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A REVIEW OF THE AVAILABILITY OF CARE AND TREATMENT FOR SMOKABLE COCAINE SUBSTANCE (SCS) USERS IN AT-RISK AREAS

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EXECUTIVE SUMMARY

This document contains the primary results of the pilot study *Assessment of the availability of care and treatment for of smokable cocaine substances, in socially high-risk areas*, carried out in the five countries that participated in the “Project on Smokable Cocaine Substances in Argentina, Brazil, Chile, Paraguay, and Uruguay.”

OBJECTIVES

- To estimate the availability and characteristics of treatment and care facilities according to therapeutic approach, structural and functional characteristics, human and professional resources, number of patients/users served, in at-risk areas.
- To define a common method to register and follow patients.

METHODS

The **unit analyzed** is the **Treatment Centers** and **Care Facilities** in areas with high use of smokable cocaine substances (SCS).

Treatment Center refers to all public or private therapeutic institutions, whether specializing or not in the drug abuse problem, that provide treatment, i.e., a process of therapeutic intervention aimed at persons who are users of alcohol and other drugs, whose objective is to overcome the problems of abuse of and/or dependence on substances.

The minimum criteria for a therapeutic institution to be considered a treatment center are for it to have a written treatment program with defined therapeutic objectives, individual clinical records, and a specialized multidisciplinary technical and professional team.

Care Facility refers to public or private institutions or organizations that deal with the problems of substance abuse (alcohol and other drugs) and do not meet the three criteria of a treatment center.

Areas were selected for the study because they have high use of SCS and social vulnerability, according to existing studies and registers in each country, applying the snowball technique to develop a register of existing institutions.

The person in charge of the institution was given a structured questionnaire, composed of eight modules to gather information on the center, operations and care capacity, human and physical resources, target population, service portfolio, and function within a network.

Field work was done in the second half of 2015 and the first quarter of 2016, depending on the country, and lasted between two and four months each. The areas surveyed were carried out in areas of high social vulnerability in the Autonomous City of Buenos Aires and the city of Rosario

in Argentina; the Central Region of São Paulo Municipality in the State of São Paulo in Brazil; San Bernardo of the Metropolitan Region and Iquique and Alto Hospicio in the Taracapá Region in Chile; Asunción and the Central Department of Paraguay; and areas of high social vulnerability in Montevideo.

With respect to the **overall evaluation of the questionnaire**, in Argentina and Uruguay it was rated average, especially the design of the questionnaire intended to characterize the Care Facilities. However, the research teams felt that it was useful for describing certain characteristics of the Care Facilities, and there were no major problems in using the questionnaire, according to the evaluation of the team in Argentina.

The Paraguay team had a different experience, rating the questionnaire as very good and good, and did not mention any major obstacle. The team in Chile rated the questionnaire as good, although it pointed out some aspects for improvement. There was a similar reaction from the team in Brazil, which felt that the instrument had dimensions to capture the main aspects of the services and was organized with well-developed subjects and a set of variables that permitted a complete and clear register. However, given the technical nature of the questionnaire, they found high level trainings were required for it to be implemented properly, and they suggested that the interviewers should be people with experience in public policy.

Main results

Because of the complexity and diversity of the situations, particularly with respect to the socially vulnerable areas, and considering the small number of cases in each country, it was deemed most appropriate to present data by country on the availability of treatment and other care facilities as opposed to aggregate. This would allow care and treatment availability to be analyzed within the local contexts. It is important to recognize role of diversity across countries as it highlights the need to focus on the local contexts.

The following are some highlights of the information gathered from a regional perspective:

- ❖ With respect to the number and type of institutions reviewed, the number of smokable cocaine users served in the month before the survey, and the size of the population of the areas in which the institutions were located, the distribution was as follows:
 - ✓ Argentina assessed 13 institutions (7 treatment centers and 6 care facilities), which attended a total of 289 users in the previous month. The areas selected have about 70,000 inhabitants in the slum of the City of Buenos Aires and 434,000 in the three districts of the city of Rosario, in Santa Fe Province.
 - ✓ Brazil recorded information on 3,449 crack users, located in the Prefecture of the Se with 431,000 inhabitants.

- ✓ Chile assessed 28 institutions (26 treatment centers and 2 care facilities), which served 5,457 patients in the preceding month, in an area with some 560,000 inhabitants (the regions of Iquique, Alto Hospicio, and San Bernardo).
 - ✓ Paraguay assessed 12 institutions, (5 treatment centers and 7 care facilities), which, during the previous month cared for 888 users in a population of 567,000 in Asunción.
 - ✓ Uruguay assessed 13 institutions (4 treatment centers and 7 care facilities), which have 64 access points in the poorest area of Montevideo. Information was only obtained on users served in 15.6% of the access points. Six institutions (with 10 access points) served about 376 users in the last month. The population of the neighborhoods in the territories studied is 368,000.
-
- ❖ More than half of the institutions assessed are treatment centers, meet the three criteria established: a written treatment program with defined therapeutic objectives, individual clinical records, and a specialized multidisciplinary technical and professional team.
 - ❖ The treatment and care facilities are very diverse, even within individual countries, which may explain the problems in obtaining information through the questionnaire (see previous chapter).
 - ❖ Both the treatment centers and care facilities are public, or if managed by an NGO, rely mainly on government funds, whether national, state, or municipal. This underscores the importance of the State for dealing with social questions, especially the ones that are most neglected.
 - ❖ The treatment centers and care facilities in three of the five countries fall under a national or state policy of care and attention for the use of psychoactive substances, at least in terms of design and management. This is the case in Brazil, Chile, and Uruguay. However, in all five countries there are cases where care facilities function as a network, especially for the entry of clients and their possible referral to other more complex or specialized care centers. The network structure encompasses both types of institutions, centers and care facilities, and in some cases they complement each other. This situation is relevant bearing in mind the development and relationship between institutions.

- ❖ Reducing use rather, than the elimination of use, and mitigating consequences of use, are the main objectives of the centers and care facilities. These approaches are based on a harm reduction concept. It may be interesting to investigate whether the same is true of care facilities for dealing with other problem drug users or whether this is a characteristic specific to the target population of this project.

1. INTRODUCTION

This document contains the main results of the pilot study *Assessment of the availability of care and treatment for of smokable cocaine substances, in socially high-risk areas*, conducted in the five countries that participated in the “Project on Smokable Cocaine Substances in Argentina, Brazil, Chile, Paraguay, and Uruguay” (SCS Project).

This project includes additional research on this specific use patterns taking into account patient profiles and follow-up, assessment of cerebral dysfunctions caused by smokable cocaine use, and the chemical composition of the substances involved (mainly cocaine base paste or freebase and its adulterants).

The SCS Project is funded by the Bureau of International Narcotics and Law Enforcement Affairs (INL) of the U.S. State Department, with technical and administrative management by the Inter-American Observatory on Drugs of the Inter-American Drug Abuse Control Commission of the Secretariat for Multidimensional Security of the Organization of American States (OID-CICAD-SMS-OAS).

CICAD convened officials and experts from the five countries for an inaugural meeting of the project in the city of São Paulo, Brazil, on April 2-4, 2014, to determine the state of the art of the SCS problem in each country, learn each country’s priorities for research and intervention in accordance with national needs, and to draft a joint work plan for the short and medium terms. The agenda focused on research lines, considering that the project’s general objectives are the establishment of a network of institutions, researchers, and national experts on the problem of SCS in the Southern Cone to undertake research programs to design strategies and actions for prevention and treatment jointly and in a coordinated and efficient manner. Another project objective is to advance in the knowledge about the different aspects of SCS use, while promoting and coordinating the exchange of knowledge among the countries.

One research line defined as a priority for the short term was to gather data on the availability of treatment and care of SCS users in high-risk areas, which are where this population tends to be concentrated, according recent national studies.

This document is organized as follows: Section 1 provides an Introduction. Section 2 presents the methodology developed, the criteria for selection of the areas where the survey was done, and the procedure for the field work. It also describes the variables in the questionnaire used, and a critical reflection on its use in the field. Section 3 presents the results by country, with an introduction on the characteristics of the territory involved and the principal data collected on the treatment and care facilities surveyed. Section 4 analyzes the assessments in each country: the availability health and social services in these areas of high use and low socioeconomic

level, and the connection with public policies. Finally, based on the evidence, there are some conclusions and recommendations. The Appendix includes the instrument used for data collection and the instructions prepared for its use.

One of the distinctive characteristics of the profile of SCS users is their concentration in high poverty, populations with high a high number of other risk factors: overcrowding, lack of decent housing, low access to health services and education, high unemployment rates, or unstable employment. Traditional studies of the general population or secondary school students generally do not provide robust information on patterns of use in marginalized or hidden populations such as SCS users. Alternative methods to estimate the population of SCS users, such as Response Driven Sampling, the Network Scale-up Method (NSUM), or purposive samples in key areas that were supplemented with ethnographic and qualitative studies function better to estimate population size in these conditions.¹

Based on this assessment, the countries at the São Paulo meeting agreed to pursue a research line that would focus on the availability of existing treatment and care programs and on other types of social programs that provide support for SCS users.

¹ Bertoni, Neilane; Burnett, Chantal; Cruz, Marcelo; Andrade, Tarcisio; Bastos, Francisco I; Leal, Erotildes; Fischer, Benedikt Exploring sex differences in drug use, health and service use characteristics among young urban crack users in Brazil. International Journal for Equity in Health (Online) *JCR*, v. 13, p. 70, 2014.

Cuz, MS; Andrade, TM; Bastos, F. I.; Leal, E.; Bertoni, N. ; Lipman, L ; Burnett, C. ; Fischer, B.: Patterns, determinants and barriers of health and social service utilization among young urban crack users in Brazil. BMC Health Services Research (Online) *JCR*, v. 13, p. 536, 2013.

Argentine Observatory on Drugs. SEDRONAR. (2012): "The magnitude of abuse of paste base-paco (PBC), patterns of use and marketing in the slums of CABA"

FIOCRUZ Foundation/National Secretariat of Drugs (2013): "Profile of users of crack and/or similar substances in Brazil"

Bastos FI, Bertoni N: National Survey on the use of crack: who are the users of crack and/or similar substances in Brazil? How many are there in the Brazilian capitals? Rio de Janeiro: ICICT/FIOCRUZ; 2014.

Institute of Sociology. Catholic University. Chile.2014: "Study of characterization of persons who use cocaine base paste (PBC) habitually in the Metropolitan Region"

Suárez H., Ramirez J., Albano G., Castelli L., Martínez E., Rossal M.: "Fissures. Two studies on cocaine base paste in Uruguay. Quantitative and ethnographic aspects" University of the Republic. National Drug Board (2014).

UNODC, UNAIDS, OUD-JND, CICAD-OAS: Studies on HIV prevalence and knowledge, attitudes, and practices of users of base paste, crack, and other forms of SCS in Montevideo and its metropolitan area. (2013).

2. Objectives and Methods

The pilot project was designed to assess the current availability of treatment and care in at-risk areas where there are high levels of use of SCS, which has the following **objectives**:

- To assess the availability of treatment and care services, and provide a description according to therapeutic approach, structural and functional characteristics, human and professional resources, and number of clients served, in at-risk territories.
- To define an agreed-upon protocol for the registry.

Since this is a pilot project, an important objective is to evaluate the methodology used so that subsequent adjustments can be made to expand the registry to other areas and improve the way the centers and care facilities are assessed.

Definitions

The **unit analyzed** is the treatment center and other existing care facilities in areas with high SCS use.

Treatment center includes all public or private therapeutic institutions, whether specializing or not in handling the problem of drug abuse, that provide treatment, i.e., a process of therapeutic intervention aimed at persons who are problem users of alcohol and other drugs, whose objective is to overcome the problems of abuse of and/or dependence on drugs. The treatment process is carried out through a wide range of therapeutic options and care resources provided by certified professionals and technicians.

The minimum criteria for a therapeutic institution to be considered a treatment center are:

- a written treatment program with defined therapeutic objectives,
- individual clinical records,
- a specialized multidisciplinary technical and professional team.

Care Facilities refers to public or private institutions or organizations that deal with the problems of substance abuse (alcohol and other drugs) and do not meet the three criteria of a treatment center.

Selection of areas (neighborhoods, cities) where the study will be conducted: based on information from specific studies on SCS use, other general studies, or other sources (field work, police, public health, justice, etc.) two areas will be identified for each country that have high SCS use, which because of their condition will also be areas of social vulnerability. Since this is a pilot project, it is suggested that areas be selected that are most typical of the problem and easily accessible given the available funds and time.

Data gathering technique: after the areas are selected for the survey of treatment centers and care facilities, existing registers in the country (national censuses, health or social development directories) are used to identify whether the area chosen has any center or care facility and then verify if it is still in operation. It is also important to have key informants in each area, which can be institutions, organizations, or individuals in that position (health centers, social and community programs, schools, soup kitchens, political parties, community centers, places of worship, social leaders of the community or territory, among others). Based on both sources, registers, and key informants, an exploratory process is started with the snowball technique to add and record new cases, until the selected territory is entirely covered.

The implementation of this pilot project was done in the following areas and months in each of the participating countries. The following chapter will describe by country the sociodemographic characteristics of each of them and the centers and care facilities found.

Country	Areas selected	Months of the survey
Argentina	South, Southwest, and Northwest Districts of the city of Rosario –Santa Fe Province Slum 21-24 Zabaleta, Commune 4 Autonomous City of Buenos Aires	June and July 2015
Brazil	Central Region of the Municipality of São Paulo, São Paulo State	February and March 2016
Chile	San Bernardo. Metropolitan Region Iquique and Alto Hospicio. Taracapá Region	July to October 2015
Paraguay	Asunción and the Central Department	August and September 2015
Uruguay	Areas of high social vulnerability in Montevideo	June, July, and August 2015

Questionnaire

An instrument was developed to assess the different centers that serve persons with problem use of substances, in coordination with the Treatment Demand Indicator Project of the Inter-American Drug Use Data System (SIDUC) of the Inter-American Observatory on Drugs of CICAD-OAS. (The version used in this project and the instructions are in the Annex).

The questionnaire should be used by a previously trained interviewer with the director of the center and/or official in charge of the program in a structured interview, guaranteeing the confidentiality of the information requested in the framework of the study's objectives.

The instrument or questionnaire has eight modules, organized as follows:

MODULE I: Identification of the center/care facility: name of the center and respondent; title; address of the establishment; and contact data.

MODULE II: Operation of the center and care capacity: financial status of the center (public or private, for profit or nonprofit, sources of funding), level of care (outpatient, residential, mixed); type of care facility (primary care clinic, day hospital, psychiatric clinic in a general hospital, psychiatric clinic or hospital, urgent psychiatric care unit, therapeutic community, self-help group, community care facilities, social inclusion residences/halfway houses, guest house, shelter, or other); principal objective of care provided (elimination or reduction of use, modification of the causes of use, reduction of the consequences of use); if the care facility offers *formal treatment*; if access to treatment is always voluntary; what are the main ways in which individuals come for treatment (spontaneous consultation, referral from health or justice system); existence of protocols or evidence-based clinical guides for treatment; existence of an

individual file or record for the clinical history; existence of an individual treatment plan; family involvement in the therapeutic process; type and number of total discharges in the previous year; number of users served in the last month; number of beds available and average length of residential treatment; care capacity of outpatient centers (average number of persons served per month, average number of times per week that they come to the center, average duration of outpatient treatment); and availability of facilities to help users with children.

MODULE III: Target population: by gender, age group (children, adolescents, youth, and adults); social security; clinical diagnosis (abuse, dependence, and other psychiatric pathology); specific populations (pregnant women, street people, completing a sentence on parole, LGBT, and others).

MODULE IV: Portfolio of services: type of service offered (food, personal hygiene, clean clothes, recreation workshops and skills training, employment guidance, support for entering the general health care network and the social security network, self-help activities, with community groups and organizations, others); services that the center offers (diagnosis; mental, psychiatric, or psychological consultation; individual, group, and family psychotherapy; doctor visits; group psychosocial intervention; individual and family counseling; home visits; self-help, formal education, and artistic activities; telephone care; post release follow-up; activities with community groups and organizations; activities initiated by the program for social inclusion); services generated by itself or outsourced with laboratory examinations.

MODULE V: Human resources: number, hours worked per week, and drug addiction training of general practitioners, psychiatrists, toxicologists, specialists in infectious diseases, psychologists, social workers, nurses, occupational therapists, nutritionists, family counselors, guidance counselors, teachers, therapeutic technical operators, nursing aides, clergy, and administrative support staff (security, cleaning, food, others).

MODULE VI: Functioning of the network: do the patients arrive spontaneously or by referral, main reasons for referral of patients/users, if the referral needs are covered, evaluation of the referral care facility, existence of waiting lists for patients/users, participation in some network of centers and how it is structured, who coordinates it and its main objectives.

MODULE VII: Physical resources: existence of a current health license, characteristics of the infrastructure (rooms, bedrooms, baths, green areas, dining room)

MODULE VIII: Information technology and systems: use of traditional telephone, cell phone, Internet, web site, e-mail, computers; method of recording data on patients/users (paper form,

electronic record, none, other); existence of a rapid means for sending information to the patients/users and their families.

Assessment of the questionnaire

With respect to the overall evaluation of the questionnaire, in Argentina and Uruguay it was rated average, especially the design of the questionnaire intended to typify the treatment centers. However, the research teams felt that it was useful for describing certain characteristics of the treatment centers, and there were no major problems in using the questionnaire, according to the evaluation of the team in Argentina.

The Paraguay team had a different experience, rating the questionnaire as very good and good, and did not mention any major obstacle. The team in Chile rated the questionnaire as good, although it considered that there were some aspects that could be improved. There was a similar reaction from the team in Brazil, which felt that the instrument had enough dimensions to capture the main aspects of the services and was organized with well-developed subjects and a set of variables that permitted a complete and clear register. However, it was necessary to have good training in its use, given the technical nature of the questionnaire, and it was suggested that the interviewers be people with experience in public policy.

Principal obstacles with the questionnaire

Here are the main aspects mentioned by the field teams in each country concerning the obstacles they encountered when using the questionnaire:

- ✓ The questionnaire intended to typify the care facilities did not fully carry out its stated purpose, at least for two countries (Argentina and Uruguay), since it did not record the principal features of this type of intervention, as well as the day-to-day operation and composition of the work teams (for example, the list of professions in the work teams omits sociologists and lawyers)
- ✓ Limited flexibility and openness. (Argentina)
- ✓ The diversity of existing services and care facilities rendered the form inadequate for most of the centers and institutions. (Uruguay)
- ✓ In the questions on entry of users in the care center, the questionnaire only considered referrals or spontaneous consultation, and not strategies for recognition and formation of demand by the teams, a task characteristic of this type of care facility. (Argentina)
- ✓ The questionnaire made it difficult to enter information on care facilities and intervention programs that do not operate in a fixed location or their own building because their day-to-day work is not carried out in clinics or offices but involves deployment in different sectors of the neighborhoods. (Argentina)

- ✓ Some questions were too specific for the interviewees to answer easily, such as physical information on the establishments, number of square meters, number of discharges or persons served during certain periods, types of contracts of the workers, and existence of health licenses. The nature of the data requested required review or elaboration that took more time than was always possible to get from the institutions, necessitating a follow-up visit after the first meeting and changes in the time allotted, logistics, and budget for the field work. (Chile and Uruguay)
- ✓ The questions induced politically correct responses, which suggest the need for another type of technique to deal with certain aspects. (Uruguay)
- ✓ The language used is highly technical, requiring that the interviewers were very knowledgeable about the matter and needed intensive training. (Brazil)
- ✓ The classification format did not include situations where the center or care facility was public but was managed by private nonprofit organizations. (Brazil)

How were the problems resolved in the field?

- ✓ The field reports presented in detail all the information that did not fit in the instrument or the database (Argentina)
- ✓ Constant monitoring and contact to explain the questionnaire and advise the respondent on how to complete it. With all the centers and care facilities contacted there was an initial face-to-face interview with follow-up by telephone and e-mail. (Chile)
- ✓ New questions were included, even open ones, to reveal the complexity discovered by the field work. (Uruguay)
- ✓ Treat the public services managed by private nonprofits as public.

Effectiveness of the questionnaire

Effectiveness of the questionnaire is taken to mean that the average length of each interview is reasonable (not longer than one hour), that the number of interviewees or informants needed to complete the required data is not more than two, and that it is possible to finish the interview in one or two attempts.

- ✓ As, Argentina had an average of one hour, Paraguay and Brazil an hour and a half, and Chile between one and two hours.
- ✓ With respect to the number of persons interviewed to get the information required in the questionnaire, Brazil reported that it was just one person and in Chile and Uruguay for some centers or care facilities it was necessary to talk to up to three persons, which complicated the process and it was sometimes impossible to get the desired information.

- ✓ On the number of interviews or visits to the centers or care facilities that had to be made to complete the information on the questionnaire, in most cases it was only one.
- ✓ In the work in Argentina, this pilot study made it possible to have interviews with more than one member of each team to ask questions beyond the scope of this study, but which revealed the main problems encountered in their day-to-day work, the history of and changes in the care provisions, the characteristics of the population served, etc. There were also interviews and meetings with officials of the municipal government, health system workers, and neighborhood sources in one of the territories selected for the study.

Recommendations to improve the questionnaire

- ✓ Make the design more flexible so it can embrace the different care strategies that the teams with social/health resources, therapeutic centers, or neighborhood centers employ in work with substance users. (Argentina)
- ✓ Do an exploratory phase with qualified informants in the centers and care facilities before constructing the survey instrument. (Uruguay)
- ✓ Consider using different types of instruments, with questions adapted to the centers' regulatory framework and actual operations. (Uruguay)
- ✓ In the question on number and type of discharges: specify whether it is occurrences or patients discharged, because the same patient may be discharged more than once in the same year. In Uruguay, the question was taken to refer to the number of persons/patients. (Uruguay)
- ✓ In question 13 include the option "others, specify" to cover a greater diversity of situations. (Brazil)
- ✓ In question 29 change the age intervals to 18 years as a break point (older or younger than 18 years). (Brazil).
- ✓ In question 34 include the function of refuge, protection, as an ethical/moral position, and not merely as a function or procedure, since the strategy is extensively used in Brazil.
- ✓ In question 36 it is suggested:
 - To break down the information with the number of professionals by category and weekly workload of each one.
 - That each of the professionals indicated individually can describe their contractual relationship, showing the diversity of labor arrangements in the same service, for a qualitative examination of the repercussions. This suggestion was questioned by the Uruguay team, owing to the difficulties it encountered in the survey to obtain

- precise and specific information on this point, which required more time and contacts in search of the data.
- Expand the variable “training in drug addiction” to other fields (Brazil).

Sampling procedure

Each country took the sample based on a modified snowball technique adjusted to fit the circumstances of each country’s local context.

Argentina

Description of the procedure

- ✓ The consultants who worked on the survey were familiar with issues in the areas surveyed (problems and stakeholders), which facilitated the field work and procedures.
- ✓ The connection with the social-health care network of Slum 21 - 24 was through a social organization and a government agency. The field work demonstrated the existence of a consolidated network of institutions and organizations that is growing with the incorporation of new stakeholders. Entry to the care facilities in area 21 – 24 Zavaleta was through two mechanisms. Either through the *Hogar de Cristo* Program, where a staff person was responsible outreach to the care facilities, prioritizing those located in the area or the work team which searched the surrounding streets for users who did not come to the care facility. The study also included the neighborhood center and family groups, among others. As these centers provided information for the survey, they connected the teams with other institutions such as Center of Health and Community Action (Spanish acronym *CESAC*) n° 35, and the Friendly House of Zavaleta, a dependency of the National Hospital in the Laura Bonaparte Network (formerly Cenareso) and they made contact with the work team of CEDECOR (SEDRONAR) using those who took part in the survey to assist in establishing contacts with other organizations engaged in the subject.
- ✓ In Rosario, the municipal government identified of the care facilities included in the study. There were interviews with the staff of the Mental Health Directorate, which coordinates referrals for problem use of substances with primary care health centers. A list was drawn up of the institutions known to the Directorate as treatment centers for substance users, identifying cases that are referred from the district health centers. There were no registered care facilities that met the criteria called for in this project. The approach to the territory was formalized through the health centers that receive the demand for care and make the corresponding referrals through the Directorate. There were interviews with women social workers and doctors in the health centers of Las Flores (South District), Maiztegui (Southwest District), and Ceferino Namuncurá

(Northwest District). The target treatment centers in the city of Rosario are not installed in the territory, although all of them work in keeping with the neighborhood problems and the vulnerabilities of their patients. In this regard, the instrument was applied to the greatest number of treatment centers identified as such. Based on the survey conducted with reference points of these same centers, and as noted with the government officials who refer patients to them, nine substance abuse treatment centers were identified that receive government referrals and finance the treatment: (SESDRONAR, DPA [Provincial Addictions Directorate], Mental Health Directorate of the Municipality of Rosario).

Obstacles encountered

- ✓ The treatment centers in the city of Rosario are not located in at-risk areas, although all of them work on the neighborhood problems and the vulnerabilities of their patients
- ✓ In the interviews with representatives of the local care network in the city of Rosario, there were no registers of care facilities, at least in the terms defined in the project (one that deals with substance abuse problems and does not satisfy the three criteria for treatment centers). This type of center was not found in the travel through the territory, either.

How were problems of the search procedure resolved?

In Rosario the instrument was applied to the greatest number of treatment centers identified as such whether or not they were in at-risk territories.

Brazil

Description of the procedure

The search for centers and care facilities was proposed initially based on access to official municipal and federal documents and web sites. The sites of the Ministry of Health, Ministry of Justice, and Ministry of Social Development and Combat of Hunger of the Prefecture of São Paulo were consulted.

Obstacles encountered

Limited access to some sites and inaccuracy of the information found.

How were problems of the search procedure resolved?

The initial methodology of using official registers was modified, and the team used services indicated by the municipal management and those mentioned by the managers interviewed (snowball technique).

Chile

Description of the procedure

- ✓ The team established coordination with the government institutions responsible for health at the communal level (principally municipalities through the Directorate of Communal Health).
- ✓ The team participated in meetings of the primary governmental and social actors working on the subject of drugs and alcohol at the communal level.
- ✓ The team participated in round tables coordinated by the National Service for Prevention and Rehabilitation of the use of drugs and alcohol (SENDA) at the communal level (only for Iquique and Alto Hospicio).
- ✓ Building on these activities, the team identified centers and care facilities in the commune that were then interviewed. During the interview they were invited to identify other centers and care facilities in the commune.

Obstacles encountered

Little accessibility to informal centers (care facilities). Health professionals in the commune do not know of the existence of informal centers. There is a possibility that they do not exist, but that is unlikely and requires more research.

How were problems of the search procedure resolved?

The search concentrated primarily on the information provided by persons responsible for drug and alcohol programs at the communal level. Social workers in the communal health clinics were also consulted, and churches in both areas were visited. The team also did a search on the Internet.

Recommendations to improve the work methodology

It is necessary to implement a work methodology that makes it possible to survey the presence of informal care facilities that are not part of the health network tied in with SENDA and the Ministry of Health. It is necessary to develop specific strategies to gather information on this group.

Paraguay

Description of the procedure

Through the *Second National Census of Treatment Centers for Persons with Problems Derived from the Use of Alcohol and other Drugs. National Integrated Program for Paraguay 2011-2014*, the team obtained the list of treatment centers and/or support care facilities located in the City of Asunción and the Central Department.

Obstacles encountered

The list or database was out of date.

How were obstacles resolved?

With appropriate action, fluid communication, and sustained cooperation between professionals on the project team and the directors or reference points of the various treatment centers or care facilities.

Uruguay

Description of the procedure

The team started with an exhaustive list of the institutions that provide treatment services to substance users in the entire country. This based on existing registers, web searches, and interviews with qualified informants of the health system, the community, and civil organizations, who made it possible to complete the primary list.

Obstacles encountered

The identification and coordination of interviews with the qualified informant in each treatment service or center.

How were problems of the search procedure resolved?

It took more time than initially planned and repeated contacts to carry out the interview with the indicated persons, which permitted it to be accomplished in most of the cases.

Recommendations to improve the work methodology

There is no way to improve this aspect in the design, given the nature of the problems raised.

3. A MULTICENTRIC OVERVIEW

The following section discusses the quality and quantity of available treatment for SCS users in socially vulnerable areas. It is also allows us to considers the connection of these centers and care facilities to a municipal, regional, or national policy.

The quantity and quality available care and treatment

Is the quantity and quality of the available treatment and care facilities adequate for the SCS user needs in the areas where this study was done?

In **Argentina** the study indicated that the care facilities which apply an outreach strategy to actively seek users have greater support and participation. These care facilities are found in area 21-24 (city of Buenos Aires). In the City of Rosario (Santa Fe Province) there are formal treatment centers that do not actively seek patients. The data suggest that the outreach

strategy achieved its goals. Unfortunately, ability to replicate the strategy is limited by the availability of existing care facilities which do not meet current demand.

The team in **Brazil** considers that in the study area chosen there is one specific program of the municipality that carries out several actions to expand the access of the user population. According to the national mental health policy it is necessary to expand the operation of the Care Facilities to provide services 24 hours per day. These care facilities are connected in a network. The waiting list demonstrates the program successes and indicates a need for expansion.

The evaluation done by the team in **Chile** indicates that in principle the availability appears to be adequate and the quality good, but there are aspects that could be improved. However, the work done to gather the information for the study was insufficient to have a complete opinion to answer this question properly.

Based on the experience in **Paraguay**, the team considers that the quantity and quality of the existing availability in the areas surveyed are insufficient. These treatment centers and care facilities have said that they lack sufficient economic resources, trained and specialized human resources are still limited, and the infrastructure is rudimentary; all this, taking into account the needs to be met because of the great demand of persons with problems arising from the use of alcohol and other drugs, who require specialized care.

In **Uruguay** the evaluation is positive. The team considers that with the formal (governmental) availability of the care facilities with minimum requirements the vulnerable territory of the department of Montevideo is being adequately covered. A specific evaluation of the quality of the services available is needed.

Care and public policy

Are the treatment centers that were interviewed linked to a (national, provincial, or municipal) government policy? Are they part of a plan or program? How?

In **Argentina** the formal care facilities or treatment centers surveyed in both territories (one in Slum 21 – 24 and six in the city of Rosario) were part of a larger-scale care system. In the slum a formal treatment center was identified in one of the care forms of the *Friendly House of Zavaleta*, a dependency of the National Hospital Network (formerly CENARESO). It is part of the action plan of that hospital and works in coordination with the primary health care area. In the city of Rosario, all the treatment centers surveyed were formal ones, organized as nongovernmental organizations, as civil associations or foundations. There were no formal treatment centers operated by the government. Most of them depend for their operation on agreements with the government (the federal government through SEDRONAR or the provincial

government through the Mental Health Directorate) or private agreements (with Social Works). In this sense they are included in a government policy.

The centers surveyed in **Brazil** are connected through the Municipal Program of Open Arms, under the principles of Harm Reduction, which are divided into three levels: a Management Committee composed of all the municipal Secretaries who make up the core of the program (Health, Security, Human Rights, Labor, and Social Development) the Secretariat of Government, and the Mayor. The second level is the field coordination (experts connected to the secretariats), and in the territory there is a store or place for connection with the health teams and the intervention is carried out. In the territory there is also a “little house” that is a physical place for the field coordination to meet at least weekly.

In **Chile** the centers are connected at the communal, regional, and national levels. Plans and program guidelines are developed at the national level for implementation through technical and financial agreements at the communal level with advice and support from the regional level.

In **Paraguay**, although the document of the Ministry of Public Health and Social Welfare says that: *“The plans, programs, projects, and specific actions must be based on and consistent with the statement of this National Mental Health Policy,”* of the five treatment centers interviewed, only one said that it was connected to a formal coordination network; the other four said they were not. According to the centers surveyed, all have a written treatment program and defined therapeutic objectives, together with a specialized multidisciplinary technical and professional team. However, there is a need for greater synergy between the public and private treatment centers to supplement the physical resources and human talents in order to optimize the resources devoted to this end.

In **Uruguay**, the various centers, services, and care facilities are connected in the framework of the National Comprehensive Health System and the National Drug Network (RANADRO).

Are the care facilities that were studied connected to a (national, provincial, or municipal) government policy? Are they part of a plan or program? How?

In **Argentina**, the care facilities surveyed in Slum 21-24 are part of public policies (CEDECOR/SEDRONAR, CESAC 35 and its programs run by the Government of the City of Buenos Aires, National Hospital Network) and Catholic Church initiatives through the *Home of Christ* Program.

Finally, the breakfast programs of the *Children's Home of Bethlehem* and the *Hurtado Neighborhood Center* are part of the care network of the *Home of Christ Program*. They work together with other care facilities that operate in the slum, as well as centers in the Buenos Aires suburbs. The *Home of Christ* program receives subsidies from various government sectors at the municipal and national levels.

Brazil reiterates the connection described for the centers through the *Open Arms Program* and its three levels of connection.

The **Chile** reports that apparently the care facilities are not linked to a national or municipal government policy.

In **Paraguay** the care facilities do not have treatment programs or specialized multidisciplinary technical and professional teams. But they are more connected in a network, so they request services from other centers when the cases need it.

In **Uruguay**, the various centers, services, and care facilities are connected in the framework of the National Comprehensive Health System and the National Drug Network (RANADRO).

4.- CONCLUSIONS AND RECOMMENDATIONS

Were there any surprises in the field work? Did it destroy any myths or prejudices? Which ones?

Argentina

The team in Argentina reports that the field work in Rosario discovered that the current use pattern in the city differs from the earlier ideas; specifically, between 2008 and 2013 there were numerous media reports of the use of SCS in Rosario. Some of the sources that mentioned social organizations, such as the *Mothers of Pain*, which expressed concern about the use of this substance. There were also overdose cases in hospitals starting in 2008 in the province, but they were not officially recorded and therefore not reflected in specific data. Moreover, officials of the municipality mentioned this situation and said that cocaine base paste/paco was the substance of choice among the youngest users.

According to the survey done for this study, based on both formal interviews and informal contacts, there were no users of cocaine base paste/paco in treatment or using it in the public streets. The Mental Health Directorate said that in recent years it had not received requests for specific care for use of cocaine base paste/paco. It said that the problem of use of psychoactive substances has been eclipsed by the simultaneous use of multiple substances. But above all, the

demand expressed in the Health Centers that results in referrals deals primarily with alcohol use.

In the framework of this project there was a survey of women social workers and doctors in at-risk neighborhoods on cases of use of paco, crack, or cocaine base paste in the health centers where they work. Professionals in the health centers of Las Flores (South District), Maiztegui (Southwest District), and Ceferino Namuncurá (Northwest District) agreed that there was no record of use of SCS (paco or cocaine base paste) at least not openly.

The sources say, however, that there is a record of use of “*alita de mosca* [little fly wing],” also a residue of cocaine base, mixed with kerosene, traces of rubber, or solvents. In this case the substance is not smokable but inhaled. The “*alita de mosca*,” like paco, is split into small doses that are marketed at low cost. Since it is considered a low-quality substance it is used by the younger population (between 12 and 16 years old), because adults prefer other types of use.

Finally, the research team reports that the centers do not receive requests for care because of specific use of *alita de mosca*, but they occur in the framework of multiple use.

Brazil

The team in Brazil says it is very important that different services are now available for the treatment of drug users because historically they have been denied care.

It also concludes that services that serve multiple populations can still be important for consolidating the network and that the shelter for transsexual women was a pleasant surprise for its growth and qualification in the *Open Arms Program*.

Chile

Researchers in Chile say that there is limited involvement of organizations and activities on drugs and alcohol at the informal level and it would appear that care is limited to institutional programs of SENDA and other health services.

Paraguay

The field work irrefutably debunked the myth that all treatment centers and treatment centers are licensed. Indeed, most of them are neither licensed nor categorized by the Ministry of Public Health and Social Welfare. It also debunked the myth that the majority of treatment provided through treatment centers and care facilities are not for profit.

Uruguay

The work in Uruguay underscored the complexity of fully understanding the phenomenon of care and treatment for problem substance users, owing basically to the design of the system in the country. There were many institutions that do not keep systematic records and their absence posed some limitations for the study, basically because it was not possible to get all the data needed to make the study as exhaustive as desired.

Does the implementation of this line of work provide useful and relevant information for designing policies?

The reflections offered by the various research teams are positive with respect to the importance of this line of work, which provides useful and relevant information for designing policies:

“The information is useful, because it makes it possible to draw up a map of the resources used in the territory, and to understand which are the elements sought or requested by users, in order to then develop care proposals in the public sphere” **(Argentina)**.

“This line of work offers useful and relevant information for evaluation and moving forward with various public policies” **(Brazil)**.

“The comparison between different countries and with the interior of the same country can help to encourage commitments by the providers and identify gaps or defects in care” **(Brazil)**.

“It is useful and relevant to gather new information that facilitates assessment of the availability of treatment and care at the communal level. It also makes it possible to see the gaps in the connection of an informal network” **(Chile)**.

“With analysis, proper systematization, and participation of qualified drug professionals, this line of work will provide useful and relevant information for designing policies, based on scientific evidence” **(Paraguay)**.

“This initial effort in this area that had not been studied before is extremely useful, and although certain characteristics of the phenomenon can only be addressed in their formal aspects, it provides a starting point for future research needed to continue producing

knowledge about the situation of the availability of treatment for substance users in Uruguay” (Uruguay).

Is it appropriate to extend the coverage of this survey to other areas, regions, or the entire country?

All the countries agree that it would be necessary to extend this experience to the whole country, to describe and understand differences between the regions.

In Uruguay’s case, the entire country was included in the survey.

General comments on implementation of the subproject

Here are comments and reflections made directly by each of the country research teams:

Argentina

The project for characterization of the treatment centers generated valuable information, which combined with previous research makes it possible to develop a map of the local assessments.

The areas selected had unique characteristics; in the case of Slum 21-24, the area was open to study because there had been community and institutional research there for some time. Because it is an enclosed area, it was possible to cover it exhaustively and establish close relations with the research teams.

The newest experiences in dealing with substance users are occurring in this place. Many factors combine to cause this: the existence of a stakeholder selected by the neighborhood to coordinate joint actions, the development of different activities that involve problems of the community, and government presence through various institutions.

In the case of Rosario, the centers included in the study can all be defined as traditional care centers. No other types of care facilities could be surveyed in the city. The questionnaire proved useful and flexible for the traditional centers, but there were problems with its use for the care facilities. On this point, we appreciate the regional coordination work that preceded its implementation, and we hope that based on feedback from neighboring countries it can be revised for subsequent use in future studies.

Finally, we emphasize that it is necessary to combine various methodological strategies to delve into the complexity and social web in which substance use occurs.

Brazil

There were initial problems in hiring the consultant, which reduced the time available for the field work. Time for processing approvals of the ethics committees should be taken into account, as well as how to carry out a strategy for access to nongovernmental care facilities.

This line of work can provide relevant information for designing policies by improving available information, structural questions, profile of the population served, and proposals for care that are being considered.

Chile

In general the project is sufficiently strong, but the time frames should be extended, because at least in Chile's case, the delivery of information from the centers takes longer than envisioned by the project. The deadlines used by the centers depend on their own institutional logic, which is beyond SENDA's control. Coordination with the treatment centers and health services at the communal level is a complex matter. We found that once the questionnaires are completed by the responsible parties they are reviewed by the health directors and/or higher-ups. This resulted in a delay in delivering more than 90% of the surveys.

Paraguay

Field work for the subproject revealed strengths and weaknesses. The weaknesses identified are: lack of complete identification of the treatment centers and care facilities, lack of records of care for users, lack of adequate control of infrastructure, insufficient qualified human resources, lack of an allocation in the General Budget of the Nation, which can be seen in the lack of necessary funding for adequate support of the treatment centers and care facilities, whether publicly or privately managed, because in the end the service is public.

The strengths encountered are the existence of specialized and trained human talent in some treatment centers, the existence of treatment centers and care facilities, and the existence of regulations and resolutions adopted by the MSPyBS² (Resolution S.G. N° 766), and the proper functioning of a government oversight body on drugs (SENAD).

² Ministry of Public Health and Social Welfare.

Uruguay

Further specific studies are needed to expand understanding of the quality of services provided by the various types of institutions, which is not reflected in the survey of the formal aspects. It would also be very interesting to look at aspects of accessibility from the drug users' perspective.