Published in final edited form as:
Subst Use Misuse. 2011 ; 46(4): 426–439. doi:10.3109/10826084.2010.495762.

With God's Help I Can Do It: Crack Users' Formal and Informal Recovery Experiences in El Salvador

Julia Dickson-Gomez[1], **Gloria Bodnar**[2], **Carmen Eugenia Guevara**[2], **Karla Rodriguez**[3], **Lorena Rivas De Mendoza**[4], and **A. Michelle Corbett**[1]

[1]Medical College of Wisconsin, Psychiatry and Behavioral Medicine, Milwuakee, Wisconsin, USA

[2]Fundacion Antidrogas de El Salvador, San Salvador, El Salvador

[3]Universidad Centroamericana Jose Simeon Cañas, Instituto Universitario de Opinion Publica, San Salvador, El Salvador

[4]Universidad Centroamerican Jose Simeon Cañas, Public Health, San Salvador, El Salvador

Abstract

Crack use has increased dramatically in El Salvador in the last few decades. As with other developing countries with sudden onsets of drug problems, El Salvador has few medical staff trained in addictions treatment. Little research has examined drug users' attempts to reduce or abstain from drug use in countries where government-regulated formal medical treatment for drug addiction is scarce. This paper uses qualitative and quantitative data gathered from active crack users to explore their formal and informal strategies to reduce or abstain from drugs, and compares these with components of informal and formal treatment in developed countries.

Keywords

drug treatment; faith based; crack; El Salvador; natural recovery

INTRODUCTION

Illicit drug and alcohol use has increased dramatically in the past decade in low- and middle-income countries with a concomitant rise in substance use disorders (Obot, 2007; Perngparn et al., 2008; Rehm et al., 2009; Thirtalli & Chand, 2009; Uchtenhagen, 2004). Large gaps in

Address correspondence to Dr. Julia Dickson-Gomez, Medical College of Wisconsin, Psychiatry and Behavioral Medicine, 2071 N. Summit Ave, Milwuakee, WI 53202; jdickson@mcw.edu.

[1]Treatment can be briefly and usefully defined as a planned, goal directed, temporally structured change process, of necessary quality, appropriateness, and conditions (endogenous and exogenous), 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 aren't also used with non-substance 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. Treatment is implemented in a range of environments; ambulatory, within institutions which can include controlled environments. Editor's note.

Declaration of Interest The authors report no conflict of interest. The authors alone are responsible for the content and writing of this paper.

knowledge exist in developing countries regarding the extent of substance use disorders which would help establish treatment and prevention needs and priorities. Even less is known about substance user treatment[1] in developing countries (Aguilar-Gaxiola et al., 2006; Hansen, 2005; Perngparn et al., 2008; Wang et al., 2007). Existing research, however, suggests that substance user needs far outweigh available services, and substance user treatment services are underutilized by those in need of them (Bobrova et al., 2008; Perngparn et al., 2008; Wang et al., 2007).

In the last fifteen years, the local market in El Salvador for cocaine has greatly expanded and crack cocaine is a growing problem (Dickson-Gomez, 2004; Santacruz Giralt & Concha-Eastman, 2001; United Nations Development Program, 2004). Like many middle- and low-income countries, El Salvador has served as a staging point for crack destined for the United States since the 1970s. A local market grew as couriers started being paid in drugs rather than money (United Nations Development Program, 2004). As with other developing countries with sudden onsets of drug use and its related problems, El Salvador has few medical staff trained in treating drug users.

In response to the lack of government or biomedical substance user treatment services, many areas in low- and middle-income countries have developed “grass root” responses to the problem. These often include faith-based residential treatment programs (Hansen, 2004, 2005; Hossain & Ahmed, 1999; Mohatt et al., 2007). On the one hand, personal, community, and religious approaches to substance use may be more culturally congruent with the values of cultures in developing countries as they focus on repairing community and family relations, and spirituality (Mohatt et al., 2007). In many countries, mental illness is stigmatized and treatments for substance abuse disorders are considered ineffective (de Toledo Piza Peluso & Blay, 2004; Hugo et al., 2003). On the other hand, many grass root treatment centers are unregulated by any government agency, their treatment may not be evidence-based, and in some cases is not even humane (Thirtalli & Chand, 2009).

In El Salvador, the majority of substance user treatment is offered in “Ministries” or faith-based residential treatment programs. These view substance use as an attempt to fill the spiritual void left by the absence of God, or sometimes as the result of demonic forces. Evangelical missions, i.e., Protestant, fundamentalist churches, have many decades of presence in El Salvador, particularly since the end of the civil war. Many low-income Salvadorans rejected the Catholic Church after the civil war because of the church's perceived political involvement in Liberation theology (Dickson-Gomez, 1999). Evangelical churches, in contrast, eschew involvement in the “world,” and focus on people's spiritual reward after death (Dickson-Gomez, 1999). The “world” is in contrast to the spiritual and includes everyday temptations (drugs, alcohol, and women) and politics and is seen as corrupting. In addition, Evangelical churches believe in sudden conversions in which one is “born again” in Christ and leaves his or her former life of sin, including addiction to drugs or alcohol, behind. Evangelical churches also provide a strong sense of community to members. However, Evangelical missions in El Salvador also reinforce the commonly held belief that drug abuse is a moral failing, and not a medical disease, further stigmatizing substance users.

Faith-based programs in El Salvador currently are not regulated by any government agency. Since 2005 El Salvador, in collaboration with the Organization of American States and Inter-American Drug Abuse Control Commission (CICAD), has attempted to establish accreditation standards for these ministries, including basic building standards, staff to client ratios, training in substance user treatment for staff, and basic treatment standards. However, the Ministry of Health, non-governmental organizations involved in substance abuse treatment, government organizations involved in interdiction and enforcement, and

institutions of higher education that could be involved in training licensed substance user counselors have not yet reached consensus regarding accreditation standards for facilities or certification standards for providers. In the meantime, CICAD and FUNDASALVA, the oldest secular treatment programs in El Salvador, have held trainings about the nature of addiction and effective treatment practices with 22 faith-based treatment programs in El Salvador. FUNDASALVA staff involved in this effort report that faith-based ministries often had no more than one full-time staff person for their drug user treatment programs, and that they were mostly staffed by persons who had recovered from their drug use through the same or similar programs with no formal training in addiction treatment. They also reported that staff turnover was extremely high due to frequent relapses of staff members.

In addition to faith-based ministries, 12-step programs, particularly Alcoholics Anonymous (AA), have flourished in El Salvador. While the exact number of AA groups is unavailable, one or more meetings can be found in nearly every community or neighborhood in the greater San Salvador area. Other 12-step programs, such as Narcotics Anonymous, are less common. However, most AA meetings allow users of other substances into their meetings, as well as polydrug users.

To date, little research has examined drug users' attempts to reduce or abstain from drug use in countries where government-regulated or formal medical treatment for drug addiction is scarce. This paper will use qualitative and quantitative data gathered from active crack users and residents of low-income communities with high rates of drug use and sales in the San Salvador metropolitan area to explore crack users' formal and informal strategies to reduce or abstain from drug use. We define formal treatment as organizations that have as their primary mission helping crack users abstain from crack use, including faith-based ministries that are not regulated by the government. We define informal attempts to abstain or decrease drug use as strategies that participants use, including seeking family support, leaving drug use contexts, joining a church or finding people who have quit using drugs for advice. We will explore (1) the various treatment options available for crack users in San Salvador and barriers to accessing available treatment; (2) whether available treatment options are culturally congruent with local beliefs about drug dependence and recovery; (3) the extent to which faith-based drug user treatment options include processes and components found to be essential to successful treatment outcomes in evidence-based research; and (4) the extent to which formal treatment options comply with minimum standards of quality including appropriate staff supervision of clients, provision of appropriate security for clients, and respect for clients' autonomy.

We will first summarize principles of effective treatment and the research about natural recovery. While most of this research has been conducted in developed countries, it offers a useful point of comparison to interpret Salvadoran crack users' formal and informal attempts to reduce or abstain from crack use. We will then summarize survey and qualitative data to reveal the extent to which participants' have had any experiences with formal treatment, the range of formal treatment options and barriers to accessing these. Finally, we will explore in more depth crack users' experiences with faith-based treatment centers and their informal strategies to quit drug use and in order to answer the questions above.

MODELS OF DRUG USER TREATMENT

There has been much disagreement in the literature about our knowledge of the essential components of effective treatment for substance abuse and dependence (Magura, 2000; Magura et al., 2002; Prendergast & Podus, 2000). However, NIDA (National Institute on Drug Abuse, 1999) has synthesized the available scientific research to propose the following principles of effective treatment: 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 three months). In addition, NIDA asserts that individual and group counseling or other behavioral therapies are 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 non-drug using activities, improve problem-solving strategies, and facilitate interpersonal relationships. Finally, effective treatment should assess and treat individuals with co-occurring mental illnesses, HIV/AIDS, and other infectious diseases (National Institute on Drug Abuse, 1999). As mentioned, what has been found effective in drug treatment in the United States and other developed countries, where the vast majority of research has been conducted, will not necessarily be effective in other countries with different cultures, values, and histories (Perngparn et al., 2008). However, exploring crack users' experiences with more locally developed drug user treatment may illuminate universal processes of successful treatment and recovery. Their perspectives may also illuminate areas of deficiency in locally available treatment options.

Including spirituality or bible study in drug user treatment, as is common in many faith-based treatment programs, does not necessarily contradict the components of successful treatment mentioned above. Although research on faith-based drug user treatment programs is rare even in the United States where they have existed for several decades (Restorehope Consulting, 2009), qualitative research has shown that faith-based treatment programs in the United States include many of the same components as secular treatment components while adding a spiritual dimension (Neff et al., 2006). The Minnesota model, for example, is arguably one of the most influential treatment models in the United States and incorporates faith-based and 12-step components into their program (Stinchfield & Owen, 1998). In addition, most U.S. faith-based drug treatment programs receive federal funding and oversight. In fact, funding of such programs has increased dramatically in the last decade (Restorehope Consulting, 2009). The Substance Abuse and Mental Health Services Administration (SAMHSA), Access to Recovery Program (ATR), for example, provides vouchers to people needing substance user treatment and allows voucher recipients a choice of faith-based or secular treatment programs (http://atr.samhsa.gov/index.aspx). The extent to which faith-based substance user treatment programs incorporate the components of successful treatment outlined by NIDA in developing countries where there is little or no government oversight and secular treatment is largely unavailable has received little research to date.

Other research in Western countries has revealed that perhaps the majority of persons suffering from substance abuse or dependency recover from such problems without the benefit of formalized treatment or 12-step programs (Cloud & Granfield, 2008; Daniulaityte et al., 2007; Granfield & Cloud, 2001). In “natural recovery” drug users' describe being motivated to abstain in order to become better family members. They describe recovery processes such as becoming more spiritual, becoming more connected with family members and others, and avoiding situations in which they used drugs. For some the process is gradual as they begin to think about abstaining and then take small steps to reduce their drug use. Others describe a critical point in which they decide to abstain from drugs (Daniulaityte et al., 2007; Mohatt et al., 2007). It is probable that in places where treatment resources are scarce, natural recovery becomes an even more prominent strategy to reduce or abstain from drug use. Cross-cultural comparison of the informal strategies used by substance users may help further illuminate processes of natural recovery that, in turn, may help improve formal

drug user treatment programs by identifying important extra-therapeutic supports necessary to achieve and maintain drug abstinence.

METHODS

Data include in-depth and survey interviews collected as part of a larger project studying the effects of community characteristics on the context in which drugs are consumed and risky sex occurs. The project also included a community assets assessment in order to build on communities' capacities to develop a multi-level HIV prevention intervention. Informed consent and project protocols were reviewed by Institutional Review Boards at the Institute for Community Research, Hartford, Connecticut, the Medical College of Wisconsin, Milwaukee, Wisconsin, and the Universidad Centroamericana José Simeón Cañas, San Salvador, El Salvador.

Qualitative Data Collection

We conducted three focus group interviews with active crack users and 20 in-depth interviews with crack users from the San Salvador metropolitan area. The focus groups included participants who resided in different low-income communities in the San Salvador metropolitan area that differed, among other things, in their access to HIV prevention and drug treatment resources. Participants were recruited through community contacts (often personnel of community-based organizations that offered services to indigent and drug using residents). Contacts approached potential participants to invite them to participate in focus group or in-depth interviews. Potential participants were screened for eligibility by FUNDASALVA staff prior to interviewing. Eligibility criteria for focus group and in-depth interviews included being 18 years or older, having smoked crack or participated in crack selling roles in the last 30 days. Four in-depth interview participants were interviewed after they had entered drug treatment. Most had been in treatment less than two weeks prior to the interview. Focus group participants were asked whether they knew of any places that crack users could go in their communities to cut down or abstain from drugs or of any programs to prevent drug use. In-depth interview participants were asked these questions and, in addition, whether they had ever received and their experiences in drug treatment. We also asked about their informal attempts to abstain or cut down from drugs, including whether they had any periods of abstinence or reduced drug use and, if so, how they achieved this. We asked them whether they knew of anyone else who had managed to abstain from drug use after having a problem and how these people were able to do this.

In addition, we conducted seven focus groups with residents of seven low-income communities in the San Salvador metropolitan area that were areas of high crack sales and use. Focus groups consisted of 6 to 7 non-drug-using residents holding community leadership positions (such as youth group leaders, or leaders elected to serve on community boards). Eligibility criteria included being 18 years or older and either living and/or working in the community being studied. Participants were asked to describe crack use and sales in their communities, and community resources available in their communities to help individuals who use crack.

Focus group and in-depth interviews were facilitated by FUNDASALVA staff, Salvadoran researchers with degrees in psychology and extensive experience and training in qualitative research with active drug users. Participants in in-depth and focus group interviews received food items worth approximately $5. Written informed consent was obtained from all in-depth and focus group participants prior to being interviewed.

Qualitative Data Analysis

All interviews were transcribed verbatim and coded collaboratively by the Salvadoran and U.S. research team using Atlas.ti. Transcripts were first coded for broad content areas such as drug use history, drug treatment, changes in the quantity of drugs consumed, and social support. Codes were then refined using an iterative and consensus-based process. For example, changes in quantity of drugs consumed included the subcode of drug abstinence that was further refined to include leaving drug areas, looking for a partner, looking for an abstinence role model, going to church, going to a drug treatment center, and AA.

Surveys

Surveys were conducted with 420 crack users in the San Salvador metropolitan area. Eligibility criteria included having smoked crack in the last week, being 16 years or older, and if under 18 years, obtaining parental consent or establishing emancipated status. Respondents were recruited using respondent-driven sampling (RDS), a version of snow-ball sampling that gathers information about participants' social networks in order to estimate and account for the probability of a participant being recruited into the study and, with long enough chains of referral, can be used to recruit a representative sample (Heckathorn et al., 2002; Salganik & Heckathorn, 2004). A small number of seeds were selected from various communities in the San Salvador metropolitan area. Each seed was screened for eligibility, consented, and surveyed if eligible. They were given three coupons to recruit other members of their drug-using networks into the study. These recruits were also given three coupons. Surveys were conducted face-to-face by FUNDASALVA staff. Participants received $5 for completing a survey, and $2 for each recruit they successfully brought into the study.

Among other things, surveys included questions about basic demographics, amount and sources of income, quantity and frequency of drug use, and whether they had ever been in drug treatment, been in drug treatment in the last six months, and type of drug user treatment attended ever or in the last six months.

Quantitative Analysis

We obtained frequencies to describe the sample in terms of gender, level of education, income and frequency of crack, and other drug use. We then analyzed data to determine whether or not the participant had ever received drug user treatment, and if so, the type of treatment (in-patient, outpatient, self-help or other), whether they had received drug user treatment in the last six months and the type of drug user treatment received. We then conducted logistic regressions with age, level of education, monthly income, age first used alcohol, age first used crack, and quantity of alcohol and crack used during the last 30 days as covariates, gender as a factor, and ever having received drug user treatment as the dependent variable.

RESULTS

Access to Drug User Treatment

As seen in Table 1, only 49% of the sample had ever been in any kind of drug user treatment program in El Salvador, while 33% had been in treatment in the last six months. The vast majority of those who had ever been in drug user treatment reported that they had been in in-patient drug treatment. A smaller but still sizeable percentage reported having participated in 12-step (self-help) programs ever and in the last six months. Very few reported outpatient drug user treatment in their lives or in the last six months. As can be seen in Table 2, participants had a very high level of current crack and alcohol use and had low levels of educational attainment and low income (per capita income in El Salvador has been estimated

at $533 per month http://siakhenn.tripod.com/capital.html). In logistic regressions, younger age first used alcohol (.006), higher levels of education (.001), and greater frequency of crack use (.038) were associated with having ever received drug user treatment.

Barriers to Treatment Programs

While the majority of participants who received drug user treatment reported receiving in-patient treatment, qualitative interviews reveal that most had probably been treated in faith-based residential treatment programs. Few drug using or non-drug-using participants reported having heard of any secular treatment programs, while all mentioned a number of faith-based treatment centers. In addition, only one participant reported having received treatment at the government-run psychiatric hospital, and one reported receiving treatment at a secular private treatment center. The higher cost of the secular drug user treatment center may have limited access for some of our participants. Government-run drug user treatment is centralized in the National Psychiatric Hospital. Referral to this program from government health clinics is limited due to stigmatization of drug users and lack of proper training to recognize and treat substance use-related problems.

> Male crack user: My use was really drastic. Like if I bought five rocks, I put five in my pipe at once. One didn't do anything for me. My mother didn't know anything about me … I didn't bathe, I didn't eat, everything I got went straight to the drug dealer. … I came to the point where I went to the hospital. They took care of me for three days and then they didn't want to take care of me because they have you sedated, they gave me like ten pills every day to help with the drug cravings and after three days the doctor said, “No, let him stay. I'll be responsible for him.” … Maybe it's not that I'm lucky or strong but the hand of God that was with me, because I started to see myself differently in a month, the cravings were going away. I had patches on my skin so they did a lot of tests and my thinking was, “Hey, if I turn out to have AIDS I'm going back to drugs and I'm not leaving on my own but I'm taking others with me.” After three months they sent me to a program at the Psychiatric hospital. [In-depth interview]

It appears that the hospital where he arrived did not have a formalized program for dealing with cocaine addiction. In fact, it appears that hospital staff were reluctant to use psychotropic medications to control his drug cravings, perhaps viewing this as simply substituting one drug for another. He was also suspected of having HIV. It was only because of the personal intervention of a doctor on his behalf who assumed responsibility for his care that he was allowed to stay.

Faith-based treatment programs are more accessible than government-run drug user treatment. However, there are also several barriers to accessing many of these programs. Faith-based treatment programs are not subsidized by the government. Some programs cover their costs by charging for the treatment. In these centers, the family members of mostly homeless and impoverished crack users are expected to pay for treatment. If family members cannot be found, or if they refuse to pay for treatment, crack users are denied treatment. This was described as a significant barrier to access in a community leaders' focus group consisting of service providers who worked directly in HIV prevention with crack users and commercial sex workers in the center of San Salvador.

> Female service provider: With respect to those places, what good does it do to have so many rehabilitation centers when in those centers they won't accept a person who doesn't have any family. I can't be responsible for five people [who need treatment]. Why? Because I only know them, so this person goes with HIV, with alcohol problems, with drug problems and they won't accept him because I don't have information about his whole family and [I can't] pay for him. I can't be next to

> that person [in treatment] all the time, following up with him because it's a long time, and they won't accept him …. Right and many of these are street people, I mean they aren't going to tell you, “Look my family lives in that part, go get them or go tell them” and even if you took the trouble to go find them, the family doesn't want to help [Community Leader Focus Group].

This barrier was confirmed by crack users who had sought treatment at these centers. In one case, a male crack user was turned away until he could bring his estranged family members with him to treatment. In these cases, treatment options in El Salvador fail to make treatment available for those who are ready for it. In fact, it seems that treatment is least accessible for those who demonstrate the most need because their drug addictions have taken them to the point of living on the streets and they no longer have the support of their family members.

Another barrier includes the relative lack of centers for women relative to men. Participants reported only one faith-based center open to women. One woman reported that she was allowed to stay in a male-only treatment center which her male partner was attending because she cooked and cleaned in the center. Other women reported leaving the woman-only treatment center because they did not wish to be separated from their male partners. Women's access is also limited due to control of abusive male partners or child care responsibilities as we will see below.

Finally, most faith-based treatment centers are based on Evangelical Christian theology. This may be a barrier for non-Christians or Catholics. While Evangelical churches have flourished in El Salvador, the majority of the population is still Catholic. The Catholic Church has not responded with treatment centers to the same extent as Evangelical ministries. Faith-based treatment programs also view same sex attraction as a sin, perhaps alienating sexual minorities.

Beliefs About Addiction

Salvadorans beliefs about addiction in some ways are congruent with faith-based treatment, and in other ways constitute an additional barrier to accessing formal treatment programs. Many crack-using participants understand their crack use in both medical terms and as a moral failing. They often talked about addiction as a “disease” and “vice” interchangeably. Non-drug-using residents also consider crack addiction most often in moral terms, leading to considerable stigmatization of people living with substance abuse. In El Salvador, crack users are not only considered weak willed but also morally corrupt. As one female community resident stated, “Remember that it's a vice, and they're happy like that …because this guy who's my neighbor says, `I'm happy. Satan loves me.”' For this woman, those who use crack not only have turned away from God but worship Satan.

Viewing substance use in moral terms can contradict the view of addiction as a chronic but treatable disease. A drug user's relapse is thus seen as a personal failure and proof that drug user treatment does not work. As one female crack user stated:

> No, I definitely don't want rock anymore. There isn't any need for me to go to a rehabilitation center. It's will power because there are people who have gone to centers and it's a lie. A few days later they are using rock again. It's will, putting your will, because it's a thing that, I mean it's playing with death that vice.

On the other hand, viewing substance use in moral terms is congruent with formal faith-based treatment options in El Salvador. In these, drug users are asked to pray to God in order to leave their vice (sin) behind. Many informal strategies to abstain from drug use such as joining a church are also congruent with the view of substance abuse as a moral and spiritual problem. Also, as will be discussed below, many participants' reasons to quit using focus on

their moral failure as parents and productive members of society more often than health concerns.

Reasons to Quit

While not all participants had access or utilized formal drug user treatment programs, all crack users who participated in in-depth or focus group interviews described wanting to cut down or abstain from drugs. The reasons participants gave for quitting are similar to reasons found in many developed parts of the world such as fear of the consequences of crack use on their health, and becoming a more responsible family member and productive member of society.

> Male crack user: The first point and the most important is that you think first in your life ….You know that you're doing yourself harm, that this is going to kill you, and if you love your life you'd be better off not doing it, you know, and from there comes your family, if you have kids, your wife, etc. Work.

Family was a particularly salient reason for quitting for women. Women face more stigma than male drug users because of the greater violation of female gender roles, in particular that of being a mother.

> I've always been a mom who takes care of her children, right, and when I started to see that I couldn't anymore because a man had me trapped in a house, locked up, and what I earned I shared with him in rock and I said to him, “I have children … and I have to send them something.” “Okay I'm going to give them the money,” and he went to give them the money. I didn't see them like before …. That was killing me … that I didn't see my children …. Then some evangelicals came where I hung out …. They were standing next to me and …they came to me to talk about things about God and they also told me, “Your children need you. Go see them.” …. I tried really hard for my children because the one who is 18, one day I found him in a *trance* [crack house], because he found out that … I smoked rock and I cried and I told him “Forgive me because the truth is it's my fault, but I don't want to see you like this. I'm going to help you anyway I can.” And all that was hurting me, all that hurt [In-depth interview crack user]

Crack using women also suffer power differentials that may make accessing drug user treatment or quitting on their own more difficult. Women are often dependent on men to obtain drugs for them (Weeks et al., 1995, 1999). This participant described giving her money to her partner and basically being kept prisoner in her own home. However, the need to see her children and seeing the harm that her own drug use had caused after finding her son using crack motivated her enough to leave that situation and start attending churches.

Experience in Faith-Based Treatment Centers

Faith-based treatment centers did not generally have formal training in drug user treatment, beyond staff and minister's previous experiences in recovery. In addition, few had formalized treatment plans such as cognitive-behavioral therapy or relapse prevention strategies. However, like effective drug user treatment, faith-based treatment centers focused on keeping people occupied in meaningful activities other than drug use. For faith-based treatment centers, much of these daily activities included prayer, bible study, household chores and work. Perhaps more importantly, faith-based treatment centers created supportive family-like environment.

> Interviewer: So you were telling me that you've been in Centers of Rehabilitation a number of times. How is it that you came to be in these Rehabilitation Centers?

> Male crack user: My family. I mean my family told me from the United States, "Look, if you don't go to a ministry, forget about our help." "Okay" I said, "I have to go." I went. I've been in three ministries. I've been in this one twice and in two more …. The first time I was here six months ….
>
> Interviewer: What type of help have you received?
>
> Male crack user: Food, how they treat you here. I mean you see the hand of God …. They love us like their own children because there's a director and she loves us like her children. You can see that she's really given herself to God and she makes us look for God as well.
>
> Interviewer: What kinds of activities do you do?
>
> Male crack user: Cleaning together, make beds, clean, peel vegetables ….
>
> Interviewer: And do you know anyone who has quit using drugs or reduced their crack use?
>
> Male crack user: Yes, there's one here that you take as an example. He gives me a lot of advice because he talks a lot. I ask him "Look, how have you done it?" "Explain it to me."
>
> Interviewer: And how has that person done it?
>
> Male crack user: Asking God, asking God. "Keep your mind occupied," he tells me. Read the bible, pray. That's how he's done it. [In-depth interview]

The participant above had family who sent him remittances from the United States. Many crack using participants reported similar separation from parents and siblings who had immigrated. Many crack users reported that their parents immigrated illegally when they were very young to help support them economically by paying school fees and housing. Illegal immigration often occurs with help from a coyote and is an expensive and dangerous journey, so many parents must have felt reluctant to send children to rejoin them in this manner. Also, the lack of legal documentation limits the extent to which absent family members can return home for visits. The family-like atmosphere created in this faith-based treatment center, therefore, fulfills a very important need for crack users whose families have been torn apart by immigration.

Many times participants, like the man quoted above, were taken to centers by desperate family members, and participants may not have been highly motivated to their own recovery. Being obligated to receive treatment, as opposed to voluntarily entering treatment, does not necessarily negatively affect treatment success, as court-mandated treatment has also been shown to be successful (National Institute on Drug Abuse, 1999). However, in many cases, crack users reported that they entered faith-based treatment centers not because they were motivated to permanently abstain from drug use. Rather some reported using treatment in order to continue receiving family support, as the participant above describes. In other cases, crack users reported entering treatment in order to rest for a while and get off the streets, particularly during the rainy season. Studies with active drug users in the United States have also described drug users who use methadone maintenance or inpatient drug user treatment to rest and let their bodies recover from illness (Koester et al., 1999). In such cases, successful treatment must try to increase clients' motivation to abstain from drugs. The participant above describes his motivation to abstain increasing as he became more open to God through the loving example of center staff.

Most faith-based treatment centers did not include practical strategies to avoid relapse, apart from praying and studying the bible. While relapse is common in all types of drug treatment,

traditional drug user treatment programs devote considerable time to anticipating triggers to relapse, helping clients plan to avoid relapse, and steps that a client should take after relapse. However, most participants viewed “rehabilitation” as a one-step process. In part this may be due to the belief in conversion among many Evangelical churches. After accepting God, drug users' lives are changed and they no longer need drugs. As in the United States and elsewhere, however, drug using and non-drug-using Salvadorans failed to view substance use as a chronic illness, like diabetes, that needs continuing treatment to manage and where relapse is common. Thus, some crack users chose to “quit on their own” because of their perception that drug user treatment did not work after observing many drug users relapse after leaving treatment.

However, it appears that in some faith-based treatment centers, drug users were encouraged to continue to attend church and prayer meetings.

> Interviewer: And how many times have you been in a rehabilitation center?
>
> Male crack user: It's three times in this one, but I was at another one another time. When you're younger, you know, you leave thinking that you're all better, but no …. You start off well, going to church and everything but because of work, working from eight in the morning until eight at night, the world starts pulling you back and you stop going to church …. You go three times [a week] to church, then a little later twice, then once to the church and when you start to feel like not going to church you don't have God's spirit, you don't have the faith that you need to quit your vice, right. You don't have that faith and you go back to the same [using drugs]. [In-depth interview]

For this participant, spirituality's role in recovery was a lifelong process. Not going to church regularly can pull you back to the corruption of “the world,” distancing one once again from God and triggering relapse.

In faith-based residential centers, no medication is given to help with detoxification, for example sedatives to help with cravings, or fluids to replace the electrolytes lost in prolonged crack binges. Participants reported that detoxification from crack was one of the most difficult parts of entering drug treatment.

> Female crack user: The detox, the change, the cleaning of your body: that causes something. If you take a hit of drugs it numbs your tiredness, your hunger, your thirst, all that disappears. When you quit using, those three things come back and you want to eat, drink and sleep. You can't even keep sleeping [in the center] and need a hit to get up but you don't have it and nobody's going to give it.
>
> Interviewer: So people don't look for help in the Rehabilitation Centers because the detox is really hard?
>
> Female crack user: Uh huh, the process of detoxification is really awful, it makes you angry, gives you fever, I mean your nerves are shattered and sometimes other women come worse than you and you fight with them. [In-depth interview]

Given the paucity of medical interventions to help with detoxification, faith-based treatment centers may resort to extreme, harsh, and inhumane methods. Some participants reported being locked in cages during their detoxification process.

Other participants reported that in addition to the lack of medication to help with detoxification, faith-based treatment organizations also required residents immediately to begin a grueling process of prayer meetings and work.

> Male crack user: I've been in Rehabilitation Centers, but Christian …. I've been in two …. The program is really drastic and maybe you come tired from the street and you need to rest the first day, to eat. And the prayer services 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 really, you can do it, but it doesn't work because you don't want to get up early because …you're tired from being on the street, and waking up early isn't very comfortable and besides you come the first days really weak, wanting to lie down. So it doesn't really work. It's worked for me for the time that I've been there, but outside, I haven't gotten the strength and I don't even remember about the program. [In-depth interview]

Although faith-based treatment centers are one of a very limited set of treatment options, in-depth interview participants reveal the extent to which they fail to fully understand and take into account the psychological and physiological realities of drug addiction.

Other participants with experience in faith-based drug user treatment programs complained about the lack of basic hygiene and security.

> Male crack user: Like three years ago, my old lady wanted to get me into a place … it was like a little house, but when she took me to admit me, I stayed like a week, I think. They talked about God, they gave talks about drugs and all that. I could have stayed to see want happened, to see if there was a change in me, but I wasn't satisfied with the cleanliness that was there. It was all too dirty, “Geez what am I doing here,” I said, “having my own house. I'd be better off quitting on my own than staying here,” like it was like being in a jail, because there was a lot of gang members and they always want to dominate or they take you as a civilian they say. [In-depth interview]

The participant implies that like in jail, gang members were in control of the treatment center, and that staff did little to protect residents who were not gang members.

In many programs, keeping the mind and body occupied is accomplished not just through prayer but also through work. This again is consistent with the substitution of meaningful activities for drug use that is found in many traditional treatment programs. Work is also consistent with the goal of reintegrating clients to be productive members of society. For many centers, work by center residents is necessary to pay for the expenses of these programs that do not receive government subsidies. The amount charged to residents is usually nominal, typically $5 a week. Residents are therefore expected to give a percentage of their earnings to the center. In some centers, clients are sent to businesses as day laborers, giving them experiences that may be translated into more permanent work in the future. However, other centers send their residents to sell pens or newspapers on the street where they are exposed to drug-using friends which may trigger relapse. This is particularly problematic for participants with only days of sobriety, as described by the participant below who had just begun treatment.

> Interviewer: So I wanted you to tell me what a typical day in your life is like.
>
> Male crack user: Good, thank God, but I can't have a lot of money because when I have money it's like the devil is pulling me and tells me “Come here” and that's when I go to get alcohol or crack …. That's why I don't go out a lot and it's better for me to stay inside the ministry. But when I go to sell [newspapers] and all that you know that in the street you can say no, but …there are a bunch of friends from before who tell you, “Come here. Here have a drink” and they know that you've been a drug addict and alcoholic and it's a lie that you're going to say no. And it's a lie that you're just going to have one drink …. The brothers [in the ministry] tell me

> to fight against it …. When I sell newspapers, I'll go get a drink with my profits, but when it's the ministry's money I don't touch it. I give the ministry its money, but then they smell liquor on me and that's what they don't like because you know that when you're in a ministry you're there to follow their rules, not to come in drunk, or high on crack. [In-depth interview]

The lack of supervision and adequate monitoring of substance use among residents was also a complaint of community residents who had rehabilitation centers located in their communities. As the participant above implies, in some centers residents could freely come and go, and when outside the centers' walls often consumed alcohol or drugs. This particular participant was caught and reprimanded because he had been drinking, and staff detected alcohol on his breath. None of the treatment centers, however, tested residents for drug use. According to the community residents below, residents from one faith-based treatment center switched their addictions from alcohol to crack because staff were apparently unable to detect residents' crack use, perhaps because staff was unfamiliar with crack's smell or behavioral effects.

> Male participant 1: There's another house here, in that house they have it like a half-way house of “X” church … for people in recovery. At first everything worked well … and then when supposedly, in quotes, these people were recovered they trusted them a lot, and now they trust them even more. Now they're drug addicts. They don't do it inside the house … but there are people from there who go to use drugs at the sports field. They sit there at the tables with their lighters and their pipes.
>
> Female participant 1: And in front of the children.
>
> Interviewer: What kind of drugs?
>
> Male participant 1: Crack more than anything ….
>
> Interviewer: But they are people in recovery?
>
> Male participant 1: Yes.
>
> Interviewer: Who live in the community as well?
>
> Female participant 2: No. They're from the half-way house that's rented by a church.
>
> Female participant 3: So they've brought people from other places.
>
> Female participant 2: Uh huh, who knows where they're from. We don't know them and sometimes it makes me afraid to say, “Look don't do that there,” because it's not like talking man to man when you talk as a woman to talk with a man, especially if they're on drugs. [Community Leader Focus Group]

While in the majority of treatment centers, crack users and community residents complained that too much freedom was allowed in that participants could come and go as they pleased, in other extremes, residents' human rights were violated and they were taken and kept in the center by force as described by the participant below. The danger of the kinds of abuses described below is a result of the lack of government regulations, appropriate monitoring, and clear avenues for complaints.

> Interviewer: Have you ever tried to reduce or quit using crack for any period of time?
>
> Male crack user: Yes, I've quit using for up to six months through God's help. I mean, I was in a ministry, but there in that ministry they took me against my will. My family took me, my parents. They took me tied up and blindfolded so that I

> wouldn't know where I was and you couldn't leave there. They wouldn't let you leave for anything and against my will, locked up, all the doors with locks. In prison practically, and the food, sleeping on the floor, I mean it was really awful and I said, “When I leave I'm just going to use and use” because I was mad.
>
> Interviewer: And how long were you in that center?
>
> Male crack user: Six months, because the first time I could I escaped over the fence.
>
> Interviewer: And while you were in that center could you use or not?
>
> Male crack user: No, no, I couldn't use. How could I? They didn't let you leave. When I escaped they had dogs chasing me, and the fence was electrified, but I work in electricity and in metal structures and so I just grabbed where there wasn't any current and jumped over. [In-depth interview]

As mentioned above, residents of some treatment centers were locked in cells during detoxification. In other centers, participants reported that relapse was punished by tying residents to a bed and throwing feces at them. Balance between freedom and appropriate monitoring and supervision appears to have been achieved in some longer running centers. However, it remains a considerable problem in the vast majority.

Quitting on Their Own

Given the barriers to access of both secular and, to a lesser extent, faith-based treatment, participants described many strategies to quit on their own including leaving the scene, finding a role model in a drug user who managed to quit, and joining a church, usually Evangelical.

Leaving the Scene—Participants who were recruited from the Center of San Salvador often came from other cities or departments in El Salvador. In fact, the historic center of San Salvador is an area concentrated with drug markets and commercial sex work, and most residents are transient drug users. Participants therefore described reconciling with family members, thereby removing themselves from daily exposure to drug use and sales.

> Male crack user 1: In my case …sometimes when I feel really agitated and all that and I'm just fed up I go home …I reconcile with my mother …. Thank God my mother understands, you know, although she at one time was an addict to her vices, but in that time this kind of drug [crack] didn't exist. She still used drugs. She says “I understand son, but take it easy.” There I go like a good boy, I wash the dishes and all that to pass the day, watch TV. I lie down on the sofa. I listen to music, sleep. And when I'm …nice and fat … I remember [crack]. Especially if I have money in my pocket I feel that …
>
> Female crack user: Ah, that burns!
>
> Male crack user 1: My hands begin to itch.
>
> Male crack user 2: That's what I have
>
> Female crack user: And your feet
>
> Male crack user 1: All I have to have is money, and that's enough in that moment to make me itch to come here again and here is the vice.
>
> Female crack user: Your feet don't even hurt after walking all the way here.

> Male crack user 1: And when you want to use drugs you have a desire, you tremble, and you feel really desperate. Even your stomach hurts. [Crack User Focus Group]

As corroborated by other crack users in the focus group and in-depth interviews, these attempts at sobriety were successful but short-lived. While crack users described removing themselves from immediate sources of temptation and receiving some support from family in their attempts at sobriety, crack cravings returned. “Leaving the scene” did not teach them how to avoid relapse or deal with cravings, nor did it re-integrate them into their communities or work. Rather, participants described this strategy as periods of self-imposed isolation. Family members' assisted in these efforts by allowing them a place to stay away from crack use temptations, feeding them to recover from the emaciation caused by long crack binges, and offering some advice.

Recovery Models—Other crack users reported that they looked for models in people they knew who had been heavy crack users but were now sober. They looked to these friends to learn how they had become sober and to seek advice in confronting their own substance abuse problems.

> Interviewer: Do you know anyone who had stopped using drugs? Do you know friends?
>
> Male crack user: Yes, I have friends. When I feel like [I want to quit] I look for them, I lean on them. There's my neighbor and another friend, who was a big drug addict for a long time …. If I feel bad, I say, “I need your help. How did you do it? Explain it to me,” And that's how I've gotten a lot better in that area [crack use].
>
> Interviewer: And they've explained to you how they quit using drugs? Did they go to a Rehabilitation Center?
>
> Male crack user: No, they didn't, no …. They did it by themselves. They're people that I look for a lot. I like to talk to [my friend] because he's overcoming it. You can't even tell that he's one of those people who was really messed up. And they have children. You can even see the change in the kids because when he was using, the kids were all skinny, all sad and now you see a big change, even in the kids …. All that makes me want to follow his example. [In-depth Interview]

This participant's friend after quitting drugs modeled many of the things that participants reported motivated them to quit drugs: living a healthy life, providing for family, and being actively engaged in work. The advice the participant's friend gave him was to think of his health, his family, and his other responsibilities in order to quit using. For the participant, the change in the children from when his friend used crack to the present when he is abstinent put in stark relief the effect crack has on families, particularly children. The participant implies that his friend's children were neglected because of his crack use. Money was spent on drugs that should have been used to feed his children. Their sadness reflected emotional neglect and the moral failing of their father.

Joining a Church—The most frequent way that participants reported that people they knew had stopped or cut down on their drug use was by becoming Christian or a brother in Christ.

> Interviewer: And do you know anyone who has stopped using?
>
> Male crack user: I know lots, but that's because they became Christian …. That's how they did it. God changed their lives. [In-depth Interview]

In some cases, recovery from addiction is seen much like a conversion experience. As described by some, when people accept God, He fills the place that was formerly filled by drugs and they no longer feel the desire to use. Others view the role of spirituality in their recovery as more of a process which needs constant reinforcement through prayer and church attendance.

Evangelical churches promote abstinence from alcohol and drugs, and focus on creating strong, nuclear families, and therefore have strong appeal to those who have problems with substance abuse. Many participants described joining churches that had specific activities for those with substance abuse problems, such as youth groups and excursions that helped them find other activities to fill the time they had previously spent obtaining and using drugs. In addition, many congregations offered social support to crack users and re-integration into productive economic activities by offering them employment.

> Male crack user 1: Our community has a lot of churches …in other words, there are lots of God's people …. Evangelical Christian.
>
> Interviewer: What kind of help do they give?
>
> Male crack user 1: Well, you know what, I think that more than anything the help is moral to begin with, I mean not so much economic, okay, or material, but more like words of hope.
>
> Male crack user 2: Also, there are youth who have been into drugs and they've
>
> Male crack user 3: and they give advice to you and help you.
>
> Malecrack user 2: Uhhuh, they take you to youth meetings
>
> Male crack user 1: because there are a lot of people who have been real drug addicts
>
> Male crack user 2: And they have talks
>
> Male crack user 3: And God has saved them and when they see you, because they were like that before, what they do is give you advice
>
> Male crack user 1: Not only that, there are also brothers that maybe have a small business, and they offer work to people who've been, like for example, they gave me a hand …. I mean they gave me work in air conditioning. And I'm going to explain something, many times people say like “Eew, what are you doing with him, something is going to happen to you, he's going to kill you.” … So a brother in Christ gave me work. So that's the people who help people like us, people who are following the Lord's path.
>
> Male crack user 2: So these are people who, I mean, don't care if you are all tattooed and the risk that that carries with it. For example, he was really bad into drugs and they gave him a hand. And not only him
>
> Male crack user 1: But lots of people
>
> Male crack user 2: but to lots of people. To lots of people they've done it, not just that person [who gave him work], but there are others who have good hearts, who are really humanitarian. [Crack User Focus Group]

As described by the participants above, these congregations were ministered and attended in large part by people who formerly had substance abuse problems. Joining congregations like this reintegrated drug users into an accepting community of former drug users. Evangelical churches are welcoming to drug users who are rejected by most members of their community. They offered “words of hope” not only through the gospel but through

examples of former users who had recovered from drug use. In many cases, congregations further helped them reintegrate by giving them jobs, and ultimately a new sense of identity as a "brother in Christ." Most of these functions are considered essential processes in effective drug user treatment, such as replacing drug use with meaningful alternative activities, reintegrating with family, and social support.

DISCUSSION

Results from this paper indicate a lack of secular treatment options in El Salvador. FUNDASALVA is the only private organization that offers secular outpatient treatment following established principles of effective drug user treatment. The Psychiatric Hospital in El Salvador also offers substance user treatment, including medications to help with detoxification and therapy for affected family members and partners. However, only one participant even mentioned the availability of substance user treatment at the psychiatric hospital, and he had been referred to this hospital only through the efforts of a physician who advocated for him. One additional participant had received services from FUNDASALVA. The dearth of secular services to respond to substance abuse problems is similar to the situation in many low- to middle-income countries in which illicit drug use has grown tremendously in recent years and the medical establishment has limited expertise in the substance abuse field (Bobrova et al., 2008; Perngparn et al., 2008). In response to this problem, drug users in El Salvador have found alternative strategies to abstain or cut down from drug and alcohol use including looking for social support, abstinence role models, and church groups in the community, entering faith-based residential treatment centers, or Alcoholics Anonymous groups. Faith-based residential treatment programs were by far the most frequently used strategy to cut down or abstain from drug use.

Faith-based treatment centers were in many ways culturally congruent with local beliefs about addiction. Most participants viewed drug addiction in moral terms—i.e., as a vice. Many who did not seek formal treatment looked for persons who modeled successful treatment. These models often described their success through joining churches, and a renewed attention to re-establishing their roles as responsible parents and economically productive members of society. Many participants reported joining Evangelical Christian churches that are welcoming to drug addicts who are rejected in most parts of society, and offered many examples of people with substance abuse problems who had changed through accepting God. For many, God filled the void that was formerly filled by drugs, and gave drug users a new identity as brothers and sisters in Christ.

Faith-based treatment centers are natural extensions of these Evangelical churches and operate with much the same philosophy. They offer acceptance and social support. In fact, faith-based treatment programs were described by many as "families." This may be particularly salient in the Salvadoran context where many families have been torn apart as members immigrate to the United States to find work and support their families economically. Faith-based treatment also emphasized the importance of creating a strong and loving nuclear family, congruent with the importance of family in Latino culture, *familismo*. Finally, they offered an alternative to the corrupt "world," particularly attractive to low-income Salvadorans who view the government as corrupt and ineffective and live in communities where violent crime, gangs, and drug sales are ubiquitous (Dickson-Gomez et al., 2009).

However, the lack of secular-based treatment program options in El Salvador is still troubling. Many drug users may not accept the conservative Evangelical tenets of these faith-based treatment centers. While Evangelical Christian churches have been growing exponentially in El Salvador, the majority of Salvadorans still consider themselves to be

Catholic. The Catholic Church has not responded to the needs of drug users to the extent that Evangelical churches have. In addition, the conservative theology of Evangelical churches views homosexuality as a sin. Sexual minorities, therefore, may not feel welcome attending faith-based treatment centers. Only one faith-based treatment center for women currently exists. Women face additional barriers to accessing treatment as many may be in abusive relationships with partners who do not wish them to enter treatment, or have child-rearing responsibilities. Finally, although more accessible than secular treatment options, faith-based treatment centers receive no subsidies from the government and some, therefore, require residents' families to agree to pay for their treatment. This also constitutes a significant barrier to these treatment options for homeless drug users who are estranged from family members. In other programs, residents are expected to “pay their own way” through work which may jeopardize their recovery.

While secular-based treatment options in El Salvador are too limited to ascertain the demand for them relative to faith-based options, the situation in Puerto Rico offers an interesting point of comparison. Evangelical churches have a longer history and even stronger presence in Puerto Rico. In Puerto Rico, faith-based residential treatment has largely replaced secular treatment. Hansen (2005) argues that there was a considerable divestment in secular drug user treatment programs after the passing of the Puerto Rican Mental Health law that defined drug addiction as a social and spiritual problem rather than a mental disorder, thus excluding drug user treatment while claiming mental health parity. Even so, secular drug user treatment programs have long waiting lists while faith-based treatment centers often have unfilled spaces (Hansen, 2004). Faith-based treatment may be flourishing in Puerto Rico because it is the only option realistically available. In El Salvador, there are even fewer secular treatment options. Faith-based treatment may be a viable option for some, but only when other treatment options are available.

While faith-based treatment programs in El Salvador share some of the same principles as evidence-based drug user treatment programs, other components are notably absent. Faith-based treatment centers offer meaningful activities such as work and prayer, and offer some limited advice to avoid relapse such as keeping busy, attending church services, and studying the bible. However, treatment plans do not appear to be individualized to particular residents' needs. Thus, in some programs residents are expected to immediately begin prayer services before detoxification from crack, or are sent out to sell products on the street when they have few days of abstinence. In many centers, effective monitoring of continued drug use is non-existent and residents continue to use while in treatment. In addition, cognitive behavioral components such as improving problem-solving skills, identifying relapse triggers, and follow-up plans to prevent relapse were not reported by participants. While faith-based treatment centers in the United States often incorporate principles of cognitive behavioral therapy in bible study (McCoy et al., 2004; Neff et al., 2006), this does not appear to be the case in El Salvador. Direct observation of treatment components in faith-based treatment organizations or interviews with service providers were not conducted as part of this study and participants' reports of their experiences may not have adequately captured the complexity of treatment. Further research should more directly observe the components of different faith-based treatment programs. However, FUNDASALVA's research with faith-based treatment centers indicated that most of the staff were former drug addicts themselves, with varying lengths of abstinence achieved through becoming Christian. In addition, few had any specific training in substance user treatment and many did not even understand the effects of drug addiction on the brain. The philosophy of most centers appears to be that drug users' acceptance of God is necessary and sufficient to begin and maintain long-term recovery from substance use. Finally, co-treatment of mental illness or medical supervision of any kind is absent in most of these centers.

As much recent research on drug users in the United States has documented (Cloud & Granfield, 2008; Daniulaityte et al., 2007; Granfield & Cloud, 2001), many Salvadorans appear to have had some success in "quitting on their own." Recovery for these people was usually precipitated by one or a series of events. Like drug users who describe quitting drugs without the help of formal treatment in developed countries, study participants in El Salvador described cutting down or abstaining from drugs through social support, assuming family obligations, and integrating themselves in religious groups. Some researchers have argued that natural recovery is evidence of the inapplicability of the disease model of addiction (Cloud & Granfield, 2008; Granfield & Cloud, 2001). This false dichotomy does little to move the field forward. The existence of natural recovery in some persons with problems with drugs or alcohol does not negate the necessity of drug user treatment, or the disease model of substance abuse or dependence. Natural recovery does, however, point out some important extra-therapeutic conditions that may help in recovery such as the importance of social support and creation of a new identity as a non-drug user. These could be incorporated into community or religious groups to support sober lifestyles. According to our participants, the people most successful in recovering from drug use were those who joined a church and became "Christian." Non-religious community groups supporting sobriety are needed in El Salvador.

Results also reveal serious deficiencies in quality of care at some of the faith-based treatment centers. In many centers, participants complained of a lack of security with gang members and other residents engaging in frequent fights. This lack of security also resulted in the continued drug use of many participants. It also suggests, as confirmed by FUNDASALVA's work on training NGOs offering drug user treatment, an insufficient number of full-time staff to provide adequate supervision. In one case, a participant reported being held prisoner in a "treatment center" against his will and having to escape electrified fences and guard dogs to leave treatment. These examples highlight the desperate need for some government regulation of faith-based treatment organizations to ensure, at a minimum, that an adequate level of security and supervision is provided to residents.

As substance abuse and dependence continue to grow in developing countries, the costs and consequences are likely to be devastating. More international efforts are needed to help develop effective drug user treatment programs and sound policy to confront the problem. In addition, more research in developing countries is needed in order to assess unmet needs for substance user treatment, the types of treatment offered, and their quality and effectiveness.

Biographies

Julia Dickson-Gomez, PhD, is a medical anthropologist with over 13 years experience working in El Salvador. Her research interests include looking at the impact of structural factors on HIV risk and developing multi-level HIV prevention interventions. She has worked with active drug users, commercial sex workers, and ethnic minority communities in the United States and El Salvador.

Gloria Bodnar, MA, is a clinical psychologist and Director of Research at the Fundación Antidrogas de El Salvador for the past 11 years. In this role, she has conducted research on treatment organizations in El Salvador, drug use among street youth, the relationship between crack use and HIV risk, and national surveillance studies. She has also been involved in building coalitions to prevent substance use, and in job training and placement programs for youth in detention.

Carmen Eugenia Guevara, BA, is a community psychologist and research associate at the Fundación Antidrogas de El Salvador. In this role, she has conducted numerous qualitative and quantitative research projects with active drug users. She is interested in pursuing a degree in clinical psychology.

Karla Rodriguez, BA, is trained as a community psychologist and worked for many years as a researcher at the Funcación Antidrogas de El Salvador, conducting research with community samples of active drug users. She currently works as a research analyst at the Instituto Universitario de Opinión Pública at the Universidad Centramericana José Simeon Cañas overseeing qualitative data collection and analysis on several projects related to community violence and public opinion regarding security and governance.

Lorena Rivas de Mendoza, MD, PhD, is a Professor of Public Health at the Universidad Centroamericana José Simeón Cañas. Her research interests have focused on determining knowledge and risk behaviors regarding HIV and other sexually transmitted diseases among at-risk populations in El Salvador and developing communication campaigns to prevent the spread of HIV.

A. Michelle Corbett, MPH, is a Certified Health Education Specialist with a BA in Cultural Anthropology and a Master's in Public Health. Specializing in qualitative methods, she is currently a doctoral candidate in the Institute for Community, Population and Public Health at the Medical College of Wisconsin. Her research interests include HIV/STI prevention in the United States and developing countries, globalization, structural violence, and women's health, participatory approaches to community development and health, and Central America.

REFERENCES

Aguilar-Gaziola S, Medina-Mora ME, Magaña CG, Vega WA, Alejo-Garcia C, Quintanar TR, et al. Illicit drug use research in Latin America: Epidemiology, service use, and HIV. Drug and Alcohol Dependence. 2006; 84S:S85–S93.

Bobrova N, Neifeld E, Rhodes T, Alcorn R, Kirinchenko S. Challenges in providing drug user treatment services in Russia: providers' views. Substance Use and Misuse. 2008; 43:1770–1784. Web of Science. [PubMed: 19016164]

Cloud W, Granfield R. Conceptualizing recovery capital: expansion of a theoretical construct. Substance Use and Misuse. 2008; 43:1971–1986. Web of Science. [PubMed: 19016174]

Daniulaityte R, Carlson R, Siegal H. “Heavy Users,” “Controlled Users,” and “Quitters”: understanding patterns of crack use among women in a Midwestern city. Substance Use and Misuse. 2007; 42:129–152. Web of Science. [PubMed: 17366129]

de Toledo Piza Peluso E, Blay SL. Community perception of mental disorders: a systematic review of Latin American and Caribbean studies. Social Psychiatry and Psychiatric Epidemiology. 2004; 39:955–961. Web of Science. [PubMed: 15583902]

Dickson-Gomez, J. Ph.D. thesis. University of California; Los Angeles: 1999. Lessons of the war: the psychosocial effects of war on morality in El Salvador.

Dickson-Gomez, J. El impacto de las drogas en la violencia: buscando soluciones. United Nations Development Program; El Salvador: 2004. Factores Estructurales relacionados a las drogas y violencia en El Salvador.

Dickson-Gomez J, Corbett M, Bodnar G, Rodrigueq K, Guevara CE. Resources and obstacles to developing and implementing a structural intervention to prevent HIV in El Salvador. Social Science and Medicine. 2010; 71(3):351–359. [PubMed: 19910099]

Granfield R, Cloud W. Social context and “natural recovery”: the role of social capital in the resolution of drug-associated problems. Substance Use and Misuse. 2001; 36(11):1543–1570. Web of Science. [PubMed: 11693955]

Hansen H. Faith-based treatment for addiction in Puerto Rico. JAMA: The Journal of the American Medical Association. 2004; 291(23):2882. Web of Science. [PubMed: 15199043]

Hansen H. Isla evangelista—a story of church and state: Puerto Rico's faith-based initiatives in drug treatment. Culture, Medicine and Psychiatry. 2005; 29:433–456. Web of Science.

Heckathorn DD, Seamon S, Broadhead RS, Hughes JJ. Extensions of respondent-driven sampling: a new approach to the study of injection drug users aged 18–25. AIDS and Behavior. 2002; 6(1):55–67.

Hossain M, Ahmed SK. A natural response to drug misuse problems: a review of drug-user treatment services in Bangladesh. Substance Use and Misuse. 1999; 34(12):1605–1617. Web of Science. [PubMed: 10499411]

Hugo CJ, Boshoff DEL, Traut A, Zunu-Dirwayi N, Stein DJ. Community attitudes toward and knowledge of mental illness in South Africa. Social Psychiatry and Psychiatric Epidemiology. 2003; 38:715–719. Web of Science. [PubMed: 14689176]

Koester S, Anderson K, Hoffer L. Active heroin injectors' perceptions and use of methadone maintenance treatment: cynical performance or self-prescribed risk reduction? Substance Use and Misuse. 1999; 34(14):2135–2153. [PubMed: 10573308]

Magura S. Introduction: program quality in substance dependency research. Substance Use and Misuse. 2000; 35(12–14):1617–1627. Web of Science. [PubMed: 11138701]

Magura S, Schildhaus S, Rosethal A, Gastfriend D. Substance user treatment program quality: selected topics. Substance Use and Misuse. 2002; 37(8–10):1185–1214. Web of Science. [PubMed: 12180561]

McCoy LK, Hermos JA, Bokhour BG, Frayne SM. Conceptual bases of Christian, faith-based substance abuse rehabilitation programs: qualitative analysis of staff interviews. Substance Abuse. 2004; 25(3):1–11. [PubMed: 16150675]

Mohatt GV, Rasmus SM, Thomas L, Allen J, Hazel K, Marlatt GA. Risk, resilience, and natural recovery: a model of recovery from alcohol abuse for Alaskan Natives. Addiction. 2007; 103:205–215. Web of Science. [PubMed: 18042193]

National Institute on Drug Abuse. Principles of drug addiction treatment: a research-based guide. NIDA; Bethesda, MD: 1999.

Neff JA, Shorkey CT, Windsor LC. Contrasting faith-based and traditional substance abuse treatment programs. Journal of Substance Abuse Treatment. 2006; 30:49–61. Web of Science. [PubMed: 16377452]

Obot IS. Limits of substance-use interventions in developing countries. The Lancet. 2007; 369:1323–1329.

Perngparn U, Assanangkamoachai S, Pilley C, Aramratanna A. Drug and alcohol services in middle-income countries. Current Opinion in Psychiatry. 2008; 21:229–233. [PubMed: 18382219]

Prendergast ML, Podus D. Drug treatment effectiveness: an examination of conceptual and policy issues. Substance Use and Misuse. 2000; 35(12–14):1629–1657. Web of Science. [PubMed: 11138702]

Restorehope Consulting. The expansion of faith-based partnerships with government. Family Community Health. 2009; 32(4):293–297. [PubMed: 19752630]

Salganik M, Heckathorn DD. Sampling and estimation in hidden populations using respondent driven sampling. Family Community Health. 2004

Santacruz Giralt, M.; Concha-Eastman, A. Barrio aden-tro: La solidaridad violenta de las pandillas. OAS, Instituto Universitario de Opinión Pública; El Salvador: 2001.

Stinchfield R, Owen P. Hazelden's model of treatment and its outcome. Addictive Behaviors. 1998; 23(5):669–683. [PubMed: 9768302]

Thirtalli J, Chand PK. The implications of medication development in the treatment of substance use disorders in developing countries. Current Opinion in Psychiatry. 2009; 22(3):274–280. [PubMed: 19346946]

Uchtenhagen A. Substance use problems in developing countries. Bulletin of the World Health Organization. 2004; 82(9):641. [PubMed: 15628199]

United Nations Development Program. El impacto de las drogas en la violencia: buscando soluciones. United Nations Development Program; San Salvador, El Salvador: 2004.

Wang PS, Aguilar-Gaxiola S, Alonso J, Angermeyer MC, Borges G, Bromer EJ, et al. Use of mental health services for anxiety, mood, and substance disorders in 17 countries in the WHO world mental health surveys. The Lancet. 2007; 370:841–850. Web of Science.

Weeks M, Schensul JJ, Williams SS, Singer M, Grier M. AIDS prevention for African-American and Latina women: building culturally and gender-appropriate intervention. AIDS Education and Prevention. 1995; 7(3):251–264. Web of Science. [PubMed: 7646948]

Weeks, M.; Grier, M.; Radda, K. AIDS and social relations of power: urban African-American women's discourse on the contexts of risk and prevention. In: Elwood, WN., editor. Power in the blood: a handbook on AIDS, politics and communication. Lawrence Erlbaum Associates; New Jersey: 1999.

TABLE 1

Type of drug use experience among crack users in El Salvador

Participants (*n* = 420)	**Frequency (%)**
Ever been in drug treatment (419)	
Yes	49
No	51
Types of drug treatment ever received (204)[a]	
Detoxification	30
Inpatient	81
Outpatient	6
Self-help	16
Other	6
Types of drug treatments received in last 6 months (326)[a]	
None	67
Detoxification (105)	17
Inpatient (104)	57
Outpatient (104)	6
Self-help (104)	19
Other	5

[a]Multiple response variable.

TABLE 2

Participant characteristics and drug use

Participant (*n* = 420)	**Frequency or mean (S.D.)**
Age	37 (9.3)
Gender	
Male	92%
Female	8%
Level of education	
Less than 6th grade	41%
7th grade to some high school	39%
High school graduate or higher	20%
Monthly income	US$ 263 (294)
Times used crack in the last month	329 (425)
Years used crack	13 (6)