

# Client's Characterization in the Community Treatment Approach: Methodological Foundations and Evidence

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**Citation** | Barros, R., Serrano P. I., Tufró, F., Canay, R., Carroli, M., Felix T. R., & Milanese, E. (2021). Client's characterization in the Community Treatment approach: Methodological foundations and evidence. *Adiktologie*, Advance online publication. <https://doi.org/10.35198/01-2021-002-0003>

**BACKGROUND:** The identity and social representation of people linked to drugs depend on their interaction with the system that collects and analyses the critical data used to describe it. **AIM:** The aim of this study is to see if by adopting a non-institutional and non-formal approach the drug users' profile will be different from that in mainstream formal studies. **METHODS:** Data was collected using a Community Treatment information and systematization tool (First Contact Form – FCF). Critical information on 6,090 cases was systematized. Data was collected by teams implementing Community Treatment in Argentina: SEDRONAR (SDR) 2,680 cases (48.1% F, 50.3% M, and 0.3% T), in Colombia: Consentidos (CNS) 2,096 cases (42.6% F, 56.7% M, and 0.7% T), and Viviendo (VIV) 1,382 cases (52.2% F, 46.7%

M, and 1.0% T). Additional data on 5,095 cases coming from Prochesta, Baraca, and Smile (Bangladesh) is included to highlight the impact of different settings.

**RESULTS:** The drug users' profile obtained using a non-formal approach based on Community Treatment is different from that obtained with formal and institutional processes. **CONCLUSION:** Community Treatment, adopting a double strategy (social inclusion and public health), allows people who, because of age, sex, personal, or community vulnerabilities, do not establish any contact with services, to get into treatment or support programmes. The profile of drug users and their communities produced by this approach allows the better targeting of policies and service providers.

**Keywords** | Community Treatment – Vulnerability – Drugs – Demand – Community Resources – Innovation

**Submitted** | 22 June 2021

**Accepted** | 2 August 2021

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## ● 1 INTRODUCTION AND THEORETICAL BACKGROUND

The development of sciences has made it possible to clarify that no system can be described outside the relationship between the described and the descriptor (Rovelli, 2021). And if this is true for the natural sciences, it is even more true for the social sciences (Ciesielska, Boström, & Öhlander, 2018). The properties of a system, in our case people linked to drugs, only describe the way in which the system interacts with something else; they only refer to interactions (Morin, 1986). The identity and social representation of people linked to drugs depend on how they interact with the methodologies and the professional profile of the people collecting and analysing the critical data used to describe it (Graham et al., 2008). Generally, data is collected through questionnaires or structured observations such as ASI, for example (Grahn & Padyab, 2020), in prisons, schools, clinics, or open communities (EMCDDA, 2017). It is on the basis of this evidence that public policies are established (Ahumada et al., 2019; OID, 2019). If a different non-institutional and non-formal approach is adopted, the drug user's profile will probably be different, as in the case of other studies (Syed, 2015). If that is the case, one could also expect differences in policies and strategies. The purpose of this paper is to provide some elements for this debate.

The non-formal method used to systematize information is based on the Community Treatment (CT) methodology operating in open contexts in highly vulnerable communities. CT operates in streets, parks, gardens, on football fields, in car parks, abandoned lots, abandoned buildings, private homes, etc., and above all by a system of non-formal and formal networks conveying and organizing community resources (Barros & Milanese, 2018; Milanese et al., 2018). The staff operating CT are made up of professional, non-professional, and community members, which implies that the observer and the observed, the describer and the described, are somehow mixed up (EMCDDA, 1999). Community approaches, generally called "community-based", are not new (WHO, 2004); they are part of the standard set of tools in the area of public health, even though their effectiveness is not always clearly demonstrated, with some, such as Curtis et al. focusing more on containing strategies than on the community as a resource (Curtis et al., 2017), while others consider this approach a promising strategy (Bruce et al., 2002; Okolie et al., 2015). What differentiates CT from community-based approaches is the inclusion of community resources through the participation of non-formal networks.

The information used in this paper focuses exclusively on what happens in the short period (from one to four weeks up to a maximum of two months) of the first contact between a drug user and a team member or a non-formal network in the community. The ways in which the first contact occurs help to determine what will happen next.

Motivation for change is considered to be more significant when the individual establishing the first contact is also the beneficiary of the process (Groshkova, 2010; López Acosta, 2009; Riehman, Hser, & Zeller, 2000). It is also considered that,

if the first contact is established by a member of the client's subjective network (a friend), this constitutes a protection factor in the event of dropout (Appel et al., 2004; Burk et al., 2012; Lutz et al., 2018; van Borkulo et al., 2015; Snippe et al., 2017; Rouquette et al., 2018).

## ● 2 METHODS

The methodology focuses on two aspects: data collection and data analysis.

As far as data collection is concerned, this is the result of the work of teams and non-formal networks operating in communities. There are therefore professionals (medical doctors, psychologists, educators, social workers, etc.) and members of the community without specific professional training, some of them drug users. Everyone uses a common tool, the First Contact Form (FCF), which is used to systematize the information collected and recorded in a field diary. Information systematized with the FCF is cross-checked and validated during staff sessions.

The FCF was created in 1995 with the participation of seven organizations working in the area of drugs (prevention and treatment) in Latin America. It has been modified repeatedly until it assumed its current aspect. It can be positioned in the tradition of rapid diagnostic tools (EMCDDA, 2018; Stimson et al., 2006).

Currently, the tool focuses on 13 topics: general data, the context and modality within which the first contact occurs, the basic data of the client's subjective network and who establishes the first contact, family structure, education, employment, vulnerability contexts, demands or requests, and responses and results of the first contact micro process. FCF is not a questionnaire or a semi- or structured interview form, it is a tool to systematize key information collected when sharing everyday community life (Da Lima, Glóra & Barros da Silva, 2020; Ministerio De Justicia & UNODC, 2020).

As far as data analysis is concerned, the procedure is based on descriptive statistics with validity tests (Chi-square) in cases where this is possible, since this is a descriptive study. The purpose is to compare the three groups of data (*SEDRONAR*, *Viviendo*, and *Consentidos*) with each other, and to compare the data obtained with the CT method with that reported in the official statistics of the countries where the study is carried out (when available). Data will be analysed by gender, first contact modality, age, family structure, occupation, education, general conditions of vulnerability (alcohol and drugs, mental and physical health, violence, poverty), demand analysis (economic, educational, health), response analysis, and outcomes of the first contact: at the end of the study there will be a comparison between females and males and the description of the main characteristics of females and males (adults), and of adolescent males and females. In some cases, a bivariate analysis will be performed.

## ● 3 RESULTS

The data presented in this section come from 6,159 cases of three CT groups: (a) *SEDRONAR*<sup>1</sup> (SDR; Government of Argentina); (b) *Consentidos*<sup>2</sup> (CNS), an NGO in Bucaramanga; (c) *Viviendo*<sup>3</sup> (VIV), an NGO in Cali, Colombia.

In the last section of this paper the data of 5,095 cases coming from three projects implemented in Bangladesh with the same methodology – *Baraca* and *Prochesta* in Savar-Dhaka and *Smile* in Chittagong – will be used.

### 3.1 Gender

Regarding gender (Table 1), the data does not differ significantly from that found in official statistics for the general population (i.e. not exclusively vulnerable populations); *Argentina*<sup>4</sup>: M 51.3% vs. F 48.7% ( $\chi^2 = 0.12, p = .733$ ); *Colombia*<sup>5</sup>: F 51.4% vs. M 48.6% ( $\chi^2 = 1.44, p = .229$  for CNS;  $\chi^2 = 0.35, p = .555$  for VIV). A previous systematization (2006–2007; Milanese, 2010) of 322 cases from five Latin American and Caribbean countries indicated that 57.8% of them were male and 41.3% female. According to SEDRONAR (Argentina; SEDRONAR, 2019) considering individuals linked to institutional treatment the male/female relationship is two women and eight men out of ten for marijuana and cocaine use and four to six out of ten for alcohol. Looking at the data from Colombia, the people linked to treatment processes are 26% women, 71% men, and 2% LGBTQ (ODC, 2017, pp. 55), while the CNS data is 42.6% women, 56.7% men, and 0.7% LGBTQ and that for VIV 52.2% women, 46.7% men, and 1% LGBTQ.

**Table 1 |** Distribution of frequencies and percentages of cases per sex and group (SDR, VIV, CNS)

	Frequency	% Female	% Male	% LGBTQ
SDR	2 680	48.1	50.3	0.3
CNS	2 096	42.6	56.7	0.7
VIV	1 383	52.24	46.74	1.01
<b>Total</b>	<b>6 159</b>	<b>47.85</b>	<b>51.48</b>	<b>0.67</b>

1 | SEDRONAR (SDR): Secretaría de Políticas Integrales sobre Drogas de la Nación Argentina (<https://www.argentina.gob.ar/sedronar>).

2 | *Consentidos* (CNS): Corporación para la Construcción de Sentido Humano, Social y Comunitario (Consentidos) started in May 2006 in Bucaramanga, Colombia (<https://www.corpconsentidos.org/contenido.php?idd=1>).

3 | *Viviendo* (VIV in Cali, Colombia) is a private non-profit organization promoting human development through research, training, institutional empowerment, and advocacy (<http://corporacionviviendo.org/quienes-somos/>).

4 | <https://www.indec.gob.ar>

5 | <https://www.dane.gov.co>

### 3.2 First contact and motivation for change

In this case motivation for change suggests that if it is the client who establishes the first contact the drop-out at the end of this process will be low.

The clients' initiative is prevalent and significant (Table 2) ( $\chi^2 = 10.77, p = .001$ ) compared to the other options; the difference between SDR and VIV is significant ( $\chi^2 = 14.95, p < .001$ ), as is the difference between SDR and CNS, ( $\chi^2 = 9.39, p = .002$ ) while there is no significant difference between CNS and VIV ( $\chi^2 = 0.69, p = .460$ ). The role of family members does not differentiate the three groups, but the role of institutions does: in this case the difference between SDR and VIV on one side and SDR and CNS on the other is significant ( $p = .017$ ).

**Table 2 |** Actor establishing the first contact, distribution of percentages per group

Who establishes the first contact?				
	SDR %	VIV %	CNS %	Average
The client	45.5	72.4	67	61.6
Family	20	7.5	18.6	15.4
A friend	7.7	10.6	9.3	9.2
An institution	23.4	9.5	1.9	11.6
Others	3.4	0	3.2	2.2

When it is the client who establishes the first contact, he/she continues implementing a CT process in 56.6% of the cases in 46% if it is established by a friend, in 45% of cases when it is established by a member of the parent's family, in 23% by a member of his/her own family, and in 44% by an institutional actor. There is no significant difference between client, or friend, or client's own family or client's parents family, or institution. The difference is significant between client and his own family ( $\chi^2 = 23.56, p < .001$ ), client's family and friends ( $\chi^2 = 11.71, p < .001$ ), client's family and institution ( $\chi^2 = 9.90, p = .002$ ), and client's parental family and his own family ( $\chi^2 = 10.78, p = .001$ ).

It seems that a personal and direct initiative and one which is taken by an institutional actor or friends or the client's parents family are the most effective for the continuity of the relationship.

### 3.3 Age

Table 3 presents the age distribution. The difference for the three institutions is significant for SDR and CNS ( $\chi^2 = 8.88, p = .003$ ), in the case of CNS and VIV ( $\chi^2 = 4.75, p = .029$ ) but not in the case of VIV and SDR ( $\chi^2 = 0.70, p = .402$ ).

When the CT data is compared with official figures, what stands out is that for SDR CT, 59.6% of the people are aged between 0 and 25, while the data reported in the SEDRONAR Bulletin does not exceed 28.9% (SEDRONAR, 2020).

**Table 3** | Distribution of the age groups (%) per institution

<b>Distribution by Age and Organization</b>				
	<b>% 0 to 10</b>	<b>% 11 to 25</b>	<b>% 26 to 40</b>	<b>% &gt; 40</b>
SDR	7.5	52.1	22	18.4
VIV	8.4	47.8	24.6	19.2
CNS	14.1	26.7	30.5	28.7
<b>Average</b>	<b>10</b>	<b>42.2</b>	<b>25.7</b>	<b>22.1</b>

In Colombia, the National Survey (Gobierno de Colombia, 2020) has no figures below the age of 11 and the life prevalence of drug use for the 12–24 age group is 19.3% and it is 44.7% for the group aged more than 24 years old. When these figures are compared with CNS and VIV, a significant difference is visible. Always referring to SDR (FCF data), 23.1% of people have a vulnerability linked to alcohol and drugs, but if the age range between 0 and 23 is considered, the percentage is 59.9%.

### 3.4 Family structure

Observations are focused mainly on single, free union, or married conditions (Table 4).

**Table 4** | Family structure: distribution of percentages by institutions and age groups

<b>Family structure</b>				
	<b>SDR</b>	<b>VIV</b>	<b>CNS</b>	<b>Average</b>
Single	64.4	71.3	53	62.9
Free union	13.2	17.7	35.8	22.2
Married	11	5.5	4.2	6.9
Others	11.4	5.5	7	8

**Age 17–23 Family structure age 17–23**

Single	85.4	85.6	49.4	73.5
Free union	11.5	12	48.7	24.1

**24–37 Family structure age 24–37**

Single	54.5	51.8	44.5	50.3
Free union	28.2	35.6	46.3	36.7

The main condition is to be single for all groups. Table 4 illustrates the relationship between age and family structure. The trend is that with increasing age the percentage of single people diminishes and that of free unions increases.

### 3.5 Education and employment

Education and employment are the last characteristic used to illustrate the basic conditions of the three groups and what differentiates them (Table 5).

**Table 5** | Education and employment, distribution of percentages by groups

<b>Education and Employment</b>				
	<b>SDR %</b>	<b>VIV %</b>	<b>CNS %</b>	<b>% Average</b>
Without primary level	23.8	9	46.5	26.4
Completed primary level	61.3	32.5	39.7	44.5
Employed	41	59.4	23.8	41.4

The percentage of cases who have completed primary level is significantly different for SDR and CNS ( $\chi^2 = 11.94, p = .001$ ), For VIV and CNS ( $\chi^2 = 11.86, p = .001$ ), but not for SDR and VIV ( $\chi^2 = 0.57, p = .449$ ).

Matching these figures with the national data: Argentina (SDR) has a completion rate of 97.1% for primary level, with a repetition rate of 2.1% and dropout rate of 0.8% (Ministerio de Educación de la Nación Argentina, 2017), while the data obtained with the FCF shows that 23.8% have not completed the primary level.

As for secondary school, in the basic course Argentina has 80% completion, with a dropout rate of 8.4%, and in the oriented course it has a dropout rate of 14.5% and an attendance rate of 85.97%.<sup>6</sup> More recent data (2018) gives a secondary school completion rate of 60.7% nationwide (Centro de Estudios de la Educación Argentina, 2018, pp. 6). In the FCF data, SDR has 23.8% of people with incomplete secondary education and 6.6% with complete secondary education.

### 3.6 Employment

For INDEC (INDEC, 2019), the employed represent 83.9% (6.9% are non-demanding sub-employed and 18.3% are demanding sub-employed) and 10.6% are unemployed. The FCF data for SDR shows 41% of employed people, that for VIV 59.4% (8.6% have a formal job, 35.7% are involved in non-formal activity) (the unemployment rate for Colombia in 2018 was 9.7% and that of employed people was 57.8%; Ministerio del Trabajo). When the INDEC and SDR data are compared, we can see that the difference between them is significant ( $\chi^2 = 8.28, p < .001$ ). For the same parameters, the difference between SDR and VIV is also significant ( $\chi^2 = 6.67, p = .009$ ).

### 3.7 Conditions of vulnerability

Raw information about clients is collected using a field diary and from there it is systematized using a table of 34 items included in the FCF.

In total (Table 6), 7,222 vulnerability conditions have been registered (an average of 2.7 per case); no vulnerability at all for 10.9%, 34% only one, 28.3% two or three, 19.6% four or five, 12.8% more than five. The context of vulnerabilities goes beyond the drug issue and helps to understand how the drug issue is connected with other aspects of everyday life.

**Table 6** | Distribution of vulnerabilities per group and averages

Vulnerabilities (% of cases)				
	SDR %	VIV %	CNS %	% Average
Drugs and alcohol	28.3	39.2	35.5	34.3
Mental health, drugs and alcohol	59.9	96.7	50	68.9
Violence (overall)	30.4	85.7	13.1	43.1
Gender violence	18.8	13.5	2.1	11.5
Community violence	19.78	70.1	2.2	30.7
Poverty	47	86	89	74
Health (physical)	5	4	12.3	7.1

There are significant differences between the three groups' local contexts. The correlation between the SDR and CNS data is  $r = 0.374$ , between SDR and VIV it is  $r = 0.131$ , and between VIV and CNS it is  $r = -0.109$ . The most significant differences between the three groups concern the following elements: intra-community violence, extreme poverty, training and education, organization and planning, inter-institutional networks (difficulties coming from institutions), relationship problems, behavioural problems, and financial support.

The figure for drugs and alcohol is not as high as expected and the differences between the groups are not significant.

Despite the perceived differences between the groups for alcohol and drugs, these are not statistically significant: the difference between SDR and CNS is non-significant ( $\chi^2 = 1.19$ ,  $p = .275$ ); the difference between SDR and VIV is non-significant ( $\chi^2 = 2.66$ ,  $p = .103$ ); the difference between VIV and CNS is non-significant ( $\chi^2 = 0.29$ ,  $p = .589$ ).

If a complex mental health variable is considered (including antisocial behaviour, psychiatric, behavioural, and relationship problems, domestic violence, sexual violence, street life, legal and school problems, severe exclusion, intra-community violence, inter-institutional networks, psychological crisis, human trafficking, no job, family problems, sexual problems, other addictions, displacement, migration, stigma resulting from sexual identity, disability, institutional violence, self-inflicted violence), the vulnerability increases significantly.

For SDR 73% of cases who have drug problems also have mental health problems, while 35.6% of people with problems related to mental health have drug and alcohol problems. Mental health particularly characterizes age groups: 10–16 and 17–23 especially with behavioural and relational problems. Crossing the use of drugs and alcohol with sex, 40.5% are men and 15.9% women. For mental health vulnerabilities, the difference between males and females is not significant: 58.2% M and 61.9% F.

Violence characterizes the different territories where CT is implemented; the context of VIV is significantly different if compared with SDR and CNS. It is also observed that mental health problems are related to problems of violence in 50% of cases for SDR, while all problems of violence are related to mental health problems. The interrelationship between violence and mental health is strong, although the cause-effect relationship has not been established. It was observed that 41.6% of the cases of violence are also related to drug or alcohol problems.

Poverty and economic life are the strongest vulnerability factors. The age ranges most exposed are 9–16 years (40%), 17–23 years (53.7%), and 24–30 years (56.4%). If sex is considered, the differences between groups are not significant: the overall distribution by sex is 53% for females and 47% for males.

Vulnerability conditions related to health if compared with poverty or violence are not significant, and neither is it the case for sex (F 54.9%, M 42.9%).

### 3.8 Clients demands

Clients demands refer to the clients' petitions at the moment of first contact (Table 7). Demands are the clients' direct expression systematized using an FCF table made up of 25 indicators.

**Table 7** | Percentage distribution of clients' demands and petitions per group

Clients' demands and petitions				
	SDR %	VIV %	CNS%	Average
Advice and orientation	53	66.7	13.3	44
Training and education	30.3	55.6	6	31
Information	28.5	76.5	62	56
Community integration	28.3	39.4	1.4	23
Financial support	12.8	31	23	22

All cases included, 19,318 requests were registered (SDR 7,222, VIV 6,919, CNS 5,177) with a general average of 3.31 requests per case (SDR 2.7, CNS 2.5, and VIV 5.0). The most significant are advice and guidance, training and education, information, community integration, and financial support.

Looking at the SDR figures, 22.3% of all requests are focused on economic needs, 10% on physical health, and 4% on orientation/training/schooling.

### 3.9 Relationship between vulnerability and client's demands

This section is focused on the relationship between staff observations and assessment and clients' demands, petitions, or complaints (*Table 8*). This coincidence is often necessary to establish a strong treatment alliance. The coincidence in the sphere of physical health is poor; it increases in the economic component and is very strong in education.

**Table 8** | Distribution of percentages of coincidence between staff vulnerability assessment and clients' demands and requests

Coincidence between staff's assessment and clients' demands				
	% SDR	% VIV	% CNS	Average
Physical health	22	25	5.8	17.6
Economy	49	39.2	47.2	45.1
Education	66.7	73.4	100	80

### 3.10 Responses

Responses describe the set of actions staff and operational networks implement immediately after the client expresses his/her demand.

Globally, the three groups (CNS, VIV, SDR) have implemented 13,482 immediate responses (SDR 6,098, CNS 3,082, and VIV 4,302) with an average of 2.27 for SDR, 1.8 for CNS, and 3.11 for VIV. The first contact process appears to be a micro process of intense activity.

If we consider the area of orientation and information (information, counselling and guidance, specific orientations), which are the mainstream streetwork activities, it is observed that for SDR this happens in 74.7% of the cases and for VIV 99.1% and CNS 86.3%. On the other hand, 42.1% are related to more complex activities such as immediate listening or accompaniment (VIV 46.7%, CNS 7.8%). Finally, 50.8% of responses (VIV), 28.8% (CNS), and 49.7% (SDR) are related to activities that can be considered as CT: immediate listening, crisis management, accompaniment, medical care, hygiene and clean clothes, or night or day shelter.

### 3.11 First Contact Process outcomes

One of the expected results of the first contact process is for the clients to remain in contact or to get into CT. Interruption of the contact at the end of the first contact phase occurs in 5.3% of the cases. The client remains in contact in 30.5%, 10% start a CT programme, 28.9% are included in and participate in street

and community activities, and 4.5% are effectively referred to other services. It is also observed that making an appointment gives a satisfactory result (especially thanks to streetwork); 72.9% actually attend the appointment. In a *follow-up* after one year and four months (average interval), 47.9% of the people contacted are still active in the CT<sup>7</sup>process and among people not in contact some of them have properly concluded their programme and others have been directed towards other and more appropriate services.

### 3.12 Profiles

In the following paragraphs some characteristics of specific groups are discussed: women, men, teens, and adults.

#### 3.12.1 Women

Women establish the first contact through a street unit or a low-threshold centre; they establish the contact by themselves and through other institutions operating in the same community. Women are mainly single (52%), married (15.5%), or in a state of free union (17.9%); 14% with an incomplete level of primary education, 16% with only primary completed, 23.8% with incomplete secondary, 7.4% with complete secondary, and 10.5% with alcohol consumption. Compared with men, women present only half as many antisocial behaviours and behavioural problems. Women need significantly more financial support than men, have fewer school problems than men, significantly more bureaucratic problems, more training and education needs, and more need for organization and planning. They have more family problems, significantly less use of marijuana, pasta base, and cocaine, are significantly more concerned by gender-based violence, are at the same level as men for tranquilizers and stimulants, and are not significantly different regarding the severity of their vulnerability; women maintain less contact with the programme (36.7%) compared to men (41.4%).

#### 3.12.2 Women aged 0 to 18

They establish the first contact mainly in a low-threshold centre (in 43% of cases) and through a node of the operational network; the contact is established directly by the client (54.3%) or it is a referral from another institution (24.3%); 47.9% of them live in a nuclear family and the rest in families with diverse configurations; 20.2% among them have incomplete primary and 43.2% have incomplete secondary education, 68.7% are studying and 10.5% work; 59.2% of them have vulnerabilities related to mental health, 24% with drugs and alcohol, 12.4% with intra-community violence, and 18.8% with family violence; 16% ask for help for economic reasons, 5% for health reasons, and 72.7% ask for help for reasons associated with the need for training and counselling.

<sup>7</sup> | In a *follow-up* carried out with three teams from three different projects working in Bangladesh (Baraca in Savar-Dhaka, Prochesta in Savar, and Smile in Chittagong) using the same approach (CT) out of 5095 cases studied 72.6% of the cases maintain contact with the equipment or operating networks after a similar interval (67.0% Baraca, 86.6% Prochesta, 74.3% Smile).

### 3.12.3 Men

Men mainly establish the first contact through a street unit or a low-threshold centre (in 89% of cases through staff members or community members). In 93% of the cases the first contact is made in a non-institutional context (in the street, in their partner's house, 93% of them through staff members or community people). They establish the contact preferably by themselves or through another institution; they are mainly single (77.8%) or in a state of free union (10.4%). In terms of their educational level, 17.4% are with incomplete primary, 15% with complete primary, 29.7% incomplete secondary, and 5.8% complete secondary education, and 28.6% with alcohol abuse. When compared with women, the percentage of men related to antisocial behaviours or behavioural problems is double.

### 3.12.4 Males 0 to 18

Most of them establish the first contact through a low-threshold centre (45.5%) or a street unit (21.4%), or a node of the operational network (16.5%). In 10.7% of cases, the first contact is established by a friend, in 20.2% by a member of the parents' family, and 43.3% by the client himself. 54% live with the nuclear family and the remaining percentage in families with different configurations; 43.7% have incomplete secondary and 15.0% incomplete primary education and 87.5% are currently attending primary or secondary school; 1.5% have a productive occupation (formal or non-formal work); 15% are linked with drugs and alcohol, 60% with vulnerabilities in the area of mental health (mainly behavioural problems), 30% with problems of violence, and 20% with gender and family violence; 17.5% ask for help in relation to economic aspects, 6.4% for reasons of physical health, and 75.3% for counselling and training.

## ● 4 DISCUSSION

CT is seeking to establish contact especially with clients who have never had any contact with any service or institution (new contacts represent 72.3%) and to contain dropouts from contact or treatment. The CT first contact process, which can last three or four weeks, has a dropout rate of 5.3% and after 16 months the rate is around 52%, including people who have dropped out from treatment but who are still in contact with street units. Palmer et al. (2009) indicate that in in-patient treatment the drop-out rate prior to three months can be 50% or more, while Wessel-Andersson et al. (2018), studying long-term and short-term treatment, find a dropout rate of 26%–66%, Brorson et al. (2013) find a drop-out rate of 21.5%–43% in detoxification and 32%–67.7% in substitution treatment. As for CT, among people staying in contact without actively participating in CT activities 36.2% belong to the 9–16 (13.7%) and 17–23 (10.3%) age groups. For the other ages, the differences are not significant. This helps to see that if the CT approach is capable of establishing contacts with children and those in early adolescence, which is difficult for an institutional approach (SEDRONAR, 2020), there is still difficulty getting them into a rehabilitation process.

Age is not associated with dropouts from contact: 10% of cases start a treatment process; 7.6% among them belong to the 9–23 age group. The cases included in Outreach activities are 33.7%; 12.9% belong to the 9–16 age group, 10.3% to the 17–23 age group. These figures illustrate that for the CT approach the concept of dropout should be redefined because dropping out from treatment does not mean dropping out from the relationship. These findings are consistent with the research of Brorson et al. (2013).

One question is about the association between the severity of vulnerability and staying in contact or dropping out of it. The data shows that the severity of vulnerability is not significantly associated with dropping out. None of the vulnerability factors, considered separately, is associated with permanence in CT. Permanence does not depend either on the sum of requests or on the requests considered separately. These findings are not congruent with the research of Şimşek et al. (2019), where the severity of addiction, for example, is one of the dropout determinants. The request for "training and education" seems to facilitate (but this is not statistically significant) permanence in the programme, as does the fact that during the first contact process the client has been "personally accompanied" to get some services. Being a man or a woman does not influence permanence in CT. Comparing these findings with other studies is not easy because these context factors are not included in their studies; this is true for the review of Brorson et al. (2013), the study of Palmer et al. (2009), and that of Wessel Anderson et al. (2018).

The first contact, the FCF, and the information it provides, are meant to strengthen the process of integration with the community, increasing social and knowledge capital. This has produced some information that differs, in certain aspects, from mainstream information especially on sex, age, employment, education, etc. On the one hand, this may bring into question the validity of the information produced but, on the other hand, it may constitute a first glance towards a world that had not been observed in this way before, a kind of intermediate way between the information produced by professionals with their tools and that produced by teams of non-formal community actors, where the tool is the relationship that is built in everyday life. This aspect is related to the issue of data validity: on the one hand, there is information that is based on the validity of the researchers' tools that would have among their objectives to avoid the risks resulting from the relationship with the source of the information; on the other hand, there is information that it would be impossible to obtain without a direct, frequent, and personal relationship with the source of the information. We also know that people make their decisions on the basis of how each of them perceives and elaborates reality and not always depending on what reality is like, and it could happen that research tools are "formally correct" but the information collected through them is the outcome of the relationship between the informer and the tool, or the researcher.

As for the 6,190 cases used (11,185 when the cases from Bangladesh are included), it appears that these are very similar to the general population even if in reality they are specific and highly vulnerable populations.

This outcome can be explained by two of the characteristics of the CT methodology. We have seen that almost 53% of contacts are established between 2 p.m. and 8 p.m. and 3% of contacts are established after that time. This indicates a work modality that adapts to the rhythms of the community. On the other hand, 56.7% of contacts are established in the context of street and community work. These two figures, joined together, suggest that the CT approach could be one of the elements explaining the different profile of this population if compared with others. A fact that can support this point of view is one that comes from Bangladesh. One of the three projects is implemented within a residential therapeutic community that also has a street team, while the other two work exclusively with an open community modality. The first (Baraca) has a population of 80.9% men and 19.1% women and of the other two Prochestra 63.5% men and 36.5% women and Smile 58.9% men and 41.1% women, recalling the fact that the Bengali communities are of Islamic culture, so contact with women is significantly more difficult and less frequent; nevertheless, community work based on informal networks can ensure that what is made invisible can emerge. As for the contexts of vulnerabilities, one of the central elements is the employment status of the people who are contacted. In this case the difference between vulnerable conditions and the general population is significantly different for Colombia or Argentina and it indicates a high-priority field of political action.

For alcohol and drugs in particular, differences between the three data groups exist; however, these are not significant. Statistically, the three groups of data (CNS, SDR, and VIV) reflect similar vulnerable conditions. In the case of SDR, it has also been observed that there is a significant difference between the data produced by this approach and the official data: SDR registers a higher percentage of women compared to the official figures. This may depend on the CT community approach, which tries to adopt optics of social integration and of public health simultaneously, thus modifying the provision and accessibility of services. The double perspective (community integration and public health) of this approach means a deep change in the work strategies. These include the physical settings where the first contacts occur (62% of the contacts occur in non-formal spaces) and who the people who establish the contact are (not only staff but also community actors, linked to the staff through a complex networking system), as well as work schedules.

CT also seems to facilitate the client's personal and direct initiative (45.5% by SDR, 66.9% by CNS, and 72.4% by VIV) strengthening the importance of individual motivation to follow in the process (56.6% remain in the process after one year, while this percentage is 23% when the contact is established by a member of their own family). SDR, if compared with VIV and CNS, also shows a significant difference for the contacts established by other institutions (23.4%); perhaps this is due to the fact that in this case CT is a state policy. It is also observed that referral by another actor of the state policy is associated with a permanence of the person in CT of 44%. This complex first contact framework probably also explains why (data from SDR) the population aged 0–17 represents 34.5% instead of the 2.6% indicated in the Official Observatory Bulletin (mainstream information).

Vulnerability conditions differentiate the territories of SDR from those of VIV and CNS. In fact, the data highlights the presence of a network of vulnerabilities where drug use finds its meaning. Relational-family-community and economic axes are the founding factors drugs and alcohol use are built upon. The importance of the “violence” which, in the case of SDR, is mostly gender-related violence, is not surprising. In a follow-up carried out with a tool of the CT (Results Assessment System) in an average period of six months after the first contact which ensures a better understanding, it has been observed that for SDR, the cases of violence inside the family reach up to 65.4%, and 92.8% is associated with the indicator of living in a high-risk community.

It has also been observed that the demands or requests expressly formulated by individuals requesting some forms of assistance are focused mainly (74% of the cases) on the issue of counselling, training, and education, while the requests for economic support, in spite of the high frequency of cases that have this type of vulnerability, count for 22%, with 10% for physical health. These elements allow us to think that it was a wise strategy for CT to articulate an approach combining public health with social integration.

## ● 5 CONCLUSIONS

The aim of this study was to highlight whether the profile of people who use drugs in highly vulnerable contexts changes if relational and non-formal observation processes are adopted, instead of the usual tools and settings of clinical research. The modalities of first contact, different settings where it occurs, actors, etc. highlight the intense interconnections and synergies between non-formal community actors and the actors of entities of organized civil society and government institutions. Among the consequences of adopting this methodology there is the way to establish an alliance with the community and through this alliance to modify the typology of services, the community settings where staff operate, and the relationships they have with the whole community. Having access to the non-formal world is not only a way to “lower the access threshold” but also to build access that did not exist before.

Comparing official figures with those produced within the CT approach, it seems that the latter try to go further than the official surveys focused on population types. Having chosen the “community” as the subject and context of *action research*, it was possible to get information describing a context in a more interconnected way, highlighting the synergies between economic factors, civil coexistence, human rights, health, education, and social integration.

As for the validity and limitation of the information produced through rapid assessment the data collected obviously refers only to the communities with which it was collected, and therefore cross-sectional studies should be implemented in the future.

As for the implications of joining CT information with that obtained with other more formal approaches, the CT modality can be used to provide additional information for mainstream sta-

tistics and also to improve and validate the CT modality. Both could be complementary.

Regarding the limitations of the study, the first one is that since this is descriptive research based on cases coming from different social, cultural, and geographical contexts statistical data does not explain that kind of complexity and how it works within each of the communities. In this case further research integrating anthropological and sociological perspectives is necessary. The second one depends on the fact that it is descriptive research; cross-sectional studies should be the next step. The third one is that the results of CT are under study with the Federal University of São Paulo and that study will provide some hints about what works and what does not and if some hypothesis of this study will find a clear response. The fourth limitation is in pulling together professional and non-professional institutions and community members in action research: the complexity of the variables and how they influence the CT process and the information used in this study should be researched further.

Concerning implications for policies, approaching the drugs issue without addressing the issue of social exclusion in all its forms (workplace, educational, support for civil society and rights) is limited. Adopting a social integration strategy based on the sustainable development of communities seems to be a suggestion coming out from this experience and these figures. Even though it is a limited presentation of data, it suggests that CT could be a promising option for policies based on community resources, but a lot more research is required.

#### Authors' contributions:

BR, CR and ME were in charge of the general direction and coordination of the study. SPI carried out the data processing and FTR was in charge of the communication and logistics. TF and CM did the field work. All authors contributed to the emergence article and approved the final version of the manuscript.

#### Declaration of interest:

None.

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