

Risk profile of individuals served by community treatment in Latin American countries: a cross-sectional study

Abstract

Aims: knowledge about the risks lived in communities across Latin America can subsidize the planning of care actions. This study aims to describe dimensions and intensity of personal and contextual risks of community residents accompanied by Community Treatment teams in 11 Latin American countries.

Methods: a cross-sectional study with 675 people accessed by Community Treatment teams. Standardized information was collected using the System of Evaluation of Results on education, substance and alcohol use, job, safety, health, primary network, housing, and basic care. Each dimension had its risk level evaluated (No risk, Moderate risk, and High risk).

Results: a sample of 54,6% men and 46,4% women; 41,9% aged between 22 and 41. The component with the highest prevalence of high risk was Housing (27.1%), Health (1.1%) with the lowest rate of high risk. Some countries peculiarities: Brazil presented the highest high risk in Education (35.1%), Mexico in Personal Safety (33.3%) and Housing (89.5%), Colombia in Substance Use (12.9%), Job (12.6%) and Basic care (18.9%) and Argentina in Primary network (17.4%).

Conclusion: the study highlights preeminent risk areas in Latin American countries. Specificities and local diversities concerning the different dimensions studied indicate the need for strategic planning considering peculiarities of the contexts of each community and country.

Keywords: community, risk, vulnerability, community treatment

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Raquel da Silva Barros,¹ André Bedendo,²
Efrem Milanese,³ Ana Regina Noto⁴

¹Department of Psychobiology, UNIFESP, São Paulo, Brazil

²Department of Health Sciences, University of York, United Kingdom

³Centro Universitário Facens, Sorocaba, Brazil

⁴Department of Psychobiology, UNIFESP, São Paulo, Brazil

Correspondence: Raquel da Silva Barros, Department of Psychobiology, UNIFESP, São Paulo, Brazil

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Introduction

In Latin America, little is known about local vulnerabilities and strategies to address them, and such knowledge is essential to subsidize the planning of care actions. In 2019, 17 million people presented harmful drug use with approximately 24 000 deaths in Latin America and the Caribbean¹ which demonstrates the significant importance of the topic for public health.² Many of these impacts are avoidable and find effective responses in prevention and treatment strategies.³ However, one of the great challenges in developing these strategies is the identification of environmental aspects, playing an important role both at the beginning and during the development of these conditions.⁴ Evaluating the available resources and present vulnerabilities is a central aspect of the identification and management of the risks at a community level.⁵

People, families, and communities are vulnerable when they do not have the material and immaterial resources to successfully face the risks to which they are subjected. Risk is the “probability” that a certain event may have harmful consequences for a person, a family, or a community.⁶

Concepts of vulnerability and risk presuppose the perspective of transience, focused on structural conditions, such as the contexts and communities in which the individual is inserted. Similar concepts were elaborated by other authors explaining areas of vulnerability, focusing on specific populations such as people being homeless, in policies, in the relationship between youth violence and social vulnerability, related to treatment resources,⁷ gender⁸ and social power relations.⁹

Most drug use research is carried out with populations in institutional contexts: schools, universities, clinics, or hospitals.¹⁰ However, the development of public policies should consider individuals in their multiple dimensions and generate proactive dynamics that support the protagonism of users and their communities. Healthcare strategies at a community level require an adequate understanding of the territory, and alternative public health an approach to the population understanding their practices and organization highlighting the co-protagonism of individuals, groups, and social movements.¹¹ Despite the existence of such initiatives, these are still limited to community protagonism and its power in policy development.¹²

Studies on risk and protection factors associated with drug use, for example, usually use a binary view: total presence or absence of that behavior.¹³ Consequently, these studies lack a more holistic and integrative view of aspects associated with protection and risk associated with drug use. The lack of this expanded view favors the stigmatization of people and communities that are described mainly by negative behaviors or lifestyles, based on deficiencies, problems, vulnerabilities, and maladaptive behaviors.¹⁴ Finally, these tend to produce control strategies and policies with little or no emphasis on the potentialities of individuals and contexts in which they are inserted.

Community Treatment (CT), a strategy developed in Latin America by social organizations supported with funds and technical consultancy from UNESCO, the European Union, the German Government through DCV, has a methodology that stands out as an alternative to traditional models. It privileges to focus on community resources: friendly

relations and friendships that structure the informal social network. The CT teams operate in a network from a resource perspective¹⁵ and investigate people's behaviors in their different dimensions: substance use, educational characteristics, health and access to it, housing, social network, guarantee of fundamental rights, and safety. Through the American Network for Intervention in Social Suffering Situations (RAISSS), CT has gained breadth in 11 Latin American countries. This study proposes to describe the sociodemographic characteristics and the intensity of multiple individual and contextual risks of people living in vulnerable communities who were under the care of CT teams in 11 Latin American countries.

Material & methods

Design/Procedure

This is a cross-sectional study describing individuals' characteristics of CT (Community Treatment) clients during a period of 1 to 3 years between 2002 and 2019. Participants were recruited and treated by CT teams in open communities across 11 Latin American countries: Argentina, Brazil, Bolivia, Chile, Colombia, Costa Rica, Haiti, Mexico, Peru, Paraguay, and Uruguay, all of which are part of RAISSS.

Participants

Community Profile and its Relationship with Community Treatment. In Mexico, Haiti, and Costa Rica, communities spontaneously outreached TC teams through community actors (parishes, citizen associations, formal groups, et.). In Argentina and Uruguay communities were linked to governmental support. The longest cooperation time was with communities from Colombia, Chile, Bolivia, Peru, Brazil, and Paraguay.

Sample construction process

Participants were accessed based on their vulnerability, as evaluated by the local team. The CT process involved weekly team activities to establish cooperative relationships with all community actors and to map resources and individuals in need of or asking for support. Between 2002 and 2019, 6 159 individuals sought support from 32 CT teams¹⁶ from 11 countries through actions related to the eight dimensions mentioned above within a structures care process. The sample for this research consists of 675 individuals (13.5%) out of the 6 159 who established initial contact with the team. All 675 participants met the inclusion criteria for the study, which were:

- I. CT duration between 9 and 24 months
- II. At least 2 weekly participations in community activities
- III. Risk assessment at T0 and T1

The exclusion criterion was not having attended the activities for more than 4 months.

CT Process description

As part of this structured process, CT work began once the network with the community had been established. It was implemented through the accompaniment of "partners" (users), individuals in vulnerable situations who sought support to reduce risks and vulnerabilities. During the treatment process, the community networks and the CT team carried out various bonding actions within the community, aiming to maintain the previously established networks and to create new subjective networks with each of the individuals being followed.

The follow-up process consisted of defining weekly and monthly goals to support the integration of vulnerable individuals with key actors in local community networks, as well as with service networks and institutions.

Bonding work was repeated throughout the process, mapping and organizing different networks with the goal of building a voluntary, non-formal support system that strengthened the team's work. Each intervention was documented in a collective field diary, and the existing networks were made visible, considering the characteristics and social roles of individuals within the community. As previously mentioned, CT actions extended across several areas, such as basic care, education, substance use, safety, health, occupation, housing, and social relationships.

Social roles of individuals—both in the context of the community and among vulnerable groups—were organized according to these categories to better understand the community's reality and its capacity to provide holistic care. For community treatment to be truly effective, it was essential that networks of action existed within the community, covering these or other complementary aspects. The objective of CT was to expand and diversify subjective networks, making individuals (partners) more protected and resilient, thereby reducing their vulnerabilities. The construction of these subjective networks focused on the highest-risk areas for each person. This strategic methodology across 11 countries aimed to improve individual risk profiles by building protective, community-based networks and integrating vulnerable individuals into broader systems of support.

Instruments

Three tools were used for data collection: First Contact Sheet, Field Diary, and System for Evaluation of Results (SER in Spanish) 15. These are standardized instruments designed for individual record-keeping by team members during their work, to systematically document the CT process.

First contact sheet

Records information about when, who, and how the initial contact was established; including sociodemographic data (age, sex), family structure, education, marital status, employment, observed vulnerability.

Field diary

A qualitative tool in which the information derives from CT professionals. It includes events, meetings, relationships, characteristics of people, activities, problems, perceptions, analyses, information, and data of teams and networks' daily life.

The system of evaluation of results (SER)

The System of Evaluation of Results (SER) is a quantitative tool that systematizes information collected through the Field Diary and/or First Contact Sheet. This information is organized into eight dimensions (Table 1), which correspond to aspects of education, substance and alcohol use, job, safety, health, primary network, housing, and basic care. Specific indicators represent the risks experienced by the participant in the last 90 days. The indicators are coded using a six-item Likert scale (0: risk factor was not observed; 1: observed only once; 2: observed more than once, but without a regular pattern; 3: observed more than once with a regular pattern; 4: indicator observed frequently and with a regular pattern; 5: indicator observed continuously).

Table 1 Dimensions and Indicators of the System of Evaluation of Results (SER)

Axis	Number of Indicators	Indicators
Education	4	He/she lacks of resources to pay necessary expenses to study, did not complete primary or secondary school, cannot read and/or write.
Substance use	8	He/she uses drugs alone, frequents places where drugs are used and sold, uses drugs in risky places, traffics drugs to sustain use, uses injectable material, uses different drugs simultaneously, doesn't control the quality of the substance, prostitutes to use drugs.
Job	6	She/he has an illegal occupation, is unemployed, works where drug use is promoted, has high-risk work with drugs and safety, works in a context of labor exploitation, maintains oneself with money produced in illegal activities, and doesn't have a job and productive skills.
Safety	6	She/he lives in a high-risk community, carries out illegal activities, carries weapons, is violent with others, commits robberies, and has sexual relations in high-risk places or with high risk people.
Health	6	She/he lacks of access to vital medications, doesn't treat STIs and HIV, have a disease and doesn't treat it, doesn't use condoms, uses drugs being pregnant, doesn't have periodic medical exams.
Primary Networks	8	She/he participates in groups with people at high risk of criminal activities, drug use, or violence, has links with drug users or people on the margins of the law, is discriminated against by people he or she hangs out with, doesn't have family or affective ties, lives events of intrafamily violence, has family members dependent on drugs, has abandoned the family, his or her family is in a condition of extreme poverty, he or she is alone.
Housing	4	He/she lives in public spaces in the open air, lives in places without basic services, lives in rented poor accommodation, lives with high-risk people.
Basic Care	10	He/she, changes clothes once a week, takes a bath less than once a week, doesn't t have a place to take a bath, doesn't have clean clothes, doesn't take care of the cleanliness of where one lives, washes clothes less than once a week, eat less than once a day or goes days without eating.

Data collection

The CT teams that carried out the data collection composed of 3 to 5 people (including professionals, community leaders, and peer educators), who were trained and certified to work in communities. All data collection was carried out during the CT teams' work in the field.

Data analysis

Descriptive analyses were performed using mean and standard deviation for continuous data and N and frequency for categorical data. Countries with a sample size smaller than 30 (Peru, Paraguay, Uruguay, Chile, Haiti, Bolivia) were combined and coded as Other. The comparison between countries was carried out using the chi-square test with the exact Montecarlo method, a 95% confidence interval, and using 10 000 samples for p-value correction. Standardized residuals

were used to identify statistically significant differences. Responses using the SER instrument were categorized as no risk (Response = 0), moderate risk (1 to 3), high risk (4 or 5). The data were analyzed using the statistical software SPSS version 20 and considering a minimum level of statistical significance of 5%.

Ethical aspects

The project was submitted and approved by the Ethics Committee. Data were anonymized with no identification of person or institution. The CT teams signed the Data Use Consent Form.

Results

Of the 675 participants, 369 (54.6%) were male, and 41,9% between 22 and 41 years old; age ranges varied significantly between countries ($\chi^2(16) = 131.327$ $p < 0.001$). See on the Table 2, below, the sample's ages and genders distribution by countries.

Table 2 Sociodemographic characteristics of the sample

	Argentina (n=197)	Brazil (n=148)	Colombia (n=202)	Mexico (n=57)	Others (n=71)	Total (n=675)	χ^2 (test)	P- value
Gender – N (%)							10,9	0,205
Feminine	100 (50.8)	60 (40,5)	88 (43,6)	28 (49,1)	26 (36,6)	302 (45%)		
Masculine	96 (48.7)	88 (59,5)	111 (55,0)	29 (50,9)	45 (63,4)	369 (54,6%)		
Transgender	1 (0,5)	0	3 (1,5)	0	0	4 (0,4%)		
Age group – N (%)							131.327	0,001
<= 21	61(31,1)	27 (18,2)	29 (14,4)	10 (17,5)	17 (23,9)	144 (21,3)		
22 to 41	52 (26,5)	69 (46,6)	105 (52,0)	32 (56,1)	24 (33,8)	282 (41,9)		
42 to 60	13 (6,6)	37 (25,0)	48 (23,8)	9 (15,8)	11 (15,5)	118 (17,5)		
61 or more	70 (35,7)	15 (10,2)	20 (9,9)	6 (10,6)	19 (26,8)	130 (19,3)		

Level of risks

As illustrated in Figure 1 a moderate level of risk is the most common evidence, focused mainly on Primary Network (67%), Job

(57.8%), Substance Use (49.7%), and Education (49.6%). No risk was prevalent for health t (54%), and basic care (48,6). Housing presented the highest percentage of high risk 27.1%).

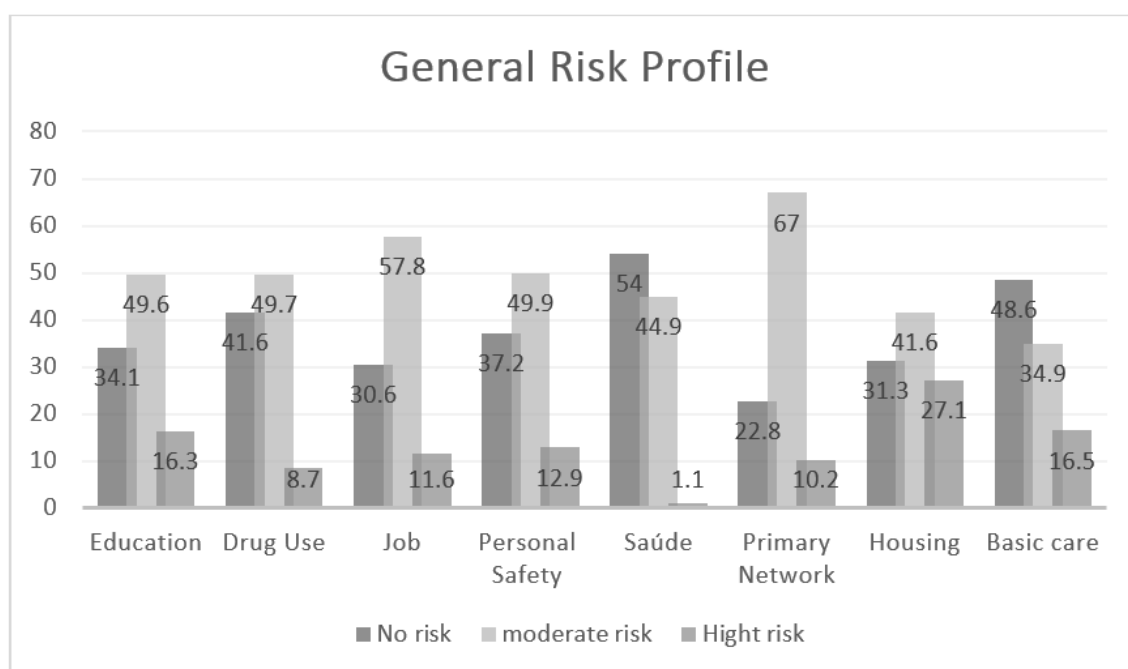


Figure 1 General Risk Profile of the sample by dimensions of risks for all 11 countries.

Risk profile and countries

Risk profile by countries will be described using data of Table 3 focusing on each one of the components separately.

Table 3 Comparison of risk levels for each risk dimension and between countries Dimensions

Dimensions	No Risk N (%)	Moderate risk N (%)	High risk N (%)	X2 (Pearson/ Monte Carlo)	P-value
Education				129.623	0
Argentina	98 (49.7)	74 (37.6)	25 (12.7)		
Brazil	31 (20.9)	65 (43.9)	52 (35.1)		
Colombia	34 (16.8)	139 (68.8)	29 (14.4)		
Mexico	37 (64.9)	19 (33.3)	1 (1.8)		
Others	30 (42.3)	38 (53.5)	3 (4.2)		
Total	230 (34.1)	335 (49.6)	110 (16.3)		
Substance Use				64.587	0
Argentina	82 (41.6)	98 (49.7)	17 (8.6)		
Brazil	90 (60.8)	54 (36.5)	4 (2.7)		
Colombia	66 (32.7)	110 (54.5)	26 (12.9)		
Mexico	9 (15.8)	48 (84.2)	0 (0)		
Others	35 (49.3)	28 (39.4)	8 (11.3)		
Total	282 (41.8)	338 (50.1)	55 (8.1)		
Work				59.198	0
Argentina	68 (34.7)	100 (51)	28 (14.3)		
Brazil	67 (45.6)	72 (49)	8 (5.4)		
Colombia	43 (21.6)	131 (65.8)	25 (12.6)		
Mexico	4 (7.5)	48 (90.6)	1 (1.9)		
Others	22 (31)	34 (47.9)	15 (21.1)		
Total	204 (30.6)	385 (57.8)	77 (11.6)		
Safety				63.256	0.015
Argentina	60 (30.6)	112 (57.1)	24 (12.2)		
Brazil	81 (55.9)	56 (38.6)	8 (5.5)		
Colombia	76 (38)	101 (50.5)	23 (11.5)		
Mexico	4 (7)	34 (59.6)	19 (33.3)		
Others	28 (39.4)	31 (43.7)	12 (16.9)		
Total	249 (37.2)	334 (49.9)	86 (12.9)		

Table 3 Continued....

Health				35.023	0
Argentina	103 (53.6)	86 (44.8)	3 (1.6)		
Brazil	99 (68.8)	43 (29.9)	2 (1.4)		
Colombia	108 (55.1)	88 (44.9)	0 (0)		
Mexico	19 (33.3)	38 (66.7)	0 (0)		
Others	27 (38.6)	41 (58.6)	2 (2.9)		
Total	356 (54)	296 (44.9)	7 (1.1)		
Primary Network				52.656	0
Argentina	41 (21.6)	116 (61.1)	33 (17.4)		
Brazil	46 (33.1)	89 (64)	4 (2.9)		
Colombia	40 (21.9)	132 (72.1)	11 (6.0)		
Mexico	3 (6.3)	44 (91.7)	1 (2.1)		
Others	13 (19.4)	39 (58.2)	15 (22.4)		
Total	143 (22.8)	420 (67)	64 (10.2)		
Housing				215.376	0
Argentina	66 (33.5)	107 (54.3)	24 (12.2)		
Brazil	85 (57.4)	52 (35.1)	11 (7.4)		
Colombia	35 (17.3)	88 (43.6)	79 (39.1)		
Mexico	4 (7.0)	2 (3.5)	51 (89.5)		
Others	21 (29.6)	32 (45.1)	18 (25.4)		
Total	211 (31.3)	281 (41.6)	183 (27.1)		
Basic Assistance				65.644	0
Argentina	127 (65.5)	50 (25.8)	17 (8.8)		
Brazil	72 (48.6)	57 (38.5)	19 (12.8)		
Colombia	94 (46.8)	69 (34.3)	38 (18.9)		
Mexico	6 (10.5)	30 (52.6)	21 (52.9)		
Others	27 (38%)	28 (39.4)	16 (22.5)		
Total	336 (48.6)	234 (34.9)	111 (16.5)		

Education: Argentina and Mexico present no risk in 49.8% and 64.9%, respectively; a higher percentage with moderate risk in Brazil (43.9%), Colombia (68.8%), and others (53.5%); a significant difference in Education ($\chi^2(8) = 129.623$, $p < 0.001$), with Argentina presenting a higher rate of no risk (49.7%) and Mexico a higher rate of high risk (35.1%).

Substance use: Argentina and Brazil presented a higher percentage of no risk (41.6% and 60.8% respectively), Colombia the highest rate of moderate risk (54.5%) and high risk (12.9%). There is a significant difference between the countries ($\chi^2(8) = 64.587$, $p = 0.001$) with Brazil presenting a higher rate of no risk (60.8%) and Mexico a higher rate of moderate risk (84.2%).

Job: all countries present a higher percentage of moderate risk, Argentina (51%), Brazil (49%), Colombia (65%), Mexico (90.6%) and others (47.9%), followed by no risk Argentina (34.6%), Brazil (45.6%), Colombia (21.6%), Mexico (7.5%) others (31%). A significant difference was observed ($\chi^2(8) = 59.198$, $p = 0.001$) for the job component for Brazil with a higher rate of no risk, while Mexico presented a larger percentage of (90.6%) of moderate risk.

Personal safety: Brazil and Argentina present the higher percentage of no risk (55.9% and 30.6% respectively), Colombia presents the highest percentage for moderate risk (50.5%) and Mexico the higher percentage for high risk (33.3%). The difference between countries is significant ($\chi^2(8) = 63.256$, $p = 0.015$) for Brazil (55.9%) with a larger rate of no risk.

Health-related risks, Colombia (55.1%) and Argentina (53.6%) gave the higher percentage of no risk. Globally high-risk rates were very low ($N=7$, 1.1%). The difference among countries was significant

($\chi^2(8) = 32.023$, $p = 0.001$), with Brazil and Mexico's higher rate of no risk (68.8% and 63.7%, respectively). A higher rate of moderate risk among the countries categorized as others (58.6%).

Primary Network. The difference among countries was significant, ($\chi^2(8) = 52.656$, $p = 0.001$), having Brazil with higher rate of no risk (33.1%), while Mexico (91.7%) and Colombia (72.1%) with higher rate of moderate risk. Finally, Argentina (17.4%) and others (22.4%) with a higher rate of high risk.

Housing. The difference among countries was significant ($\chi^2(8) = 215.376$ $p = 0.001$): Brazil (57.4%) with a higher rate of no risk. Argentina (54.3%) with a high rate of moderate risk, Colombia (39.1%) and Mexico (89.5%) had the highest rates of high risk.

Basic care. The difference between the countries was significant ($\chi^2(8) = 65.644$ $p = 0.001$): Argentina (65.5%) with the highest rate of no risk, and Mexico the highest rate of high risk (36.8%).

Discussion

If we look at the global data we see that the dimension with the highest risk rate is housing (followed by basic care and education), the one with the highest moderate risk rate is primary network (followed by job) and the one with the lower is health (followed by primary network), the difference between countries being however significant. The observed dimensions seem to significantly differentiate the conditions of the territories and communities of different countries, underlining the prevalence of local aspects over global aspects, for example the need to take into consideration local elements over national ones or national over continental ones.^{4,5}

Risks and overview of vulnerabilities in Latin America

Education was the axis that presented the most significant differences among countries, with Brazil being the country with the highest risk. A report by UNESCO (2022) indicated that many countries in Latin America have reduced their public spending on education since 2015; highlighting that even before the COVID-19 pandemic, there was limited progress in educational indicators, particularly among the most vulnerable populations. Consequently, our findings may reflect the low public investment in education made by Latin American countries. In particular for Brazil and Colombia.

Mexico presented a higher risk, and Argentina the lower risk. According to the ILO (International Labor Organization) report, 70% of the jobs generated between 2020 and 2021 in Latin America informal.¹⁷ Even presenting differences among risks, all the communities studied by the CT have very poor labor inclusion policies, participation in the formal economy is very limited.

Mexico presented a higher risk for security. Security in vulnerable communities refers to mainly to micro-trafficking and incarceration rates. Data indicate that as prison sentences increase, paradoxically, violence or marginalization increases.¹⁸ Mexico and Colombia were the countries that presented the highest risk for Housing. Particularly in these countries, the war on drugs strategy favored the displacement of entire communities, increasing the likelihood of people ending up on the street.¹⁹

Health presented the highest rate of “no risk” in Brazil and moderate risk in Mexico. Public policies for vulnerable populations frequently offer health services. For example, in Brazil, there are Street Clinics,²⁰ and in Latin America, harm reduction was disseminated. Data from our study seem to reflect the prioritization of policies.

The high risk related to the primary network stands out in Argentina, as well as moderate risk for Mexico and Colombia, it is noticeable that social relations among people in a vulnerable situation can often be impaired due to stigma, which isolates instead of integrating them.²¹ Our data highlights the importance of social integration as a strategy for reducing relational risk.

Our data also corroborate the findings of Silva and collaborators²² that highlight the risks related to basic care in the countries of Latin America and the particular significance of Mexico.

Strengths and limitations

This is the first study to assess systematically risk levels in multiple dimensions, in a large sample of people in vulnerable contexts in 11 Latin American countries. It highlights the approach of the participants in their community's daily life through teams certified in the standardized CT methodology. This work also presents an observation and evaluation tool sensitive to the conditions of people living in vulnerable communities, starting from informal participant observation, following with an informal collection of critical data for the organization of treatment processes, up to the register of objectively observable behaviors, attitudes and conditions that constitute the body of information used for the research. Another limitation: data were not collected at the same period for all countries. This study did not aim to collect a representative sample of the evaluated countries and it is not appropriate to generalize the findings. Despite applied statistical corrections, some countries had risk levels with categories of small or absent sample size.

Practical implications

The study points out that policies, mainly those on drugs, have focused efforts on Health programs, failing to cover other areas of people's lives as indicated by the study by Kaplan.²³ The data supports the need for local policies that can have greater scope and impact. The variability of risks among countries, both concerning the types and levels of risks suggests the need to plan policies more focused on local community characteristics.

Conclusion

The study shows that except for risk in health and basic care, moderate and high risk were predominant in all other dimensions. Our findings highlight the heterogeneity among countries and the complexity of the relationships between variables. It is necessary for future studies to detail the diversities among communities and countries. Despite the articulation of policies among Latin American countries being important, strategies aimed at vulnerable communities must pay attention to the specificities of local contexts.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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Conflict of interest disclosure

The authors declare that they have no conflicts of interest.

Ethics approval statement

The project approved by the Ethics Committee of the Federal University of São Paulo (50519021.1.0000.5505). Data were anonymized with no identification of person or institution. The CT teams signed the Data Use Consent Form.

Author contributions

Raquel was responsible for data collection, conducting interviews, overall research development, communication with community and country representatives and writing the manuscript. Ana provided research guidance, contributed to the discussion, and final considerations. André supported statistical analyses and the description of the results. Efreem was responsible for database development and software implementation.

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