SUBSTANCE ABUSE IN THE DEVELOPING COUNTRIES

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Investigations at the World Health Organization define substance abuse as the use of a drug which is viewed as a problem by the society concerned. This definition recognizes the fact that drug dependence is firmly embedded in culture and points to the need of keeping in mind this relationship when talking of the international dimensions of the drug problem and specially when thinking about and carrying out the formulation of policy and the planning of preventive and treatment programs.

That drug dependence is a cultural phenomenon is widely ignored in program planning and implementation. A frequent error has been to use imported ideas and technologies with insufficient concern for the adaptation and modifications they need for their successful cultural transposition. This paper pursues three purposes: (1) to survey the latest information about substance abuse in the developing countries of the world with the intention of identifying some of the underlying causal factors, (2) to review some of the most successful treatment programs in the Third World in an attempt to identify the elements that are most responsible for their success and (3) to discuss a particular Latin American system for the prevention and treatment of substance abuse that was specifically designed for the conditions prevailing in developing countries and to present it as a model of wide transcultural applicability.

In the past, the use of indigenous mood altering substance by members of a stable culture was maintained at a moderate level by social customs and traditions. In recent times, specially since the Second World War, profound changes in the traditional pattern of drug use has paralleled the profound social changes occurring in the wake of economic ferment in the developing countries of the world. For example, according to Frederick Turner from the University of Connecticut, projections of recent rends to the year 2000 indicate that unless the process of migration from the country side toward the cities in search of opportunities is significantly slowed, Latin America's population in urban centers will grow at a staggering rate. By the year 2000 urban centers in Latin America are expected to contain 500 million people, with 19 metropolitan areas alone encompassing 250 million, up from just 70 million in 1975. Cities in these regions are growing at more than 4% a year, with some increasing at a considerably greater rate. Annually, Latin America's rural population rises by 1.5 million whereas its urban areas swell by 7 million. The bulk of the metropolitan population growth occurs in the ubiquitous shanty towns, called faceless misery villages barricades, etc., and populated by great numbers of people living in precarious conditions. Unhealthy living quarters, and non-existing public services lead to high incidences of somatic illness, social disruption, violence and substance abuse. The basic model for this socioeconomic phenomenon of developing countries was described by Oscar Lewis in his concept of the subculture of poverty. In these adverse, crowded conditions, there develops among many of the inhabitants, specially the younger ones, a collective attitude characterized by carelessness towards the environment, apathy towards civic life, hostility towards fellow human beings, cruelty towards children and the elderly, lack of concern for health and hygiene, lack of moderation in pleasure-seeking behavior., disdain for property, tardiness, limited capacity for commitment, chauvinistic machismo in males, self-debasing submission in females, dishonesty, banality and anti-intellectualism. This pattern is seen in the personal background of the street addict, especially in the most endemic areas.

The changes related to rapid urbanization and industrialization affect not only the inhabitants of the marginal communities in the big cities but extend to the general population. For example, the socially

stabilizing tradition of the extended family, which provides a strong support system for mental illness and behavioral problems, has been gradually supplanted by the nuclear family, whose members work or study and who have neither the time nor the patience to give the traditional supports. In the marginal communities, one finds that even the nuclear family is not achieved, because of the frequent absence of the father.

A similar picture is seen in Thailand, Malaysia, India, Pakistan, Burma, Egypt, and Kenya. People migrate to the cities and discard the cultural settings and expectations associated with social conduct and what was before culturally integrated substance utilization patterns (with opium, cannabis, coca leaves, etc.) become culturally less-integrated and thus, problematic. When substance abuse becomes recognized as a social problem, it is an indication of deep social and cultural change. Problematic substance abuse is symptomatic of serious social pathology.

Another contributing factor in the emerging problems of substance abuse in the developing countries is the shrinking of the world due to the explosive expansion in the means of communication and transportation. The symbols of Western life styles, from music, to clothing to drug use, generate an epidemic of imitation, especially among the younger generation. The old stabilizing traditions and mores are eclipsed and disrupted by the new styles pouring in via satellite TV transmissions.

Two factors that emerge as consistently in common among the areas studied in the literature are deviance and impairment. A pattern of drug use is seen as a problem when it deviates from a traditionally accepted or an emerging cultural norm. Secondly, it is seen as *a* problem when it impairs health or social functioning. Deviance may or may not be associated with a threat to health. Often a culture accepts a pattern of substance consumption that is associated with a high degree of health injury (for example: tobacco) and social dysfunction (alcohol). There is not necessarily a direct link between a behavioral pattern and the degree of cultural concern. For example, in the USA all drug-related deaths combined (if we exclude those attributable to tobacco) are fewer than deaths caused by motor vehicles but one rarely hears of an outraged crusade against vehicles.

In Hong Kong, where 20 years ago drug addiction was seen as a physical-moral problem, a group of community leaders formed a committee in 1960 to plan for a program to respond to a pressing demand for voluntary treatment. . The Society for the Aid and the Rehabilitation of Drug Addicts (SARDA) was incorporated in 1961 and started the construction of treatment centers in an island rented from the government for- HK $1.00 (US $.20) per year. The Drug Addicts Treatment and Rehabilitation Ordinance was enacted in February of 1961 which provided for protective custody of up to 100 days for voluntary patients. The program expanded and diversified so that 500 beds for men and 30 for women were available by 1968.

Drug-free rehabilitation through institutional treatment is the major goal of SARDA's program. Flexibility in outpatient treatment and variable inpatient length of stay were adopted in 1972. A full course of rehabilitation in a therapeutic community runs from 20 to 25 weeks. A detoxified patient is invited to join anyone of 18 houses each of which is a group living, working and recreational unit, with its own dormitory, tea house, workshop and vegetable garden or animal farm. The new residents earn their acceptance by the house group through helpfulness in the dorm and diligence in work, while the senior residents give him encouragement and advice. Confrontation techniques and attach therapy are seldom applied because traditional Chinese culture advocates harmony and cooperation. Each house bears the title of a cultural value such as Humanity Righteousness, Fortitude and Wisdom. People who have gone through, the program and -successfully completed the aftercare phase become the leaders in the different residential facilities. They are assisted by elected representatives of the patient's population. Discharged patients join the Alumni Association of SARDA which is self-help and mutual support organization composed and managed by ex-addicts. The goals of aftercare are to enhance family reconciliation vocation training or placement, severance from secret societies or antisocial connections, prompt readmission for repeated treatment for those relapsing to drug abuse and wholesome fellowship in the Alumni Association.

In Thailand, the Buddhist temple of Tarn Kraborg represents an example of that country's effort to utilize a dominant influence of its society the temple and its priests and modify it to cope with their drug abuse problem. Five such temples across the country offer their own model of help conceived from traditional experience and belief.

The Tarn Kraborg temple holds 300 to 400 residents and about 100 priests of which about 40 are former clients. Treatment, carried out by the priests, start a vow to the Buddha at which the addict promises to follow the program rules: complete abstinence from drugs, obedience to the priest, no disruptive behavior, and to remain in the temple compound throughout the treatment period. Herbal medicine to induce vomiting is given to the addict to purge his body of drugs. They are helped and supported by older residents. Clients are encouraged to attend discourses in Buddhist doctrine. As soon as they are physically recovered from purging and withdrawal they are assigned; to temple chores assisting new cases and vocational training. In ten days they are reminded of their pledge and released. Those who want to become ordained must remain a much longer period.

Community based low cost outpatient clinics are opening in the crowded quarters of Cairo. Opium addicts are helped through withdrawal with insulin treatment. It is found to relieve craving for opium and is regarded by patients as potent medicine. Group therapy is conducted 'by psychiatrist's social workers and clergymen. A club for patients to gather before and after treatment reinforces the group therapy dependent is encouraged to participate. A follow up of 100 opium addicts treated in this clinic showed that 65 had improved and not relapsed up to one year after the end of the treatment.

Side by side the community based clinics the Muslim mosque has joined the effort to help opium addicts by instilling the Islamic teachings against alcohol and emphasizing the view that the use of other dependence producing drugs such as opium, is no less profane than drinking. Prejudice by non-users against having addicts take part in religious ceremonies was delay with by a sustained efforts to convince them that drug dependence was a symptom of an underlying disease and should be treated like other sociomedical problems rather than punished. Selected verses of the Koran were quoted to back this view. Four hundred of the four thousand mosques in Cairo are taking part in this program.

In Japan, the Alcohol Abstinence Society (Danshukai) uses Naikan, a self-observation psychotherapy derived from Japanese Buddhist practice. Similar to Alcoholics Anonymous, in that it believes that there is no alternative but for alcoholics to abstain from drinking since they cannot drink moderately, and in that the alcoholic cannot cure himself but needs the encouragement of one another in their meetings, Danshukai differs from its Western counterpart in that it depends heavily on the cooperation of the family particularly of the wives as indispensable help for alcoholics to continue abstaining. Also, they are not anonymous. Naikas, the close collaboration by wives in the process of treatment and the refusal of anonymity reflect the cultural traditions of religious practice, family closeness and social mores that are essential elements in the Japanese life creed.

In examining these programs through out the developing world one is impressed by the diversity of their treatment approaches but also one is struck by some fundamental similarities: (a) each successful treatment approach is sensitive to the cultural roots of the substance abuser. Appeals are made in the appropriate way to have the client make a commitment to some deep religious cultural of traditional belief system that gives cohesion and continuity to the greater society. (b) The therapists leaders and helpers are mostly drawn from culture-steeped social roles and are seen as role models to guide the alienated addict back to a degree of cultural integration, (c) Many of the addicts themselves are pressed into supportive therapeutic roles as soon as they are able. (d) There are always opportunenities for the addict to become a therapeutic leader through extra effort and prolonged apprenticeship. (e) Family members are involved in the rehabilitation process so the addict is not treated in isolation from his family ties. (f) The wider community is involved in the process of rehabilitation with the double purpose of fighting

prejudice and opening aftercare employment opportunities. (g) The ideology of the treatment must be congruent with the drug user's cultural expectations, (h) Treatment must be congruent with the cultural expectations of the wider society. (i) Successful programs will meet the real needs of a drug user in a particular society. (k) Self-help mutual support and self-sufficiency are crucial elements in successful programs.

A program fulfilling all these criteria is the Puerto Rican Therapeutic Community system known as Hogares CREA. Hogares means homes and CREA is an acronym that stands for casa de re-education de addicts (home for the re-education of addicts). The program was specifically designed by myself and a mixed staff of professionals and former addicts as a pilot project between 1961 and 1965. It was first described at a conference on new developments in the rehabilitation of the narcotics addict held in Fort Worth, Texas, on February, 1966, the presentation was published by the Vocational Rehabilitation Administration of the Department of Health, Education and Welfare under the title of "The Mental Health Program of the Commonwealth of Puerto Rico" (Ramirez, 1966).

The pilot project was a professionally supervised prevention treatment and rehabilitation unit a Dome (Ramirez, 1973a), that included outreach Community Orientation Centers in endemic areas to engage the street addict in long term treatment, Day-Night Care Center for additional motivation and partial detoxification, a detoxification ward for physical and mental detoxification, a residential therapeutic community for personality reconstruction, and a re-entry program for resocialization and vocational training. The re-entry program had 5 stages or levels of progress from which the ex-addict staff was selected. The ex-addict staff helped the professional staff in the detoxification and therapeutic community services and ran prevention and orientation services rendered to the wider society schools and prisons and the follow-up services of discharged residents. A dome was designed to engage about 700 addicts in all the phases of the rehabilitation process at a total cost of under $1,000 a year per treated addict. The dome model was adapted to New York City where it became known as Odyssey House. Between 1966 and 1968, I brought the dome model to the City of New York when I founded Phoenix House and the Addiction Services Agency. In Puerto Rico, group of-graduates from the pilot project under my clinical supervision adapted the model to a self-help community based program, the Hogares CREA. At the present time there are 20 domes in the system, 18 in Puerto Rico with 61 residential therapeutic communities. We have 68 therapeutic communities with a total^ resident capacity of 3,000. At present there are 3,215 addicts each in treatment including 80 women, about 200 children and adolescents, and 900 discharged former addicts in re-entry 'follow up. There are 45 outreach centers located in the areas of maximum drug abuse incidence to provide Induction services for thousands of addicts per year plus monitoring the re-entry process. The total full time paid staff is 170, 130 of which are program graduates and about 40 are professionals. A volunteer staff of 1,660 trained local citizens constitutes the more than 70 local steering committees 20 regional (dome) steering committees, and the 25-member central steering committees, plus several advisory and supervisory groups in specialized fields such as agriculture, mechanics, construction, animal husbandry, and education. Teams of residents and staff members run Induction programs in the prison system in Puerto Rico, the Dominican Republic and the State of Pennsylvania. Deserving prison inmates are transferred to the Hogar CREA residential therapeutic communities to spend their prison sentence in the rehabilitation program. Similar teams provide prevention services to schools near each therapeutic community.

The CREA-type program requires for its proper development and survival the organized support of the neighborhood it serves. This cross section of support is best achieved by the selection and training of citizens of high personal integrity who can take upon themselves the task of serving without remuneration as working members of steering committees, boards of advisors and human resources groups. These groups serve as the neighborhood based foundation for the therapeutic community, and are actively involved in securing initial operating capital, mobilizing favorable public support for the program and inducting local addicts into nearby CREA homes, for months and even years before the trained ex-addict staff is authorized to open a therapeutic

community. The local citizen's group provide the legal basis for incorporation of the program as a tax-exempt not for profit organization. They assume responsibility for providing public accountability of the program's funds. They provide volunteer staff time for the operation of out-reach centers, thrift shops, industries, agricultural programs, real state operations and sales programs. They, in conjunction with the ex-addict executive staff, are responsible for policy making. They engage in an ongoing training/therapeutic experience which parallels the process of rehabilitation available to the resident. They provide individually and as group role models for the addict in rehabilitation, with whom they maintain a constant personal relationship through visits and actual participation in selected therapeutic activities of the home. They serve as sponsors and advisors to former addicts in individual Re-entry providing help in securing educational and job opportunities for them. Lastly, they provide an ever widening network of knowledgeable individuals in-the communities which make the concepts of long term follow up of re-entering ex-addicts feasible.

If all these services were to be contracted, the costs would be astronomical. The fact that there are so many qualified citizens who enthusiastically commit themselves to this service is one of the major factors towards achieving financial self sufficiency. Besides the direct services they provide, these individuals are at the same time a source of low cost supervisory expertise. People who have been very active as volunteers can from time to time be hired as part time employees supervising other volunteers and ex-addicts in a wide variety of income producing activities for the therapeutic communities.

The participation of the resident in' programmatic self sufficiency is multiple. Before they can be hired as full time employees in the program, the residents go through months and sometimes years of fulfilling administrative responsibilities as trainees during which time they receive nominal remuneration. In terms of maintenance, repair and operation of their home, the residents take full responsibility under proper supervision as a personal contribution in exchange for the rehabilitation services they receive. This responsibility includes the pooling of their personal resources for the good of the community; food stamps, welfare and social security checks and family donations become the resident's personal contribution to the support of his treatment program.

In the area of income producing activities, CREA has been having success in the following categories:

1. The weekly sale, by subscription and thru peddling, of plastic garbage bags has consistently provided substantial flow of revenue to the local steering committees. We are negotiating the purchase of a factory to produce our own bags and increase our revenues.

2. Community services brigades. Formed by groups of residents who, after acquiring the basic skills in painting, roofing, gardening, home repair, construction, electrical work, auto mechanics and body work, and after securing the cooperation of the local trade unions, are hired by neighborhood families to provide these services.

3. Agricultural projects to provide vegetables, milk, eggs, meat, and fertilizer for the use of the homes. The surplus is being sold at competitive prices to the local consumers. A consumer's union is being organized to improve the distribution of goods, and further draw the neighborhoods into a closer collaboration with our pro gram for our mutual benefit. The agricultural programs can range from small victory garden type of activities to large farming complexes.

4. Fishing for local consumption is being carried on the several homes located near the sea. With the establishment of the consumer union, fishing will be increased to satisfy demand. A shrimp growing industry is being developed utilizing abandoned sugar cane mill tanks.

5. Recycling. All the CREA homes receive used furniture donations from the community. Most of these

items are repaired in the homes by the residents and utilized locally. Resale of repaired items thru a network of thrift shops promises to become another significant source of revenue.

6. Municipalities and local civic groups and organizations are contracting clinical services on a perdiem basis for individual addicts whom they sponsor.

7. Training revenues. Although most of our community training and orientation is done at no charge, some local organizations, usually civic groups, are contracting our personnel for training and orientation activities. The fees collected go to the general fund of the local program.

The CREA dome model has been successfully transposed to the Dominican Republic since 1975. The success of this transposition has aroused the interest of other Latin American countries like Venezuela, Costa Rica, Nicaragua, Ecuador and Columbia. We are trying to respond to those requests by inviting interested groups to train in Santo Domingo and Puerto Rico for the purpose of organizing local steering committees in their countries. As soon as these local groups are organized and receive enough community support, we will send a team of trained program graduates and supervising professionals to establish the program. According to the Dominican experience, the program that results is the integration of the Puerto Rican model modified and adapted to the local cultural economic and political circumstances as understood by the local steering committee.

Clinical Experience in the underdeveloped and developing countries reflects a correlation between economic development and the incidence of substance abuse. The poss World War II parallel course of -economic development and substance abuse in the Commonwealth of Puerto Rico is presented as a model of substance abuse epidemics to be expected as concomitants of economic growth.

Besides world-wide traffic control, massive, inexpensive high professional/patients ratio programs are needed. The Psychia-trically-oriented, community based and supported therapeutic community for the prevention and treatment of epidemic substance abuse is presented as the ideal model to be considered by developing countries with emerging substance abuse program. The twenty year experience of the Hogar CREA program, first in Puerto Rico and more recently in the Dominican Republic is presented as an example of the feasibility of this prevention and rehabilitation modality for developing countries.

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