuse disorders in developing countries is usually inadequate to meet demand, not evidence based, and of poor quality. In response, international health organizations have developed best-practice guidelines for substance user treatment in developing countries, although little research has evaluated their implementation. This opinion piece will examine one such effort to improve substance user treatment in El Salvador. It will be argued that the program failed (2007–2008) because of a lack of political will by the Salvadoran government through their Ministry of Health to effectively supervise, monitor, and subsidize substance user treatment.

Keywords

faith based; substance abuse disorders; substance user treatment; developing countries

Preface

It is necessary to consider the history of El Salvador in order to better understand the current failures with regard to substance user treatment. Treatment is not only a process, but also a value, an ethic, a culture of, and for caring, compassion, dignity, and decisions about the use of available and accessible resources for those who make up the population.

El Salvador, since its colonization in 1525 by Spain, has not experienced a lengthy history of democratization. Its failed declaration of independence from Spain in 1821 was followed by its becoming part of the United Provinces of Central America, which consisted of the five Central American states in 1823. The Central American federation was dissolved in 1838 and El Salvador became an independent republic and was ruled by landed elite oligarchies for decades, authoritarian governments, and military dictatorships.

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El Salvador's authoritarian governments employed political repression and limited reform to maintain power, despite the trappings of democracy. For example, its constitution was amended repeatedly (in 1855, 1864, 1871, 1872, 1880, 1883, and 1886); the wealthy landowners were granted supermajority power in the national legislature.

During its military dictatorship, 1931–1944, rural resistance was brutally suppressed. The government responded to the 1932 Salvadoran peasant uprising, commonly referred to as *La Matanza* (the “slaughter”), by murdering, imprisoning, or exiling approximately 30,000 indigenous people and political opponents.

During El Salvador's 12-year civil war, 1979–1992, human rights violations by both the government security forces and the left-wing guerrillas were rampant. The ensuing political democracy in El Salvador, after 500 years of conflicts, remains in a precarious state. Such precariousness, and the state of limited available resources, can and do serve as barriers to the planning, implementation, assessment, availability, accessibility of treatment for the population at large, and more specifically, for such stigmatized “others” as substance users.

El Salvador's history of military dictatorships and political oppression is shared by many of its neighboring countries, in particular Guatemala and Nicaragua (Figure 1). These countries, following the signing of formal peace accords in the late 1980s and early 1990s, are still plagued with income inequality, high rates of violent crime, human rights abuses, and a culture of violence stemming from previous oppressive regimes and civil war. Likewise, Honduras, while avoiding the civil war that plagued much of Central America, also has high levels of violent crime, human rights abuses, particularly in overcrowded prisons, and income inequalities.

The focus point of this opinion piece is on the failure to confront the growing substance abuse¹ and substance use disorders in developing countries, using El Salvador as a case example. I examine one unsuccessful attempt to improve substance abuse treatment in El Salvador that trained and accredited personnel working in mainly faith-based nongovernmental organizations providing substance user treatment.² Using a formal report of an evaluation of the program, and personal communication with staff from the Fundación Antidrogas de El Salvador (FUNDASALVA) who implemented trainings in nongovernmental treatment facilities, I will describe some of the reasons why this project was unsuccessful. The efforts to improve substance user treatment in El Salvador have failed because of the Salvadoran government's lack of political will to effectively supervise, monitor, and subsidize substance user treatment, and the failure of the international community to pressure developing countries, such as El Salvador, to commit as many resources to decrease the demand for drugs through effective drug user treatment as it has in

¹The journal's style utilizes the category *substance abuse* as a diagnostic category. Substances are used or misused; living organisms are and can be *abused*. Editor's note.

²Treatment can be defined as a planned, goal-directed, temporally structured change process, of necessary quality, appropriateness, and conditions (endogenous and exogenous; micro to macro levels), which is *bounded* (culture, place, time, etc.) and can be categorized into professional-based, tradition-based, mutual-help-based (AA, NA, etc.), and self-help (“natural recovery”) models. There are no unique models or techniques used with substance users—of whatever types and heterogeneities—which are not also used with nonsubstance users. In the West, with the relatively new ideology of “harm reduction” and the even newer quality of life (QOL) treatment-driven model, there are now a new set of goals in addition to those derived from/associated with the older tradition of abstinence-driven models. Editor's note.

combating drug production, drug trafficking, and interdiction. El Salvador is by no means unique in their failure to adequately respond to persons' suffering from substance abuse disorders, and the experiences in El Salvador are likely paralleled by experiences in many other developing countries.

Over the past decade, I have partnered with FUNDASALVA and the Universidad Centroamericana Jose Simeón Cañas (UCA) to conduct research focusing on the combined problems of crack use, HIV risk, and violence in El Salvador. Crack use is a serious problem in El Salvador. El Salvador has served as a transit country for cocaine destined to the United States since the 1980s. Starting in the late 1990s, drug traffickers began to be paid in product and opened up a local crack market ("Crack invade El Salvador," 1999; Santacruz Giralt & Concha-Eastman, 2001; Smutt & Miranda, 1998). The last national survey of illicit drug use in El Salvador, conducted in 2004, estimated the prevalence of crack use in the last 30 days to be over 1% among residents of San Salvador between the ages of 12–45 (Carr et al., 2004). However, even without effective surveillance, the impact of crack and alcohol use in El Salvador is more than evident. San Salvador is a city in which open drug markets and homes selling drugs are ubiquitous, and turf wars between rival drug dealers and gang members occur daily (Dickson-Gómez, 2004, 2010). El Salvador also has among the highest homicide rate in the Western Hemisphere, with a mean of 12 homicides per day in the first 3 months of 2009, in a country with a population of just over 6 million (Wilkinson, 2009). In addition, crack use is associated with high rates of sexual risk behaviors, including multiple partners, sex for crack or money exchanges, and unprotected sex (Dickson-Gómez, Bodnar, Guevara, Rodriguez, & Gaborit, 2007; Dickson-Gómez, McAuliffe, Rivas de Mendoza, Glasman, & Gaborit, 2012).

In spite of the obvious need for effective substance user treatment, the only government-funded residential treatment facility is located in the National Psychiatric Hospital, located in the San Salvador metropolitan area (De La Haye & Huidobro, 2010). Crack users in our studies, both in the past and currently, have reported numerous attempts to quit using drugs, with almost all attending faith-based residential programs at some point. Participants reported that these offered few evidence-based practices, with most relying on prayer and bible study as their main program activities. As one participant put it, "More than anything, prayer services is what they give you. They wake us up at four in the morning. The prayer service starts at five. So it doesn't really work because ... you're tired from being in the street, and waking up early isn't very comfortable and besides you come the first days really weak, wanting to lie down." In addition, faith-based treatment centers are self-financed, and patients are often sent to work outside the treatment centers in order to pay for their treatment as ambulatory sellers of cheap goods such as pencils, notebooks, or newspapers. Many reported that this put their sobriety at risk because they were exposed to drug-using acquaintances and places where they used to buy and sell drugs. Finally, most reported little or no monitoring of continuing substance use. Some reported ongoing drug use while at treatment centers, while others felt that their recovery was jeopardized by viewing other residents who continue to use. At the other extreme, other participants reported being locked into treatment organizations against their will, and being physically mistreated within them (Dickson-Gómez et al., 2010).

El Salvador is not alone in facing these problems. Illicit drug use and substance abuse disorders have increased dramatically in developing countries during the past decades (Obot, 2007; Perngparn, Assanangkornachai, Pilley, & Aramrattana, 2008; Rehm et al., 2009; Thirtalli & Chand, 2009; Uchtenhagen, 2004). Sadly, evidence-based substance user treatment has lagged far behind (Bobrova et al., 2008; Perngparn et al., 2008; Wang et al., 2007). Substance user treatment in developing countries is insufficient to meet the need, inequitably distributed, and inefficiently used, which results in a large majority of people with these disorders receiving no care at all (Dua et al., 2011). Like in El Salvador, the few treatment options that do exist are often “grass-roots” responses to the problem, most frequently faith-based residential treatment programs (Hansen, 2004, 2005; Hossain & Ahmed, 1999; Mohatt et al., 2007). These programs are often neither evidence-based nor of high quality (Dua et al., 2011), but are congruent with many people's view of substance use as a moral failing rather than a disease. While ongoing and accurate surveillance of illicit drug use and substance use disorders are often lacking in developing countries (Aguilar-Gaxiola et al., 2006; Hansen, 2005; Perngparn et al., 2008; Wang et al., 2007), the extent of the problem is as obvious as it is in El Salvador. More important than lack of surveillance is the inadequacy of appropriate infrastructure and personnel trained in effective substance abuse disorder treatment guidelines (Dua et al., 2011). While health care services are often inadequate in developing countries, the gap between need and services is particularly great for mental health and substance user treatment, perhaps because of the stigma associated with these disorders (de Toledo Piza Peluso & Blay, 2004; Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003) where they are often considered moral failings, not diseases (Dickson-Gómez et al., 2010). The lack of attention to substance use disorders has disastrous effects for developing countries, including loss of productivity, high traffic fatalities, higher rates of crime, and HIV infection (De La Haye & Huidobro, 2010).

In response to the need for more access to effective, evidence-based substance user treatment in developing countries, the Organization of American States (OAS), in collaboration with the Inter-American Drug Abuse Control Commission (CICAD), and the World Health Organization have developed best-practice guidelines and minimum standards of treatment, including matching an individual's treatment needs to different treatment modalities; making treatment readily accessible to take advantage of opportunities when addicted individuals are ready for it; addressing multiple needs of the individual in addition to his or her drug use; assessing and modifying an individual's treatment and services plan continuously, based on the person's changing needs; monitoring drug use during treatment; and offering treatment for an adequate period of time (usually at least 3 months). In addition, guidelines include individual and group counseling or other behavioral therapies as critical components of effective therapy. These should focus on issues of motivation, build on skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, improve problem-solving strategies, and facilitate interpersonal relationships. However, there is little published research on the effectiveness of these programs or the difficulties in implementing these guidelines into developing countries (Dua et al., 2011; Perngparn et al., 2008).

In 2007, CICAD/OAS funded FUNDASALVA to train 29 nongovernmental agencies that provide drug user treatment services. The training, chosen to fit with CICAD's best-practice

guidelines and based on evidence-based research in developed countries, consisted of 10 modules with 160 hours of instruction based on the Substance Abuse and Mental Health Services Administration (SAMHSA)'s Technical Assistance Publication 21 (TAP 21) Competencies for drug treatment counselors. After completing the trainings, FUNDASALVA expressed doubts about whether the trainings would have their intended effects due to the high staff turnover during the training period, with at least a third of the voluntary personnel changing from one month to the next. Many organizations were staffed by former patient volunteers with less than 1 year sober (G. Bodnar, personal communication, August 2008). Thus, FUNDASALVA staff speculated that many personnel were lost to relapse, while others who were more successful in their recoveries may have searched for paid employment. In addition, few staff at the centers had any formal training in substance user treatment and most relied on their own recovery experiences to guide their provision of services.

In 2008, the Pacific Institute for Research and Evaluation (PIRE), with funding from the Bureau of International Narcotics and Law Enforcement Affairs, US Department of State, evaluated the 29 centers that had participated in the CICAD/FUNDASALVA trainings. The aims of the study were to

1. assess the impact of the CICAD/FUNDASALVA training on drug user treatment center staff and center practices;
2. assess pre-post change in illegal drug use, problem drinking, and related problems (e.g., criminal activities, number of arrests); and
3. to examine the association between the level of success of former residents of drug user treatment programs and the treatment processes (e.g., length of stay), and the extent and type of training that program staff had received (<http://www.pire.org/internationalprojects.asp?cntry=El+Salvador>).

This study had a baseline sample of 625 patients, 72% of whom were located for 6-month follow-up interviews. The mean length of stay for patients was 51.2 days. Pre-post test results showed significant decreases in past 30-day and 6-month use of any illicit drug, crack, marijuana, cocaine, and tranquilizers. However, there was no control group and much research suggests that the majority of persons manifesting substance abuse disorders cease their substance use without the benefit of formalized treatment or 12-step programs, the “natural recovery” literature (Cloud & Granfield, 2008; Daniulaityte, Carlson, & Siegal, 2007; Granfield & Cloud, 2001; Klingemann & Sobell, 2001). In addition, PIRE found that the size of reductions in substance use was not correlated with the length of treatment stay (Courser et al., 2011), adding to doubts about whether reductions in drug use can be attributed to the treatment programs.³ Finally, the evaluation showed that program directors and staff who had participated in the CICAD/FUNDASALVA training correctly answered on average only 69% of questions testing their knowledge about drug user treatment and topics covered by the training, with a range of 25%–100% correct. In addition, only 18% reported a high use of the information learned in the trainings, 50% reported a moderately high use of

³The reader is referred to Hill's criteria for causation, which were developed in order to help assist researchers and clinicians determine if *risk factors* were *causes* of a particular disease or *outcomes* or *merely associated* (Hill, 1965). Editor's note.

the information, and 14% and 18% reported a moderately low or low use of the information learned. Directors and personnel, who were most likely to have a higher knowledge of drug user treatment and were the most likely to use the information received, were those who had more experience of working in addictions, had more time in recovery,⁴ were older, and worked in larger centers. Based on these results, PIRE recommended more intensive training with program center staff as a necessary next step in improving drug treatment services in El Salvador.

These recommendations ignore the root cause of the problem. In 2004, El Salvador approved Standards of Care for Persons with Behavior Affected by Psychoactive Substances, Ministerial Agreement 153 that contains the technical standards that regulate interventions for persons with drug addictions. In 2006, the Salvadoran Antidrug Commission approved a protocol guide for authorization of the opening and operation of institutions that provide care for those manifesting and/or diagnosed with substance abuse disorders. However, to date, in spite of appropriate standards and legislation, there is no direct supervision of treatment programs at the local or national levels (De La Haye & Huidobro, 2010). In addition, the government does not subsidize nongovernmental treatment programs. Thus, for directors and staff of nongovernmental drug user treatment programs, there is little incentive to adopt best-practice guidelines or standards of treatment because they receive no government funding to support their operations. There is also no disincentive to not meeting standards of care, as nongovernmental treatment organizations are not effectively monitored to ensure that they are compliant. Thus, many faith-based treatment centers continue to operate according to spiritual beliefs rather than evidence-based science, with many of the quality problems mentioned earlier. To date, the Salvadoran government has lacked the political will to improve substance user treatment in any significant sense. Promising rumors have begun that the Ministry of Health is beginning a new, more comprehensive substance user treatment strategy including more decentralized Ministry of Health outpatient treatment facilities (Dr. Quezada, personal communication, January 19, 2012).

Not surprisingly, the lack of effective monitoring of faith-based centers to treat substance use disorders and substance users, who represent a heterogeneous group of people and not a homogeneous one, and lack of secular, evidence-based treatment options has resulted in many community residents viewing drug user rehabilitation as ineffective (Dickson-Gómez, Corbett, Bodnar, Rodriguez, & Guevara, 2010). Indeed, community residents viewed some treatment centers, in which substance users were free to leave their treatment program and were viewed using crack in community parks, as worsening drug users' addictions. This, in turn, leads to a vicious cycle in which nondrug-using residents do not advocate for more and higher-quality treatment services, viewing such programs as ineffective. The government, thus far, has responded in a lack of real action to improve such programs. Rather, Salvadoran citizens have demanded, and the government has largely responded, with increasingly punitive criminalization of drug users. The antigang laws, *Mano Dura* (strong arm)⁵ and

⁴There are many definitions associated with the concept and process of *recovery*. The following definition is based on a consensus of 12 individuals representing and experienced in substance user treatment, research and policy—some of whom were in recovery—who met for 2 days during September 2006 at the Betty Ford Center. Recovery is a *voluntarily maintained lifestyle composed characterized by sobriety, personal health, and citizenship*. It moves beyond traditional models of abstinence and remission of symptoms to include functioning, well-being, perceived quality of life, and one's citizenship roles and responsibilities. Editor's note.

Super Mano Dura (super strong arm)⁶ while not specifically targeting drug users, seem to have increased police brutality against indigent drug users (Corbett et al., in press).

As mentioned, El Salvador is not the only country with growing substance-use-related problems and a lack of appropriate substance user treatment infrastructure. In fact, El Salvador may be better than most countries in terms of trying to improve access to substance user treatment, although this remains an unanswered question as few scientific studies have examined the context of substance user treatment in developing countries, or efforts to implement evidence-based programs (Dua et al., 2011; Perngparn et al., 2008). The scientific community has a responsibility not only to train personnel in developing countries about effective, evidence-based substance user treatment interventions, but also to evaluate effective ways of implementing and scaling up such interventions. Developed countries should fund such research, in addition to financing the necessary improvements in infrastructure and increasing the number of trained personnel. Perhaps most importantly, the international community should exert as much pressure on developing countries to implement policies that support effective substance user treatment as they have on source control measures. These steps are, in fact, a moral imperative considering that many developing countries' local drug problems are a result of serving as transit or producing countries to satisfy developed countries' demand for illicit drugs. "Drug problems" not only include the people misusing illicit substances, but also have wide ranging effects on communities and society through increasing signs of community disorder, crime related to local drug dealing and trafficking, and violent crime to control local drug markets and international trafficking routes. The causes of drug problems are equally multilevel and include structural inequalities within countries, as drug selling and trafficking may be the most lucrative or, in some cases, the only perceived opportunity to earn a living, and inequalities between developed and developing countries. However, drug problems are often used as a political mantra by governments that often look for scapegoats for the problem, rather than trying to fix the root causes of substance misuse, selling, and trafficking. In El Salvador, as in many countries, this scapegoating includes gang members and crack users. Voices advocating more humane treatment and rehabilitation of substance users and gang members are few in El Salvador, and include nongovernmental organizations and the Universidad Centroamericana, a Jesuit University, which argue that the tough on crime measures are ineffective, miss the root causes of the problem, and violate human rights. Residents of communities most affected by drugs and gang violence are ambivalent about the "Iron Fist" approaches of the government, feeling, on the one hand, that the measure has not been effective due to police corruption and ineffectiveness, and, on the other hand, because they fear for their daily security, hoping for effective police actions. Criminalization as a response to the drug problem has been paralleled by the US government whose response

⁵In July 2003, President Francisco Flores implemented Plan Mano Dura (Plan Iron Fist). Among other measures, Mano Dura "advocated the immediate imprisonment (for up to 5 years) of youths as young as 12 who displayed gang-related tattoos or flashed gang signs in public" (Jütersonke, Muggah, & Rodgers, 2009). Between July 2003 and August 2004, activities carried out through Mano Dura on the part of the PNC, with assistance from the Armed Forces, resulted in the capture of 19,275 youth suspected of being in gangs ("Aplicación de la Ley combate," 2005). Ninety percent of those cases were immediately dismissed by the judicial system (Cruz, 2006).

⁶In 2004, President Tony Saca passed Plan Super Man Dura, which included lengthier prison sentences. While it also included preventative measures, "Mano Amiga" (Operation Helping Hand; "Aplicación de la Ley combate," 2005), these have received much less funding (USAID, 2006). Neither of these measures has reduced gang-related violence.

to the drug problem in Latin America has been the “war on drugs,” eradicating crops and punishing those who transit drugs. While developed nations, in particular the United States, have begun to see the value in combating drug demand as a way of decreasing the crime associated with drug production and trafficking in their own countries, efforts to reduce demand are equally vital in developing countries (<http://iipdigital.usembassy.gov/st/english/article/2012/03/201203081853.html#axzz1ouWpe7Ux>). Without these efforts, the economic, social, and political stability of these countries is increasingly threatened.

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Biography

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Figure 1.
El Salvador and its neighbors.