Originales

What is (and what is not) a treatment for drug abuse?

¿Qué es (y qué no es) un tratamiento para los consumos de drogas?

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Abstract

*Introduction***:** The definitions of drug treatment developed by international organizations and implemented in the regulations of the countries were characterized, until the 2010s, by a significant lack of specificity. This enabled a great heterogeneity of institutions and treatments for drug abuse. There are works that analyze drug policies and others that address the actions of preventive and assistance institutions, but knowledge of the links between the regulatory and treatment levels is scarce. *Objective***:** To analyze the meanings of directors of two opposite types of institutions (religious therapeutic communities and governmental addiction prevention centers) who provide drug addiction care in Argentina, about the ways in which they define what is a treatment for drug abuse. *Method***:** Qualitative research with document analysis, semi-structured interviews and participant observation. *Results***:** In both groups of institutions, drug use is not considered a problem itself, but rather the expression of a situation that transcends it. *Conclusions***:** The treatments they implement are non-specific and the work to be carried out does not primarily revolve around drug use, but rather on what would explain its occurrence.

Keywords

Drug use; Treatment; International agencies; National drug policies.

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Resumen

Introducción: Las definiciones sobre tratamiento para los consumos de drogas elaboradas por organismos internacionales e implementadas en la normativa de los países se caracterizaron, hasta la década de 2010, por una importante inespecificidad. Esto habilitó una gran heterogeneidad de instituciones y tratamientos en el campo de los consumos de drogas. Existen trabajos que analizan las políticas sobre drogas y otros que abordan el accionar de instituciones preventivas y asistenciales, pero el conocimiento de las vinculaciones entre los planos normativo y de tratamiento es escaso. *Objetivo:* Analizar las significaciones de directivos/as de dos tipos polares de instituciones (comunidades terapéuticas de fuerte impronta religiosa y centros comunitarios de prevención de los consumos problemáticos de gestión estatal) que brindan asistencia para los consumos de drogas en Argentina, acerca de los modos en que definen lo que es un tratamiento. *Método:* Estudio cualitativo con análisis documental, entrevistas semi-estructuradas y observación participante. *Resultados:* En ambos grupos de instituciones, el consumo de drogas no es considerado un problema en sí mismo, sino la expresión de un emergente de una situación que lo trasciende. *Conclusiones:* Los abordajes que implementan son inespecíficos y el trabajo a desarrollar no gira, prioritariamente, sobre el uso de sustancias psicoactivas, sino sobre lo que explicaría su ocurrencia.

Palabras clave

Consumo de drogas; Tratamiento; Organismos internacionales; Políticas Nacionales de Drogas.

INTRODUCTION

In this article, we analyse the views of managers of institutions for drug abuse in Argentina on the ways in which they define what is (and what is not) a treatment for drug use. Specifically, we investigate the meanings of actors who are in charge of or make up the work teams of two types of devices that constitute polar cases within the broad spectrum of initiatives to address drug use: therapeutic communities with a strong religious mark and governmental community-preventive centres. In a complementary manner, we recovered their visions in relation to the way they characterise the actions of their own organisations.

Within the field of socio-therapeutic approaches to drug use, these institutions could be thought of as polar, by virtue of the way they conceive the problem, their modality and the make-up of their work teams, to mention just a few relevant dimensions. The governmental community centres for the prevention of drug abuse, which are staffed by social workers, psychiatrists, child and family technicians, psychologists and socio-therapeutic operators, are characterised by their adoption of a risk and harm reduction approach, their outpatient approach and their conceptualisation of drug abuse as a phenomenon associated with social vulnerability. Therapeutic communities with a strong religious mark, on the other hand, develop a non-professionalised approach with an abstentionist outlook, propose long-term internment and conceive drug use as a spiritual problem associated with the loss

of the meaning of life. In our opinion, the selection of two such divergent groups of institutions has the potential to answer the central analytical question of this paper: what is meant by *treatment for drug use?* Or, in other words, what is the specificity attributed to an initiative that aims to address this problem?

The way in which the problem of drug use is defined and, in particular, the way in which its causes are conceptualised leads to the type of approach that is considered most appropriate. However, we understand that the treatment modalities developed, far from constituting a completely original action of a manager who decides to found a drug treatment centre, are part of an accumulation of social experience. It is these managers who incorporate and process this wealth of social experience and add it to their *stock of knowledge at hand*. The stock of knowledge at hand is made up of typifications from the world of common sense. For Alfred Schütz ([1962] 1995), the individual, from childhood onwards, incorporates and processes a series of "recipes" which he or she then puts into play in his experience in the social world. The problematic situations that are presented to him or her, and which he or she must face in some way, are perceived and even formulated in terms of the body of knowledge that the individual has at hand (Güelman & Azparren, 2017).

The heterogeneity of conceptions and the difficulties in reaching a consensus on what drug treatment is (or should be) is not a characteristic found only in the leadership of organisations, both state and civil society (secular and religious). Without seeking to establish causal relationships or to postulate that one phenomenon precedes and explains the other, definitions of *treatment for drug use* exhibited, as we shall see, until the 2010s, a significant laxity and lack of specificity that meant that virtually any initiative involving drug users could be considered as such. Although there are, on the one hand, studies that analyse international and national drug policies (Camarotti, 2011; Vázquez, 2014; Güelman, Camarotti & Azparren, 2022; Nobre & Kurihara, 2023) and, on the other, contributions that address the actions of institutions that seek to prevent or address drug abuse (Güelman, 2017; Fernández Pérez, 2018; Azparren, 2021), there is little knowledge in the social sciences about the links between the normative and treatment spheres.

Over time, the guidelines contained in the definitions developed by international organisations dedicated to drug use, which in Argentina are adopted by the leading government agency on the issue -the Secretaría de Políticas Integrales sobre Drogas de la Nación Argentina [Secretariat of Comprehensive Drug Policies of Argentina] (SEDRONAR)- became increasingly precise. However, they retained a non-binding character that allowed the term *treatment* to be assigned to a wide range of interventions, developed by extremely heterogeneous institutions and with very different results. As Ambros Uchtenhagen (2012) points out, guidelines for the treatment of drug use are not always reliable. In turn, there are often discrepancies and disagreements in the objectives and regulations governing the approach to the problem.

METHOD

The empirical material we analyse in this article comes from three research projects framed within the qualitative paradigm devel-

oped between 2014 and 2022.[1] As they were carried out within the framework of previous research, both the interview guidelines and the observation guides responded to objectives that do not coincide exactly with what we intend to investigate in this paper. In any case, the re-reading of the empirical material, from a new analytical perspective, was possible because the questions that we address in depth in this paper were included in the previous projects.

The *corpus* is composed of 12 semi-structured interviews with managers of two types of socio-therapeutic institutions that provide treatment for drug users: therapeutic communities with a strong religious mark (Catholic and evangelical) located in the Metropolitan Area of Buenos Aires and governmental community-preventive centres located in the Argentinean Patagonia. At the same time, we analysed documents produced by the institutions themselves and field notes recorded in participant observations in activities organised by these institutions, both inside and outside the centres. Complementary, we also analysed interviews with 18 leaders and decision makers from the field of drug use in Argentina. In our opinion, they can be considered key informants for understanding the process of formulating guidelines for the design and implementation of drug policies -in particular, prevention and treatment - by international organisations and the way in which these guidelines are incorporated by each country and adapted to each local situation.

In turn, we surveyed and analysed national laws, resolutions of public institutions, State reports, national plans for drug demand reduction, reports of Committees of Experts, statutes of national and international organisations, planning and implementation guides of international agencies, recommendations for the formulation of policies and regulations for the treatment of drug use drawn up by international agencies. The purpose of this survey was to analyse changes in the definition of *drug treatment*, both at the international level and in its policy implementation at the national level.

As mentioned in the introduction, the two types of institutions that we selected can be thought of as polar cases within the heterogeneous field of socio-therapeutic initiatives for drug abuse. This paper is therefore a study of multiple cases selected for their dissimilarities (Marradi, Archenti & Piovani, 2018). According to the typology proposed by Bent Flyvbjerg (2004), this type of study seeks the maximum variation of cases within a given universe.

We took into account the ethical safeguards for social science research when conducting the interviews. In all the projects, before each interview we read and gave each participant an informed consent, which briefly explained the institutional framework of our research, its objectives, the voluntary nature of participation, the conditions of confidentiality of the data collected, and requested authorisation to record the audio of the conversation. In this paper, we anonymised not only the treatment centre managers and

1 1) PICT 2012-2150 Project: "Iniciativas religiosas en prevención y asistencia en jóvenes con consumos problemáticos de drogas en el Área Metropolitana de Buenos Aires". Director: Ana Clara Camarotti; 2) UBACyT Project: "Políticas públicas sobre drogas en el Área Metropolitana de Buenos Aires. Conflictos y alianzas entre el Estado y organizaciones de la sociedad civil entre 2003 y 2015". Director: Daniel Jones; and 3) Master's thesis in Territorial and Urban Development by Bruno Colombari.

drug policy leaders interviewed, but also the institutions in which they work or worked. In other words, we refer to two types of institutions (therapeutic communities and governmental community-preventive centres) without mentioning their geographical location so it´s not possible to identify each centre.

As previously mentioned, this paper is the result of a novel re-reading of empirical material that comes from research carried out in the last decade. The analytical strategy deployed consisted, initially, in the development of a new round of coding of the interviews (Dabenigno, 2017) of the two types of institutions selected and a review of the field notes taken in participant observations. This new round of coding was carried out with the support of the *Atlas ti* software (version 8). Subsequently, we prepared a file in which, together with a description of the salient characteristics of each institution (composition of their work team, modality, admission process), we sought to condense the most relevant information from each institution in relation to the analytical questions we asked: 1) how do they understand the idea of *treatment for drug use* and what specificity do they give to this work? and 2) how do they characterise the work of their own centre? The information from the files was then entered into a thematic matrix that facilitated the descriptive reconstruction of the three analytical dimensions and allowed us to make progress in the comparison between the cases, as well as in the conceptualisation and theoretical construction (Freidin, 2017).

RESULTS

1. The definition of *treatment for drug abuse*: from laxity and unspecificity to "non-binding" precision

According to the definition of the World Health Organisation (WHO) Expert Committee on Drug Dependence (ECDD), treatment is defined as "a process that begins when users of psychoactive substances come into contact with a health or other community service provider and may continue through a succession of specific interventions until the highest possible level of health and well-being is achieved" (WHO, 1998, p.3). On the other hand, the United Nations Office on Drugs and Crime (UNODC) states that treatment can be defined as one or more structured interventions to address health and other problems caused by drug abuse and to enhance or optimise personal and social functioning (UNODC, 2003a).

In another 2003 document, UNODC advances a precision that was not contained in the two previous definitions. Whereas those definitions posited indicators of success not directly associated with drug use, this document postulates that the most important goal of any treatment, regardless of its setting, modality, philosophy or rehabilitation methods should be the elimination or reduction of alcoholism and illicit drug use (UNODC, 2003b). The report points out that treatment also seeks to maintain

> (...) physiological and emotional improvement initiated during detoxification and stabilisation to prevent the need for further detoxification (...); Teaching, modelling and supporting behaviours aimed at improving

> personal health and social function and reducing the risks to public health (e.g., HIV/AIDS) and safety associated with drug abuse; Teaching and encouraging behavioural and lifestyle changes that are incompatible with substance abuse. (UNODC, 2003b, p.29)[2]

With the exception of the clear delimitation of the target population of interventions (users of psychoactive substances) and the objective of reducing or eliminating drug use in the latter document, the two United Nations (UN) agencies - on the one hand, the WHO, the most relevant institution in global health terms; on the other, the UNODC, the most important in terms of formulating guidelines for drug policies - do not offer operational definitions of *treatment for drug use*. Until the early 2000s, definitions exhibit significant indeterminacy, unspecificity and laxity. Let´s look at this in detail.

Firstly, the actions envisaged are not necessarily limited to the biomedical or psi field. Thus, for example, in one of the documents, reference is made to the

> (…) wide range of strategies and treatments that can be used in the rehabilitation and relapse prevention phase [which] include such diverse elements as medication with psychotropic substances to alleviate "underlying psychiatric problems"; prescription medication to alleviate the pressing need to use alcohol or drugs; acupuncture (...); educational seminars, films and group therapies (...); group and individual counselling and therapy sessions (...) and support groups for people in similar circumstances (...). (UNODC, 2003b, p. 29)

Hence, for the analysis of the experiences of people linked to the search for treatment for drug use, a notion such as *therapeutic itineraries* acquires legitimacy and heuristic potential. This concept refers to the set of activities developed in the search for treatment for a condition, ailment or affliction, which are not restricted to biomedical and hospital care (Alves, 1993; Alves, 2015; Alli et al., 2020).

A second element, linked to the previous one, that emerges from the above-mentioned definitions is that the professionalised nature of the interventions is not presupposed. This makes it possible to include under the category of *treatment* actions conducted or involving religious leaders, as well as "former-addicts"/"recovering addicts"/"rehabilitated addicts" or peer supporters, without technical training in drug dependence.

Thirdly, the first two definitions present indicators of success that are not linked to the use of psychoactive substances. In neither of the two definitions is there any reference to changes in patterns of use (e.g., reduction of doses or frequency of use or replacement of certain substance(s) by others) or cessation of use, but rather to the achievement of a high level of health and well-being and the optimisation of personal and social performance. The latter aspect is evidenced by what happens in multiple socio-therapeutic institutions for drug use. These institutions regularly address problematic situations and processes of vulnerability of those who attend them that are not strictly associated with drug use practices, but which, in line with the definitions in question, would allow them to achieve a higher level of health and wellbeing

2 This document and the others that we cite in this paper were read and analysed in their Spanish version. The fragments that we present were translated from Spanish to English.

or a better performance in different areas of their lives. Ignacio Apodaca Gorostidi (1995) points out that the fundamental objective of drug treatment is often the rehabilitation of the individual or an improvement in his or her quality of life, but there are major discrepancies as to what these expressions mean in operational terms. When is it possible to determine that an individual has been rehabilitated or has improved his or her quality of life?

Argentina is one of the 194 State Members of the WHO. SEDRONAR, as the governing institution for public prevention and care policies on drug abuse, adheres to the international commitments made by the country. These commitments are basically derived from documents agreed at the UN, political declarations and action plans (SEDRONAR, 2016). In turn, this secretariat participates in the sessions of the UN Commission on Narcotic Drugs, the regular sessions of the Inter-American Drug Abuse Control Commission (CICAD) of the Organisation of American States (OAS) and in specialised meetings organised by UNODC and the South American Council on the World Drug Problem of the Union of South American Nations (UNASUR).

Participation in these agencies is usually accompanied by adherence to and ratification of bilateral and international agreements and conventions. As was revealed in the interviews with leaders and decision makers from the drug use field, international organisations and supranational agencies draw up guidelines for drug policies that should not be thought of as guidelines for countries, but rather as suggestions. As one of the informants interviewed, a member of a network of prevention and treatment organisations, pointed out: "CICAD cannot oblige states, they give you guidelines and you [as a state] comply with them if you want to". Along the same lines, another interviewee, a member of a risk and harm reduction organisation, argued that "international associations set the path, they set a precedent for the moral value of certain visions, but this is not entirely the policy adopted by the government".

In 2016, SEDRONAR established a National Drug Demand Reduction Plan for the period 2016-2020. This plan was developed taking into account the current regulatory framework at the national level and the guidelines agreed at international meetings such as those mentioned above.[3] The Plan states that the elaboration of public policies related to drug use must be developed in an articulated and consensual manner with national ministries, the legislative and judicial powers and the provinces, as well as with civil society organisations and international agencies. In the third section, referring to the issue of treatment, the Plan recognises a plurality of interventions to address the problem, such as community and/or neighbourhood centres, primary health care centres, detox units, specialised devices for acute care and clinical stabilisation, outpatient approaches, day centres, halfway alternatives and residential treatment. The Plan's actions in relation to

3 Joint Resolutions 153 of SEDRONAR and 361 of 1997 of the then Department of Health and Social Action constituted a fundamental precedent for the 2016 National Demand Reduction Plan, in terms of coordination and articulation of competences between both agencies (SEDRONAR and the current Department of Health). These resolutions established the minimum criteria for the licensing, operation and registration of care facilities (governmental and non-governmental) dedicated to the prevention and treatment of drug dependence. The resolutions establish three types of preventive and care centres (First Level: Outpatient; Second Level: Day Hospital; Third Level: Establishments with inpatient capacity).

treatment for drug use have five objectives, which are presented and analysed below.

The first of these is to promote quality treatment adapted to the needs of each person, directly or indirectly affected by drug and alcohol use, always using internment as a last therapeutic resort and when duly justified. Two observations should be made in relation to this objective. On the one hand, the indeterminacy of the target population through the imprecise reference to people "indirectly affected by drug and alcohol use". On the other hand, the consideration that treatment should, as a general rule, be provided on an outpatient basis, which could only be reversed in individual cases. This option for outpatient treatment should be understood within the framework of the provisions of the Argentinian Ley Nacional de Salud Mental [National Mental Health Law] passed in 2010 and regulated in 2013, and of Law 26934, which established the Plan Integral para el Abordaje de los Consumos Problemáticos (Plan IACOP) [Comprehensive Plan to Address Problem Drug Use] in 2014.

A second objective is to

> assume, sustain and strengthen the role of the agency in defining, implementing and accompanying the implementation of treatment strategies, based on the diagnoses, surveys and systematisations necessary to fully comply with the mandatory standards of quality and accessibility. (SEDRONAR, 2016, p. 40)

The third objective is to "design and implement the regulation and standardisation of existing services within the framework of international standards that regulate procedures, action protocols, plans and intervention strategies" (SEDRONAR, 2016, p. 41). In relation to this objective, the importance of the guidelines of international organisations in the formulation and implementation of drug policies can again be observed.

In line with the plurality of recognised interventions, the fourth objective aims to strengthen diverse and extensive networks to ensure total and heterogeneous coverage of the demand for treatment. In this way, it seeks to promote joint strategies between public, private and civil society health care providers in order to guarantee a quality treatment offer that is accessible to the public at large.

The last objective presents claims already outlined in the previous ones. It aims to ensure the quality of services through intervention strategies based on scientific evidence. Once again, it is indicated that these strategies should be designed "in full coherence with international standards and criteria" (SEDRONAR, 2016, p. 42).

In short, SEDRONAR's National Demand Reduction Plan mentions the need for treatment to be of high quality and accessible, in line with international guidelines on the subject, and to have good geographical coverage. At the same time, it gives public, private and civil society actors the authority to address the problem. However, the document defines the target population in a lax manner and, in the same way as those previously analysed, does not advance in an operational definition of *treatment for drug use*. The Plan does not indicate the type of treatment that is valid for tackling the problem, but lists a set of type of institutions that can carry it out. The latter can be understood as a comparison between the type of treatment and the type of establishment, which contributes to the lack of specificity of the term *treatment*.

So far, we have seen that the definitions of *treatment* in the late 1990s and the first two decades of the 21st century reflect - and provide normative support for - the heterogeneity that is characteristic of the field of preventive and care institutions for drug use. The lack of specificity means that, under the label of *treatment*, there are centres that develop very dissimilar interventions and work methodologies, with sometimes opposing approaches (e.g., abstentionism and harm reduction), with different work teams and with different objectives.

Almost twenty years after the first definition cited above, in 2017, UNODC and WHO published the document "International Standards for the Treatment of Drug Use Disorders". The document emphasises that drug dependence treatment interventions must

> (...) address the needs of affected people at different stages of the *disease, in a manner consistent with the treatment of any chronic disease*.[4] [These standards] (...) were prepared to support States Members in developing and expanding services (...) that offer ethical and effective treatment. (UNODC & WHO, 2017, p. 7)

The document describes in detail the different types of interventions, with their treatment perspectives and target populations, and provides guidance on how they should work. Emphasising that no single approach fits all substance use disorders and the various stages of substance use, UNODC and WHO postulate the need for a "(...) diverse range of interventions in a variety of settings to adequately address the needs of clients (...)" (p. 83). However, as in the documents discussed above, there is also no operational definition throughout the document to differentiate between what is a treatment for drug abuse and what is not. The only exception is the distinction made between "services for treatment" and "care", a category that includes self-care practices and "informal community care", such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) groups. What is new here, compared to the lax definitions of 1998 and 2003, is that interventions such as those carried out by AA and NA do not seem to be labelled as *treatment*.

In 2019, the Secretaría de Gobierno de Salud [Department of Public Health] and SEDRONAR published the Resolución Conjunta [Joint Resolution] 5/19. This resolution established guidelines for the organisation and operation of drug treatment facilities and guidelines for institutional adequacy. Argentina's membership of UNODC and WHO, and the stated purpose of these international organisations to support their member countries with guidelines for the development of ethical and effective care interventions, explain why the joint resolution finds inspiration in the aforementioned 2017 document. A central aspect of the resolution is that the recommendations for the creation of establishments or the orientation or adaptation of existing ones to the current regulations on mental health and addictions (laws 26657 and 26934) are non-binding.

Joint Resolution 5/19 presents a typology of inpatient and outpatient facilities. However, there is no description of how treatment should be in each of these facilities. This leads one to think, as in the National Demand Reduction Plan 2016-2020, that treatment and facility are the same thing. These facilities are considered health care providers and therefore, according to the provisions of Law 26657, they must meet three fundamental criteria: 1) have professional coordination; 2) have the patient's informed consent; and 3) be framed within the paradigm

4 The emphasis belongs to the authors of this paper.

of community mental health and, therefore, include a risk and harm reduction approach.

The mention of these three elements is an indicator of a process of specification of the definition of *treatment* (and thus of greater precision regarding the therapeutic approach to drug abuse or addictions). This process of specification has been observed, since 2017, in the documents of international agencies, as well as in local regulations and the plans and resolutions of SEDRONAR.

However, the non-binding nature of the indications means that institutions that are not considered health care providers are socially legitimised to address the problem, even if they do not receive funding from public agencies. The great heterogeneity that exists in the field of drug use care provision, with initiatives with very different working methods, even without health professionals in their teams, can be explained by this last factor.

Below we present table 1 summarising the information analysed in this section, organised by year, author and document/regulation. The main aspects we highlight are the definitions of *treatment* present in each of these documents or regulations and the modifications they present with respect to the preceding ones. The documentary and normative survey that we have carried out does not claim to be exhaustive. However, we consider that the analysis carried out allows us to observe the transition, in two decades, both at the international level and in its national application, from the laxity and lack of specificity of the notion of *treatment for drug abuse* to greater precision, which, however, retained a non-binding character.

Table 1. Treatment definitions and changes from previous regulations (1998-2019)

Year	Author	Document/ Regulation	Definition of treatment	Changes to previous documents/regulations
1998	World Health Organisation (WHO) Expert Committee on Drug Dependence (ECDD)	Thirtieth Report	A process that begins when users of psychoactive substances come into contact with a health or other community service provider and may continue through a succession of specific interventions until the highest possible level of health and well-being is achieved.	-
2003a	United Nations Office on Drugs and Crime (UNODC)	Drug abuse: treatment and rehabilitation. A practical guide to planning and implementation	One or more structured interventions to address health and other problems caused by drug abuse and to enhance or optimise personal and social performance.	-
2003b	United Nations Office on Drugs and Crime (UNODC)	Why invest in drug abuse treatment. Policy Discussion Paper	Interventions aimed at: 1) detox and stabilisation; 2) learning patterns aimed at improving personal health and social function and reducing the health risks of drug abuse; and 3) introducing behavioural and lifestyle modifications that are incompatible with substance abuse.	More precise definition of treatment and indication that its most important goal is the elimination or reduction of alcoholism and illicit drug use.

Year	Author	Document/ Regulation	Definition of treatment	Changes to previous documents/regulations
2016	SEDRONAR	National Drug Demand Reduction Plan 2016-2020	It does not advance an operational definition of treatment, nor does it indicate types of valid treatments, but rather lists a set of interventions to address the problem. Lax definition of the target population and matching between type of treatment and type of establishment.	As a general rule, treatment should be provided on an outpatient basis, which could only be modified in special situations.
2017	UNODC & WHO	International Standards for the Treatment of Drug Use Disorders	There is also no operational definition of treatment to differentiate between what is and what is not treatment. There is a description of the types of interventions, with their perspectives and target populations, and guidance on how they should work. They point out that there are no one-size-fits-all approaches to drug use disorders. Hence, they assert the need for varied interventions in a variety of settings.	Drug dependence should be considered a disease and treated like any chronic disease. A distinction is made between services for treatment and care (self-care and informal community care). Interventions such as AA and NA are not considered treatment, but care.
2019	Ministerio de Salud [Department of Public Health] and SEDRONAR	Resolución Conjunta [Joint Resolution] 5/19	It presents a typology of inpatient and outpatient facilities, but there is no description of treatment in each of these facilities. It includes recommendations for the creation of establishments and the adaptation of existing ones to the regulations in force, but these are non-binding.	Providers must have the patient's informed consent and be framed within the community mental health paradigm and therefore include a risk and harm reduction approach (these points are related to laws 26657 and 26934). There is a greater specification of the notion of treatment, but the non-binding nature of the indications means that institutions that are not considered health care providers are socially legitimised to address the problem.

Source: Own elaboration based on documents and regulations consulted.

Having arrived at this point, it is worth asking how the notion of *treatment* is present in our discursive *corpus*. In other words, as we mentioned, we are interested in investigating the way in which the directors of two types of polar institutions (therapeutic communities with a strong religious mark and community centres for the prevention of drug abuse) define treatment, the way in which they characterise the actions of their own institutions and the specificity they give to drug rehabilitation work. As we made clear in the introductory section, we will address these aspects according to the two types of institution we are considering.

2. The idea of *treatment* in two types of polar institutions

2.1. Therapeutic communities with a strong religious mark

In some of the religious institutions that provide treatment for drug users, especially those that adopt the therapeutic community methodology, drug use is seen as an expression of a spiritual problem. The "addict" is understood as the exacerbated expression of an unanchored, disaffiliated and uncertain individual. Faced with the "absence of God in the heart", the subject would find in drug use a refuge to fill his or her existential void. Along with other "morally reprehensible" behaviours (lying, deceit, fornication, adultery, sexual promiscuity, violence), drug use would be the expression of the deviation from a path of righteousness.

> You take the drugs out and... what do you have left? And well, the emptiness you had before. We have to fill it with something. And well, it was prayer, charity, change... be better (...) [The nun who founded the institution] understood that we needed God to fill our emptiness in life. (Darío, director of a Catholic therapeutic community)

By virtue of this, the distinction that is usually made among drug use, abuse and dependence; or the establishment of a gradient of use (Camarotti & Güelman, 2013) is meaningless in these institutions. If the use *per se* of an illegalised drug is seen as the tip of the *iceberg* of a broader problem - in this case, spiritual - it is of no use to discriminate between patterns of use or to differentiate among substances with varying degrees of toxicity, harmfulness and addictive potential.

A particular situation arises from this conceptualisation of drug use. In many cases, the type of drug use that leads a person to begin the admission process in these therapeutic communities would not be considered drug abuse from the point of view of managers or health professionals (mainly psychologists and psychiatrists) of other institutions, including some that also adopt the therapeutic community methodology.

The institutions in this group adopt a particular modality within the therapeutic community methodology. The elements that make up this particular implementation are: the strong religious mark of their therapeutic programmes; the intense community life; the strict work routine; the absence of health professionals in their work teams; the membership of international networks; the requirement of abstinence in the use of any type of illegal substance, as well as legal drugs (tobacco, alcoholic drinks and psychotropic drugs); and the prolonged duration of the treatments. In turn, residents are exposed to isolation that

is not only operationalised through spatial confinement, but also through a series of prohibitions such as being visited by family members on a frequent basis; consuming mass media; watching television programmes, series or films that have not been previously supervised by the directors or those responsible for the community; reading secular literature; and listening to non-Christian music, among others (Güelman, 2017).

> Life here is very simple: work, prayer, sharing, friendship. There is no television, no music from outside, no newspapers. Those who come here know that they have to leave school (...) They have to get out, get away from everything... for a while. (Darío, director of a Catholic therapeutic community)

As we mentioned, one of the distinctive characteristics of this type of institution is its conceptualisation of drug use as a problem whose causes are associated with the loss of the meaning of life in contemporary societies. This conceptualisation explains each of the guidelines of their treatment programmes. In turn, it leads them to deploy an undifferentiated therapeutic strategy that does not take into account the patterns of drug use (type of substance/s, frequency and modality of use) or the socio-demographic characteristics of the people they receive.

The conceptualisation of drug use as an eminently spiritual phenomenon and the irrelevance of the particularities of the contexts in which these centres are located in the design and implementation of treatment programmes distances itself from the close link between drug abuse and social vulnerability that has gained significant prominence since the end of the 2000s in Argentina. The existence of divergent and sometimes contradictory conceptualisations of the phenomenon of psychoactive substance use and the socio-therapeutic responses that are considered most appropriate to address it is, in our opinion, a fundamental characteristic of the heterogeneous field of drug use. As we have been developing, these divergent or contradictory views are supported, in part, by the laxity and lack of specificity with which treatment for drug use is defined, or by the non-binding nature of the guidelines for the socio-therapeutic approach to drug use.

The managers of the institutions in this group do not use the term *therapeutic community* to designate the centres in which they work. The terms used to define them are "school of life", "community of love in which work, prayer and community life are cultivated" and "spiritual sanatorium for addicts where they are not cured of alcohol or drugs, but of the meaning of life".

The managers interviewed point out that it is a mistake to think of the stay in the community as treatment, since what is transmitted and shared there is "something else". The reluctance to use the term *treatment* to define their actions is also explained by two expressions that were made in the context of an activity organised by a Catholic institution: "we don't know anything about drugs" and "we are not professionals of anything, we are only professionals of God's love".

The two preceding expressions are inseparable from the way in which the causes of drug use are conceived of in therapeutic communities with a strong religious mark. The fact that the use of psychoactive substances is given the same status as other types of problems that also express the loss of meaning in life takes away the specificity of the

therapeutic work needed to address them. In other words, if drug use is only a superficial symptom of a much broader problem (the loss of meaning in life), knowledge of the different types of substances, their risks, psychological, psychiatric or pharmacological therapies to neutralise their effects or prevent withdrawal syndromes is irrelevant, if not counterproductive. The aim is to "heal spiritually", "incorporate God's love", "train in values" or help to (re)find the meaning of life. In short, addressing the spiritual aspects associated with addiction (understood as one of many practices that express the deviation from the path of righteousness) and achieving religious conversion would lead to the resolution, by decantation, of the problem for which the institution was approached.

2.2. Community centres for the prevention of drug abuse

In the community centres for the prevention of drug abuse developed by SEDRONAR's Dispositivos Integrales de Abordaje Territorial (DIAT) [Integral Territorial Approach Devices Programme], drug use is mainly understood as a problem that generally occurs together with other problems such as domestic violence, dropping out of school, lack of work, poverty, lack of documentation, conflicts with the criminal law. Thus, substance use appears as one among a set of social problems and its treatment must be tackled simultaneously with the others. People with substance use problems are understood as subjects with violated rights. Instead of being the expression of "deviation from a path of spiritual righteousness" as in the previous case, drug abuse is seen as the expression of problems linked to contexts of poverty and social inequality. This perspective includes a displacement of the "protagonism" of drug use in the diagnosis, in order to attend to the multiple violations that people may experience.

The statement of the objective of these centres is related to the IACOP Plan's definition of drug abuse as a phenomenon associated with social exclusion. Just as the violation of rights would produce a scenario that favours drug abuse, its promotion and restitution would have a therapeutic potential (Jefatura de Gabinete de Ministros-Presidencia de la Nación Argentina, 2017).

In contrast to therapeutic communities with a strong religious mark, in governmental community prevention centres, the notion of *drug abuse* allows for the identification of different types of commitment to the substance(s) and, based on this, to establish strategies for support. For these institutions, the expression *drug abuse* is a fundamental axis for ordering actions and establishing priorities. Here, definitely, not every drug use is considered abuse.

Admission to the centres is by means of a brief interview conducted by a member of the technical team in which an initial diagnosis is made. The interview is guided by a series of guidelines whose objective is to gather basic information (contact and socio-demographic data); reasons for accessing the centre; socio-affective relationships; vulnerability in accessing rights; and the existence of situations of violence and/or drug abuse. In the event that the person requires some kind of accompaniment, the initial diagnosis built through the interview guides the actions of the work team. This initial conversation also allows them to problematise the meanings surrounding substance use, to provide certain

observation guidelines to those who come to the centre, which allow them to take into account other types of elements that are often overshadowed by the primordial place of the substance in the diagnosis, and to make it clear that not every use is abuse.

In this type of centre, the analysis of technical workers makes it possible to distinguish which cases require treatment with greater restrictions and, therefore, should be referred to other institutions (day hospitals or centres with inpatient capacity). At the same time, it enables the delimitation of situations in which the use of substances is of an occasional or recreational nature, a fact that does not prevent these users from attending the centre.

The testimonies of the workers interviewed show the diversity of actions that are carried out in this type of centre aimed at the prevention of drug abuse. At the same time, they emphasise what, in their opinion, defines their work approach.

> I believe that human beings, when they go to a place, they are well treated, they are respected, and they are truly given the space to participate, they feel included in that place (...) the kids have a good time, it is observed that the kids have a good time. (Guillermo, social worker, member of the work team)

> Look, beyond what its name means [Community centres for the prevention of drug abuse] (...) it is a place to listen, a place of support, that they [those who attend] know that there is always someone there. That if something happens to them, one of the professionals can accompany them, can help them. (Victoria, psychologist, member of the work team)

The preceding fragments allow us to appreciate some of the features that define this type of centre, and which suppose, in the first instance, a process of integration that takes place through regular transit and the construction, with a certain frequency, of links between the people who live there. Reinforcing the idea of containment, the meaning attributed by the second interviewee refers to the functions of accompaniment and help offered to those who attend, by the working team of the centre. Enjoyment is conceived as a fundamental factor to generate a regular transit and sustain participation, a condition for advancing in the processes of integration and accompaniment. These characteristics give it a particular identity and distinguish it from other institutions.

> I think it is one of the only places in the city [in] which prevention and promotion of rights are worked on (...) We work not only on problems of [psychoactive substances] use but also on family, vocational, educational and work-related problems. It involves a cross-cutting approach. There are other institutions that provide internment. (Victoria, psychologist, member of the work team)

The particularity of these centres lies in the development of prevention and rights promotion actions aimed at people with or without drug abuse. In accordance with the work carried out by the centros barriales [neighbourhood centres] belonging to the Hogar de Cristo Federation and to popular economy organisations, analysed by Ana Laura Azparren (2021) and Agustina Rossi Lashayas (2023) respectively, the work in these centres is multifaceted.

> From obtaining a National Identity Card [Documento Nacional de Identidad], to accompanying people to carry out judicial procedures, police procedures. It may have

> to do with home visits, or with [conducting] psychological interviews on a particular issue. (Gabriela, psychologist, member of the work team)
>
> Advising, accompanying, in particular [people] who were suffering from some kind of situation, both addictions and violence (...) is to go to the house, talk to them, and look for some alternatives and work through the support of different areas of the State. (Guillermo, social worker, member of the work team)

As can be seen, treatment involves working inside (listening spaces in the centre) and outside the centres (visits to homes or state institutions by members of the work team), and in coordination with various areas of the state. These centres address problematic situations and vulnerability processes that are not strictly associated with drug use practices, but which would allow for a higher level of health and wellbeing or a better performance in the areas in which they live their lives. In the terms of the lax and unspecific definitions of the WHO in 1998 and the first UNODC 2003 document, they deploy "treatment", although most of their workers do not use this term to refer to the actions they carry out.

DISCUSSION

In this paper we have analysed the meanings of managers of institutions that provide treatment for drug use about the way in which they conceptualise treatment for drug use, the specificity they attribute to working with addictions and, finally, the ways in which they characterise the actions of their centres. Specifically, we carried out a multi-case study with a comparative aim. We have selected a group of therapeutic communities with a strong religious mark and governmental community centres for the prevention of drug abuse, institutions that can be seen as polar within the heterogeneous field of institutions that provide treatment for the use of psychoactive substances. This polar character is given by their way of conceiving the problem, their methodology of work, their expected results and the composition of their work teams, among other aspects.

One of the main findings we arrived at from the analysis of the interviews with managers is that, in both groups of institutions, drug use (whether or not it is designated as "abuse", depending on the institution in question) is not considered a problem in itself, but the expression of a broader phenomenon, an emergent of a situation that transcends it. For the therapeutic communities with a strong religious mark, drug use (irrespective of the substance and the intensity with which it takes place) is the expression of a spiritual problem associated with the loss of meaning in life. For the governmental prevention centre, in line with the legal regulations to which it must conform and which led to its institutional emergence, drug abuse is a facet of social vulnerability.

The conceptualisation that both types of institutions have of the problem of drug use explains the second finding: the approaches they implement are characterised by their lack of specificity. Although in the governmental preventive centre the technical teams incorporate professional profiles that, due to the characteristics of their disciplines of origin, could have a closer approach to the problem of substance use (social workers, psychologists, psychiatrists), in neither type of institution is there a requirement to have specific training

in drug addiction in order to be part of the *staff*. In both types of institutions, we observe that the interventions deployed go far beyond what could be considered a specific approach to drug use. The work to be developed does not therefore focus primarily on the use of psychoactive substances, but rather on what is considered to explain their occurrence.

The third finding is closely linked to the previous two. Those who attend both types of centres are not -in their entirety or necessarily- drug users.

Among the limitations of this article, it should be mentioned, firstly, that the documentary and normative survey we carried out did not pretend to be exhaustive. A second limitation we identified is the fact that we considered only two groups of institutions within the broad spectrum of existing socio-therapeutic approaches to drug use. These limitations could be addressed by future lines of research that broaden, e.g., the *corpus* of sources by including documents from other supranational agencies in order to achieve greater richness and depth in the analysis of what drug treatment means. In turn, comparative work could be carried out that includes treatment institutions of other modalities or even beyond the national character of this article.

CONCLUSIONS

The definitions of *treatment for drug abuse* developed by the international governing agencies in the field (WHO, 1998; UNODC, 2003a; 2003b; UNODC & WHO, 2017) and then "downgraded" in the regulations and resolutions of member countries (such as Argentina) were highly unspecific until the 2010s. In our opinion, an operational definition of *treatment for drug use* would leave out many approaches and interventions that currently exist in the field. This laxity and lack of specificity can be seen as a normative underpinning for the great heterogeneity of approaches that exist in the field of drug use. These work from divergent -and sometimes contradictory- paradigms; they define the problem in dissimilar ways; and they present significant differences in the composition of their work teams. To what extent are international regulations and recommendations on the subject known by treatment institutions? How present are they in their actions?

Since the 2010s, definitions have become more precise, but have retained a non-binding character that has allowed a wide range of interventions to be labelled as *treatment*, implemented by very heterogeneous mechanisms. Does this laxity in regulations and in the way of defining what is meant by treatment for drug use explain the heterogeneity of working methodologies within the field and the divergent views on the problem? Or is it this heterogeneity and diversity of conceptualisation that has led the leading international organisations in the field to elaborate lax and unspecific definitions of *drug treatment* in order to "leave nothing out"? Has the coexistence of heterogeneous treatment methodologies allowed for different criteria of effectiveness or expected outcomes? In other words, if the "success" of a treatment varies according to the expected outcomes -which differ according to the nature of the institution-, are there different criteria for establishing the effectiveness of a treatment?

In conclusion, we believe that from the analysis carried out, some questions emerge that we consider relevant to the field of drug use treatment. Does the treatment of drug

use require a specific approach? When can we say that we are in the presence of a treatment for drug use? And, finally, what effects could be expected from a hypothetical scenario in which the resolutions indicating how drug abuse treatment should be would be binding?

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