MANUAL FOR THE DESIGN, MONITORING, AND EVALUATION OF A DRUG TREATMENT INFORMATION SYSTEM: GENERATING INFORMATION
MANUAL FOR THE DESIGN, MONITORING, AND EVALUATION OF A DRUG TREATMENT INFORMATION SYSTEM:
GENERATING INFORMATION

Authors
Maria Elena Alvarado | Marya Hynes | Francisco Cumsille
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The Inter-American Observatory on Drugs (OID) of the Organization of American States (OAS) has set up an epidemiological research network to help member states produce timely, reliable, and comparable information and statistics on demand and supply of psychoactive substances. This information provides an overview of the issue and shows the impact of drug use in the Americas, while supporting the development of policies tailored to each country’s particular circumstances.

In the area of demand reduction, the OID works with the National Drug Observatories (NDOs) of the National Drug Commissions (NDCs), using the Inter-American Uniform Drug Use Data System (SIDUC), which develops, records, collects, stores, and analyzes information on the demand for drugs.
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Introduction

Drug use has a major impact on countries' public health. The chapter on Drugs and Public Health of the 2013 report *The Drug Problem in the Americas* stresses the importance of taking a public health approach to address problems related to drug use. Among the conclusions of that report:

- Drug abuse is a serious health problem for many people in the Americas—particularly the initiation of drug use at an early age, which is associated with a higher risk of drug dependence.

- There is likely no single drug problem in the Americas; drug use varies widely among countries in the hemisphere, both in terms of the extent of use and the type of substance, and policies need to be developed and implemented to address these problems.

- Drug abuse and dependence is a chronic disease and should be treated as such. Treatment of substance use problems should be provided through a continuum of care involving every level of the health care system, and treatment interventions should be evidence-based and of proven effectiveness.

- Many countries lack adequate treatment services or sufficient trained personnel, and many others do not have information that would allow them to assess whether they have the right resources.

- Implementing and assessing effective public health policies requires having up-to-date information of sufficient quality and quantity. Countries need to strengthen information systems so that they can properly monitor the drug problem and fund research to develop the most effective approaches. They should also invest in human capital and infrastructure.

Along these lines, building on the analysis in *The Drug Problem in the Americas*, the Inter-American Observatory on Drugs proposes a discussion about the importance and role of National Drug Observatories in providing accurate, high-quality information on treatment for people with problem drug use.

The systematic collection of data to understand who is receiving treatment for drug problems is critical to understanding the problem and its scope, characteristics, and trends. It also enables countries to track the

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appearance of new substances, routes, and modalities of use, as well as the characteristics of the people using them.

It also helps policymakers and program planners and experts to design, implement, and evaluate strategies, policies, and programs on drugs that will ensure that the treatment provided is both timely and of high quality.

There are wide variations among the countries of the region in terms of treatment services, and especially in terms of access to information about such services. There is also no standardization or consensus about coverage, concepts, methods, or tools, which makes it very difficult to get a full picture of the issue across the region and to make comparisons between countries.

This manual has two chapters. The first introduces the concept of demand for treatment—how to estimate it by means of household surveys on drug use and how to characterize the population in treatment based on studies in treatment centers. This chapter also proposes a methodology for assessing and describing the network of centers and care facilities that are available to offer treatment to people who need it (available treatment), and thus the gaps that must be filled to provide sufficient high-quality and appropriate coverage to those who need it.

The second chapter proposes a methodology for implementing a National Treatment Monitoring System to obtain reliable, standardized data on a regular, systematic basis on the characteristics, processes, and outcomes of the treatment of patients in the various centers. This chapter also proposes the creation of a regional protocol to create drug treatment indicators that will produce valid, comparable information on drug demand in the Americas.

1. Background

The following section briefly discusses the Inter-American Uniform Drug Use Data System and the National Drug Observatories, which have a very important role to play in the creation of a national and regional drug treatment system.
Inter-American Uniform Drug Use Data System (SIDUC)²

SIDUC is a system for recording and analyzing information; its methodology focuses on understanding drug demand so as to obtain data, develop explanatory concepts, and support the response to the problem of drug use.

The objectives of this methodology are:

1. *To obtain cross-sectional information that reflects some of the characteristics of drug users in specific groups.*

The problem here is how to obtain information that describes the characteristics of a group in one country—with a known, acceptable margin of error—and the same characteristics measured in another country. The techniques involved in solving this type of problem allow inferences to be made about a population when only a portion of it is studied.

2. *To obtain longitudinal information that will describe how the characteristics of users in these same groups evolve over time.*

If a country wishes to add a longitudinal or diachronic perspective (the behavior of a variable over time) to the cross-sectional or synchronic view—in other words, if it wants to compare measurements of the same variable over time—it again needs to measure using the same tool applied to the same population. This is the only way to ascertain a trend. Repeating a measurement to make comparisons requires consistently using a specific methodology.

3. *To develop explanatory models.*

The process of developing explanatory models seeks to identify the mechanism that generates the data collected by the observation tools. It involves progressively building the causal structure of the phenomenon, creating a map or representation to indicate the points where a minimum of energy can trigger the most significant changes in the system.

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Role of the National Drug Observatories in Creating a National Treatment System

Experts in drug demand reduction generally agree that there is a large unmet need for treatment among people who abuse drugs or are drug-dependent. Only a fraction of those who need help go into treatment programs. Worldwide, an estimated one out of six problem drug users receives treatment every year.\(^3\) This figure masks wide disparities in the availability and accessibility of drug treatment services in different regions, but it also reflects differences in information systems on treatment demand.

There is also little information available on how this potential excess demand is distributed by demographic group, place of residence, types of drugs used, or appropriate treatment modalities.

Therefore, for countries to be able to plan a treatment system and allocate resources, they need information on both the current availability of treatment and the actual demand for treatment that exists in the country. They must also understand the means by which the need for treatment becomes actual demand.

In this regard, National Drug Observatories play an essential role in gathering, organizing, and analyzing information to assess drug use and problem drug use in the country and in providing that information to policymakers, service providers, the academic community, and the public at large.

National Drug Observatories play an important role in supporting public drug policies and programs by:

- Collecting existing drug-related data
- Organizing and analyzing available data
- Producing new information
- Evaluating the policies and programs that have been implemented
- Disseminating the information

2. Objectives

This manual has the following objectives:

Main Objective

To provide the countries with a methodology for collecting comparable information that will enable them to design, implement, monitor, and evaluate a drug treatment system.

Specific Objectives

The specific objectives of this manual are:

- To develop a shared methodology for estimating the potential and actual demand for drug treatment, by means of a regionwide set of treatment indicators that will make it possible to collect standardized, comparable information on the numbers and characteristics of treatment clients in the countries.

- To describe the availability of treatment and social and health care support in the country, and thus provide the basis for designing, planning, and managing a treatment system that is responsive to the needs of the country’s problem drug users.

- To design a National Treatment Monitoring System that will yield standardized, systematic, and reliable information on a regular basis on the characteristics, processes, and outcomes of the treatment provided to people in the various treatment centers, in order to conduct epidemiological surveillance, manage services, and establish continuous quality improvement.

- To develop a regionwide protocol of indicators on drug treatment that will assemble information that can be compared between countries and between cases involving treatment for problems related to drug use.
CHAPTER I
ASSESSING THE DEMAND FOR TREATMENT FOR ALCOHOL AND OTHER DRUGS
Chapter I: Assessing the Demand for Treatment for Alcohol and other Drugs

1. Concept of Demand for Treatment

When we talk about demand for treatment for alcohol and other drugs, we must clarify some concepts. Not everyone who uses drugs requires or would benefit from a treatment process; it is only problem users\(^4\) who are potential candidates for some type of therapy. At the same time, not all problem substance users recognize that they have a health problem, and therefore they do not see the need for treatment. The reasons for this include society’s acceptance of the use of certain substances (alcohol, for example) and people’s perception that using certain substances carries a low risk, causing those affected to delay seeking help or treatment. In other cases, some drug users who are socially marginalized (users of cocaine base paste, inhalants, or crack, for example) do not seek treatment until the consequences and harm produced by their drug use are far advanced. That is why it is important to differentiate between need for treatment and demand for treatment.

This manual will use need for treatment to refer to all those who present with substance abuse or dependence, whether they perceive that their situation requires treatment or not. Potential demand refers to those who meet the condition of abuse or dependence and who have felt the need for treatment, regardless of whether this translated into a request for help at a treatment center. This group includes people who recognize that they have a problem caused by substance use and who have felt the need for treatment but who, for various reasons, have not asked for help. This group represents the potential number of people who could enter treatment if they were encouraged to seek help.

\(^{4}\) Problem use is a concept suggested by the UNODC to help focus on the population that requires treatment, rehabilitation, and social inclusion. It is not found in international classifications, but it is considered a useful concept for studies, research, and program and policy implementation. In operational terms, problem use may refer to abuse (according to DSM-IV criteria), harmful use (according to ICD-10 criteria), or dependence (DSM-IV and ICD-10).
We will use **actual demand or real demand** to refer to those who, recognizing that they have a problem as a result of using alcohol or other drugs, do in fact consult with a treatment center. This group includes those who consulted and were treated (satisfied demand) and those who consulted and did not receive care, whether because there was no treatment available that fit their needs or because they were on a waiting list (unsatisfied demand). This group represents the minimum number of people that a treatment system needs to cover. It is also essential to understand the characteristics of those who represent actual demand, since that will determine the type of treatment that needs to be made available.

The figure below lays this out in graphic form:

**Figure 1: Demand for Treatment**
2. Estimating the Demand for Treatment Using Population Surveys

One way to estimate the need and demand for treatment is through prevalence studies on the abuse of and dependence on alcohol and other drugs. The more precise the estimate, the closer it will be to the true value.

The Inter-American Observatory on Drugs, via the Inter-American Uniform Drug Use Data System, provided the Protocol of the Household Survey on Drug Use to the OAS member states so that they could have information that can be compared across countries and over time within the same country.\(^5\)

This protocol sets out the methodology for developing drug-use indicators that will provide representative information on the prevalence and incidence of use for each substance, sociodemographic characteristics of users, patterns of use, and other important aspects related to drug use.

The Protocol of the Household Survey on Drug Use also makes it possible to estimate the prevalence of abuse of and dependence on the substances most frequently used in the countries, by including the diagnostic criteria of the DSM-IV\(^6\) for abuse and the ICD-10\(^7\) for dependence. These classifications are applied to all those who say they have used a substance during the past 12 months (past year prevalence).

Drug dependence refers to cases in which drug users meet three or more of the ICD-10 diagnostic criteria, and drug abuse to those who meet at least one criterion of abuse in the DSM-IV but do not meet the criteria for dependence.

2.1 Estimating the Need for Treatment

The Protocol of the Household Survey on Drug Use can be used to estimate the population needing treatment by calculating the number of people in the sample who meet the criteria for substance abuse or dependence. By extrapolating this group from the sample to the population under study, we can obtain

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\(^5\) Similar surveys and data collection tools used in other countries and regions include the National Survey on Drug Use and Health (NSDUH) in the United States and the Treatment Demand Indicator (TDI) of the European Monitoring Centre for Drugs and Drug Addiction.

\(^6\) Diagnostic and Statistical Manual of Mental Disorders (DSM).

\(^7\) International Classification of Diseases (ICD-10), WHO criteria.
the number of people in the population who would need treatment because they are problem users of one of the substances under study.  

In other words:

\[
\text{Need for treatment} = \text{Population of problem drug users (abuse + dependence)}
\]

### 2.2 Estimating the Potential Demand

As stated above, not all those who meet the criteria for abuse or dependence see themselves as being ill or recognize the need for treatment; therefore, this population will not spontaneously seek treatment. To estimate the population that actually wants to receive treatment, the *Protocol of the Household Survey on Drug Use* suggests two pertinent questions (104 and 105):

**Question 104.**
Over the past 12 months, have you felt the need for help or treatment of some kind to reduce or stop drinking?

**Question 105.**
Over the past 12 months, have you felt the need for help or treatment of some kind to reduce or stop taking any drug?

These questions ask whether the person felt the need to receive help or treatment for the use of any drug. By analyzing the responses, we can estimate the population that may potentially ask for help and thus come up with the real demand for treatment.

By adding the extrapolated number of those who meet the criteria for abuse or dependence and those who also answered “yes” to Questions 104 or 105, we come up with the potential demand for treatment.

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It should be noted that the survey covers a sample of households that represents a certain population; therefore, when calculating the need for treatment of the whole population, we must apply statistical weights in order to extrapolate to the entire population.
2.3 Estimating the Actual Demand for Treatment

Actual demand consists of those who have sought treatment at a care facility. Using the Household Survey on Drug Use, we can make a rough estimate of the size of this population and some of its characteristics.

When we do not have other sources of data, such as information taken from health care records or waiting lists at treatment centers, we can use this information to make an initial estimate.

We can estimate actual demand for treatment based on the number of people who meet the criteria for abuse or dependence and who say they have been treated in a treatment center for use of alcohol or other drugs within the past year.

Question 100 enables us to identify those who received treatment:

**Question 100.**
Over the past 12 months, have you ever been treated for taking alcohol or drugs?

This population—an extrapolation of those who meet the criteria for abuse and dependence and who also answered “yes” to Question 100—represents an estimate of the actual demand for treatment in the country.

It is important not only to find out the size of this group but also to be able to describe it, to understand its members’ needs and thus ensure that treatment programs can tailor their services appropriately.

The Household Survey on Drug Use includes some variables related to sociodemographic factors and drug use that can help describe this population. The main variables that may be obtained from this survey are:

- Sex
- Age
- Occupational status (working/studying)
- Region of the country where he/she lives
- Substances responsible for the abuse or dependence
- Treatment history
2.4 Limitations to the Information Obtained from Household Surveys

While this type of measurement has certain advantages, it also has some limitations; these should be kept in mind so that they do not jeopardize the proper interpretation of the data and the development of policies and programs. Here are some of these limitations:

- The surveys are representative only of the population living in private homes, and therefore cannot be used to estimate demand among groups of people in institutions (armed forces and law enforcement institutions, mental or physical health care facilities, prisons) or among people living on the street. Some of these groups have a high prevalence of drug abuse or dependence and also have a higher concentration of psychosocial risk factors, which means that they might require different treatment strategies to address their particular and specific needs.

- The findings for the 12-18 age group must be interpreted with caution, since the classifications used in these surveys (ICD-10 and DSM-IV) do not have diagnostic criteria for abuse and dependence that are specific to that population. Some tools have been specially developed and validated for the adolescent population and have been incorporated into studies on drug use among students; these could provide more exact measurements for this age bracket.

- Due to the type of questions asked, the description of the population that requires treatment is not as complete as the description that can be obtained from a survey specifically for treatment center clients. It is therefore recommended that information coming from treatment centers be used to gain a more comprehensive view of the situation.

In summary:

*Countries that employ the Household Survey on Drug Use can use it to estimate and describe potential demand and actual demand.*
3. Characterizing the Actual Demand for Treatment

The main objective of studies in treatment centers is to characterize the population that sought treatment, both in terms of clinical diagnosis (abuse, dependence, dual diagnosis, related disorders) and from a sociodemographic standpoint, namely, age of the individuals, sex, level of schooling, and other factors.

This will help to identify treatment needs—a matter of considerable importance, since the closer the available treatment can come to meeting the specific needs of each population group, the more effective it will be. It is important to keep in mind that the needs of those who require treatment vary not only between countries but also within the same country.

The information from household surveys, combined with data from surveys in treatment centers, will give the country accurate, precise information on the actual demand for treatment. This will enable those in charge of the national treatment program or system to design a model that is accessible, available, and appropriate, and that includes a gender and social inclusion approach, for people who require treatment.

3.1 Operational Definitions

“Population under study” refers to people with problem drinking or drug use who are being treated in the country’s treatment centers (actual demand).

Here are some key definitions to help apply concepts that are important at this stage:

- **People in treatment** are all those individuals who make contact with a treatment center, no matter how long that relationship lasts. This definition thus includes those who have a single consultation with the center, those who begin treatment and stay at the facility, those who leave before the therapy process is complete, those who receive outpatient treatment, etc.

- **Treatment** is a process of therapeutic intervention for people who present with problem use of alcohol or other drugs, the goal of which is to overcome their drug abuse or dependence problems. Treatment includes a set of health care, psychological, social, occupational, and educational actions, both individual and in groups and families. Treatment processes make use of a wide range of therapeutic options and health care resources provided by staff and technical personnel accredited in the field.

- **Treatment centers** are specialized units that provide treatment to people who have been diagnosed with a psychoactive substance use disorder. These are facilities that comply with the health regulations in each
country and that conduct health care interventions provided by staff and technical personnel who are accredited in the field.

Social and health care facilities work with people who present with various problems or needs, providing intervention that is primarily social or related to health care other than drug treatment. There are two types of social and health care facilities: The first includes those that can conduct screening for alcohol and other drugs as part of their work (though this is not their main function) and can connect those who need treatment with treatment centers. The second group includes facilities whose origin and main function is related to drug treatment (though they themselves do not provide it); basically, they provide support to people who are in treatment and who have other needs that treatment itself does not meet. These facilities help the person remain in treatment and maintain what they have achieved.

3.2 Developing a National Registry of Treatment Centers

The sampling frame is a list that should include all the treatment centers in the country, to ensure that everyone receiving treatment is represented in the sample.

The most efficient way to conduct this type of study, particularly in countries with a large number of centers, is first by taking a sample of treatment centers and facilities, then proceeding to describe the population receiving care by interviewing those selected.

For this sample to accurately represent the population of people in treatment and to ensure that valid inferences can be made, it is necessary to use a sampling frame and a probability sampling method.

Conducting Surveys in Treatment Centers

Treatment centers use a wide variety of modalities of care and theoretical models, and address needs that go beyond treatment. It is thus important to find out what social and health care facilities are available, to be able to link them into the treatment system. This is why the National Registry of Treatment Centers should include both treatment centers and social and health care facilities.

It is therefore important to clearly establish the criteria for including or excluding facilities from the National Registry of Treatment Centers. The registry will include all treatment centers that meet the criteria set out in the definition above, as well as all social and health care facilities that, as part of their work, do screening for the use of alcohol and other drugs and connect people who need treatment to treatment centers. It
will not include facilities that address other needs that treatment itself does not meet, even when these facilities’ work is related to drug treatment (though they do not perform it themselves).

If this type of registry of centers does not exist, the National Drug Observatory in each country will be tasked with creating one and updating it annually. This registry will provide information on the pool of treatment centers and social and health care facilities.

Developing a registry of treatment centers and social and health care facilities that rises to the level of a census—in other words, one that includes all facilities—can be a long and cumbersome task unless a systematic search strategy is proposed at the outset.

This strategy should be designed in line with how each country’s health system is organized and bearing in mind current laws and regulations. However, in general terms, any such census should be able to draw on information provided by:

a. The Ministry of Health, either at the central level or through regional agencies. This primary source can provide information on state-run facilities and treatment centers, as well as on those listed as registered service providers, either because they have been authorized by the Ministry of Health to operate, or because they are part of a formal or informal network working in this field.

b. The ministry or agency responsible for social policy, either at the central level or regionally. This is a very important source of information on state-funded social and health care facilities, in addition to private facilities that may be listed in a registry.

c. Municipalities. Information can be obtained here on facilities and treatment centers operating locally and recognized at the municipal level because, for example, they are listed in a formal or informal registry that authorizes them to operate.

d. Groups of nongovernmental organizations (NGOs) that work with people with problem substance use. If there are instances when these NGOs work as a group, it is more efficient to approach the groups to obtain their membership lists.

e. Foundations that work with people with problem substance use.

f. Churches that do community work.

g. Websites.
The information on treatment centers and social and health care facilities that is obtained at this first stage may be considered a preliminary registry. This search strategy will probably serve to identify the larger centers, but it is likely that there are more facilities and treatment centers than can be captured by this means.

A second stage is therefore needed to complete the registry by identifying new facilities, building on those already discovered in the preliminary stage. One way to do this is to use the “snowball” technique.

This is a non-probability sampling technique that operates on the assumption that participants tend to know others who share similar attributes. In this case, the treatment centers included in the initial registry have information about other centers that also provide treatment to problem drug users and that could be added to the registry. The same is true for the social and health care facilities. Thus, each of the treatment centers and facilities interviewed provides information about another facility or center. This chain process makes it possible to reach centers that would otherwise be difficult to identify, which makes this a more economical method that is easy to implement.

Ideally, the registry should cover all treatment centers in the country; however, not all countries are in a position to do this. One solution is to expand the registry systematically, starting with the capital city and gradually adding other cities, until a national registry is developed (Figure 2).

Figure 2: Stages of Developing a National Registry of Treatment Centers

<table>
<thead>
<tr>
<th>STAGE 1</th>
<th>STAGE 2</th>
<th>STAGE 3</th>
<th>STAGE 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Registry of all centers in the capital city</td>
<td>Registry of centers in regional capitals</td>
<td>Registry of centers in other cities</td>
<td>Registry of all centers nationwide</td>
</tr>
</tbody>
</table>

This diagram illustrates that it is possible to make valid comparisons between countries even if they are at different stages of developing their registry. For example, in the figure above, a country in Stage 2 can compare its data with a country that is in Stage 4, since there is comparable information available in each of these situations.
3.2.1 Characteristics of a National Registry of Treatment Centers

A national registry should have the following characteristics:

1. It is based on the previous year’s information. To update it annually, at the end of each year the National Drug Observatory will prepare an updated list of treatment centers available.

2. The centers should have a unique, non-transferrable code that they retain over time. Centers that cease operations or that stop providing information retain their code, which is never assigned to any other center.

3. The registry should be used to create a database containing the following information:
   a. The center’s code
   b. Public or private facility
   c. Type of treatment center (hospital, therapeutic community, NGO, among others)
   d. Geographical location
   e. Size (number of patients treated)

3.3 Methodological Considerations for Studying Patients in Treatment Centers

Unit of Analysis

The unit of analysis refers to individuals who are receiving treatment for drug abuse or dependence in a treatment center or social and health care facility.

Design and Calculation of the Sample

With the registry of treatment centers and social and health care facilities in hand, the centers that will make up the sample can be selected. The selection process should follow strict criteria to avoid introducing biases that could distort the comparisons. Failure to be rigorous here will necessarily affect the validity of
the country data in comparisons over time, which will produce confusing information about the national situation and also affect comparisons at the international level.

Therefore, the selection process should consider four essential requirements for obtaining a probability sample (that is, a sample with a known probability of sampling error). These have to do with the way cases are selected (Points 1 and 2, below) and the proper size of the sample (Points 3 and 4):

1. A complete, up-to-date sampling frame for counting the units in the population under study: a census or national registry of centers.

2. A randomized selection process that will ensure a known, independent probability for each of the elements that make up the population.

3. The determination of a probability of sampling error, the level of significance or probability of error $\alpha$, a value generally set by the researcher at between 1 and 5 percent.

4. An estimate of the population’s heterogeneity, in statistical terms its variance (or the square root of the variance, the standard deviation) when dealing with interval measurement levels. Variance is a measure of how much a set of random observations vary from a mean. One category becomes “$p$,” or probability of success, and the other, “$q$”.

A stratified sampling is a probability sampling technique in which the whole population is first divided into different subgroups or strata and then the clients in the different “strata” are selected proportionately at random.

The main advantages of this type of sampling:

- It highlights a population subgroup to ensure that it is present in the sample.
- It detects relationships between the subgroups.
- It represents subgroups that may be small.
- It improves the accuracy of the estimate, given that there is less variability within subgroups compared with variations in the population as a whole.
- It requires a smaller sample size.

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To apply this sampling methodology, the stratum or strata to be used should be defined—in this case, the size of the center and whether it is public or private. This is because different dynamics may come into play depending on the relative size and nature of the centers.

The National Registry of Treatment Centers that the country has created should be organized in such a way as to identify these strata, in a table containing the following information:

- Code identifying the center
- Public or private facility
- Number of patients treated during the prior year; centers are categorized into strata based on size
- Cumulative percentage for each line of the table

Below is an example of how to calculate the sample size and select the sample. The size of the sample is calculated according to the following formula:

Figure 3: Calculating the Sample Size

**Calculating the Sample Size**

Given that:

\[
    n = \frac{Nz^2 \cdot pq}{(N-1) \cdot e^2 + z^2 \cdot pq}
\]

Where:

- \( n \) = size of the sample
- \( N \) = size of the population: in this example, it is 2,218 patient records
- \( z \) = confidence level chosen: in this example, 1.96
- \( p \) = proportion of a category of the variable 0.30 (drug of greatest impact)
- \( e \) = maximum error 0.02

Result:

\[
    n = \frac{2218 \cdot 1.96^2 \cdot 0.30 \cdot 0.70}{(2218-1) \cdot e^2 + 1.96^2 \cdot 0.30 \cdot 0.70} = 1,056 \text{ patients}
\]
Table 1 below shows the distribution of centers based on whether they are public or private and the number of patients treated each year.

Table 1: National Registry of Centers by Size and Whether Public or Private

<table>
<thead>
<tr>
<th>CENTER CODE</th>
<th>NATURE OF CENTER</th>
<th>SIZE</th>
<th>% PATIENTS</th>
<th>CUMULATIVE %</th>
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</thead>
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<td>83</td>
<td>Public</td>
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<td>74.0</td>
</tr>
<tr>
<td>63</td>
<td>Private</td>
<td>80</td>
<td>3.6</td>
<td>77.6</td>
</tr>
<tr>
<td>54</td>
<td>Private</td>
<td>73</td>
<td>3.3</td>
<td>80.9</td>
</tr>
<tr>
<td>68</td>
<td>Public</td>
<td>71</td>
<td>3.2</td>
<td>84.1</td>
</tr>
<tr>
<td>53</td>
<td>Private</td>
<td>69</td>
<td>3.1</td>
<td>87.2</td>
</tr>
<tr>
<td>57</td>
<td>Public</td>
<td>64</td>
<td>2.9</td>
<td>90.1</td>
</tr>
<tr>
<td>110</td>
<td>Public</td>
<td>60</td>
<td>2.7</td>
<td>92.8</td>
</tr>
<tr>
<td>51</td>
<td>Private</td>
<td>40</td>
<td>1.8</td>
<td>94.6</td>
</tr>
<tr>
<td>19</td>
<td>Public</td>
<td>36</td>
<td>1.6</td>
<td>96.2</td>
</tr>
<tr>
<td>115</td>
<td>Private</td>
<td>35</td>
<td>1.6</td>
<td>97.8</td>
</tr>
<tr>
<td>44</td>
<td>Public</td>
<td>25</td>
<td>1.1</td>
<td>98.9</td>
</tr>
<tr>
<td>77</td>
<td>Private</td>
<td>23</td>
<td>1.0</td>
<td>100</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>2,218</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

*Source: Authors’ own creation*
Table 2 shows the six strata created and the size of each, by number of clients served in the centers making up each stratum.

Table 2: Distribution of Centers by Strata of Interest

<table>
<thead>
<tr>
<th>SIZE AND NATURE OF THE CENTER</th>
<th>CENTER CODE</th>
<th>SIZE OF THE STRATUM</th>
<th>%</th>
<th>SAMPLE SIZE BY STRATUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>Large, public</td>
<td>83</td>
<td>460</td>
<td>20.7</td>
<td>219</td>
</tr>
<tr>
<td>Medium, public</td>
<td>36, 81, 55</td>
<td>467</td>
<td>21.1</td>
<td>223</td>
</tr>
<tr>
<td>Small, public</td>
<td>56, 68, 57, 110, 19, 44</td>
<td>345</td>
<td>15.6</td>
<td>165</td>
</tr>
<tr>
<td>Large, private</td>
<td>26</td>
<td>337</td>
<td>15.2</td>
<td>160</td>
</tr>
<tr>
<td>Medium, private</td>
<td>22, 20</td>
<td>289</td>
<td>13.0</td>
<td>137</td>
</tr>
<tr>
<td>Small, private</td>
<td>63, 54, 53, 51, 115, 77</td>
<td>320</td>
<td>14.4</td>
<td>152</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2,218</td>
<td>100%</td>
<td>1,056</td>
</tr>
</tbody>
</table>

Source: Authors’ own creation

Here, the size of the sample calculated according to the formula given above is 1,056 people; this number will be distributed proportionately to the size of each stratum. Within each stratum, centers will be selected at random, and within these, the individuals who will make up the sample.

3.4 Data Collection Tool

To describe this population, we propose using a tool that incorporates a general information module that includes identification of the center, along with seven clusters of questions to collect the necessary data on the clients in treatment centers. The tool covers:

1. Socioeconomic background of the interviewees
2. Family and social background
3. Characterization of substance use
4. History of prior treatment  
5. Mental and physical health  
6. History of conflicts with the law  
7. Clinical history  

Each of these aspects is included because it yields the information needed to get an idea of what treatment the country should make available to its citizens. The questionnaire and the justification of the variables are provided in Annexes 1 and 2 of this manual. Annex 3 gives a suggested informed consent form, which must always be considered before the tool is applied.

3.5 Collecting the Data

The following actions will help in applying this tool properly:

a. Meetings should be held between the National Coordinator in charge of the process and the directors of the treatment centers or their technical teams. This is to brief them on the SIDUC system in general and on the training of the professional staff who will be involved in administering the tool, as well as to secure the centers’ full cooperation and ensure that the questionnaire becomes institutionalized as part of their normal routine.

b. It should be explained to the treatment centers that the purpose of this process is not for SIDUC to evaluate the effectiveness of the therapy they are providing, but rather to understand the patterns of heaviest substance use occurring in the country.

c. The center should number the questionnaires and send them each month to the National Coordinator, who will perform quality control as these come in. If problems are detected, the National Coordinator will contact the center to have it correct the information. Say, for example, that a country sends in a database one year in which 21.6 percent of the center codes have not been recorded. Since this is an important variable, the problem must be corrected in time.

d. The questionnaire is administered during the initial evaluations of the patient by the professional team. The person administering the questionnaire should be a professional who has established some level of trust with the patient.
4. Describing the Treatment Available

Studies in treatment centers can describe both the population being treated and the centers that are providing this service. As mentioned earlier, there are wide varieties of treatment centers, which differ as to type of funding, model of care, target population, and services provided, among other factors.

Most countries do not have information on the characteristics of their treatment centers, and it is therefore difficult to plan a treatment system that can respond to the needs of their population.

To properly implement a comprehensive treatment system that addresses clients’ different needs, a country needs to have information on the population that requires treatment as well as on the treatment that is available.

The National Registry of Drug Treatment Centers should be used to describe the nature of the treatment centers. As with the studies describing demand, it will represent the total population on which the estimates are based. The unit of analysis will be each treatment center and social and health care facility that meets the criteria for being included in the National Registry of Treatment Centers.

4.1 Data Collection Tool

We propose that the tool used to describe treatment centers be distinct from the one used to describe social support facilities, and that it be administered to the technical director of each facility. The questions are grouped into six modules, as follows:

1. Identification of the center

2. How the center operates

3. Patient capacity

4. Target population, that is, the population to which its activities are geared. The main categories used to define the target population are related to the following variables:

   - Sex, age group, social insurance program
   - Complexity: abuse, dependence, dual diagnosis, psychiatric comorbidity
   - Specific populations: prisoners, street people
5. Portfolio of services, meaning treatment interventions, inclusion, and support services. This has implications in terms of the facility’s human and material resources and determines its level of complexity.

6. How the network operates: an assessment of the links between care facilities, treatment, and the health care system. Taken together with the information above, this will help to construct a model for a treatment network in which each facility has its place and function within the system, such that the client can enter the system and move within it based on his or her needs at each stage of the treatment process.

7. Human resources, namely the type and number of staff working in the centers, and their training in the field.

8. Material resources, that is, the physical characteristics of the facilities and the equipment they have at their disposal.

9. Technology and information systems: an assessment of the centers’ technology and information systems.

The questionnaires for treatment centers and social and health care facilities can be found in Annexes 4 and 5, respectively.
CHAPTER II
CHAPTER II: NATIONAL TREATMENT MONITORING SYSTEM AND REGIONAL PROTOCOL OF DRUG TREATMENT INDICATORS
The goal of a National Treatment Monitoring System is to obtain regular, standardized, reliable, and systematic information on the characteristics, processes, and outcomes of the treatment patients receive in the various facilities.

This information, which should be gathered on a regular, systematic basis, is particularly useful for understanding the problems caused by drug use and their scope, characteristics, and trends. A National Treatment Monitoring System can also track the appearance of new substances, routes, and methods of use, and describe the characteristics of users.

In terms of policy and management, such a system serves as the basis for planning treatment, enabling an assessment of needs and quality of treatment provided. Together with the rest of the information collected by the National Drug Observatory (NDO), it contributes to the development of the countries’ drug policies.

There are wide variations among the countries of the region in terms of treatment services provided, as well as the ease or difficulty of accessing information on such services. In addition, there is no consensus on coverage, concepts, methods, or tools, which makes it very difficult to gain an overall understanding of the issue in the region.

The advantages of having such a system are many, and we can organize the main ones by whether they have an impact at the national or regional level.
At the national level:

- The system makes it possible to describe sociodemographic characteristics, patterns of drug use, and risks and problems for people in drug treatment, and to discern trends over time.

- It tracks the appearance of new substances or types of substance use that lead to demand for treatment.

- It enables an evaluation of the process and the outcomes of different models or types of treatment.

- It provides decisionmakers with information to use in the development of evidence-based policies, for promotion, prevention, and treatment purposes.

- It provides useful information for conducting new research on drug addictions.

At the regional level:

- The system collects comparable information from the countries on treatment and on treatment clients, for the Inter-American Observatory on Drugs.

1. National Treatment Monitoring System

1.1 General Considerations

Two basic pillars must be in place for a country to implement a National Treatment Monitoring System on drugs:

- The authorities must be willing to invest time and resources in creating and maintaining the system, which means they must be convinced that the initiative will have an impact on the population.

- The centers that offer treatment must be interested in participating in the system, something that will be achieved only when they understand the potential value and benefit for their clients.
In addition to meeting these first two conditions, the country must have appropriate legislation, and a permanent registry of cases in treatment; the National Observatory must have professionals assigned to this issue to follow up, coordinate, and do analysis; and treatment providers (specialized centers, therapeutic communities, hospitals, detox facilities, and other care providers) must be properly registered and regulated, to ensure that the registration mechanism is standardized and permanent.

Figure 3: Considerations for the Implementation of a National Treatment Monitoring System

1.2 Implementation of a National Treatment Monitoring System and Role of the National Drug Observatories

Once the political support is in place and the decision has been made to implement a National Treatment Monitoring System, the National Drug Observatory will take on the role of coordinating the system's implementation.

The first activity or product of the National Drug Observatory should be to assess the information already being produced in the country on drug treatment. This first stage will include surveying the drug treatment data being produced and documenting the context and tools associated with the data collection and the ways the information is being used.
An analysis of the context in which the data is being collected will clarify the reasons behind the initiative and the implicit or explicit incentives that have made it possible to generate this information. In every country, there are centers that systematize information on their clients’ treatment process, not only for clinical purposes but also for management purposes and to evaluate their own performance. Finding out this information will help bring in strategic allies and shed light on the incentives that were used to successfully implement the system.

Some countries that have monitoring systems have used financial incentives for reporting information, making the transfer of funding to the facilities conditional upon reporting patient data. While this does force centers to report information, it does not give those that do not get this type of funding an incentive to participate in the monitoring system; nor is it an incentive for participating centers to report information on clients it serves who are not funded.

It is therefore important to pay attention to the incentives that will be required to make the monitoring system viable. One key point is to ensure that the participating centers see the production of systematic information on treatment as a benefit for their own management, not as a task imposed by an outside coordinator. For this to happen, the treatment centers must be involved in the process from the very beginning.

The second step that the National Drug Observatory should take is to convene the key stakeholders, institutions and individuals, to create a drug information network to support the implementation of the National Treatment Monitoring System. This network will participate in determining the information that will be collected and in producing operational definitions, data collection tools, and mechanisms for linking and exchanging information—in other words, a protocol of treatment information at the national level (Figure 4).

Figure 4: Implementation of a National Treatment Monitoring System
The National Drug Observatory should also determine the resources that will be needed to set up a National Treatment Monitoring System using a data platform, which is the most efficient way to receive timely information from the centers. However, this requires that the reporting centers have computers and an internet connection. This is probably the case with most of the health centers located in metropolitan areas. However, there are many small, poorly funded centers that provide treatment and that are located in rural areas or far from large cities and do not have computers or an internet connection.

The National Drug Observatory should assess the situation and, to the extent possible, take action to provide funding to these centers or link them up with entities that can help meet these needs.

Finally, and importantly, the National Drug Observatory should train the centers in how to manage software programs and how to produce and use epidemiological indicators to report data and then use that data to improve the quality and relevance of the services that they provide.

1.3 National Drug Treatment Monitoring System and its Relationship with the Inter-American Observatory on Drugs

The goal of the Inter-American Observatory on Drugs is to gain an understanding of the drug problem in the Americas as a whole. Much of the information needed for this purpose comes from drug treatment centers themselves; it complements the drug demand data that is obtained by other means, such as through countries’ population studies on drug use.

The information originates in the treatment centers and part of it is sent to the National Drug Observatories. Most of this data will be used inside the country, and only some will be useful at the regional level. It is important to provide feedback to the centers or institutions that provide the data, to keep the information loop going (Figure 5).

For the information provided by the treatment centers to be useful in reflecting what is really happening in the region, it must be capable of representing the actual status of people in treatment in the countries and must also be able to be compared among the member states. This requires developing a set of Drug Treatment Indicators, agreed upon by member states, according to identified needs, and key methods.
2. OID Protocol of Indicators on Drug Treatment

The purpose of developing a regional protocol to create drug treatment indicators is to provide a common methodology for collecting and reporting information using basic data on the profiles of drug users in contact with treatment services. This will yield information that can be compared among countries of the region and among cases involving treatment for drug use problems.

2.1 Treatment Indicators

The first task will be to reach agreement on a basic set of treatment indicators that all countries can adopt. Each country may add other indicators to its National Drug Treatment Monitoring System, in accordance with local needs, while maintaining the core indicators from the common protocol.

The proposed set of basic indicators is based on the experiences of member countries in gathering data from drug treatment centers, and on a review of international systems.
The main treatment indicator proposed is: **Number of new treatment admissions during the year.** This indicator is designed to find out the number of people that treatment centers admit annually into treatment for drug abuse or dependence.

Based on the information collected, additional indicators can be developed:

- Number of new admissions to treatment involving people with drug abuse or dependence (problem use) in one year
- Number of new admissions to treatment by type of treatment center
- Number of new admissions to treatment by substance
- Number of new admissions to treatment for injection drug use
- Number of new admissions to treatment by sex of the patient
- Number of new admissions to treatment by age of the patient
- Number of treatment episodes per year
- Prevalence of use for each substance

### 2.2 Definitions

Along with selecting a set of basic treatment indicators, the countries need to reach agreement on some operational definitions that will enable standardized data collection.

The unit of analysis will be every person who has entered treatment—whether outpatient or residential, for drug abuse or dependence (problem use)—in a treatment center.

*Treatment* is a process of therapeutic intervention for people with problem use of alcohol or other drugs, the goal of which is to overcome their drug abuse or dependence problems. Treatment includes a set of health care, psychological, social, occupational, and educational actions, both individual and in groups and families. Treatment processes make use of a wide range of therapeutic options and health care resources provided by staff and technical personnel who are accredited in the field. These may be provided on
an outpatient or inpatient basis. Patients who spend the night at the center only sporadically will be considered as receiving outpatient treatment.

Contacts made solely to ask for information about therapy or about social benefits are not considered treatment. Nor are individuals on a waiting list considered to be in treatment.

**Start of treatment** refers to formal contact between therapist and patient, during which a clinical evaluation is made of the need for treatment and the patient agrees to begin the therapeutic process.

**End of treatment** can refer to different occurrences, which must be differentiated: discharge from therapy because the therapeutic goals that were established have been achieved; referral to another facility based on the client’s profile; voluntary dropout from treatment by the client; administrative discharge or expulsion of the client by the treatment team; death of the client.

**Readmission to treatment** means restarting the therapeutic process after it had ended. The objectives laid out previously are taken up again upon readmission.

**Problem use** is a concept suggested by the United Nations Office on Drugs and Crime (UNODC) to help focus on the population that requires treatment, rehabilitation, or social reintegration. It is not found in international classifications, but is considered a useful concept for studies, research, and implementation of public policies and programs. In operational terms, it includes abuse, harmful use, and dependence, according to the DSM-IV and ICD-10 classifications.

**Abuse** is a maladaptive pattern of substance use that involves a significant deterioration or discomfort over a period of 12 months due to one or more associated problems: failure to meet obligations at work, school, or home; substance use in situations that endanger others (such as driving a car or operating machinery under the influence of the substance); repeated legal problems related to the substance (such as arrests for disorderly behavior); continued use of the substance despite having ongoing or recurring social problems or interpersonal problems caused or exacerbated by the effects of the substance.

**Harmful use**, according to the ICD-10, is a pattern of use of a psychoactive substance that causes harm to health. The harm may be physical (such as hepatitis due to the administration of psychotropic substances through one or more layers of skin or mucous membranes) or mental (depressive disorders secondary to excessive drinking, for example).

**Dependence** is a set of physiological, behavioral, and cognitive manifestations where the use of a drug becomes the individual’s highest priority. Dependence can be diagnosed using the criteria of the ICD-10 or the DSM-IV, both of which agree on including withdrawal and tolerance criteria in the diagnosis.
**Treatment centers** are specialized units that provide treatment to people diagnosed with mental or behavioral disorders due to the use of psychoactive substances. These units operate in conjunction with other types of health care services offered by the public sector, such as primary care units, general and specialized hospitals, and the network of mental health services. Both in the public and private arena, there are support groups and other types of community organizations. Beyond the health care sector, there are also ties to the criminal justice system and to the social development and education sectors, among others. There should also be coordination with universities and other educational institutions where the various types of professionals receive training, particularly health care training.

**Social and health care facilities** work with people with various problems or needs, providing intervention that is primarily social or related to health care other than drug treatment. There are two types of social and health care facilities: The first includes those that can conduct screening for alcohol and other drugs as part of their work (though this is not their main function) and can connect those who need treatment with treatment centers. The second group includes facilities whose origin and main function is related to drug treatment (though they themselves do not provide it); basically, they provide support to people who are in treatment and who have other needs that treatment itself does not meet. These facilities help the person remain in treatment and maintain what they have achieved.

**Primary or main drug** is the drug that causes the user the most, and the most serious, problems and motivates the person to start treatment. This is determined by what the client says and by the clinical diagnosis, which means that it is jointly defined by the client and the therapist.

**Treatment episode** refers to the period of treatment from the start of treatment to its conclusion. An individual may have more than one treatment episode in a calendar year.

### 2.3 Data Collection Tool

Treatment centers should keep an individual record on each person admitted to treatment, to report a list of variables. This may be done in the form of a paper report or, if a country has been able to implement an online information system for the centers, this will be the means used.

Not all the information the centers send to the National Drug Observatory is needed to develop the proposed treatment indicators. The observatories will therefore report to the OID only the minimum information required for developing the indicators. This information is shown in the table below:
Table 3: Minimum Information Required

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>HOW TO REPORT</th>
<th>PURPOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case code</td>
<td></td>
<td>Identifies each case at the national level</td>
</tr>
<tr>
<td>Patient identifier</td>
<td>Use initials of first name and surname, followed by month and year of birth, both of which are shown with two digits; for example, Mary Peters, born November 1975. Code: <strong>MP1175</strong></td>
<td>Identifies individuals who have been admitted to different centers or even in different regions more than once during the year.</td>
</tr>
<tr>
<td>Center code</td>
<td></td>
<td>The center is identified with this code</td>
</tr>
<tr>
<td>Type of center</td>
<td>Treatment center=1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Social and health care facility=2</td>
<td></td>
</tr>
<tr>
<td>Type of care</td>
<td>Outpatient=1</td>
<td>Classified according to whether the person stays overnight in the center where he/she is receiving care.</td>
</tr>
<tr>
<td></td>
<td>Residential=2</td>
<td></td>
</tr>
<tr>
<td>Date of admission to treatment</td>
<td>Six digits are used: 2 for the day, 2 for the month, and 2 for the year.</td>
<td>Identified date of exit from treatment.</td>
</tr>
<tr>
<td>Date of leaving treatment</td>
<td>Six digits are used: 2 for the day, 2 for the month, and 2 for the year.</td>
<td>Identified date of exit from treatment.</td>
</tr>
<tr>
<td>VARIABLE</td>
<td>HOW TO REPORT</td>
<td>PURPOSE</td>
</tr>
<tr>
<td>---------------------------</td>
<td>--------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Date of birth</td>
<td>Six digits are used: 2 for the day, 2 for the month, and 2 for the year.</td>
<td>Used for the age variable</td>
</tr>
<tr>
<td>Nationality</td>
<td>Country of birth/Nationality</td>
<td></td>
</tr>
<tr>
<td>Country of residence</td>
<td>Country of residence in the past year</td>
<td></td>
</tr>
<tr>
<td>Sex</td>
<td>• Male</td>
<td>In order to develop gender-specific treatment policies.</td>
</tr>
<tr>
<td></td>
<td>• Female</td>
<td></td>
</tr>
<tr>
<td>Age at start of treatment</td>
<td>Age in years on the date of admission to treatment</td>
<td>In order to develop age-specific treatment policies.</td>
</tr>
<tr>
<td>Level of education</td>
<td>• Did not complete primary school</td>
<td>Gives an indication of the socioeconomic level of the adult population</td>
</tr>
<tr>
<td></td>
<td>• Completed primary school</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Completed secondary school</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Higher education</td>
<td></td>
</tr>
<tr>
<td>VARIABLE</td>
<td>HOW TO REPORT</td>
<td>PURPOSE</td>
</tr>
<tr>
<td>---------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Drug that motivated admission to treatment</td>
<td>• Alcohol</td>
<td>The drug that caused the most, and the most serious, problems for the user, motivating him/her to start treatment (see definition).</td>
</tr>
<tr>
<td></td>
<td>• Marijuana</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cocaine (cocaine hydrochloride)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cocaine base paste (CBP, paste, basuco, paco)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Crack</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Amphetamines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Methamphetamines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• MDMA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Heroin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Methadone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sedative-hypnotics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hallucinogens</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Inhalants (solvents, glue, volatile fuels)</td>
<td></td>
</tr>
<tr>
<td>VARIABLE</td>
<td>HOW TO REPORT</td>
<td>PURPOSE</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Past year substance use</td>
<td>• Alcohol</td>
<td>Even though the remaining substances are not causing the need for treatment, this helps to track new substances</td>
</tr>
<tr>
<td></td>
<td>• Marijuana</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cocaine (cocaine hydrochloride)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Cocaine base paste (CBP, paste, basuco, paco)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Crack</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Amphetamines</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Methamphetamine</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• MDMA</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Heroin</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Methadone</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sedative-hypnotics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hallucinogens</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Inhalants (solvents, glue, volatile fuels)</td>
<td></td>
</tr>
<tr>
<td>Routes of administration</td>
<td>• Oral</td>
<td>Number of injecting drug users. This is an indicator of the severity of drug use and its impact on public health.</td>
</tr>
<tr>
<td></td>
<td>• Inhaled, sniffed</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Injected</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Smoked</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Transdermal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Transmucosal</td>
<td></td>
</tr>
<tr>
<td>VARIABLE</td>
<td>HOW TO REPORT</td>
<td>PURPOSE</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>---------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Age of first substance use</td>
<td>Age in years</td>
<td>Provides information on treatment, and also provides some guidance on prevention.</td>
</tr>
<tr>
<td>Communicable diseases</td>
<td>• Hepatitis B</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Hepatitis C</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Tuberculosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• HIV/AIDS</td>
<td></td>
</tr>
</tbody>
</table>
DEMAND FOR DRUG TREATMENT
Appendix 1: Demand for Drug Treatment

Tool for Persons in Drug treatment

The information provided for this questionnaire is kept strictly confidential. All information will remain anonymous and will be used only to improve the quality of treatment in our country.

1. Name of center or code for center:________________

2. Identification code of the person interviewed (e.g. initials followed by day, month, and year of birth)________________________

MODULE I: Sociodemographic background

3. Date of Birth: _ _/ _/ _ _ _

4. Sex:
   a) F
   b) M

5. Children:
   a) No children
   b) Yes, number of dependent children ________
6. If you answered yes, do your children live with you?
   a) No
   b) Yes

7. For women: Are you currently pregnant?
   a) No
   b) Yes, number of weeks______________________

8. Residential community/region_______________

9. Nationality ____________________________

10. If you are in a migrant situation:
    a) Visiting
    b) Temporary resident
    c) Permanent resident
    d) Undocumented migrant

11. Race or ethnic group (provide list according to country categories)

12. Health insurance, health service access (categories vary by country)
    a) Health insurance (public)
    b) Health insurance (private)
    c) No health insurance
    d) Other, please explain __________________

13. Education level:
    a) Some primary education
    b) Primary education completed
    c) Some high school
    d) High school completed
    e) Some university or technical school studies
    f) University or technical school certificate/degree
    g) No response
14. If you did not complete a level of education, what were the reasons? \textit{(Choose as many as are relevant.)}

\begin{itemize}
\item[a)] Financial problems
\item[b)] Family issues
\item[c)] Substance/ Drug use
\item[d)] Still in school
\item[e)] Other _________________________
\end{itemize}

15. Do you currently have a spouse, significant other, boyfriend, girlfriend?

\begin{itemize}
\item[a)] No
\item[b)] Yes
\end{itemize}

16. What is your civil status?

\begin{itemize}
\item[a)] Single
\item[b)] Married
\item[c)] Widowed
\item[d)] Separated/divorced/annulled
\item[e)] Other type of civil union?
\end{itemize}

17. Employment status?

\begin{itemize}
\item[a)] Employed full time
\item[b)] Employed part time, or occasional work
\item[c)] Full-time student
\item[d)] Out of workforce: unemployed, not seeking work
\item[e)] Unemployed and seeking work
\item[f)] Homemaker
\item[g)] Retired
\item[h)] Other _________________________
\end{itemize}

18. Do you bring in household income?

\begin{itemize}
\item[a)] Yes
\item[b)] No
\end{itemize}
19. Are you the primary breadwinner in your household?
   a) Yes
   b) No

MODULE II: Family and social background

20. ¿Who did you live with during the 30 days prior to initiating treatment? (Choose all that are relevant.)
   a) Mother
   b) Father
   c) Brother or sister
   d) Grandparents
   e) Wife/husband/domestic partner
   f) Children
   a) Friends
   b) Alone
   c) With people in another institution
   d) Other_______________________________

21. ¿What has been your most frequent living situation over the past 30 days? (For those in residential treatment, indicate your situation prior to entering treatment.)
   a) In own home or family home
   b) In the home of friends
   c) On the street
   d) In an institution, shelter, or other care facility
   e) Prison or other justice system facility
Social Support Scale

22. Please indicate agreement/disagreement with each of the following statements. *(Check the option, 1 to 5)*

<table>
<thead>
<tr>
<th>Statement</th>
<th>Disagree Completely</th>
<th>Disagree Somewhat</th>
<th>Not Sure</th>
<th>Agree Somewhat</th>
<th>Agree Completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>[I/You] have people close to [me/you] who motivate and support [my/your] recovery.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>[I/You] have people close to you in your family who want to help you stay off drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>[I/You] have good friends who do not use drugs.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>[I/You] have people close to you in whom you can always confide.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>[I/You] have people close to you who understand you and your problems.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Disagree Completely</td>
<td>Disagree Somewhat</td>
<td>Not Sure</td>
<td>Agree Somewhat</td>
<td>Agree Completely</td>
</tr>
<tr>
<td>----------------------</td>
<td>---------------------</td>
<td>-------------------</td>
<td>----------</td>
<td>----------------</td>
<td>------------------</td>
</tr>
<tr>
<td>[I/You] work in places where drug use is common.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>[I/You] have people close to you who hope you can make positive changes in your life.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>[I/You] have people close to you who help you develop self-confidence.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>[I/You] have people close to you who respect you and the efforts you are putting into this program.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

**MODULE III: Characterization of substance use**

23. Identify which substances you have used during your lifetime, including alcohol and tobacco, in order of the age you first used them. *Provide code cards*

<table>
<thead>
<tr>
<th></th>
<th>First drug used</th>
<th>2nd</th>
<th>3rd</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychoactive substance (See codes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Frequency of use during the past 30 days prior to being admitted (See codes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First drug used</td>
<td>2nd</td>
<td>3rd</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>-----</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>Frequency of use during the past 12 months prior to being admitted (See codes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most frequent route of administration (See codes)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age at which you first used (write age)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age when you stopped using this substance (Write age. If you have not stopped using, write 88)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

24. What substance motivated you get help and/or enter treatment and how often, and how much did you use before being admitted? *Provide code cards*

<table>
<thead>
<tr>
<th>Name</th>
<th>How often used in the 30 days prior to being admitted</th>
<th>Number of days used in the past 30 days</th>
<th>Number of doses/ grams, on average, used each day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Main substance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second substance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Third substance</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

25. Have you ever injected a drug in your veins, in your muscles, or under your skin without a doctor’s supervision or instructions from a health professional?

   a) Yes
   b) No (skip to question 34)
26. When was the last time you injected a drug?
   a) In the past 30 days
   b) More than a month ago, but less than a year ago (12 months)

27. Which of the following drugs have you injected? (Choose as many as you have used.)
   a) Alcohol
   b) Cocaine
   c) Amphetamines/methamphetamines
   d) Heroin
   e) Ketamine
   f) Others ____________________________________________

28. How old were you when you injected for the first time?
   a) Years old _____________
   b) No response

29. The first time you injected, did you use a new needle or a needle that had already been used by someone else?
   a) New
   b) Used by another person
   c) Don’t know

30. The last time you injected, did you use a new needle or one that had been used by another person?
   a) New
   b) Used by another person
   c) Don’t know

31. During the past 12 months, on average, how many days a month did you inject drugs?
   Average number of days per month___________
MODULE IV: Treatment history

32. How many times have you been admitted to treatment for drug or alcohol use in your lifetime?
   Number of times: ___________

33. Have you been in any treatment program during the past 12 months?
   a) Yes, number of programs admitted to in past 12 months: _______
   b) No

34. Have you entered centers/programs that, although they do not offer treatment, do offer support for people in treatment and support for social, work, or family networks to prevent relapses, or to cover other needs you may have?
   a) Yes, number of centers/programs: _______
   b) No

35. Are you currently participating in one of these centers/programs?
   a) Yes, reason__________________________
   b) No

36. In what type of center/program did you last receive treatment or support?
   a) Residential
   b) Outpatient/ walk-in / drop-in
   c) Intensive outpatient/ walk-in/ (morning and afternoon at least 5 days per week)
   d) Detoxification in hospital setting
   e) Evening/nighttime center
   f) Halfway house/ social integration program
   g) Self-help group (AA/NA)
   h) Community center
   i) Other _____________________

37. Why did you leave the last treatment program/center? (Choose all that you consider relevant.)
   a) I graduated/ completed the program
   b) I was kicked out
   c) I was referred to a different program
   d) I dropped out
   e) Other reason ______________________________
38. If you dropped out, what was the reason?
   a) Because I felt I had recovered enough
   b) Because I was having financial difficulties
   c) Because I was having problems with my family
   d) Because I was having problems with that treatment center/program
   e) Because I felt that the program/center was not helping
   f) Other _________________________

39. What motivated you to enter this treatment program/center?
   a) Personal motivation
   b) Motivated by family and/or friends
   c) Motivated by school
   d) Motivated by work
   e) Obligatory/ forced
   f) Because I was invited to participate
   g) Other _________________________

40. How did you find this center/program?
   a) Contacted this center/ program directly (or spontaneously)
   b) I was referred to this treatment program/center
   c) I was referred by health network (insurance, clinic, hospital, medical practice, etc.)
   d) I was referred here by the legal system (This question should be adapted according to the context in each country.)
   e) Invited by people at this institution
   f) Other _________________________

41. What are your expectations for being admitted to this center/program?
   a) To stop using completely
   b) To stop or reduce use
   c) To get away from the police
   d) To improve things with my family
   e) Start over, go back to work/ school
   f) I have no expectations
   g) Other _________________________
42. Once you finish treatment, who will be able to help you stay clean/stay off drugs and help you sustain the goals you reach?

   a) Parents or siblings
   b) Spouse/ significant other or children
   c) Other family members
   d) Friends
   e) Professionals or staff from this center/program
   f) Self-help group
   g) No one. I can stay clean/ stay off drugs on my own
   h) Others ________________________

**MODULE V: Mental and physical health**

43. How would you describe your health currently?

   a) Very good
   b) Good
   c) Fair
   d) Bad
   e) Very bad

44. Indicate if you have been diagnosed with a chronic illness, such as:

   a) Diabetes
   b) Hypertension
   c) Cancer
   d) Chronic respiratory disease
   e) Other _____________________________

45. Indicate if you are currently receiving medical treatment for any of the following: [choose as many as are relevant]

   a) Diabetes
   b) Hypertension
c) Cancer

d) Chronic respiratory disease

e) Other _____________________________

46. Have you been diagnosed with any of the following diseases? [choose as many as are relevant]

   a) Hepatitis B
   b) Hepatitis C
   c) Tuberculosis
   d) Sexually transmitted disease (STD) (syphilis, gonorrhea)
   e) HIV/AIDS

47. Are you currently receiving medical treatment for any of the following?

   a) Hepatitis B
   b) Hepatitis C
   c) Tuberculosis
   d) Sexually transmitted disease (STD) (syphilis, gonorrhea)
   e) HIV/AIDS

48. Have you ever been diagnosed with any of the following psychiatric illnesses?

   a) Mood disorders (depression, bipolar disorder)
   b) Personality disorders
   c) Psychotic disorders (schizophrenia)
   d) Other _____________________________

49. Are you currently receiving treatment for any of the following psychiatric disorders?

   a) Mood disorders (depression, bipolar disorder)
   b) Personality disorders
   e) Psychotic disorders (schizophrenia)
   c) Other _____________________________
50. In the last 12 months, how often have you engaged in violent acts (hitting, kicking, shouting, insults, threats) or been involved in street fights?
   a) Never
   b) Once or twice
   c) About every month
   d) About every week

51. In the past 12 months, how often have you been involved in violent situations within your family (hitting, kicking, shouting, insults, threats)?
   a) Never
   b) Once or twice
   c) About every month
   d) About every week

52. In the past 12 months, have you broken the law? For example, robbery, theft, threats, kidnapping?
   a) Never
   b) Once
   c) Two or three times
   d) Four or more times

53. In the past 12 months, have you been arrested or detained for committing a crime such as robbery, theft, threats, kidnapping?
   a) Never
   b) Once
   c) Two or three times
   d) Four or more times
54. In the past 12 months, have you been arrested or detained just for using drugs?
   a) Never
   b) Once
   c) Two or three times
   d) Four or more times

55. In the past 12 months, have you been chased by the police or other security forces for no reason? (For example, just for being with your group of friends in your neighborhood or area?)
   a) Never
   b) Once
   c) Two or three times
   d) Four or more times

MODULE VII: Clinical review form
(Prior to going over this form with the patient, you should obtain authorization from the patient, and the patient should sign an informed consent form.)

56. Is there an individual clinical form for each patient?
   a) Yes
   b) No

57. Diagnosis for drug use disorder
   a) Dependence
   b) Harmful use
   c) Abuse

58. Diagnosis of psychiatric disorder associated with drug use (ICD-10)

59. Diagnosis of physical disability
60. Comprehensive treatment plan and time stipulated in treatment.

   a) No
   b) Yes

THANK YOU!

Name of interviewer_____________________________________

Signature of interviewer__________________________________
Appendix 2:
Instructions for Users Questionnaire

The purpose of this questionnaire is to characterize the population currently receiving treatment for drug abuse or dependence in a treatment center or similar facility.

Prior to applying this questionnaire, it is important to read the informed consent form and respond to any questions the client may have. In no way should clients feel pressured, nor should they be led to believe that their treatment at this center is conditional upon their response.

This questionnaire contains eight modules; each module contains a series of questions for that area. The modules are the following:

1. Socioeconomic background of the interviewee
2. Family and social background
3. Drug use history
4. Previous treatment history
5. History of family substance use
6. Mental and physical health
7. Social support
8. History of conflict with the law
Each of the above conceptual areas provides important information for understanding and describing the subject. The order of the modules allows the interviewer to begin the interview with questions regarding everyday life and moves forward from there.

Some considerations prior to the interview:

- The interviewer has an essential role in ensuring that the entire questionnaire is completed. The interviewer should understand the objectives of the study in order to properly explain the purpose to the client.

- No questions should be added or removed from the questionnaire.

- The interviewer should not impose his or her own opinions or responses, nor should he/she indicate what they are. The interviewer must ask only the questions on the questionnaire and take note of the responses from the interviewee.

- It is important to make clear to the interviewee that all information shared is confidential and will be used only for statistical purposes.

- The interviewer should read each question clearly and be sure the client fully understands each one before requesting a response. Given the population, it is likely that dialogue will be difficult to initiate, and understanding what is being asked may require help from the interviewer. In such a case, use appropriate synonyms when required.

- The questionnaire refers to different time periods: lifetime, past 12 months, past 30 days, past four months, etc. The interviewer should ensure that the client has understood each time period and responds appropriately.

- When changing from one conceptual area to another in the questionnaire, the interviewer should make an introduction to the new topics, to help the interviewee focus on the new aspects. For example, “Okay, now I am going to ask you about the treatment programs in which you have participated....”

- The questionnaire should not be applied to people who are under the influence of alcohol or drug use or are in a state of confusion (e.g. due to medication, illness etc.).
**Questionnaire**

Identification of the client: An identification code should be used for each interviewee. An example of how a code might be created: Apply initials from any of the first, middle, or last names, followed by day, month, and year of birth, e.g. Pedro Pablo Guevara Rojas, born November 2, 1975, could be coded as PGR021175.

**Background and Sociodemographics Module**

This module asks about age, sex (assign according to what the client states), and children. In the case of children, the question refers only to the children the client currently cares for. This question is meant to determine the number of children for whom the client is currently responsible in order to understand family and other needs. The question on migration/immigration status should be adjusted according to the laws in each country and should demonstrate needs that must be met such as residential needs, in order to assist and support the person during social integration. Ethnic group and/or race should be adapted according to the reality in each country.

This module also addresses other potential needs such as social security, education, and employment. There are two questions regarding relationships; the first refers to living with another person, and the second refers to marital status.

**Family and Social Background Module**

It is helpful to know what the family unit has been during the prior 30 days: With whom did you live during the last 30 days before entering treatment? Ten answer choices are offered. Select as many as are relevant.

With regards to the question: What has been your most frequent living situation in the last 30 days? Responses should be single answers only. For clients in residential treatment, the question refers to their situation prior to entering treatment.
This module applies a scale to measure the degree of social support; the Social Support aspect of the SOCFORM Social Functioning Scale (Texas Christian University) is used. This form was developed for patients undergoing treatment and has also been validated in the Latino population in the United States. The scale comprises nine statements to which the respondent must reply, according to the options: I totally agree, I somewhat agree, I am not sure, I do not agree.

The statements should be read calmly, and if necessary repeated, until the client understands the meaning and is able to express his/her opinion. Note, if the client responds “I do not know,” this is considered equivalent to “I’m not sure.” If the client does not wish to respond, the item is left blank.

**History of Drug Use Module**

This module explores the client’s history of drug use in chronological order. In other words, it identifies the drug of initiation or first drug ever used, followed by the second drug, third, and so on sequentially. (Space is available for six drugs, but if the interviewee has used more than six, please note it on an additional sheet of paper.) It is also important to ensure that the interviewer remind the client that both tobacco and alcohol are considered psychoactive substances and therefore should be included.

The following questions should be asked regarding the first three substances the client used in his or her lifetime, and in chronological order:

- Frequency of use during the 30 days prior to entering the program.
- Frequency of use during the 12 months prior to entering the program.
- Most frequent route of administration.
- Age when used for the first time. (Age of initiation).
- Age at which the client stopped using, or age the last time he or she used the substance.
Answers should be noted according to the codes below. In order to ensure a smooth interview, the code cards should be printed prior to beginning the session.

This module also asks about the drug that motivated the client to seek treatment. The purpose is to identify the substance that produces the most dysfunction in the person’s life, and therefore the drug upon which to focus. It may be that there is more than one drug that motivated entering treatment; in that case, the information should be filled out for each drug.

Injection drug use (excluding medication administered via syringe and with medical supervision) provides valuable information for monitoring, particularly in countries where injection drug use is low or negligible and is difficult to capture in surveys. If the interviewee responds that he or she has never used injection drugs, you should end this module and move on to the next. For those who indicate that they have used injection drugs, you should continue with the questions regarding which drugs were used, frequency, and use of new or used syringes.

History of Previous Treatment Module

In this module, the interview focuses on previous treatment experiences. This population tends to have a high rotation between institutions, although it may be for short periods of time. The main goal is to register the experience distinguishing lifetime and past 12 months. In addition, information should be added regarding the last treatment program the person attended/was admitted to, the type of center, and completion status upon exiting the program.

Regarding the current program, the interviewer should ask about the motivations for entering treatment, how they chose that center, what type of treatment program they are doing, what are their expectations, and what support will they have once the program is completed.
Mental and Physical Health Module

This module seeks to describe the needs that may be covered by healthcare (access to care), as well as understand the person’s perception about his or her state of health. For this we use a general health perception question and questions about acute, chronic, and mental illness.

Conflict with the Law Module

This module looks at three important issues. The first refers to the client’s participation in violence or violent events, whether domestic or public. The second issue refers to the commission of crimes, or acts punishable by law. Finally, this module looks at the perception of police harassment, or similar events, by police or other law enforcement suffered by the interviewee in the past 12 months.

Clinical Record Review Module

Individual clinical records are an important tool for health care, in addition to providing key indicators and information for researchers. Clinical records should be made by a health professional.

The other questions look at diagnoses received by health professionals, whether a psychiatric comorbidity exists, whether there is a physical disorder, and what therapeutic program has been developed for the client.
INFORMED CONSENT
Appendix 3: Informed Consent

Dear Mr./Miss/Ms./Mrs. ___________________________

The National Drug Commission is carrying out a study to characterize the individuals who are receiving care or treatment for psychoactive substance use and describe their needs. The purpose of this study is to understand the treatment and care needs of people with problematic substance use in order to improve existing programs in the country. Your participation in this study will entail answering a questionnaire on topics related to your personal life, such as education/studies, family, occupation, health, substance use, treatment received for substance use, among other things, in addition to questions regarding needs with respect to substance use. In addition, we would like to obtain information from your clinical admission form, including clinical diagnostic, psychosocial, and comorbidity information, recommended therapeutic plan, and treatment modality. Participation in this study is entirely voluntary, and you are free to refuse to participate or withdraw at any time. All information collected through this study will be confidential and will not be shared with the center where you are currently receiving treatment.

If you have any questions or concerns regarding this study, you may contact (include the reference for the contact person, telephone/email and their title or function). We would like to thank you for your participation in this study and for sharing this valuable information, which will improve public health policy in the future.

Date….. I declare that I have read and understood the above informed consent statement regarding my participation in this study. I hereby acknowledge that I accept the conditions and agree to participate.

__________________________________________  ______________________________
Signature of interviewee                      Name and signature of interviewer
QUESTIONNAIRE FOR TREATMENT CENTERS
Appendix 4: Questionnaire for Treatment Centers

Characterizing Drug and Alcohol Treatment Centers

MODULE I: Identification of the Center

1. Name of center: ____________________

2. Date: _____/_____/_______

3. Name of person filling out form: _______________________________________

4. Position/s: ________________________________________________________

5. Number of years in position: __________________

6. Address (region if applicable):_________________________________________

7. Telephone: _________________________________________________________

8. Email: _____________________________________________________________

9. Web page address (URL): ________________________________
MODULE II: How the Center Operates

10. Agency (Does center operate independent of its funding? May be public and receive private funds) 
   (Note: Distinctions between non profit and not-for-profit may vary by country)
   
   a) Public
   b) Private, non profit
   c) Private, not-for-profit
   d) Private, profit

11. Funding: (indicate all appropriate)
   
   a) Public
   b) Private contributions
   c) Donations
   d) Client payments
   e) Other

12. Public health codes in force
   
   a) Yes
   b) No

13. Type of care:
   
   a) Outpatient/day program
   b) Residential
   c) Mixed

14. Type of treatment center
   
   a) Primary care office
   b) Outpatient hospital
   c) Psychiatry service in general hospital
   d) Hospital or psychiatric clinic
   e) Psychiatric emergency unit
   f) Therapeutic community
15. Which of the following best reflects the main objective of the care your center provides?

a) Eliminate use
b) Reduce use
c) Mitigate the causes of use
d) Reduce the consequences of use

16. Do people who access treatment always do so on a voluntary basis?

a) Yes
b) No

17. Does the center have evidence-based clinical protocols or guidelines for the treatment of its patients/users?

a) Yes
b) No

18. Is there an individual history record or record?

a) Yes
b) No (skip to question 21)

19. Is an individual treatment plan made in the record of the medical record?

a) Yes
b) No

20. Is the family included in the therapeutic process?

a) Yes
b) No
MODULE III: Treatment Capacity

21. What were the expenses your center incurred for each case during the past year?
   
   a) Expenses due to therapy __________
   b) Expenses due to client dropout __________
   c) Expenses for expulsion __________
   d) Transfer or diversion fees ______
   e) No information ___________________

22. Capacity of care for residential centers (only residential centers should answer)
   
   a) Number of available beds _________________________________
   b) Average length of residential treatment________________________

23. Care capacity for outpatient centers (only outpatient centers should answer)
   
   a) Average number of people attending to in one month: __________
   b) Average number of times someone attends the center in one week: __________
   c) Average length of stay each day someone attends the center: __________
   d) Average length of outpatient treatment: ______________________

24. If you are an outpatient facility, do you have a strategy to enable users with children to go for treatment? (only outpatient centers should answer)

   a) Yes
   b) No
   c) What is it? __________
25. The population that your center serves is:
   a) Only men
   b) Men and women
   c) Only women

26. The population that your center serves, by age, is (check all that apply):
   a) Children under 10 years
   b) Adolescents between 10 and 15 years old
   c) Adolescents ages 15-20
   d) Adults 21 years and over

27. Population by social insurance (check all that apply)
   a) Public health insurance
   b) Private health insurance
   c) Uninsured or indigent

28. Population by clinical diagnosis (check all that apply)
   a) Substance abuse
   b) Dependence
   c) Dependence and other associated psychiatric pathology

29. According By specific populations (check all that apply)
   a) Pregnant women or children
   b) Street people
   c) Individuals serving a sentence on release/parole
   d) LGBTQ
   e) Other _____________________________
30. What services are provided at the center? Check all that apply

<table>
<thead>
<tr>
<th>Type of Activity</th>
<th>YES</th>
<th>Performed by</th>
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<tbody>
<tr>
<td>Diagnostics</td>
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<tr>
<td>Mental health consultation</td>
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<td>Psychiatric consultation</td>
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<tr>
<td>Medical consultation</td>
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<td>Psychosocial group intervention</td>
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<td>Individual counseling</td>
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<td>Family counseling</td>
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<td>Home visit</td>
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<td>Self-help activities</td>
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<td>Formal educational activities</td>
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<tr>
<td>Educational activities</td>
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<tr>
<td>Telephone support</td>
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<tr>
<td>Post-treatment follow-up/</td>
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<tr>
<td>Follow up services</td>
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<tr>
<td>Activities with community</td>
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<tr>
<td>groups and organizations</td>
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</tr>
</tbody>
</table>

31. Does the center provide laboratory testing?

   a) Yes, because it has its own laboratories in the same center.
   b) Yes, they are carried out through the public health care network.
   c) Yes, it has agreements with specific laboratories.
   d) It can request them, but the users must go to particular laboratories for tests.
   e) It does not have laboratory testing.

**MODULE VI: How the Network Operates**

32. Patients are referred to the center by (check all that apply)

   a) Drop-in, individual choice to request consultation
   b) Referred by health care centers
   c) Referred by the judicial system
   d) Referred by any social or health care facility
   e) Other __________________________
33. The major patient / user referral needs are

a) Referral to centers of greater complexity that can provide the necessary treatment
b) Referral to centers that provide appropriate care based on the type of population or condition
c) General medical evaluation
d) Pharmacological management
e) Community centers to support social integration (educational or occupational)
f) Halfway house
g) Self-help groups (support and follow-up to therapeutic gains)
h) Other ____________________________

34. Can these referral needs be met?

a) Yes
b) No, why? ____________________________

35. How would you evaluate the operation of the referral mechanism?

a) It exists, but it is not always effective
b) Effective (referred) patients are received by another center in a timely manner

c) It does not exist formally and only works through personal contacts between technicians or professionals at the centers / facilities
d) No referrals are made

36. Do you perform coordinated and systematic work with social and health care facilities?

a) Yes
b) No (skip to question 39)

37. What kind of social and health care facilities do you coordinate with?

a) Self-help groups
b) Community or social support center
c) Residential treatment centers
d) Local clinics
e) Other, specify_____________________
38. Is there a waiting list of users to enter your center?
   a) Yes, how many people are on the list at this time______________
   b) No

MODULE VII: Human Resources

39. What human resources does your center have?

<table>
<thead>
<tr>
<th>Position</th>
<th>Length of Contract</th>
<th>Type of contract</th>
<th>Training in dependence Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
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<tr>
<td>Psychiatrist</td>
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<td>Medical toxicologist</td>
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<tr>
<td>Infection doctor</td>
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<td>Psychologist</td>
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<td>Social worker</td>
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<td>Nurse</td>
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<td>Occupational therapist</td>
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<td>Family counselor</td>
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<tr>
<td>Teacher</td>
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<tr>
<td>Religious adviser</td>
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<tr>
<td>Therapy provider (Rehab technician)</td>
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<tr>
<td>Length of Contract</td>
<td>Type of contract</td>
<td>Training in dependence Y/N</td>
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<tr>
<td>Former addict</td>
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<tr>
<td>Nursing assistant</td>
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<tr>
<td>Case worker</td>
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<td>Other</td>
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<tr>
<td>Secretary</td>
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<tr>
<td>Administrative staff</td>
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<td>Security</td>
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<td>Janitorial</td>
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<tr>
<td>Nutrition</td>
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<tr>
<td>Others</td>
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</tbody>
</table>

**MODULE VIII: Technology and Information Systems**

40. Does the facility have any of these services? Check the option or options that best describe your circumstances:

   a) Traditional telephone system
   b) Cellular telephones
   c) Internet access
   d) Website
   e) Institutional email
41. There are computers in the facility for

a) Administrative use  
b) Use of professionals and technicians  
c) Clients

THANK YOU VERY MUCH

Interviewer name_______________________________________
Signature of interviewer_____________________________________
CHARACTERIZATION OF SOCIAL AND HEALTH CARE FACILITIES
Appendix 5: Characterization of Social and Health Care Facilities

MODULE I: Identification of the Center

1. Date: _____ / _____ / ______
2. Name of center: _______________________
3. Name of respondent: ______________
4. Position(s): ______________________________
5. Senior Center: _______________________
6. Address: _______________________________
7. State: _______________________________
8. Phone: __________________________________
9. Website___________________________________

MODULE II: Operation of the Center

10. Private vs Public (Does the center operate independent of its funding sources? May be public and receive private funds) (Note: Distinctions between nonprofit and not-for-profit may vary by country)
   a) Public
   b) Private, nonprofit or not-for-profit
   c) Private, profit
11. Financing: (indicate all appropriate)
   a) Public
   b) Private contributions
   c) Donations
   d) Client payments

12. Public health codes in force
   a) Yes
   b) No

13. Type of Care:
   a) Outpatient/day program
   b) Residential
   c) Mixed

14. Type of Treatment center
   a) Therapeutic community
   b) Psychiatric emergency unit
   c) Hospital or psychiatric clinic
   d) Psychiatry service in general hospital
   e) Other, specify: ______

15. Which of the following best reflects the main objective of the care your center provides?
   a) Eliminate use
   b) Reduce use
   c) Mitigate the causes of use
   d) Reduce the consequences of use
   e) Other, specify: ______

16. Is the family incorporated into the therapeutic process?
   a) Yes, how?____
   b) No
MODULE III: Treatment Capacity

17. How many people receive services in your center per month? ______________

18. What is the average time per service / per person? _________________

19. Treatment capacity in residential settings (only respond if this center provides residential services)
   a) N° of beds ______________

20. Treatment capacity for outpatient services (answer only if this center provides outpatient services)
   a) Average number of persons treated per month:_____________
   b) Average number of service requests per week:______________
   c) Average length of treatment stay:______________

21. Do you have options for users with children to attend treatment sessions? (answer only if the center provides outpatient services)
   a) Yes, Describe ______________
   b) No

MODULE IV: Target Population

22. The population that your center serves is
   a) Only men
   b) Men and women
   c) Only women

23. The population that your center serves, by age, is (check all that apply):
   a) Children under 10 years
   b) Adolescents between 10 and 15 years old
   c) Teenagers ages 15-20
   d) Adults 21 years and over
24. Insurance status (all that apply)
   a) Public health insurance [individual countries define, for example, Medicaid, Medicare]
   b) Private health insurance
   c) Uninsured

25. By specific populations (check all that apply):
   a) Pregnant women or children
   b) Street people
   c) Persons serving a sentence while on release/parole
   d) LGBTQ
   e) Other _____________________________

MODULE V: Portfolio of Services

26. What type of service does the facility offer?
   a) Food
   b) Personal grooming
   c) Clean clothing
   d) Recreational workshops
   e) On-site training workshops
   f) Employment orientation
   g) Support in entering the general health care network
   h) Support in joining the social safety net
   i) Self-help activities
   j) Activities with community groups and organizations

27. Community Participation. Benefits offered by the center, mark all that apply

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes</th>
<th>Who performs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnostic services</td>
<td></td>
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<tr>
<td>Medical consultation</td>
<td></td>
<td></td>
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<tr>
<td>Psychosocial Group Intervention</td>
<td></td>
<td></td>
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</tbody>
</table>
Individual Counseling  
Family Counseling  
Home visit  
Self-help activities  
Formal educational activities  
Educational activities (workshops, art, recreation, etc.)  
Telephone support  
Follow-up post  
Activities groups and organizations  
Other

MODULE VI: Network Operations

28. How are persons referred to center?
   a) Drop-in, individual choice  
   b) Health center referral  
   c) Drug treatment center referral  
   d) Judicial system referral  
   e) Other _______________________

29. The primary referral needs are
   a) Drug treatment referrals  
   b) General medical evaluation  
   c) Other _______________________
30. Is the center able to cover these needs?
   a) Yes
   b) If not, why not? _________________________

31. How would you evaluate the referral process?
   a) It exists but is not always effective
   b) The referral process is effective (referrals are received in a timely manner)
   c) No information exists, network only functions through personal contacts between personnel at the center.
   d) There is no referral process

32. Is there a waiting list or register of persons awaiting admission?
   a) Yes, number of persons presently on list______________
   b) No

MODULE VII: Human Resources

33. What are the human resources available at the center?

<table>
<thead>
<tr>
<th></th>
<th>Length of Contract</th>
<th>Type of contract</th>
<th>Training in drug dependence Y/N</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practitioner</td>
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<tr>
<td>Psychologist</td>
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<td>Social assistant</td>
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<td>Nurse</td>
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<td>Occupational therapist</td>
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<td>Family counselor</td>
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<td>Role</td>
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<tr>
<td>Teacher</td>
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<tr>
<td>Religious</td>
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<tr>
<td>Other</td>
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<tr>
<td>Therapeutic support (Rehabilitation Technician)</td>
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<tr>
<td>Former addict</td>
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<tr>
<td>Nursing Assistant</td>
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<td>Other</td>
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</tbody>
</table>

**MODULE VIII: Technology and Information Systems**

34. Does the facility have any of these services? Check the option or options that best describe your circumstances:

a) Landline telephone
b) Cellular telephone
c) Internet
d) Website
e) Institutional email
35. There are computers in the establishment for

a) Administrative use
b) Use of professionals and technicians
c) Others

Date_______________________________________
Interviewer_________________________________
Interviewer's signature_______________________


About the Observatory:

The Inter-American Observatory on Drugs (OID) was created in 2000 as the statistics, information and research branch of CICAD.

Our mission is to help promote and build a drug information network for the Americas that offers objective, reliable, up-to-date and comparative information so that member states can better understand, design and implement policies and programs to confront the drug phenomenon in all its dimensions.