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ARTICLE

Civil society-state partnerships in integral community-based substance abuse treatment in Latin America

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Abstract

The complex interconnection between socioeconomic disadvantage and drug use disorders has raised global interest in community-based approaches to substance abuse prevention and treatment. This article analyses the origins, implementation, and opportunities for diffusion in Latin America of an Argentine programme that promotes access to treatment through partnerships between the national drug policy agency and geographically dispersed care and support facilities managed by civil society organizations. It argues that severe socioeconomic crisis, rising drug use, and inadequate government response, at the turn of the century, created the conditions for social innovation in substance abuse treatment by civil society. Central aspects of the programme are ensuring accessibility through territorially based facilities and proactive outreach; attending multidimensional needs through the creation of local intersectoral support networks; and addressing addiction by building relationships. Remaining challenges include the need to improve coordination between national and subnational governments and develop a robust monitoring and evaluation system.

Keywords: civil society; community-based treatment; substance abuse; addiction; coproduction

Introduction

According to the Global Burden of Disease Study, in 2021, 17.5 million people in Latin America and the Caribbean had substance use disorders, defined as chronic and relapsing mental health disorders characterized by the harmful use or dependence on alcohol, illicit drugs, or both (GBDCN, 2024). Substance abuse negatively impacts the health and wellbeing of consumers, families and communities, and at the same time, poverty, inequality, adverse homelife, and neighbourhood disorder are risk factors for substance abuse, producing what has been described as a "vicious cycle between socioeconomic disadvantage and drug use disorders" (UNODC, 2020, p. 9).

In Argentina, the prevalence of illicit drug use during the past month doubled during the first two decades of this century (Miguez, 1999; OAD, 2017). The increase in the availability of the highly addictive paste base cocaine (known locally as *paco*) during the severe economic and social crisis of 2001–2002 deepened health vulnerability and drug-related violence, especially in marginalized neighbourhoods

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(Epele, 2011). While all socioeconomic groups consume drugs and alcohol, the most vulnerable tend to access cheaper, lower quality drugs, elevating the risks of negative health impacts and addiction (Camarotti and Güelman, 2017). The life-time prevalence of *paco* consumption is estimated to be nearly 20 times higher in Argentina's informal settlements (10.2%) than in the general population ages 12 to 35 (0.6%) (OAD, 2012).

The clustering of drug use and abuse in disadvantaged neighbourhoods increases the relevance of community-based approaches to drug prevention and treatment. Community-based approaches seek to harness communities' innate cultural resources and construct a network of care providers within the community to attend to the diverse needs of people in addiction recovery, enabling them to experience recovery from their natural environment (UNODC and WHO, 2009; White, 2009; Camarotti and Kornblit, 2015; OAD, 2019; Azparren and Rossi Lashayas, 2024).

In 2014, the central government of Argentina initiated a shift in its substance abuse treatment policy toward an integral community-based approach (*Resolución N° 266/2014*, 2014). The most prevalent type of facility within its network of nearly 800 geographically dispersed facilities is Community Care and Support Centres (or CAACs, by the Spanish acronym), facilities co-managed by the national Secretary of Integral Drug Policy (SEDRONAR)[1] and civil society and faith-based organizations.

This article aims to analyse the origins, implementation process, and opportunities for diffusion in Latin America of the CAAC programme. It addresses the following research questions: How did Argentina's integral community-based approach to substance abuse treatment emerge? In what ways do public sector entities and civil society organizations (CSOs) collaborate in the implementation of the CAAC programme across different levels of government? What opportunities and challenges exist for the diffusion of this approach in Latin America? The paper employs a qualitative methodology based principally on interviews with civil society actors and public functionaries from national, provincial, and municipal governments in the areas of mental health and addiction.

The remainder of the article is organized as follows. The second section presents key elements of the literature on social innovation, multilevel governance, policy integration, and policy diffusion relevant to the subsequent analysis. The third section describes the research methods. The fourth section presents and discusses the results of the qualitative analysis. The fifth section concludes.

Social innovation, multilevel governance, policy integration, and policy diffusion

Addressing complex problems, like substance abuse, through integral and integrated policies requires a comprehensive and coherent mix of policies, along with mechanisms for policy adaptation and coordination across multiple institutions (Cejudo and Michel, 2017).[2] The network of relationships formed through these types of policies – within and across levels of government, civil society and the private sector – can shift and evolve over different stages of policy formulation, implementation and diffusion. The analysis of the CAAC programme draws on key insights from the literature on social innovation, multilevel governance, policy integration, and policy diffusion, focusing on relationships within and across institutions. These interconnections are particularly important for understanding substance abuse treatment policy in Argentina, where both national and subnational governments are involved in policy coordination and direct service provision, working independently and in partnership with CSOs.

[1]SEDRONAR (*Secretaria de Programación para la Prevención de la Drogadicción y la Lucha contra el Narcotráfico*) created in 1989, initially was responsible for policies to control the supply and demand of illicit drugs. In 2014 the responsibility for drug supply was transferred to the Ministry of Security and its name was changed but the entity continued to use its original acronym.

[2]Cejudo and Michel (2017, p. 750) define policy coherence as the "design of a set of policies in a way that, if properly implemented, can potentially achieve a larger goal," coordination as "a process in which members of different organizations define tasks, allocate responsibilities, and share information in order to be more efficient when implementing the policies and programs they select to solve public problems," and policy integration as a "process of making strategic and administrative decisions aimed at solving a complex problem."

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Social innovation can be defined as "innovative activities and services that are motivated by the goal of meeting a social need and that are predominantly developed and diffused through organizations whose primary purposes are social" (Mulgan et al., 2007, p. 8). Examples of social innovation include microcredit institutions, Wikipedia, and telemedicine. This definition captures several aspects of social innovation over which there is expanding consensus, namely, its orientation toward the social or public good, the participation of civil society organizations as agents of innovation, and the role of unmet needs as drivers of change (Ayob et al., 2016). Social innovation often begins through CSO actions to substitute an absent or ineffective state; later innovations are frequently scaled up through alliances with larger public or private institutions (Mulgan et al., 2007).

Social innovations developed by civil society can alter the nature of civil society-state relationships and create new multilevel governance systems for the delivery of social services (Pradel Miquel et al., 2013). Co-production of public services through partnerships between CSOs and the state has been promoted as a means for delivering public services effectively and promoting social inclusion (Brandsen and Pestoff, 2006). While some have raised concerns that this form of partnership can undermine the activist role of civil society in driving social change (Osborne and McLaughlin, 2004), research has shown that CSOs can combine collaboration and critical opposition toward public administrations (Pradel Miquel et al., 2013). Another form of civil society-state partnership is based on trust and cooperation between public and civil society actors embedded within communities, through the formation of social capital, particularly at the local level (Evans, 1996).

Research on multilevel governance emphasizes the importance of the interconnection between political, managerial, and bureaucratic actors across multiple levels of government in shaping policy implementation and outcomes (Meier et al., 2004). These relationships may be especially complex and relevant when national governments operate, on the ground, in policy areas that are the responsibility of subnational governments, as in the case of mental health and addiction policy in Argentina.[3] Research on the education sector in Colombia, for example, showed that national governments influence subnational policy outcomes both indirectly, by providing financial support, technical assistance, and guidance to subnational governments or through national policies in related policy areas (for example, in security and justice) and directly, through the national government's own bureaucracy on the ground (Bello-Gomez, 2020). This research also showed that the marginal contributions were greater in jurisdictions with weaker subnational government capacity, suggesting that in situations of policy overlap, national governments should concentrate their efforts in jurisdictions with lower capacity. The coproduction of public services through partnerships with CSOs adds an additional layer of complexity to the analysis of these types of multilevel governance arrangements.

The literature on policy integration highlights the need for coordination across institutions and adaptive governance to respond to changing conditions. Cejudo and Michel (2021) identify three instruments that facilitate policy integration. First, integrated policies require a "policy frame" or common understanding of the problem to be addressed and the responsibilities of each actor. Second, they require an authority or strategic decision-maker with a mandate over the set of policy tools needed to reach overarching goals. The third instrument is the production, exchange, and utilization of information regarding the attributes of the tools within the policy mix. These three instruments, they argue, create interdependence across institutions and make policy integration effective.

Finally, relationships within and across institutions influence how policies spread from one government to another. The literature on policy diffusion offers insight into the different motivations and pathways of policy transfer, such as learning, competition, emulation, and coercion (Shipan and Volden, 2008). In the learning process, governments assess not only evidence on policy effectiveness but also their own ability to implement policy innovations, which will depend on institutional structures, the

[3]Argentina has a federal system of government. In health, its 23 provinces and the Autonomous City of Buenos Aires are responsible for defining health strategies and providing public health services in their territories and the national government is responsible for health policy guidance, disease surveillance and funding and coordination, especially for underserved areas (Palacios et al., 2020). In large cities, municipalities also provide primary healthcare services.

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regulatory environment, monitoring and enforcement capacity, and the influence of interest groups (Nicholson-Crotty and Carley, 2016). Policy diffusion can be influenced by multidirectional pressures, working through domestic (e.g., information transmission through professional networks or CSOs), cross national (e.g., bilateral information sharing or competition in the development of innovative "models"), and international political mechanisms (e.g., inducements or information dissemination by international organizations like the World Bank) (Borges Sugiyama, 2012).

Methods

CAACs are "outpatient community-based care centres co-managed by SEDRONAR and social and faith-based organisations that aim to facilitate access to guidance, support and assistance for individuals with problematic substance use and in situations of social exclusion" (OAD, 2023a, p.5). CAACs operate in vulnerable social contexts and are distributed across Argentina, with at least one facility in each of the country's 23 provinces (OAD, 2023b). The faith-based organization, *Hogar de Cristo* (or "Home of Christ"), operates the largest number of community-based substance abuse treatment centres, with a total of 277 facilities, of which 120 are CAACs (OAD, 2024). Nearly 70% of CAAC beneficiaries are between ages 19 and 39, 65% are men, 86% have not completed secondary school, and 70% had never participated in addiction treatment before their initial contact with the facility (OAD, 2024).

The analysis of the CAAC programme is based on the triangulation of three qualitative data sources (Patton, 1999). The principal source was interviews conducted by the author between July and November 2024 with key civil society and state actors associated with the CAAC programme. To ensure variation in viewpoints and perspectives on the programme I used a purposive sampling method, drawing participants from multiple sectors (e.g., CSOs; local, provincial and central governments), with diverse roles (e.g., policymakers, street level bureaucrats; CSO leaders and staff), and who have engaged with the programme during different phases of the programme's development and implementation.

The semi-structured interviews were recorded (after obtaining the participant's consent), transcribed using the Trint transcription software, and then corrected by a research assistant. I used an inductive strategy to code and analyse the interview transcripts, identifying key passages of each text around emerging themes. From these groups of texts, I then identified repeated themes and made connections between the passages. I also used the theoretical literature on social innovation, multilevel governance, policy integration, and policy diffusion as a lens for interpreting the qualitative data. The quotations included in the paper are those that provided the richest details and most revealing descriptions.

The second data source was notes taken at a symposium held at the University of Buenos Aires in August 2024 to celebrate the 10th anniversary of the CAAC programme, in which representatives of eight civil society and faith-based organizations discussed their experiences participating in the CAAC programme. These testimonies enabled the study to capture a broader range of experiences and perspectives of civil society actors. The final data source was government laws, resolutions, and reports; information extracted from civil society and faith-based organization websites; and the academic literature. These documents were used to better comprehend the normative framework of mental health policy in Argentina and validate findings based on the qualitative analysis.

Integral community-based substance abuse treatment

The qualitative analysis is divided into four parts. The first analyses the temporal process of development of the CAAC programme, from social innovation in substance abuse treatment by CSOs to the design of the CAAC programme. The next two subsections focus on programme implementation, by first analysing the "vertical" partnership between CSOs and the national governing agency and, second, the process of building "horizontal" multisectoral care and support networks at the local level. The fourth subsection assesses the opportunities and challenges for diffusion of the approach in Latin America.

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Integral community-based substance abuse treatment: a case of social innovation

The CAAC programme, created in 2014, had its origin over ten years earlier in the actions of civil society in disadvantaged communities. Following a decade of deteriorating social and labour market conditions, in 2002 Argentina fell into a severe economic crisis. GDP dropped by 10%; the poverty rate reached 58% and the unemployment rate 22% (INDEC, n.d.). The economic crisis coincided with the emergence and rapid increase in use of a "new drug" *paco* in the marginalized neighbourhoods of Buenos Aires (Epele, 2011). Although shifts in illicit drug patterns had already begun in the 1990s, the cheap price, high toxicity and addictiveness of *paco* led to the proliferation in its use, producing visible transformations, including the rapid decline in the health of *paco* users and rising homelessness, begging, thefts and conflict with police and among local gangs (Epele, 2011). The public sector, however, lacked the institutions to prevent and treat drug abuse in vulnerable neighbourhoods. The principal source of publicly funded substance abuse treatment at that time was therapeutic communities operated by civil society or private sector institutions supervised and funded by SEDRONAR through a per-day, per-person subsidy system (OAD, 2019). The capacity of these institutions, however, was insufficient to meet the demand, and the system lacked mechanisms for attending to the needs of people in situations of extreme poverty (Olivero, 2019; Jones and Cunial, 2017).

These three interconnected factors – socioeconomic crisis, increasing drug use, and an inadequate government response – created the conditions for social innovation in substance abuse treatment through the actions of civil society. Among the first new interventions were mothers' collectives, such as *Madres contra el paco* (or "Mothers against paco"), created to provide support to families and denounce the lack of a public response to the expanding problem of drug abuse (López Bouscayrol, 2021). Social movements, such as the Movement of Excluded Workers and the Popular Movement Dignity (MTE and MPLD, by their Spanish acronyms), created their first centres specializing in the prevention and treatment of addictions in 2006 and 2012, respectively (Ferreyra, 2022).

The *Hogar de Cristo's* integral community-based approach emerged beginning in the late 1990s from the actions of the Catholic priests living and working in the informal settlements of the City of Buenos Aires (CBA) to attend to the needs of people living with substance abuse in their communities.[4] Contacts with drug consumers often began on the streets, in *ranchadas*, or drug user peer groups. The initial actions ranged from providing a hot meal to accompanying a young pregnant woman to the hospital or finding temporary shelter for a man living on the street. Through the experience of providing individualized support to drug users, it became evident that drug abuse was a symptom of a broader problem of social exclusion. The residents of these neighbourhoods experienced multiple interconnected forms of deprivation related to overcrowding, precarious housing, violence, health risks, employment problems, and inadequate public services. As one interview participant said, "Addiction is just one element: it's the fever, not the flu. The person faces all sorts of problems: an education problem, a health problem, a housing problem…" (S3).[5] The situation demanded an integral response that shifted the focus from the addiction to the person and aligned the forms of support with each person's specific needs.

In 2003, the *Hogar de Cristo* opened its first facility, a low-threshold facility serving people living on the street; in 2008, it inaugurated its first neighbourhood centre; and by 2011, it had three neighbourhood centres located on the periphery of informal settlements in the CBA. The neighbourhood centres provided food, clothing, and showers; therapeutic groups; individual therapy; educational, training, and recreational activities; and, above all, care and support through the construction of networks of public and civil society service providers at the local level. The territorial embeddedness of the facilities within vulnerable neighbourhoods enabled the growing teams of collaborators (including social workers, psychologists, volunteers, and former drug users) to make contact with drug users and better diagnose

[4]The analysis of the case of the *Hogar de Cristo* is based on the interviews and documents available at https://hogardecristo.org.ar/biblioteca/.

[5]The alpha-numeric codes following the quotations are used to differentiate between the anonymous interview participants. The letters refer to the sector (CS: civil society, S: SEDRONAR, OPS: Other public sector) and the numbers to the participants. The numbers do not correspond to the order in which the interviews were conducted.

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each person's needs. The open doors policy meant that participants had to learn to manage their recovery process from within an environment with prevalent drug use.[6] Another pillar of the approach is addressing addiction by building community, as illustrated by the testimony of one of the organization's leaders:

> In the end, whether it's addiction, disability, or elderly people, it doesn't matter to us, because what we want to do is build community…Whether they consume, have a psychiatric problem, or are living on the street, it's anecdotal. The biggest problem is the abandonment of the social fabric, the relationships, and the best thing we can do as a community, is to create connections (CS4).

The approach focusses on building valuable relationships with each person struggling with substance abuse and creating local support networks.

The case of the *Hogar de Cristo* aligns with some defining aspects of social innovation. It is a novel method of engagement (an integral, relational, community-based approach), motivated by unmet social needs, developed and diffused by an organization whose primary purpose is social. Central elements of the innovation process included learning by doing, the assessment of unmet needs within a complex and evolving environment, and the focus on creating connections. In addition, while the *Hogar de Cristo* is a bottom-up approach in the sense that both the diagnosis of the problem and the form of response emerged from the community, the mobilization for collective action was initiated by people (the Catholic priests) from outside of the community, a trait found in other cases of social innovation (Pradel Miquel et al., 2013). The priests lived in the neighbourhood and had relationships of trust and legitimacy within the community but also could exploit contacts with people in positions of power, who were instrumental for garnering economic resources and building partnerships with public entities.

To respond to the increasing demand for treatment, in 2014 the *Hogar de Cristo* approached SEDRONAR to request funding for the expansion of its network. A former SEDRONAR official, responsible for drafting the 2014 resolution creating the CAAC programme, confirmed in an interview that the programme was developed in direct response to a funding request from the *Hogar de Cristo* and that this organization's integral, community-based approach served as a model for the programme's design. This assertation was corroborated by other interviewees and aligns with Ferreyra's (2022) account of the events leading to the programme's creation. A closer examination of the process, however, shows that several recent institutional changes created the conditions for the programme's development. The National Mental Health Law adopted in 2010 and implemented through the 2014 National Mental Health Plan recognized the right of people with mental illness – including addictions – to integral healthcare and social assistance and promoted the substitution of residential psychiatric institutions with integrated, intersectoral, interdisciplinary, community-based service networks (Ministerio de Salud de la Nación Argentina, 2013). The paradigm shift from an asylum-based to a community-based approach produced by this law had its roots in the social and collective medicine movements, which had emerged decades earlier, and was supported by professional and technical associations, social and community organizations, and users and their families (OAD, 2019). This new normative framework paved the way for a strengthened role for community-based organizations in substance abuse treatment and the development of new forms of civil society-state partnerships in vulnerable communities.

Vertical civil society-state partnerships in substance abuse treatment policy

The CAAC programme creates a "vertical" partnership between CSOs providing support and care to vulnerable people with substance abuse problems and the national public entity responsible for drug

[6]In 2012, the *Hogar de Cristo* inaugurated a treatment farm, where many participants spend a short time away from their neighbourhood of origin. In some cases, when requested by the participants, the organisation facilitates access to a public subsidy for internment in a therapeutic community.

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policy (SEDRONAR, 2023a). Instead of a per-person subsidy system, the CAAC programme provides an institutional subsidy to support the organization's activities. The size of the subsidy depends on the number of beneficiaries, quality of infrastructure, quantity and qualifications of personnel, and variety of services offered by each organization. The conditions for receiving the subsidy include the presentation of a monthly report by the organization detailing the services provided and a bimonthly report presented by the CAAC supervisory team at SEDRONAR (*Resolution 266/2014*, 2014).[7] The subsidy can be used for any purpose, an aspect that several civil society leaders said they valued because it enables their organizations to respond more effectively to changing and complex circumstances. They also appreciate not having to submit receipts, noting that many organizations operate in informal settlements or indigenous communities where transactions are often informal.

The role of SEDRONAR is to provide financing, programme coordination, technical support and training (e.g., workshops for former drug users who often work in the organizations). A SEDRONAR official explained that the CAAC supervisory team seeks to strike a balance between allowing flexibility in the programme's administration and promoting accountability, saying "If we enforce strict accountability, we will end up excluding people" (S4). Supervisors aim to visit each CAAC (when necessary, virtually) at least four times per year, although communication is usually more frequent (often weekly) as the organizations depend on the supervisors for technical support or referrals. The representative of a CAAC in an isolated community in the north of Argentina described the style of supervision in the following way:

> Those who came to visit saw that the place was functioning, that we were working with young people. They did not come with an accusatory finger, but rather with chalk and a blackboard, guiding us, helping to give a new twist to the work we had been doing with the money we were receiving (CS2).

When irregularities are found, the response is not punitive; rather, the supervisors provide technical support and work with the local staff to identify solutions. Coproduction within this framework means collaboration between sectors, not the delegation of responsibilities to civil society.

The number of CAACs increased from 37 in 2014 to 184 in 2018 and 518 in 2023, and the proportion of SEDRONAR's budget spent on the CAAC programme increased from 2% in 2014 to 26% in 2018 and 45% in 2023.[8] Growth in the programme coincided with a decline in the proportion of CAACs associated with the *Hogar de Cristo*, which fell from 48% in 2015 to 28% in 2018 and 23% in 2023, while the proportion of the CAACs affiliated with social movements rose.[9] To aid in the expansion process in 2017 SEDRONAR created two new institutions: CAIPPA (by its Spanish acronym) an advisory council coordinated by SEDRONAR and comprised of 12 CAAC organization representatives, which provides guidance on the formulation of integral community-based addiction policy, and a CAAC Training School which grants subsidies to existing CAACs to support the training and development of new facilities (*Resolution 17E/2017*, 2017). Only facilities that can demonstrate that they have experience working within the community can be incorporated into the CAAC network. Ferreyra (2022) argues that these institutions enabled organizations related to the Catholic Church and social movements to expand their influence over the programme.

Accountability was the issue that generated the most disagreement among interview participants. Several interview participants expressed concern that, as the programme expanded, insufficient efforts were made to uphold standards, promote accountability, and ensure that CAACs remain focussed on serving individuals with addictions. One former SEDRONAR employee denounced that the programme had been used to channel economic resources to social movements politically aligned with the government in power. Although there is no concrete evidence to support this claim, it raises questions concerning the risk that programmes may be used for political purposes when based on alliances with

[7] A subsequent resolution revised these criteria (Resolución 464/2021 2021).
[8] 2014 and 2018 figures from Ferreyra (2022) and 2023 figure from Presupuesto Abierto (2024).
[9] 2015 and 2018 figures from Ferreyra (2022) and 2023 figure from OAD (2024).

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politically active organizations. Other interview participants argued that the scaling up process had produced a highly diverse network of facilities in terms of infrastructure, human resources, target population, methods and practices and viewed this diversity as an advantage. According to testimonies of CAAC leaders at the symposium for the 10 years of the programme, while some centres were established through collective action, such as land occupations, others originated as soup kitchens, educational programs for homeless individuals, or voluntary initiatives by street-level bureaucrats, such as hospital employees, to support substance users outside their formal duties. One CSO leader said that although the CAAC organizations have different origins and approaches, "there is a lot of similarity in how we provide support, how we provide a place for each person, the approach to care" (CS1).

Another issue raised in the interviews concerns the need for better coordination between SEDRONAR and subnational governments. An official from a provincial health ministry complained that several CAACs had been created in his province without coordination with the provincial government. In one case, a CAAC was established in a small, isolated town that already had a provincially managed addiction prevention and treatment facility, resulting in a duplication of services and a waste of resources. Analysis of this case through the lens of Cejudo and Michel's (2021) framework on instruments for policy integration indicates that coordination failures arose from two issues: the absence of a strategic decision-maker with authority over the full array of policies to address substance abuse in Argentina and insufficient information exchange among institutions. Under Argentina's federal system, SEDRONAR is responsible for coordinating substance abuse prevention and treatment policies nationwide, while the provincial governments manage health service delivery. This division of responsibilities makes the lack of centralized authority an inherent feature of the system. Nonetheless, the observed policy failure could have been mitigated through systematic data collection and sharing between national and subnational actors combined with the creation of incentives to promote the use of that information to pursue common policy objectives.

Networks of care and support at the local level

A central component of the CAAC programme is the creation of integrated, intersectoral networks of care and support at the local level. The interview participants were asked to describe how these "horizontal" partnerships between civil society and state institutions are formed and what are the outcomes or benefits of the network.

One civil social leader likened the network-building process to the creation of a path:

> What builds the network is accompanying that person with the problems they bring to you. If that person is living on the street, then you accompany them to the shelter, and you talk to the shelter staff…Then the shelter might call you about them because that person doesn't have an ID. And so, you help them get their ID, accompanying them to the police station. So, you take steps, like in the countryside. At first, the path isn't marked, but after going to the same place twenty times, well, the path is made. (CS4)

This description illustrates the dynamic and unpredictable nature of network building. Rather than originating from a top-down plan, it emerges from repeated interactions between civil society actors and street-level bureaucrats in the process of responding to individuals' specific needs.

Many interview participants highlighted the importance of personal relationships in the construction of these networks, in consonance with Evans's (1996) theory on embedded civil-society-state relationships. The leader of one CAAC noted that when arranging for programme participants to be given priority in public hospitals, personal connections are important at first but later the arrangements needed to be institutionalized.

> At first, we went directly to the [hospital] director – everything seemed fine – but unless we had something posted on the window saying that the person should be given priority, they would be

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> turned away. It's crucial to connect with someone who can institutionalize the relationship. So we made an agreement with the ministry, then we talked to the hospitals, and after that, we spoke with the staff. (OPS5)

The importance of institutionalizing relationships and procedures within the network was reiterated by a SEDRONAR official, who said:

> We shouldn't settle for a handcrafted approach. The employee is a friend of mine, so I send her a WhatsApp. That's valid and works at first, but later, we need to establish something that is agreed upon so that it doesn't depend on individuals. If the people leave, it should still be in place. (S4)

For networks to remain effective in the long term, facilities need to implement mechanisms or protocols to ensure these actions do not depend on personal connections.

Another SEDRONAR official noted that, while networks form naturally in some contexts, in others, they are fractured or fraught with conflict. Challenges in building networks can stem from contextual factors (such as community insecurity or neighbourhood conflict), the characteristics of the CAAC (insufficient personnel or poor infrastructure), or ineffective municipal or provincial government entities. She explained that "Where it doesn't happen naturally, we personally go to work with the provincial teams, with the municipal teams, with the neighbourhood, to promote the network framework, by providing training and fostering dialogue" (S6). The official highlighted the variability in capacity across provinces and offered as an example of high capacity, the case of Santiago del Estero, which has created an interconnected network across health, education, justice, and addiction treatment services, supported by a platform that contains patients' medical histories. It is evident that SEDRONAR functionaries play a more significant role in supporting the development of local intersectoral support networks in low-capacity provinces than in high-capacity ones, a finding consistent with work by Bello-Gomez (2020), cited above.

The most frequently mentioned benefit of local support networks is their ability to facilitate access to public services. One civil society leader noted, "It breaks down barriers. It facilitates access to services for individuals who wouldn't otherwise be able to receive treatment for their addiction, while also enabling access to healthcare, housing, education, and more" (CS3). Similarly, a physician who works in a community-based facility explained why proactive outreach efforts are needed to reach certain populations.

> With vulnerable populations, you have to go out and find them. You can't wait for them to come because it's not going to happen. Even with my background, it would be difficult for me to access the hospital. I would need at least four days off work to make the appointment, call the 147 hotline, set aside one day to go and another day to pick up the medication, and have an ID so I'm registered in the system. For a kid without a phone or an ID, it's impossible. So, if you don't bring the solution to where people are, it won't work. This approach works because it's rooted in the community, in the territory. The response is where the problem is. (OPS5)

The community-level networks help eliminate the invisible barriers to access of public services by separating the responsibility for accompanying individual cases from that of delivering social services.

Other interview participants underscored that local support networks enable institutions to collectively make choices and design support strategies for individual cases. One civil society representative remarked, "Working in a network means making decisions together with other organisations to maintain a line of care" (CS1). Another noted, "The reality we face is so complex that we can't do it alone…This is where the health services, addiction areas, and CAACs come into dialogue" (CS3). Similarly, a SEDRONAR official explained, "Sitting down with the other organisation, whether governmental or non-governmental, and thinking together with others about how to respond, taking into account it's one person going through the process" (S4). All three of these participants emphasized that

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when responding to complex problems, like addiction, there is a need to work together and make decisions together, incorporating the perspectives of different sectors and disciplines.

Another interview participant highlighted how networks can foster improved relationships between people in addiction recovery and their communities of origin, which often harbour resentment stemming from behaviours exhibited during active substance use.

> During the Covid-19 pandemic, participants who perhaps weren't well-regarded by the neighbourhood stepped up and took on numerous caregiving tasks, such as caring for grandparents and elderly people and, as a result, this helped the neighbourhood to view them differently and also changed perceptions about our facility. (CS3)

This example of healing of the community is consistent with work by White (2009), who sustains that community-based treatment approaches enable communities that have been impaired by drug-related problems to go through a recovery process.

A healthcare social worker offered a distinct perspective on the benefits of participating in a local support network. She described the relationships within the network as reciprocal, benefitting both CAACs participants and leaders while also providing much-needed support to hospital staff navigating a demanding work environment.

> Sometimes, you see, accessing public healthcare can be complicated, and we always try to facilitate whenever we can, right? Because we know how they work, and we know that when we don't have the resources for a patient's discharge, they [the CAACs] speed things up to find a place. It's mutual help…Sometimes the priests [of the *Hogar de Cristo*] give us contacts at SEDRONAR to make things easier, to secure a spot more easily in a community. They streamline the referral process…or they act as mediators for patients with substance use who are impulsive or aggressive, helping them to reflect and accept a strategy. (OPS4)

This example illustrates how this social worker exercises discretion when facilitating access to care for patients affiliated with a CAAC and capitalises on this relationship when seeking placement for a patient with substance abuse problems or needs support with difficult cases, forms of discretionary behaviour described in the literature on street-level bureaucrats (Maynard-Moody and Musheno, 2000).

Diffusion of the CAAC model in Latin America

Since the early 2000s, international organizations like the United Nations Office of Drugs and Crime, the World Health Organization, and the Inter-American Drug Abuse Control Commission of the Organization of American States (CICAD) have supported the development of voluntary, evidence-informed, community-based approaches to substance abuse treatment over compulsory detention and punitive approaches (UNODC and WHO, 2009; OAD, 2019). Today, Latin American countries employ diverse substance abuse treatment approaches, encompassing residential treatment centres, outpatient services, and community-based approaches, managed by public entities, CSOs or through collaboration between sectors (OEA, n.d.). While community-based approaches to substance abuse treatment share common features – such as being integral, multidisciplinary, and territorially based responses developed in collaboration with communities – experiences with such approaches in Latin America have varied significantly in terms of their theoretical foundations, governance structures, objectives, activities, target population, implementation process, etc. (RIOD, n.d.).

What institutional structures and capacities are needed for other countries to adopt the CAAC model? What mechanisms exist for promoting the diffusion of substance abuse treatment policy in Latin America? What evidence on the effectiveness of this model is available or needed to support its replication in other countries? A first aspect to consider is the size and characteristics of the civil society sector. A feature that distinguishes the CAAC programme from other models is that it relies heavily on

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building partnerships with organizations that have proven experience working in marginalized communities. In many cases, the staff of these organizations are willing to withstand highly demanding work conditions and low pay because they are motivated by religious or social convictions (Azparren and Rossi Lashayas, 2024; Mitchell et al., 2021). A potential challenge to diffusion of this model is that governments in other countries may not encounter the counterpoints needed to construct civil society-state partnerships in marginalized communities. Governments also will likely take into consideration political factors, such as the alignment of community-based organizations with its own administration.

A second aspect to consider is the governance structure and healthcare system. Although in Argentina a federal government agency is responsible for financing, coordination, and management of the CAAC programme, there is evidence that the programme could function under alternative governance structures. For example, an official from the mental health and addiction agency of a large city government noted in an interview that the municipal government has invested in improvements in infrastructure in some CAACs, fortified their staff by adding professionals, and integrated the facility into the municipal public health network through their clinical records system. This example suggests that the CAAC model could be adapted to alternative governance structures in which subnational governments are responsible for the programme's coordination. As noted above, a benefit of programme coordination by the federal government is that it can provide enhanced technical support in jurisdictions with low capacity, when there is marked inequality in health care capacity.

Third, multiple mechanisms exist for the transfer of information and technical support on the CAAC model via international organizations, bilateral discussions with delegations from other countries, or bottom-up processes involving professional associations and transnational CSOs. One SEDRONAR official explained, for instance, that "CICAD has recognized it [the CAAC programme] as a very interesting model and is looking at how it could be implemented in other countries that require policies of this kind" and that in bilateral exchanges with Colombia, Paraguay, Peru and Uruguay, representatives "looked with great interest at the Argentine model" (S2).

Policy diffusion, however, requires not only information sharing mechanisms but also reliable evidence on policy success. An interview participant from SEDRONAR recognized that Argentina has made less progress in monitoring and evaluating its substance abuse treatment policies than other countries in the region, a finding confirmed through document analysis. The only published studies evaluating the CAAC programme focus either on participants' access and therapeutic trajectories (OAD, 2023c) or on assessments by civil society actors working in the CAACs (OAD, 2021).

Two recent independent studies, however, provide evidence on the positive impacts of some facilities within the CAAC network. First, researchers at the Catholic University of Argentina conducted an impact evaluation of the *Hogar de Cristo* using the Qualitative Impact Protocol (or QuIP), a method designed to gather evidence on the causal effects of social interventions based on participant narratives (Mitchell et al., 2021). Data were collected through 36 interviews and three focus groups with participants at five *Hogar de Cristo* facilities in the CBA. The findings indicate that all but one participant perceived improvements in multiple life domains since they began attending the facilities, and they attributed more than half of all positive changes to the *Hogar de Cristo*. The most prevalent changes included improved diet and personal care, reduced drug use, increased self-esteem, and better relationships. Positive changes in education and employment were less common and typically involved a heightened interest in pursuing work or returning to school. The primary drivers of change identified were connections with local public or civil society entities, individual therapy, and peer group sessions. In addition, quantitative evidence on the duration of participation – an important predictor of the impact of treatment (see, for example, Simpson, 2002) – based on information from a database on programme participants in the CBA showed that 78% of participants remained in the programme for a period of at least two years. In March 2024, the director of SEDRONAR presented the results of this study at a parallel event organized with CICAD during the 67th sessions of the United Nations Commission on Narcotic Drugs in Vienna, Austria. A second study, supported by the Pan American Health Organization, focusses on *Casa Masantonio*, a facility which supports people with substance abuse problems combined with complex illnesses (Jimenez et al., in press). Using retrospective, longitudinal data on tuberculosis

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patients registered in the National Health Surveillance System during 2019–2023, the study found that patients who received supervised treatment through this facility had a higher success rate (cured or completed treatment) and a lower rate of follow-up loss (93.8% and 2.1%, respectively) than non-participants (70.2% and 19.9%).

While these findings cannot be generalized to the entire CAAC network, they provide evidence on the effectiveness of the treatment approach. A robust future approach for the monitoring and evaluation of the CAAC programme could involve combining qualitative evaluation methods to explore the processes of change (i.e., how the programme works) with the creation of a participant database to continuously collect and analyse data on participation patterns and outcomes.

Conclusions

This paper has examined the origins, implementation, and opportunities for diffusion to other Latin America countries of an Argentine programme that provides subsidies to geographically dispersed facilities, providing comprehensive support to vulnerable individuals affected by substance abuse. It focussed on the analysis of civil society-state partnerships in community-based substance abuse treatment.

The paper argues that the CAAC programme's approach to integral community-based substance abuse treatment emerged as a bottom-up strategy led by civil society during a period of extreme socioeconomic crisis, increasing drug use, and inadequate government response. The faith-based organization *Hogar de Cristo* developed the substance abuse treatment model that inspired the CAAC programme. Central aspects of this approach are the promotion of access through territorially based facilities and proactive outreach; attending multidimensional needs through the creation of local intersectoral support networks; and addressing addiction by fostering relationships. This case aligns closely with core elements of social innovation identified in the literature.

The "vertical" partnership between the CAAC organizations and the national entity responsible for financing and coordinating the programme represents a form of coproduction characterized by cross-sector collaboration rather than the outsourcing of service delivery to civil society. The programme's supervisors aim to balance flexibility and independence for CSOs in operating the facilities with technical support and accountability measures. The programme's expansion did not rely on strict replication but instead on the diffusion of key practices and their adaptation to local contexts. This approach has resulted in a highly diverse network of facilities, varying in infrastructure, human resources, methods, and practices. While some interview participants viewed this diversity as a strength, others raised concerns about the need to ensure minimum standards, promote accountability, and maintain the programme's focus on substance abuse treatment. Another challenge concerns the need for more effective information exchange and policy coordination between SEDRONAR and subnational governments.

The process of development of "horizontal" partnerships between civil society and state institutions at the local level is dynamic and unpredictable. The network is the outcome of repeated interactions between civil society actors and street-level bureaucrats who work together to design support strategies that incorporate the perspectives of different sectors and disciplines. While connections within the network are often initiated by personal relationships, it is important to institutionalize arrangements over time. The CAACs serve as points of entry for the initiation of addiction recovery for people that otherwise may be excluded from public services through proactive outreach efforts. The networks can also foster the development of mutually beneficial relationships between civil society actors and street-level bureaucrats.

Argentina's integral, community-based approach, particularly the CAAC programme, has attracted the attention of policymakers in other Latin American countries, and mechanisms exist for the exchange of information on successful policies through international organizations, professional associations, and transnational civic organizations. Although recent independent studies provide evidence on the effectiveness of the CAAC model, a remaining challenge is the development of a robust monitoring and

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evaluation system, which could combine the use of qualitative evaluation methods and the creation of a participant database to track participation patterns and outcomes.

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