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PREVENTION TREATMENT REHABILITATION SECTION

REPORT

A Review of the Quality of Drug Treatment, Sustained Recovery and Related Support Services based on data submitted in the Annual Report Questionnaire collections in 2020 and 2021

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This document has not been formally edited

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Abbreviations and acronyms

ARQ	(UNODC) Annual report Questionnaire
CBT	Cognitive behavioural therapy
CM	Contingency management
CND	Commission on Narcotic Drugs
CRA	Community reinforcement approach
MET	Motivational enhancement therapy
MI	Motivational interviewing
OAMT	Opioid agonist maintenance therapy
OAT	Opioid agonist therapy
QA	Quality assurance
the Standards	The International Standards for the Treatment of Drug Use Disorders (2020)
UNGASS	United Nations General Assembly Special Session on Drugs
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization

Abstract

In 2021, the Commission on Narcotic Drugs (CND) approved resolution 64/3 on "Promoting scientific evidence-based, quality, affordable and comprehensive drug prevention, treatment, sustained recovery and related support services"[1]. This resolution calls upon the United Nations Office on Drugs and Crime (UNODC), in collaboration with Member States and other relevant stakeholders, to prepare a comprehensive report on the quality of drug prevention, treatment, sustained recovery and related support services, as well as other health-related measures, in line with the International Standards on Drug Use Prevention[2] and the International Standards for the Treatment of Drug Use Disorders[3] developed by the United Nations Office on Drugs and Crime and the World Health Organization, in order to ensure the continuous improvement of such services and with the aim of understanding the possible linkages between drug use and crime, health and socioeconomic factors.

This report aims to present an analysis that is indicative of the quality of drug use disorder treatment, sustained recovery and related support services, as well as other health-related measures, under the analytical framework of the International Standards on Drug Use Prevention and the International Standards for the Treatment of Drug Use Disorders (UNODC and WHO, 2020). This analysis was carried out with data routinely collected in 2020 and 2021 with the UNODC Annual Report Questionnaire[4] (ARQ). ARQ modules of specific relevance for the treatment of drug use disorders were selected for the analysis presented here. Having a better understanding of not only the accessibility of drug use disorder treatment, as reported in UNODC's World Drug Report regularly, but also a global understanding of the quality of available services is essential. In this regard, the exercise undertaken for this report was an attempt to see the extent to which ARQ data received from Member States can be used to gain an overview of the quality of drug use disorder treatment and care services in different regions. Based on this initial in-depth analysis, it seems that ARQ data only allow for a limited understanding of the quality of drug use disorder treatment around the world. The availability of different types of drug treatment services and different treatment interventions could be described.

The data analysed in this report shows that some of the main broad categories of drug treatment (i.e., psychosocial and behavioural interventions and pharmacological treatment) seem to be available in most countries, although coverage could be limited, and gaps in provision of services still prevail. The analysis also highlighted potential regional differences. Beyond this, the information to describe and draw conclusions for other domains of treatment quality in line with the International Standards for the Treatment of Drug Use Disorders is more limited.

[1] Commission on Narcotic Drugs. (2021). Resolution 64/3 Promoting scientific evidence-based, quality, affordable and comprehensive drug prevention, treatment, sustained recovery and related support services. In Resolution. https://www.unodc.org/documents/commissions/CND/Drug_Resolutions/2020-2029/2021/resolution_64_3.pdf

[2] United Nations Office on Drugs and Crime & World Health Organization. (2018). International Standards on Drug Use Prevention (Second updated edition). UNODC. https://www.unodc.org/documents/prevention/UNODC-WHO_2018_prevention_standards_E.pdf

[3] United Nations Office on Drugs and Crime & World Health Organization. (2020). International standards for the treatment of drug use disorders: revised edition incorporating results of field-testing [Book]. World Health Organization and United Nations Office on Drugs and Crime. https://www.unodc.org/documents/drug-prevention-and-treatment/UNODC-WHO_International_Standards_Treatment_Drug_Use_Disorders_April_2020.pdf

[4] United Nations Office on Drugs and Crime (UNODC). (n.d.). Annual Reports Questionnaire. United Nations Office on Drugs and Crime. https://www.unodc.org/unodc/en/data-and-analysis/arq.html

Nevertheless, and despite the limitations of this study, the data presented in this report provides an important insight into the quality of drug treatment services worldwide and helps to identify areas for developing this work further, with a view to continuously support the improvement of the quality of treatment and care offered to people living with drug use disorders across the globe.

1 Introduction

1.1 Background

Drug use disorders are a public health, developmental and security problem both in high- and middle-/low-income countries. It is associated with health problems, poverty, violence, criminal behaviour and social exclusion. Prevention and treatment of drug dependence are essential demand reduction strategies of significant public health importance. Therefore, the implementation of adequate programs is key in ensuring an appropriate balance between the need for evidence-based prevention and treatment interventions and the needs of people at risk or affected by drug use disorders.

Through its global programs on drug dependence treatment and care, the United Nations Office on Drugs and Crime (UNODC) supports Member States in their efforts to develop effective drug dependence treatment systems and services and to address the associated health and social consequences of drug use disorders. With the involvement and active participation of public governmental institutions, universities, treatment centres, civil society organisations and health and social professionals, UNODC promotes a systematic, inter-sectorial and multidisciplinary response to drug use disorders. The main objective is to increase access to quality, affordable, comprehensive, evidence- and human rights-based drug treatment and care services for people in need and help improve the beneficiaries' well-being and social integration.

In 2009, the UNODC and the World Health Organization (WHO) launched the "UNODC-WHO Joint Programme on Drug Dependence Treatment and Care"[5] in response to the Political Declaration and Plan of Action on International Cooperation Towards an Integrated and Balanced Strategy to Counter the World Drug Problem[6], which encouraged Member States to develop and adopt 'appropriate health-care standards'. Subsequently, the UNODC and WHO developed the International Standards for the Treatment of Drug Use Disorders – A Draft for Field Testing ("*the Standards*") in the framework of the UNODC-WHO Programme on Drug Dependence Treatment and Care. *The Standards* were recognised by resolution 59/4 of the Commission on Narcotic Drugs[7] (CND) and the 2016 United Nations General Assembly Special Session on Drugs (UNGASS) Outcome Document[8], which called for their promotion and implementation. After being field tested, the final version of *the Standards* was published in 2020.

Furthermore, the latest 2021 CND resolution 64/3 on "Promoting scientific evidence-based, quality, affordable and comprehensive drug prevention, treatment, sustained recovery and related support services" calls upon UNODC, in collaboration with Member States and other relevant stakeholders, to prepare a comprehensive report on the quality of drug prevention, treatment, sustained recovery and

[5] United Nations Office on Drugs and Crime (UNODC) & World Health Organization (WHO). (2009). The joint UNODC-WHO Programme on Drug Dependence Treatment and Care. UNODC. https://www.unodc.org/documents/drug-treatment/UNODC-WHO-brochure.pdf

[6] Commission on Narcotic Drugs, & Costa, A. M. (2009). Political Declaration and Plan of Action on International Cooperation towards an Integrated and Balanced Strategy to Counter the World Drug Problem. In United Nations, United Nations [Report]. https://www.unodc.org/documents/drug-prevention-and-treatment/High-level_segment_Commission_on_Narcotic_Drugs_11-12_March_2209.pdf

[7] Commission on Narcotic Drugs. (2016). Resolution 59/4: Development and Dissemination of International Standards for the Treatment of Drug Use Disorders. United Nations Office on Drugs and Crime (UNODC). https://www.unodc.org/documents/commissions/CND/CND_Sessions/CND_59/Resolution_59_4.pdf

[8] United Nations Office on Drugs and Crime (UNODC). (2016). Outcome Document of the 2016 United Nations General Assembly Special Session on the World Drug Problem. https://www.unodc.org/documents/postungass2016/outcome/V1603301-E.pdf

related support services, as well as other health-related measures, in line with the International Standards on Drug Use Prevention and the International Standards on the Treatment of Drug Use Disorders developed by the United Nations Office on Drugs and Crime and the World Health Organization, in order to ensure the continuous improvement of such services and with the aim of understanding the possible linkages between drug use and crime, health and socioeconomic factors.

1.2 Aims and structure of the report

This report reviews the findings from an analysis of data relevant to understanding the quality of drug use disorder treatment and care services. Data collected as part of the 2020 and 2021 routine UNODC Annual Report Questionnaire (ARQ) process was analyzed in an attempt to get a better understanding of the quality of drug use disorder treatment services globally and to assess to the extent ARQ data can be used for this purpose. . The ARQ modules (14 annual modules and 13 rotating modules) can be accessed online[9]. This report entitled "A Review of the Quality of Drug Treatment, Sustained Recovery and Related Support Services based on data submitted in the Annual Report Questionnaire collections in 2020 and 2021" considers these data under the analytical framework of *the Standards* (UNODC and WHO, 2020) with the view to assess the quality of drug treatment and care services in the light of *the Standards* and considers both the global picture and regional differences, highlighting areas of good practice as well as areas that may need greater focus and development. It is worth noting that, at the time of its latest revision, the ARQ was guided by the 2016 version of *the Standards* framework. For that reason, in some cases, the definitions and terminology in the ARQ may slightly differ from those in the 2020 revised version of *the Standards.* It is also worth noting that 2020 and 2021 were years in which drug treatment service provision and data collection were affected by the global COVID 19 pandemic.

The picture is inevitably partial – not all countries respond to the ARQ, and the information collected must be limited to not overburden responding countries. The availability of the requested information also varies widely between countries, as does the level of development of the treatment systems and the extent and type of drug problems, which impacts what types of treatment will be appropriate. It is also important to recognise that a non-response does not necessarily mean that a service does not exist. Moreover, the individuals completing the questionnaire may not always have access to complete information about the provision of services.

The findings presented here should, therefore, be viewed as indicative only. However, they can provide some insights into the current situation of drug use disorder treatment services and highlight areas on which to focus future work. Some ARQ modules are not included every year, for example, a rotating module R03 on core treatment services will not be utilized until 2023, so more data may become available in the future.

[9] United Nations Office on Drugs and Crime (UNODC). (2019). Consultation on the improved and streamlined Annual Report Questionnaire. United Nations Office on Drugs and Crime. https://www.unodc.org/unodc/en/data-and-analysis/statistics/consultation-annual-report-questionnaire-2019.html

2 Data sources and methods used

2.1 Data sources

The data used in this report come from the 2020 and 2021 data collections, focusing mainly on system-level questions and Type I (qualitative) data[10], i.e., qualitative information that requires the basic capacity to monitor drug-related matters, such as expert assessments. The first area to be considered is **question A06.06 on treatment coverage, availability and accessibility** from module A06[11] on drug-related treatment. In this module, countries are asked firstly if certain interventions are available in the country, then to give assessments of coverage and then accessibility of them, and then an open question about barriers to accessibility. Information on the following types of interventions addressed in the ARQ were included in the analysis on the quality of drug use disorder treatment:

1. Pharmacological interventions
   - Management of withdrawal
   - Opioid Agonist Maintenance Therapy (OAMT)
   - Opioid Antagonist Maintenance treatment
   - Another agonist treatment (to be specified)
2. Psychosocial and Behavioural interventions
   - Cognitive behavioural therapy (CBT)
   - Contingency management (CM)
   - Motivational interviewing (MI) and motivational enhancement therapy (MET)
   - Community reinforcement approach (CRA)
   - Social support (involvement of family members and concerned significant others)
   - Peer support groups
   - Other
3. Rehabilitation and aftercare (Recovery management and social support)
   - Interventions based on scientific evidence and focused on the process of rehabilitation
   - Recovery and social reintegration

– Other

These questions are asked every year, so the data used either came from the complete 2020 collection or responses submitted in the collection relating to 2021 up to the end of August 2022. In total, 93 countries had submitted data in response to this questionnaire: 35 had responded to this section in 2020 only, seven in 2021 only, and 51 in both years. Since the annual submission process for the 2021 ARQ was incomplete at the time this analysis was being carried out, it is possible that in some cases, the submission was incomplete and changes could be made before finalization, so where data from both years was available, a decision needed to be made as to which dataset to include. In many cases where data was submitted in both years, the data were essentially identical, and in those cases, 2020 data has

[10] According to the Guidelines for the Annual Report Questionnaire (ARQ), Type I are mainly qualitative questions, whereas Type II refers to more quantitative questions in the ARQ. See for reference: United Nations Office on Drugs and Crime (UNODC). (2021). Guidelines for the Annual Report Questionnaire. https://www.unodc.org/documents/ARQ/ARQ_Guidelines.pdf

[11] United Nations Office on Drugs and Crime (UNODC). (n.d.-b). ARQ Module A06: Drug-related treatment. In Annual Report Questionnaire. https://www.unodc.org/documents/ARQ/final_consultation/A06_Drug-related_treatment.pdf

been used in the analysis. In the remaining cases, the two submissions were compared, and the year that had the most complete data (in terms of the number of sub-questions completed) was selected for analysis. In cases where the data differed in terms of answers given, but the quantity of data was similar, then 2020 data has been used in this analysis.

The second ARQ item analysed in this report is **question A06.08 on the availability of data on drug-related treatment**, also from the annual module on drug treatment. This question considers whether data on the number of patients or clients who have undergone drug-related treatment and/or drug treatment episodes are available in the country. Also, whether these are available at the national level or only at the sub-national level, and whether the data provides information on the treatment of specific groups of the population, socioeconomic characteristics of patients/clients, or polydrug use. As was the case for responses to A06.06, responses were available in some cases from the 2020 data collection, in other cases from 2021 up to the end of August, or in some cases from both years. In total, 102 countries had provided some data in response to this question: 32 only in 2020, nine only in 2021, and 61 in both years. For those countries who had responded to the question in both years, a similar process to that described above was used to decide which year's response to use in this analysis. In 50 of these cases, 2020 data was chosen, while 2021 data was selected in 11 cases.

The third block of questions included in this analysis is **R12.12 [12], which covers national policies/strategies on drug treatment** and is part of the recurring module on the National Framework. This module was included only in the 2020 ARQ process. In total 74 countries answered at least one of the questions in R12.12. The following topics were covered in this section:

- The policies and/or strategies on the provision of treatment interventions for people with drug use disorders in place in the country (countries were asked to provide links to or attach any relevant documents);
- The main components of the policy/strategy on drug use disorder treatment (types and objectives of treatment interventions, target groups, etc.);
- Whether policies and/or strategies exist on the provision of treatment interventions for people with drug use disorders in specific groups of the population and, if so, which groups (the groups prompted for were Persons with disabilities; People living in rural areas; Indigenous people; Persons with migrant background; Homeless people; People who engage in sex work; People with mental illness; Other (specify);
- The approaches used for the funding coverage of those services (All treatment covered by the public health system; Mixed coverage (some treatment covered by the public system, some by the private system); Other (specify);
- The types of treatment intervention covered in the existing legal provisions or strategies (selected from Pharmacological (detoxification, opioid antagonist maintenance); Psychosocial (counselling, cognitive behavioural therapy (CBT), social support); Rehabilitation and aftercare (interventions based on scientific evidence and focused on the process of rehabilitation); Recovery and social reintegration; Other (specify));
- Whether there are mechanisms in place to map available interventions and/or to monitor treatment interventions (Yes; No; Unknown);

[12] United Nations Office on Drugs and Crime (UNODC). (n.d.-c). ARQ Module R12: National Framework. In Annual Report Questionnaire.
https://www.unodc.org/documents/ARQ/final_consultation/R12_National_Framework.pdf

- The existence of standard operating procedures in place for treatment interventions and for assessing their quality in the country (Yes; No; Unknown);
- The central coordinating entity and other institutions involved in the implementation and management of treatment services (including non-governmental organizations, if applicable).

Modules and questions were not mandatory, so the number of countries completing each section and the completeness of the data they provided to each was very variable. *Table 1* summarizes the number of countries providing any response to each of the three groups of questions described above by region[13]. This shows that the analysis in this report is based on information provided by 106 countries in total. Europe was the region that contributed the most data, with some information provided by 39 countries, followed by Asia (29 countries), the Americas (21 countries), and Africa (15 countries), while in Oceania, only two countries responded.

Table 1: Number of countries responding to different ARQ question areas, by region

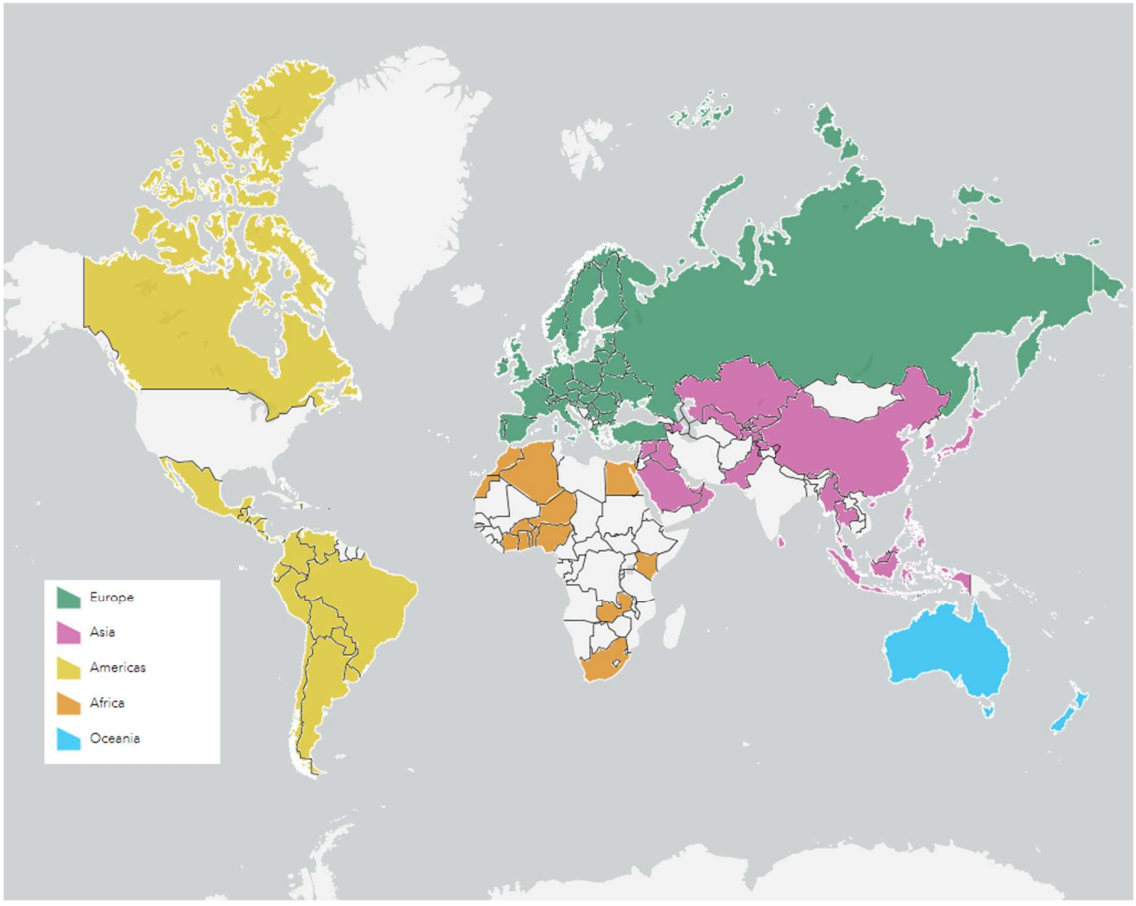
Region	A06.06 Treatment coverage, availability & accessibility	A06.08 Availability of drug-related treatment data	R12.12 National policies/strategies on drug treatment	Any data provided
Africa	13	15	8	15
Americas	18	21	15	21
Asia	24	26	18	29
Europe	36	38	32	39
Oceania	2	2	1	2
TOTAL	93	102	74	106

The extent to which the countries that are included in the study are representative of all countries and of the total population, varies considerably by region (*Table 2*). In all regions except Asia, larger countries were more likely to be included, and so the proportion of the population covered was larger than the proportion of countries included. Just over three-quarters of the 51 countries in the European region provided some information that is included in the study, and these covered 99% of the region's population. Only two out of the 23 countries in Oceania are included in this study but as they were very much the largest in the region, they covered over two-thirds (70%) of the population in the region. In the Americas, only 38% of countries (21 out of 55) are included, but they covered almost two-thirds (64%) of the regional population. In Asia, 29 out of 49 countries – 59% of countries covering 57% of the population – provided some information in the study. The coverage of countries in the African region is much more limited. Only a quarter (26%, 15 out of 58 countries) provided information in the relevant parts of the ARQ, covering just under half of the region's population (48%).

[13] The regional groupings used in this report are those used in the World Drug Report. The definitions of these groupings can be found in UNODC (2022).

Table 2: Proportion of the countries and of the population included in this study by region

Region	Total no. of countries	No. of countries included	% of countries included	Total population	Population of included countries	% of population included
Africa	58	15	26%	1 360 677	655 454	48%
Americas	55	21	38%	1 025 793	656 900	64%
Asia	49	29	59%	4 578 951	2 618 823	57%
Europe	51	39	76%	831 598	820 847	99%
Oceania	23	2	9%	43 933	30 731	70%
WORLD	236	106	45%	7 840 952	4 782 755	61%



The depiction and use of boundaries, geographical names and related data shown on this map do not imply official endorsement or acceptance by the United Nations.

Figure 1: Distribution of countries providing information included in this study

2.2 Analytical framework

The analysis described in this report uses the International Standards for the Treatment of Drug Use Disorders: revised edition incorporating field-testing results published by the UNODC and WHO (UNODC and WHO, 2020) to provide an analytical framework. It provides an overview of what the recent ARQ data suggests about the quality of treatment systems around the world and how it varies between regions, highlighting potential areas to prioritize for further work and also important gaps in our knowledge, that might be addressed in the future.

The Standards (UNODC and WHO, 2020) highlight seven key principles for the delivery of high quality, effective treatment for people with drug use disorders:

Principle 1: Treatment should be available, accessible, attractive, and appropriate.

Principle 2: Ensuring ethical standards of care in treatment services.

Principle 3: Promoting treatment for drug use disorders through effective coordination between the criminal justice system and health and social services.

Principle 4: Treatment should be based on scientific evidence and respond to the specific needs of individuals with drug use disorders.

Principle 5: Responding to the special treatment and care needs of population groups.

Principle 6: Ensuring good clinical governance of treatment services and programmes for drug use disorders.

Principle 7: Treatment services, policies and procedures should support an integrated treatment approach, and linkages to complementary services require constant monitoring and evaluation.

These principles need to be considered at both the system, and the service level and within *the Standards* (UNODC and WHO, 2020), there is discussion of how these principles can be operationalized and applied. The main objective in developing *the Standards* (UNODC and WHO, 2020) was to assist in organizing and delivering treatment services, providing guidance on how to organise the delivery of interventions rather than clinical guidance on what interventions to use in treating drug use disorders.

As indicated above, the ARQ data provide information on treatment services reported at the system level. Chapter 3 of *the Standards* (UNODC and WHO, 2020) is, therefore, particularly relevant.

3 An effective system of treatment for drug use disorders

Principle 1 in *the Standards* (UNODC and WHO, 2020) is that treatment should be available, accessible, attractive, and appropriate. It highlights how effective treatment of drug use disorders requires that people have access to a wide range of evidence-based services that cover the spectrum of issues that individual patients may face. To be effective, these services need to be affordable, attractive, available in both urban and rural settings and accessible, with a wide range of opening hours and minimal waiting time. Other barriers that may limit access also need to be minimized. For example, the legal framework should not discourage these patients from attending treatment, and the treatment environment needs to be friendly, culturally sensitive and focused on each patient's specific clinical needs and level of preparedness.

The Standards (UNODC and WHO, 2020) specify the broad types of services that are needed within the treatment system: community-based outreach; services in non-specialised settings; inpatient and outpatient treatment; medical and psychosocial treatment (including the treatment of alcohol and other substance use disorders as well as other psychiatric or physical health comorbidities); long-term residential or community-based treatment or rehabilitation; and recovery-support services. Also, services should not only offer treatment for substance use disorders per se but also provide social support and protection, as well as general medical care.

Chapter 3 in *the Standards* (UNODC and WHO, 2020) then expands on this, highlights the key characteristics of effective treatment systems for drug use disorders, provides guidance on the planning of treatment services, and proposes frameworks for health service organization and models of care. The aim is to deliver services and interventions in multiple settings and target different groups at different stages in terms of the severity of their drug use disorder and their additional needs. Therefore, an effective national system will require a coordinated and integrated response by many actors. The public health system, often working in close coordination with social care and other community services, is likely to be best placed to take the lead in delivering effective treatment services for people with drug use disorders although NGOs and the private sector will play a vital role in some countries.

An assessment of the quality of the treatment system and services in a country, therefore, needs to consider the following criteria:

- Availability – a sufficient, sustainable presence of services capable of treating patients with drug use disorders.
- Accessibility – the reach of the services and their availability for the whole population.
- Affordability – affordability both for patients and the local treatment system.
- Evidence-based – treatment interventions should be based on scientific evidence and follow evidence-based guidelines like the treatment of any other health disorder. This is key to ensuring the quality of treatment services.
- Diversity of provision – a variety of treatment services will be necessary to meet the varying needs of the target population and offer different treatment approaches. No single approach fits all types, severities or stages of drug use disorders.

The responses to ARQ question A06.06 (treatment coverage) and some elements of R12.12 (national policies/strategies on drug treatment) provide some information about these criteria.

3.1 Availability and diversity of services

The Standards (UNODC and WHO, 2020) describe a cost-effective treatment system based on a service organization pyramid, in which most interventions take place at lower intensity levels in community or non-specialised settings, intervening early to prevent people from developing more severe drug use disorders. Interventions in specialised settings, which are much more costly, are then used for those with more severe problems who really need, and will benefit from, these higher-intensity treatment services.

The types of interventions that may be provided at different levels are illustrated in *Table 3*, taken from *the Standards* (UNODC and WHO, 2020). The ARQ does not ask directly about the provision at different levels of the pyramid but instead focuses on key types of intervention as described earlier. These encompass interventions that may be provided at different levels. In some cases, they may be available at more than one level, and the level at which they are provided may vary between countries. For example, medication-assisted treatment may be provided by general practitioners or services at the community level or in specialised services.

Table 3: Suggested interventions at different system levels

System level	Possible interventions
Informal community care	• Outreach interventions • Self-help groups and recovery management • Informal support through friends and family
Primary health care services	• Screening, brief interventions, referral to specialist drug use disorder treatment • Continued support to people in treatment/contact with specialized drug treatment services • Basic health services including first aid, wound management
Generic social welfare	• Housing/shelter • Food • Unconditional social support • Referral to specialized drug treatment services, and other health and social services as needed
Specialized treatment services (outpatient and inpatient)	• Assessment • Treatment planning • Case management • Detoxification/withdrawal management • Psychosocial interventions • Medication-assisted treatment • Relapse prevention • Recovery management
Other specialized health care services	• Interventions by specialists in mental health services (including psychiatric and psychological services) • Interventions by specialists in internal medicine, surgery, paediatrics, obstetrics, gynaecology and other specialized health care services • Dental care • Treatment of infectious diseases (including HIV, Hepatitis C and tuberculosis)
Specialized social welfare services for people with drug use disorders	• Family support and reintegration • Vocational training/education programmes • Income generation/micro-credits • Leisure time planning • Recovery management services
Long-term residential services for people with drug use disorders	• Residential programme to address severe or complex drug use disorders and comorbid conditions • Housing • Vocational training • Protected environment • Life skills training • Ongoing therapeutic support • Referral to outpatient/recovery management services

Source: The International Standards for the Treatment of Drug Use Disorders (UNODC and WHO, 2020).

In question A6.06 (treatment coverage), respondents were first asked to indicate which of a range of different treatment interventions for substance use disorders were available in their country (response categories: Yes/No) and then to give their overall assessment of the coverage of these interventions in terms of the number of people in treatment versus those in need. For the assessment of coverage, the response options were: fully adequate (>90%); adequate (75-90%); some gaps exist (50-75%); barely adequate (25-50%); not at all adequate (<25%) or unknown. If no assessment was made and this field was blank because it was indicated that this type of treatment was not available in the country, the field was recoded as not available, or otherwise a blank response was recoded as unknown.

The interventions included came under four broad categories: pharmacological treatment, psychosocial and behavioural interventions, rehabilitation and aftercare (recovery management and social support), and other services (*Box 1*). Within each of these categories, the same questions on availability were asked regarding more specific types of treatment interventions. This section of the report first provides an overview of the extent of provision of the four broad categories of treatment interventions and then looks in more detail at the provision of more specific interventions within each of the four categories in turn.

Box 1: Four broad categories of treatment interventions included

- **Pharmacological treatment**
- **Psychosocial and behavioural interventions**
- **Rehabilitation and aftercare (recovery management and social support)**
- **Other services**

3.1.1 Overview of the availability of the four broad categories of treatment

A total of 106 countries have been included in the dataset analysed for this report but not all of them completed the group of questions concerning availability, coverage and accessibility of treatment interventions and in these cases all of these questions are marked as “no response”. In addition, completion of the ARQ questions is voluntary, and the number of countries responding varies from question to question (*Figure 3*). Thus, in some cases, a non-response may mean that the question is not deemed relevant (as is likely to be a reason for higher non-response to the question about ‘other interventions’) or that the respondent does not know the answer, or it may indicate that the intervention does not exist, while in other cases the whole module may have been omitted. Therefore, it cannot be assumed that all non-responses indicate that the intervention is unavailable. However, the ‘not available’ response option was used by very few countries (two in the case of pharmacological treatment, none for psychosocial interventions, five for rehabilitation and five for other interventions) which suggests that in at least some of the countries that did not answer these questions those interventions were not available.

The majority of the countries included in this study (59% of the whole sample and 68% of those who gave valid responses to question A06.06 on treatment coverage) reported having all four broad categories of treatment available to some extent within their country (*Figure 2*). A further 19% (22%

of those with valid responses) indicated that three broad types of treatment were available, 6% that only two types were provided and 3% had only one type available.

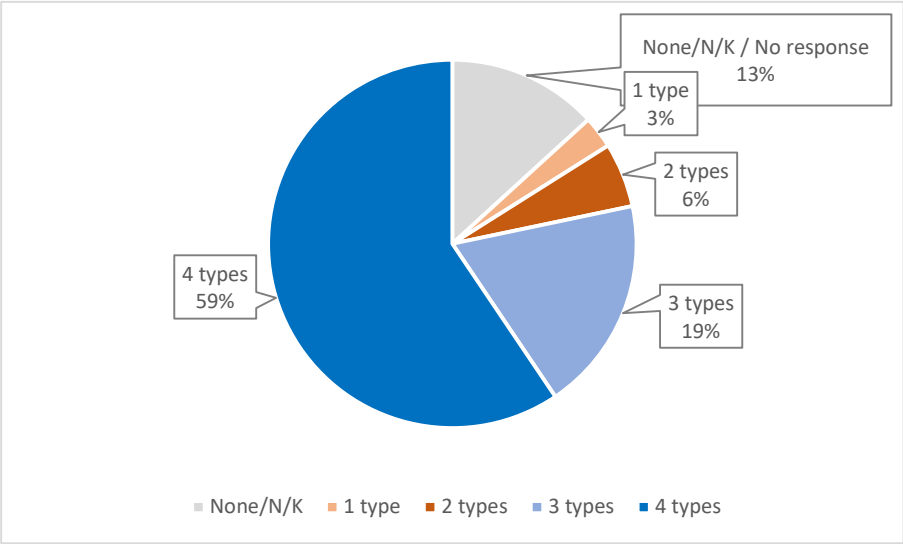


Figure 2: Overview of the reported availability of the four broad categories of treatment

Figure 3 shows that pharmacological treatment and psychosocial and behavioural interventions were the type of intervention most widely reported as being available (by 89 countries), with psychosocial and behavioural interventions reported as having the best coverage of the four broad treatment categories. Rehabilitation and aftercare were the next most available type of intervention (in 79 countries), while other interventions were reported to be available by fewer countries (only 70 countries). In total, 47 countries (53% of responding countries) assessed the coverage of **psychosocial and behavioural interventions** to be adequate or fully adequate (at least 75% coverage), while 14 countries indicated that some gaps existed, and 11 rated their coverage as barely or not at all adequate. The availability of **pharmacological treatment** was slightly lower: 41 countries (45% of those responding) assessed coverage to be adequate or fully adequate, 15 countries indicated that some gaps existed and 11 rated their coverage as barely or not at all adequate. **Rehabilitation and aftercare (recovery management and social support)** were somewhat less available, with five countries reporting that they did not exist. Where they were available, 39 countries (46% of respondents) considered their coverage to be adequate or fully adequate, 10 indicated that gaps existed, and 13 assessed coverage to be barely or not at all adequate. The question relating to other interventions had very high levels of non-response, and only 25 countries (33% of those responding) assessed coverage as adequate or fully adequate, 14 indicating gaps in coverage and seven saying coverage was barely or not at all adequate.

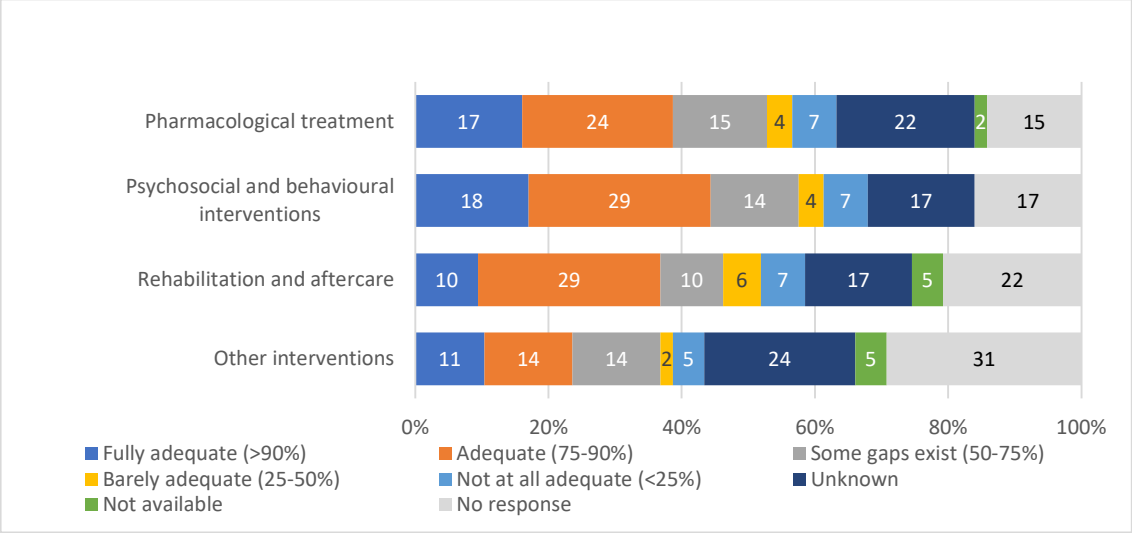
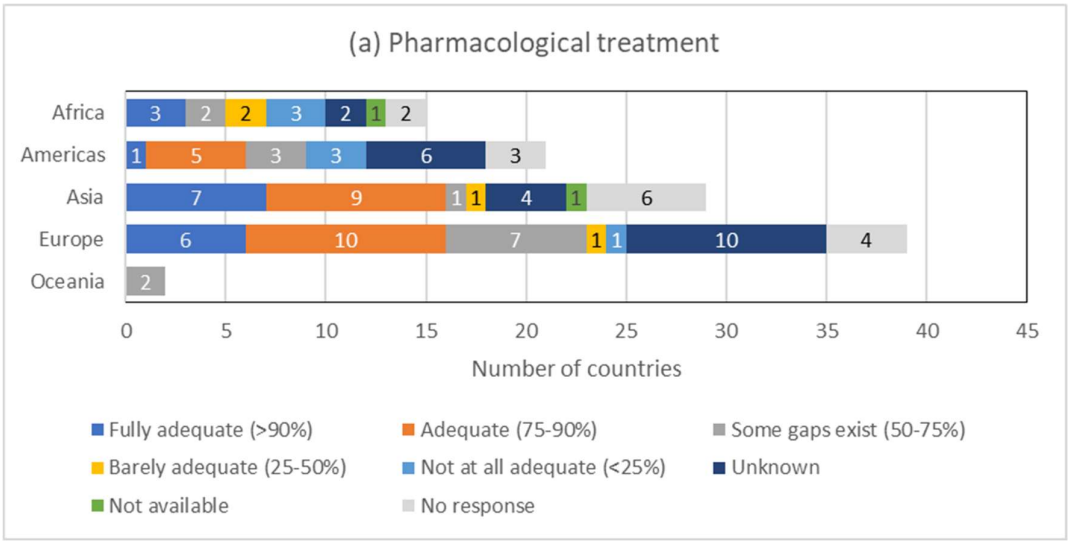


Figure 3: Number of the countries reporting the availability of the four broad categories of treatment (pharmacological treatment, psychosocial and behavioural interventions, rehabilitation and aftercare, other interventions)

3.1.2 Overview of availability by region

The following charts show the number of countries in each region that report each level of coverage for these broad categories of intervention (*Figure 4*). Here again the level of non-response varies between regions, as does the number of countries responding, so the data needs to be interpreted with caution. In addition, the assessments may have been arrived in different ways, have been made by people with different backgrounds and perspectives based on data of varying quality, and may be somewhat subjective.



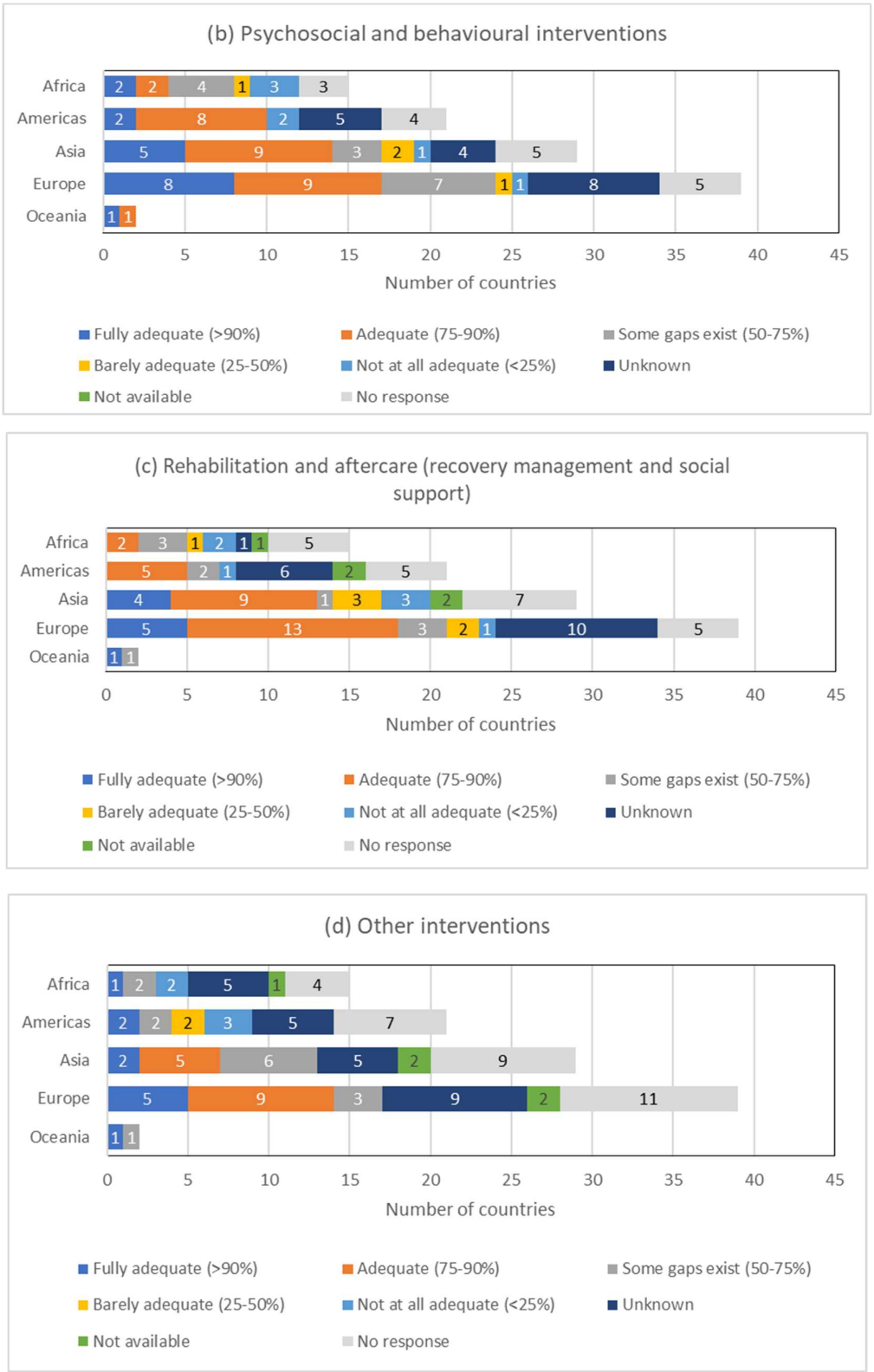


Figure 4: Number of countries reporting different levels of availability of the broad types of drug treatment interventions, by region

3.1.2.1 Pharmacological treatment by region

In general, the number of countries in **Africa** that responded was lower than in other regions, except Oceania, and coverage was reported to be lower for all of the broad categories of treatment. Of the 15 countries from the African region, two did not respond to the question on availability of pharmacological treatment services, and two did not provide any coverage assessment. Of the remainder, only one reported that these types of treatment were not available in their country, but five assessed coverage as barely or not at all adequate; two countries reported that gaps in coverage existed, with just three (23% of those that responded) considering coverage to be fully adequate.

The availability of pharmacological treatment in the **Americas** was slightly better. Of the 21 countries included in this dataset, three did not respond to this question, while in six cases the level of coverage was unknown, three indicated coverage was not at all adequate and the same number reported that some gaps existed. In total, six countries from the Americas (33% of those responding to the question) assessed coverage as fully adequate or adequate.

Six of the 29 countries from **Asia** in this study did not respond to this question, and one reported pharmacological treatment was not available in their country and four did not provide an assessment of the extent of their coverage. However, most of the remainder, 16 countries (70% of those responding to the question) assessed coverage as adequate (9) or fully adequate (7).

More countries in **Europe** (39 in total) are included in this study than for any other region. Four of these did not respond to the question on availability of pharmacological treatment services and 10 did not provide information on their coverage. However, 16 (46% of respondents to the question) reported coverage was fully adequate (6) or adequate (10), while seven indicated that some gaps existed and just two reported coverage was barely or not at all adequate. Only two countries in **Oceania** are included in this; both reported that some gaps in coverage existed.

3.1.2.2 Psychosocial and behavioural interventions by region

Of the 15 countries in the **African** region included in the study, 12 (80%) reported that psychosocial and behavioural interventions were available within their country. However, only a third of these (4 countries) reported coverage was adequate or fully adequate, a third reported that some gaps in coverage existed, and a third that coverage was barely or not at all adequate.

A similar proportion of countries in the **Americas** responded to the questions about the availability of psychosocial and behavioural interventions, 17 (81%) of the 21 countries included in this report. However, a higher proportion of these (11% of those responding) indicated that coverage was adequate or fully adequate, while two countries reported coverage was not at all adequate and five indicated that coverage was unknown.

Among the 29 countries in **Asia** included in the study, 24 responded to this part of the question. Of these, 14 countries (58%) reported that coverage of psychosocial and behavioural interventions was adequate or fully adequate, three countries reported some gaps existed, and another three indicated that coverage was barely or not at all adequate, while in four cases, coverage was unknown.

Thirty-four (87%) of the 39 countries from **Europe** in the study responded to the question on availability of psychosocial and behavioural interventions. Of these, a half (17 countries) reported that coverage was adequate or fully adequate, just over a fifth (7 countries) reported that some gaps existed, while two indicated that coverage was barely or not at all adequate and eight that coverage was unknown.

Both of the countries in **Oceania** included in this study reported that psychosocial interventions were available in their country; one reporting coverage was fully adequate and the other assessed coverage as adequate.

3.1.2.3 Rehabilitation and aftercare (recovery management and social support) by region

Provision for rehabilitation and aftercare (recovery management and social support) was reported to be somewhat lower than for the other main types of intervention, particularly in Africa and the Americas. Only two-thirds of the countries in **Africa** included in this study (10 out of 15) answered the questions about the availability of these types of interventions and, of these, two reported coverage was adequate, three that gaps in coverage existed, three that coverage was barely or not at all adequate, and one country reported that these types of intervention were not available and another that coverage was unknown.

A slightly higher proportion of countries from the **Americas** (16 out of the 21 included countries, 76%) provided an assessment of availability of these interventions. Of these, just under a third (5 countries) indicated that coverage was adequate, two that gaps existed, one that coverage was not at all adequate, two that these interventions were not available, and six reported coverage was unknown.

Similarly, about three-quarters (22 countries) of the countries included from **Asia** provided an assessment of the availability of rehabilitation and aftercare provision and over half of these reported that coverage was adequate (9 countries) or fully adequate (4 countries). Only one reported that gaps existed, while six indicated that coverage was barely or not at all adequate, and two countries reported this type of intervention was not available.

The majority of the countries included from **Europe** (34 out of 39 countries) provided an assessment for this category of intervention and over half reported that coverage was adequate (13 countries) or fully adequate (5 countries). Three countries reported that some gaps in coverage existed, three reported that coverage was barely or not at all adequate, and for 10 countries, the level of coverage was unknown.

Of the two countries in **Oceania** included in the study, one reported that coverage of this intervention category was fully adequate, and the other that some gaps in coverage existed.

3.1.2.4 Other interventions by region

In general, fewer countries provided an assessment of the availability of this category of interventions than for other broad types of intervention and a higher proportion for which coverage was unknown. The options offered within this category were: ‘treatment of psychiatric comorbidities’; ‘treatment of other medical comorbidities’; and ‘other interventions, not specified previously’. The very broad nature of these options may have made this question more difficult to respond to.

3.1.3 Availability and coverage of specific types of drug treatment intervention

Countries were asked to describe the availability and coverage of the broad categories of treatment services described above, and they were asked the same questions about specific types of drug interventions within each category. As mentioned above, questions were not mandatory so countries may have tended to respond only to the questions about available interventions. This needs to be borne in mind when considering the data presented below.

3.1.3.1 Pharmacological treatment across regions/ by intervention

The specific pharmacological interventions included were: management of withdrawal, opioid agonist maintenance therapy, opioid antagonist maintenance treatment, other agonist treatment, and other pharmacological interventions. *Figure 5* provides an overview of the availability of different types of pharmacological interventions among all respondents.

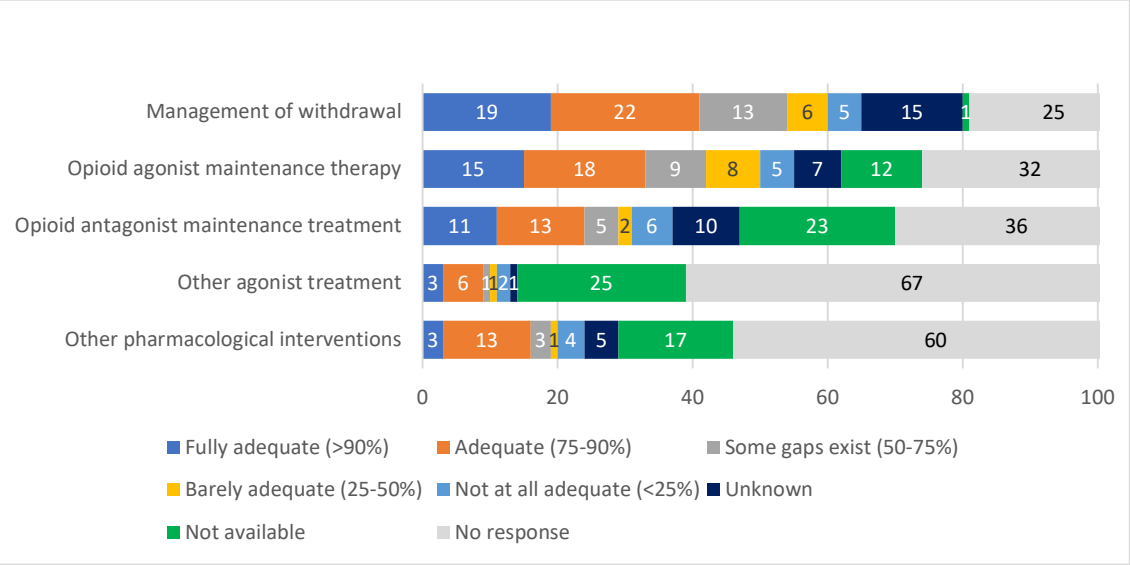


Figure 5: Number of countries reporting the availability of pharmacological treatment

Out of the 106 countries that have been included in this analysis, the **management of withdrawal** was the most commonly reported pharmacological treatment intervention with over three-quarters of countries in the sample responding to the question and only one country reporting that it was not available. Coverage of this type of intervention was also better than for others, with 41 countries (51% of those responding to the question) assessing coverage as either fully adequate or adequate. Nevertheless, 13 countries indicated that some gaps in provision existed, 11 reported coverage was barely adequate or not at all adequate, while 15 indicated that the level of coverage was unknown. This indicates there is still an unmet need for this basic intervention.

Opioid agonist maintenance therapy (OAMT) is the next most common type of pharmacological therapy; nevertheless, 12 countries reported it was not available, and 32 countries did not respond to this question. Coverage was assessed as fully adequate or adequate by 33 countries (45% of those

countries answering the question), but nine countries reported that some gaps existed, and 13 reported coverage was barely or not at all adequate and seven that the level of coverage was unknown.

Opioid antagonist maintenance treatment was less widely available: over half of the countries either did not respond (36 countries) or reported it was not available (23 countries). Among those who reported that this type of treatment was available, about half reported coverage was either fully adequate (11 countries) or adequate (13 countries), while five countries reported some gaps existed, eight reported coverage was barely or not at all adequate and 10 that coverage was unknown.

Only 14 countries reported that **other agonist treatment** was available, with 25 countries saying it was not available and the remaining 67 countries giving no response. **Other pharmacological interventions** were also relatively uncommon: over half of the countries (60) did not respond and 17 reported they were not available in their country. Where they were reported as being available, 16 countries reported coverage was adequate or fully adequate, three that gaps existed, five that coverage was barely or not at all adequate, and in five countries coverage was unknown.

3.1.3.2 Psychosocial and behavioural interventions across regions/ by intervention

Psychosocial and behavioural interventions include a range of programs that address motivational, behavioural, psychological, social, and environmental factors related to substance use that, for different drug use disorders, have been shown to reduce drug use, promote abstinence and prevent relapse. In the ARQ, the questions on availability covered the following specific interventions:

- Cognitive behavioural therapy (CBT)
- Contingency management (CM)
- Motivational interviewing (MI) and motivational enhancement therapy (MET)
- Community reinforcement approach (CRA) and social support (involvement of family members and concerned significant others)
- Peer support groups.

Countries could also include any other psychosocial interventions that were available in their country.

Figure 6 provides an overview of the availability and coverage of these specific interventions as reported by the responding countries. This shows that cognitive behavioural therapy (CBT) was the most widely available type of psychosocial and behavioural intervention, closely followed by community reinforcement approach (CRA)/social support approaches and motivational interviewing (MI)/motivational enhancement interventions, then peer support groups with contingency management (CM) slightly less frequently available.

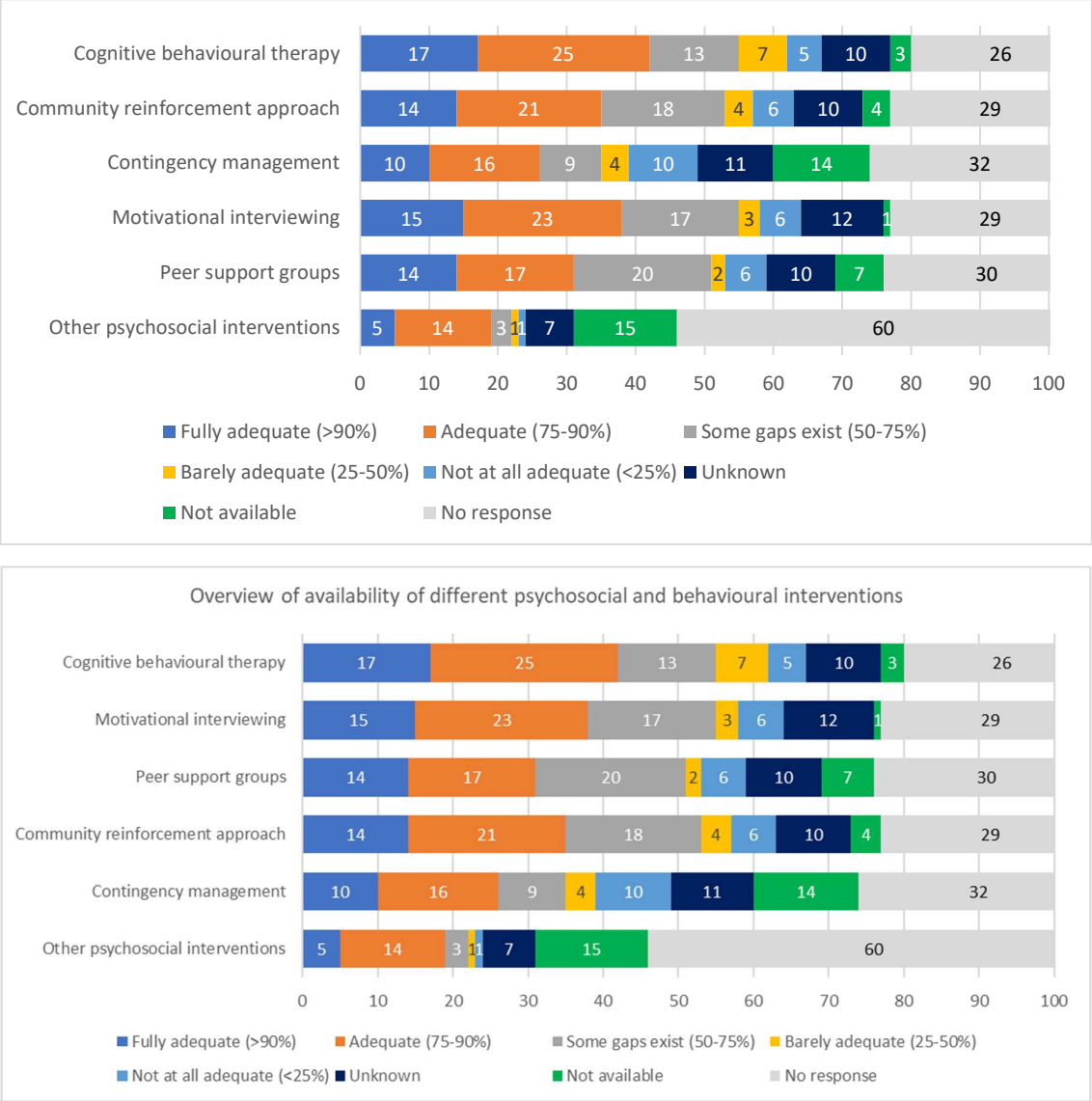


Figure 6: Number of countries reporting the availability of psychosocial and behavioural interventions

Cognitive behavioural therapy (CBT) is based on the understanding that behavioural patterns and cognitive processes around drug use are learned and can be modified. Patients are introduced to new coping skills and cognitive strategies during treatment to replace maladaptive behavioural and thinking patterns. CBT is effective for many substance use disorders and works well alongside a range of other psychosocial and pharmacological treatments.

Out of the 106 countries included in this study, three-quarters provided an assessment of the availability of CBT, and of these, only three reported it was not available in their country. Coverage also appears to be generally fairly good. In countries where CBT was available, more than half indicated that coverage was fully adequate (17) or adequate (25), 13 countries reported that some gaps existed, and

seven rated coverage as barely adequate and five as not at all adequate. For 10 countries, coverage was unknown.

Motivational interviewing (MI) **and motivational enhancement therapy** (MET) are psychosocial interventions that increase motivation to change a behaviour and hence may be applicable to different types of substance use disorders. They use a collaborative approach in which the clinician seeks to understand what the patient values.

Of the 106 countries in this study, 29 did not answer the question about the availability of MI and MET, and one country reported that it was unavailable. Coverage was generally quite good, but a little below that for CBT. Fully adequate coverage was reported by 15 countries, and adequate coverage was reported by 23 countries – half of those who indicated it was available. 17 countries reported gaps in coverage, while nine reported coverage was barely or not at all adequate and 12 countries reported coverage was unknown.

Community reinforcement approach (CRA) **and social support** (involvement of family members and concerned significant others) use social, recreational, familial, and vocational reinforcers to aid clients in the recovery process. The CRA is a behavioural approach to reducing drug use in which people with drug use disorders seek to modify the way they interact with their community, in order to gain more positive reinforcement from such interactions.

The availability and coverage of this group of interventions was similar to, albeit slightly lower than that for MI and MET, with 29 countries not responding to the question and four saying they were not available. Just under half of those countries saying these types of interventions were available indicated that coverage was fully adequate (14 countries) or adequate (21 countries), while 18 reported gaps existed, and 10 reported coverage was barely or not at all adequate. A further 10 countries reported the coverage was unknown.

Peer support groups, also sometimes called mutual-help groups, are established and run by individuals with lived experience of substance use disorders and provide information, structured activities and peer support in a non-judgmental environment. They can be valuable in supporting engagement with treatment and afterwards to sustaining recovery.

In those countries that reported peer support groups existed, coverage was generally quite good, with a little under a half reporting coverage as fully adequate (14) or adequate (17). However, 20 countries indicated that gaps in coverage existed, eight reported coverage was barely or not at all adequate, while 10 reported coverage was unknown, and seven countries indicated that such groups were not available in their country.

Contingency management (CM) involves giving patients rewards to reinforce positive behaviours, such as abstinence, treatment attendance, compliance with medication or a patient's particular treatment goals. The effectiveness of CM requires an agreed positive outcome with an objective measure and immediate feedback.

CM was reported less often than the other types of psychosocial and behavioural interventions specified in the ARQ. Over 40% of the 106 countries included in the report either did not respond to this question

(32 countries) or reported CM was not available in their country (14 countries). Of those who suggested CM was available, less than half reported coverage was fully adequate (10 countries) or adequate (16), while nine reported gaps in coverage existed, 14 that coverage was barely or not at all adequate, and 11 indicated that coverage was unknown.

Other psychological or behavioural interventions were only reported to be available in 31 countries, with coverage adequate or fully adequate in 19 of these, gaps in coverage in three, barely or inadequate coverage in two, and unknown coverage in seven countries.

3.1.3.3 Rehabilitation and aftercare (recovery management and social support) across regions/ by intervention

Recovery management, also known as recovery-oriented "aftercare", "continuing care" or social support, describes a long-term process of increasing patients' health and wellness, as well as supporting them in recovery from drug use disorders. Recovery management goes beyond a single treatment episode or a short-term aftercare program. It focuses on reducing the risk of relapse to substance use by comprehensively supporting social functioning, well-being, as well as social reintegration into the community and society. It helps improve patients' social functioning by enabling them to build on their strengths and resilience while keeping the focus on personal responsibility in managing their drug use disorder. To provide effective recovery management, it is necessary to involve the whole system, integrating all treatment modalities and the participation of stakeholders outside the health sector. Multiple community stakeholders play a role and should be engaged in the recovery process. These include families and caregivers, friends, neighbours, mutual self-help groups, spiritual and community leaders, stakeholders from the educational sector, the criminal justice system as well as sports and recreational facilities.

The types of interventions specified within this category of interventions were: recovery and social reintegration, interventions based on scientific evidence and focused on the process of rehabilitation, and other rehabilitation and aftercare services (countries were asked to specify what these were). These are very broad and imprecise descriptors and respondents may have had difficulty distinguishing between the different categories. *Figure 7* demonstrates the number of countries reporting different levels of availability of different types of rehabilitation and aftercare (recovery management and social support).

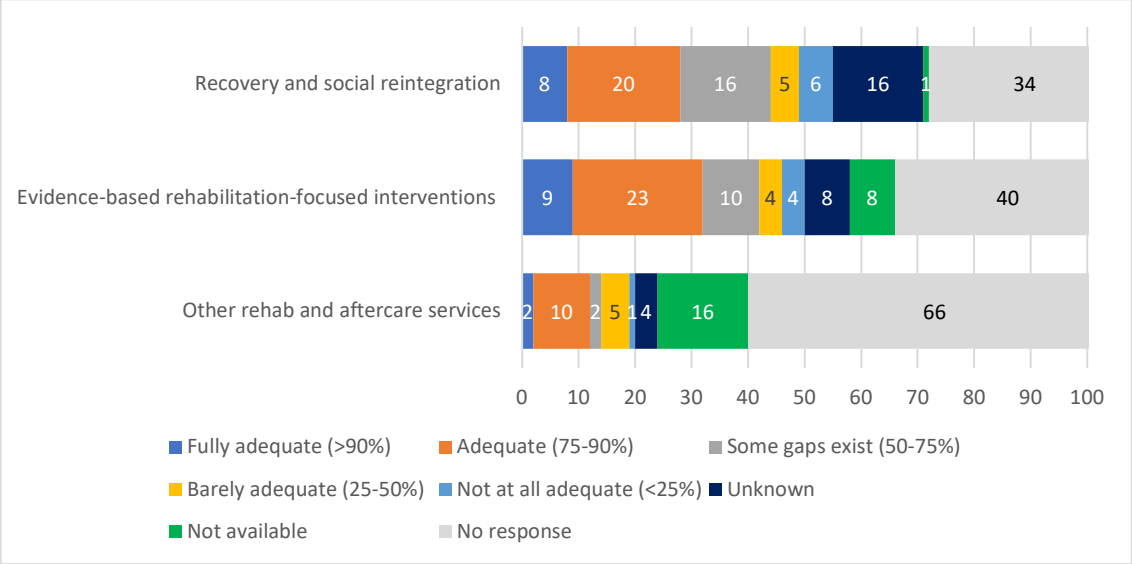


Figure 7: Number of countries reporting different types of rehabilitation and aftercare (recovery management and social support)

Within the broad category of rehabilitation and aftercare (recovery management and social support) interventions, **recovery and social reintegration** was the type of intervention most often reported to be available, although 34 countries gave no response to this item, and one (1) reported it was not provided in their country. Also, 16 countries reported coverage of recovery and social reintegration support was unknown. Of the countries where an assessment of coverage was given, about half reported coverage was fully adequate (8 countries) or adequate (20 countries), but a similar proportion reported that some gaps existed (16 countries) or coverage was barely (5 countries) or not at all adequate (6 countries).

Forty countries did not respond to the item relating to '**interventions based on scientific evidence and focused on the process of rehabilitation**' and eight countries indicated that these were not available. Of those reporting providing these interventions, over half reported coverage was fully adequate (9 countries) or adequate (23 countries), while 10 countries reported that some gaps in coverage existed, and four countries each reported barely adequate and not at all adequate coverage.

Only 24 countries reported that **other rehabilitation and aftercare services** were available in their treatment system, 16 countries reported they were not available, and the remaining 66 gave no response to this item. Half of those countries saying that these services were available reported coverage was adequate (10 countries) or fully adequate (2 countries). Of the other half, two countries reported that some gaps in coverage existed, five that coverage was barely adequate and one that it was not at all adequate, while four countries indicated that the extent of coverage was unknown.

3.1.3.4 Other types of treatment interventions across regions/ by intervention

In addition to treatment for drug use disorders – both pharmacological and psychosocial, and recovery management and social support – *the Standards* (UNODC and WHO, 2020) highlight the need for services to be provided to treat other mental and physical health problems that are often experienced by

people who use drugs in addition to substance use disorders. Rates of co-occurring psychiatric disorders are very high and, particularly in the case of people with severe drug use disorder or who inject drugs, serious medical health problems are also common. The ARQ question A6.6, therefore, included a section on the availability and coverage of other interventions and, specifically, treatment of psychiatric and medical comorbidities.

Figure 8 shows the number of countries reporting different levels of availability of other types of intervention. Treatment of psychiatric comorbidities was reported as being available in slightly more countries (67 countries) than treatment for medical comorbidities (64 countries). However, coverage of treatment for psychiatric comorbidities was reported to be lower: in those countries where it was available, 43% of countries reported either fully adequate (15 countries) or adequate coverage (14 countries), while 17 countries reported gaps existed, 12 reported coverage was barely or not at all adequate and nine that it was not known. In comparison, 58% of countries reporting availability of treatment for medical comorbidities rated coverage as fully adequate (15 countries) or adequate (22 countries) and only 11 reported that some gaps existed, 10 that coverage was barely or not at all adequate, while six reported that coverage was unknown.

Beyond treatment for psychiatric or medical comorbidities, very few countries reported any other types of intervention, with most countries (76 in all) leaving the question blank.

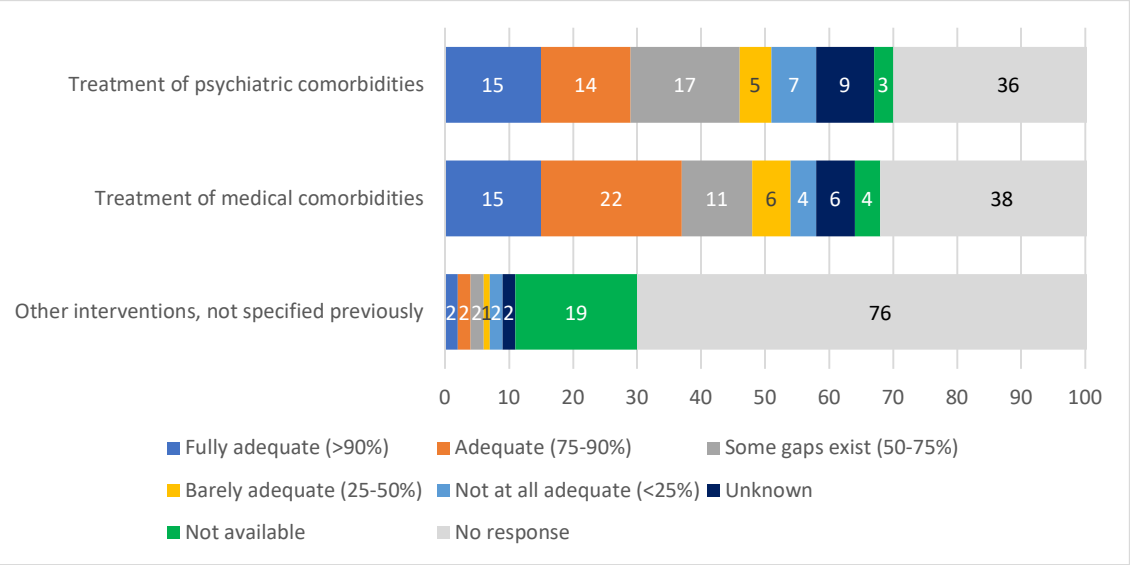


Figure 8: Number of countries reporting the availability of other types of intervention

3.2 Accessibility of services

The accessibility of treatment services refers to their reach or availability for the whole population. Principle 1 of *the Standards* (UNODC and WHO, 2020) highlights the need for essential treatment services for drug use disorders that should be within reach of public transport and accessible to people living in urban and rural areas. Treatment services also should be available during a sufficiently wide range of opening hours to ensure access for individuals with employment or family responsibilities and make provision to meet the needs of different sub-groups in need of treatment for drug use disorders

(such as childcare facilities for patients with children). Appropriate services also need to be available to the 'hidden' populations most affected by drug use but often unmotivated to receive treatment or that relapse after a treatment program. It is also very important that attitudes towards certain population groups or other factors do not hinder access to services, and treatment services should be accessible through multiple entry points.

In the ARQ, module A06.06 (treatment overage) asks responding countries to provide an assessment of the accessibility of the services that they indicated were available, as discussed in section 3.1 above. The possible response categories were:

- fully accessible (>90%);
- overall accessible (75-90%);
- some barriers exist (e.g. in relation to costs) (50-75%);
- some barriers exist for certain population groups (50-75%);
- hardly accessible (25-50%);
- not accessible (<25%);
- unknown.

Where countries indicated that some barriers existed, they were asked to specify what these barriers were. Some countries also highlighted barriers when they gave other accessibility ratings. As before, responses were not mandatory, and so the item was sometimes left blank. In the dataset received for analysis, only one was found in the 'some barriers exist' category.

3.2.1 Overview of the accessibility of the four broad categories of treatment

The responses to the item on the accessibility of the four broad categories of drug treatment are shown in *Figure 9*. Overall, psychosocial and behavioural interventions were reported to be the most accessible of the broad treatment categories, although the reported accessibility of pharmacological interventions was very similar.

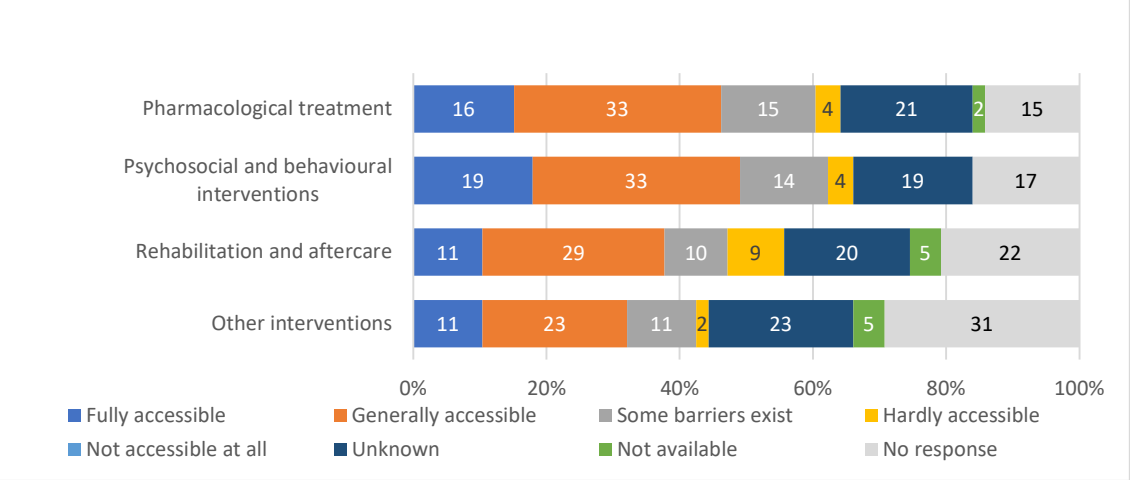


Figure 9: Number of countries reporting the accessibility of broad categories of treatment

Of the 89 countries that responded to the group of questions on the provision of **psychosocial and behavioural interventions** in general, the majority (58%) reported these interventions were either fully accessible (19 countries) or generally accessible (33 countries). Some barriers to access were reported by 14 countries (16% of those responding), while four countries reported these interventions were hardly accessible, and in 19 countries, accessibility was not known. Slightly more countries (91) responded to the items on **pharmacological treatment** overall, and a slightly lower proportion of these countries (54%) indicated that such treatment was either fully accessible (16 countries) or generally accessible (33 countries). However, 15 reported that some barriers to accessing these treatments existed; four reported they were hardly accessible, and in 21 cases, accessibility was not known, while two countries reported they were not available.

The accessibility of **rehabilitation and aftercare** services appears to be slightly lower than is the case for clinical interventions. While 22 countries did not respond to the block of questions on this category of intervention at all, another five reported they were not available. Of those countries that did respond, almost half (48%) reported that recovery and aftercare services were either fully (11 countries) or generally accessible (29 countries). Some barriers were reported to exist in 10 countries, and nine countries reported they were hardly accessible and for 20 countries, accessibility was not known. Non-response was highest for the category '**other interventions'**, which mainly comprises treatment for psychiatric or medical comorbidities, with only 75 countries providing any response. Of these, five indicated they were not available, and 23 that accessibility was unknown. Nevertheless, 45% of those responding indicated that other interventions were either fully accessible (11 countries) or generally accessible (23 countries), 11 that some barriers to access existed and 2 that they were hardly accessible.

3.2.2 Overview of the accessibility of the broad categories of drug treatment by region

Figure 10 shows the reported accessibility of each of the four broad categories of treatment by geographical region. As discussed above, the variation in the number of countries in each region responding means that the representativeness of the data will also vary, and caution is necessary in drawing conclusions. However, the findings may highlight areas of possible concern and pointers for further investigation.

3.2.2.1 Accessibility of pharmacological treatment by region

Overall, it appears that the accessibility of pharmacological treatment is lower in Africa and the Americas, with less than half of the countries who responded reporting it to be fully or generally accessible, although, especially in the case of the African region, the number of countries in the sample is limited. In other regions, well over half of countries reported full or general accessibility, but still a considerable proportion reported these interventions were not available or that accessibility was unknown (*Figure 10a*).

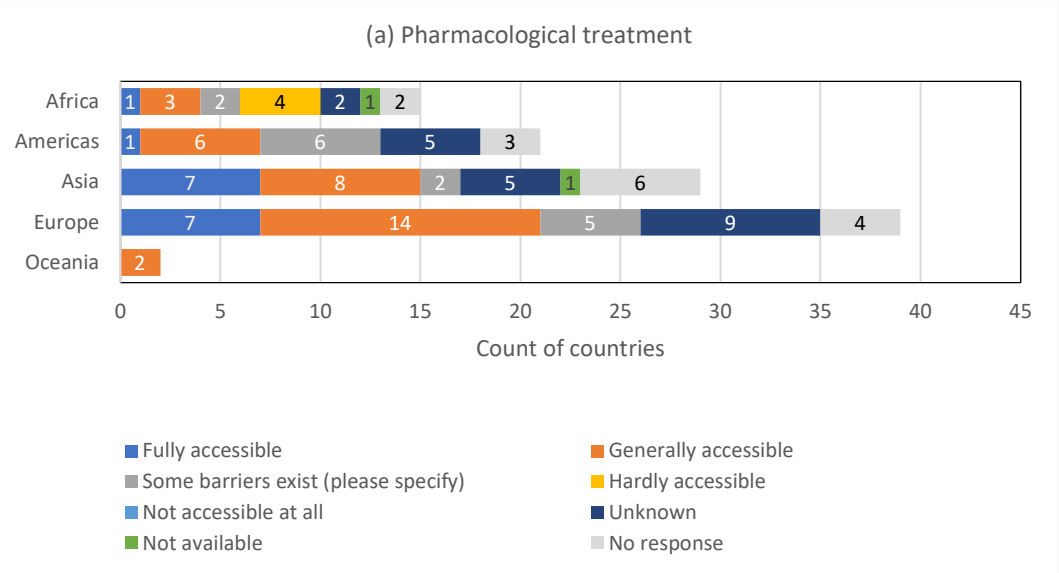
Of the 15 countries in **Africa** included in this study, 13 responded to this group of questions. Among those who responded, almost a third (31%) reported that pharmacological interventions were fully accessible (1 country) or generally accessible (3 countries). In contrast, two countries (15%) indicated that some barriers to access existed. Four countries (31%) responded that this type of treatment was

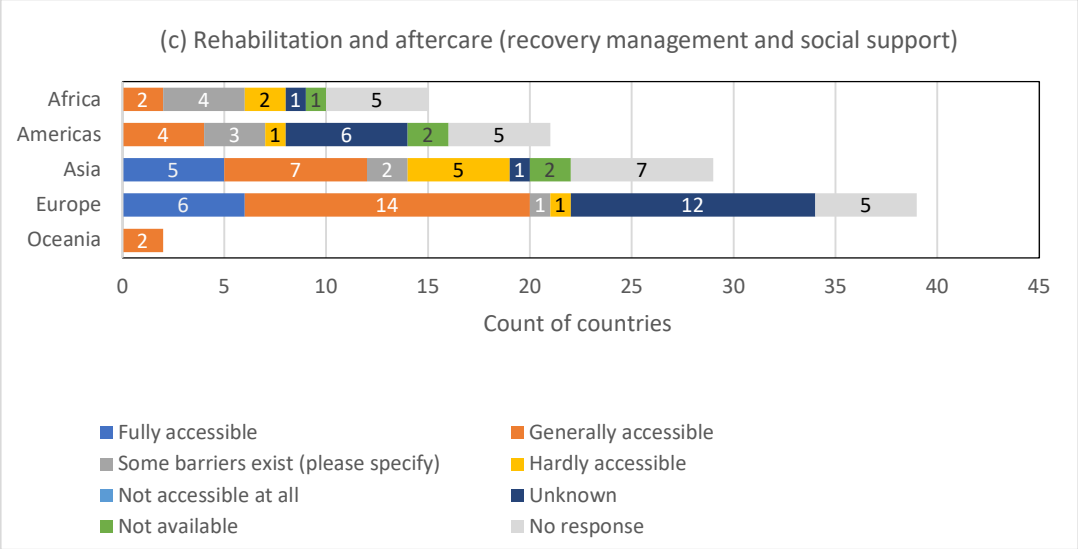
hardly accessible, two reported accessibility was not known and one reported this group of treatments was not available in their country.

Responses to the question about the accessibility of pharmacological treatment were available for 18 of the 21 countries from the **Americas** included in the study. Only 39% of those responding reported that pharmacological interventions were fully (1 country) or generally accessible (6 countries), while six countries (33%) reported that some barriers to access existed and the remaining five countries that accessibility was not known.

While only 23 out of the 29 countries from **Asia** included in this study responded to the item on accessibility of pharmacological treatment overall, those that did were generally quite positive about it. About two-thirds (65%) of those responding gave ratings of fully accessible (7 countries) or generally accessible (8 countries). Of the remainder, two countries reported some barriers to access existed, five that accessibility was not known and one that these treatments were not available.

Only four of the 39 included countries from **Europe** did not respond to this item. Of the 35 responding countries, about two-thirds (60%) assessed accessibility as either fully accessible (7 countries) or generally accessible (14 countries), while 14% (5 countries) reported some barriers existed. The remainder indicated that accessibility was not known (9 countries). Both countries in **Oceania** included in this study reported the pharmacological treatment was generally accessible.





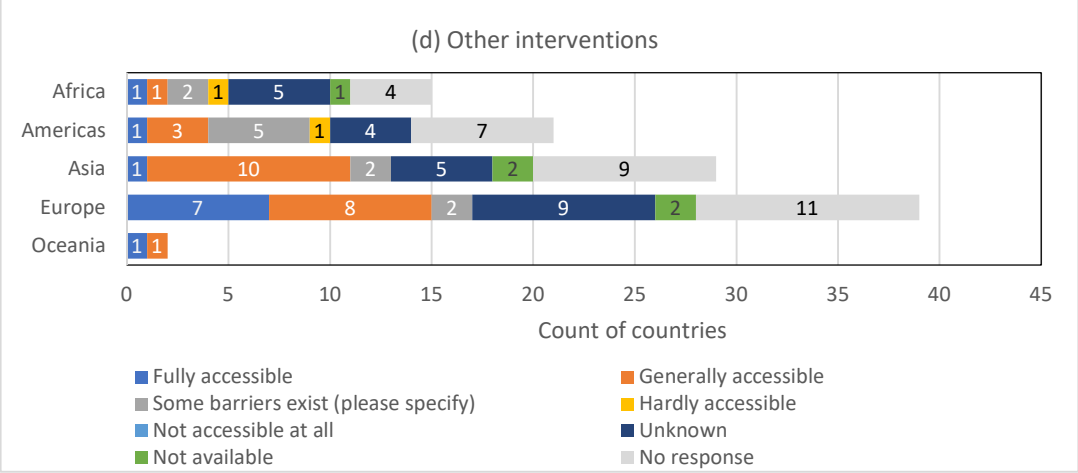


Figure 10: Number of countries reporting different levels of accessibility of the broad categories of treatment, by region

Out of the 106 countries included in this study, 26 countries provided some information in response to the open question asking for a description of the barriers to access to pharmacological interventions that existed in their country. The most commonly reported barrier, mentioned by 12 countries, was geographical issues, often emphasising how services were only available in a few places. This was highlighted as a particular issue for medication-assisted treatment, which in some cases was not available or only in very limited places when 'Dispensing the medicine in person on daily basis is a challenge due to distance between home and clinics'. The next most commonly reported barrier was related to cost or financial constraints, mentioned by 10 countries. This could relate to issues for governments in providing financing; for example, one country answered 'lack of budget allocated for the purchase of medicines', or for individuals wanting to access treatment. Two countries mentioned difficulties with getting '... access to certain medication on international markets' and 'insufficient drugs'. Three countries mentioned COVID-19 as having an impact, while two countries mentioned lack

of information acting as a barrier – in one case in relation to service providers 'doctors do not prescribe due to ignorance' and in the other suggesting that for people who use drugs, there is a problem with 'access to the appropriate information about availability of treatment'. Three countries highlighted issues around access for some particular groups of people, in one case problems for some people with disabilities, in another a lack of provision for adolescents, while a third country highlighted 'barriers because of necessity of health insurance to get the services (e.g., migrant population is excluded)'.

3.2.2.2 Overview of the accessibility of psychosocial and behavioural interventions by region

Responses to the overall question on the accessibility of psychosocial and behavioural interventions (*Figure 10b*) revealed a very similar pattern to those for pharmacological interventions generally. Although accessibility was generally slightly better than pharmacological treatments, accessibility was lower in Africa and the Americas than in the other three regions, with less than half of countries saying psychosocial and behavioural interventions were fully or generally accessible.

In **Africa**, 12 of the 15 countries in this study responded to the questions about accessibility of psychosocial and behavioural interventions. Of these, 42% indicated that these interventions were either fully accessible (1 country) or generally accessible (4 countries), while the same proportion (5 countries) reported that some barriers to access existed, one reported they were hardly accessible, and in one case, accessibility was unknown. Seventeen of the 21 countries in the sample from the **Americas** responded to this question, and 41% reported that this group of interventions were either fully accessible (2 countries) or generally accessible (5 countries). Almost a third (5 countries) reported that some barriers existed, and one country indicated that they were hardly accessible, while in about a quarter of cases (24%, 4 countries), accessibility was unknown.

In total, 24 of the 29 countries from the **Asia** region in the sample answered the questions in section A06.06 (treatment coverage) of the ARQ and, of these, two-thirds (67%) reported that psychosocial and behavioural interventions were either fully accessible (6 countries) or generally accessible (10 countries), while just two countries reported some barriers to access existed and one reported they were hardly accessible. However, in five countries (21%), accessibility was unknown. Of the 39 countries from **Europe** in the sample for this study, 34 responded to this question, but for over a quarter of these (26%, 9 countries), accessibility was unknown. Nevertheless, psychosocial and behavioural interventions were assessed as being either fully or generally accessible by most of those who gave an assessment, two-thirds (65%) of respondents (9 and 13 countries, respectively). Only two countries reported some barriers to access existed and one that this category of interventions was hardly accessible. Of the two countries in **Oceania** included in this study, one reported these interventions were fully accessible and the other reported they were generally accessible.

In total, 23 countries provided some additional information about the nature of the barriers to access to psychosocial and behavioural interventions in their country. The largest group of these related to a lack of trained staff mentioned by nine countries, with a lack of or distance to services mentioned by seven countries. These issues may, of course, be interlinked. Financial/cost issues were mentioned by five countries, including, for example, 'payment problems for professionals to motivate them to work in the public system, they choose to work private (in their 'own practice' and the 'lack of coverage by insurance companies who do not cover a lot of necessary care'). Another issue raised by three countries related to a lack of understanding of the value of these therapies in the population, for example, 'low patient motivation' and 'access to the appropriate information about the availability of treatment'. Other

comments related to the impact of the COVID pandemic (3 countries) and organisational/structural issues (4 countries).

3.2.2.3 Overview of the accessibility of rehabilitation and aftercare (recovery management and social support) by region

Figure 10c shows that, in general, accessibility to rehabilitation and aftercare (recovery management and social support) appears to be lower than that of pharmacotherapy and psychosocial and behavioural interventions, although this is most marked in the regions of Africa and the Americas. The pattern of regional variation is similar to that reported above. However, the response rate to this question was slightly lower in general.

Only 10 of the 15 countries in **Africa** responded to this question, and none reported these services were fully accessible, and only two (20%) reported they were generally accessible. Forty per cent (40%) of respondents (4 countries) reported that some barriers to access existed, and two countries indicated that they were hardly accessible, while one country reported they were not available and another that accessibility was not known. In the **Americas** region, a slightly higher proportion of countries in the sample (76%, 16 out of 21 countries) responded to this section, but in six of these countries, the level of accessibility was not known, and two countries reported that this group of interventions was not available. No countries in the region reported these interventions were fully accessible and only a quarter of respondents (4 countries) reported that they were generally accessible, while a quarter reported that either some barriers to access existed (3 countries) or they were hardly accessible (1 country).

In the **Asia** region, 22 of the 29 countries included in this study responded to this section of the ARQ. Of these, 55% reported that rehabilitation and aftercare (recovery management and social support) services were either fully accessible (5 countries) or generally accessible (7 countries). On the other hand, two countries reported some barriers to access existed; five countries reported they were hardly accessible, and two that they were not available, well over a third (41%) of those who responded. For only one country in the region, the level of accessibility was unknown.

While the response to this section of the ARQ was as high as 87% (34 out of 39 countries) among the countries in **Europe** in the sample, quite a high proportion of respondents (35%, 12 countries) did not provide an assessment of accessibility for this broad group of interventions as a whole. However, the majority of the remaining respondents reported that they were either fully accessible (6 countries) or generally accessible (14 countries), making up 59% of respondents. Only one country reported that some barriers to access existed, and one reported these services were hardly accessible. Both of the countries in the sample from **Oceania** reported that rehabilitation and aftercare (recovery management and social support) services were generally accessible.

In total, 17 countries provided specific comments on the types of barriers to access to recovery and rehabilitation provision. These comments highlight limited services and lack of trained staff as for other interventions, but several countries also describe barriers for specific vulnerable groups, for example, '*certain risk groups have lower access ... (women, children and youth and socially disadvantaged area's inhabitants)*' and '*no residential rehabilitation places for children*'. Another issue raised here was that many key areas for rehabilitation and reintegration (e.g., employment) are outside the health system, so drawing on them requires co-ordination with other agencies/departments, e.g., '*not own*

academic or employment training or rehabilitation resources, depends on co-ordination'. Stigma was also highlighted as a barrier to reintegration.

3.2.2.4 *Overview of the accessibility of other interventions by region*

In general, fewer countries provided any information in relation to this group of interventions, and those countries that did quite often did not provide an overall assessment of accessibility. However, generally, the pattern of variation between regions was similar to that of the other broad categories of interventions.

Of the 11 countries in **Africa** that responded to this question, only one reported full accessibility and one general accessibility to this 'other interventions' group (18% of respondents). The same proportion indicated that some barriers to access existed (2 countries) and one country reported they were hardly accessible, while another country reported these services were not available. No assessment was provided for five countries. Of the 14 countries in the **Americas** that responded to this set of questions, 29% reported that other interventions were either fully accessible (1 country) or generally accessible (3 countries), while 36% (5 countries) reported that some barriers to access existed and one country that they were hardly accessible. The accessibility of these services in the remaining four countries was not known.

While only 20 of the 29 countries in the **Asia** region included in this study responded to this group of questions about other interventions, those that did rated accessibility quite highly. Over half (55%) assessed their services to be either fully accessible (1 country) or generally accessible (10 countries), while two countries indicated that some barriers to access existed, two countries reported such services were unavailable, and five countries did not give an assessment. In **Europe**, response to this group of questions was also low: only 28 of the 39 countries from the region that were included in this study answered this group of questions and of those who did respond, about a third (9 countries) did not provide any assessment for other interventions overall. However, among the remainder, accessibility was generally assessed as good, with seven countries reporting these interventions were fully accessible and eight reporting they were generally accessible (54% of all respondents when taken together). Only two countries reported that some barriers to access existed, and two reported these services were not available. In the two countries in **Oceania** in the study, one reported these other services were fully accessible and one that they were generally accessible.

3.2.3 Accessibility of specific types of drug treatment intervention

3.2.3.1 *Accessibility of specific pharmacological interventions*

Figure 11 shows the accessibility ratings given for each specific pharmacological intervention covered within module A06.06 (treatment coverage) of the ARQ. As discussed in section 3.1.3.1, **management of withdrawal** was the type of pharmacological treatment most likely to be reported as available, and it also had the highest proportion of reporting good accessibility. Of the 81 countries who responded to the item relating to this type of treatment, about two-thirds (64%) reported that it was either fully accessible (19 countries) or generally accessible (33 countries). Of the remainder, 12 countries reported that some barriers to access existed, two reported management of withdrawal was hardly accessible, 14 indicated that accessibility was unknown, while one country reported it was not available.

Some brief information on the types of barriers to access to withdrawal management in their country was provided by 19 countries. Geographical barriers were the most commonly reported (6 countries), while four mentioned costs or financial issues. Five countries reported a variety of organisational or structural issues, including: *'long waiting list'*, *'lack of structures'*, *'eligibility'* restrictions, and *'conception that the management of abstinence is a hospital intervention therapeutic communities of a social nature not authorised to provide health services*.' '*Insufficient skilled human resources'* was mentioned specifically by one country, and two mentioned issues related to the COVID-19 pandemic, while one mentioned stigma being a barrier and another, a lack of information affecting access.

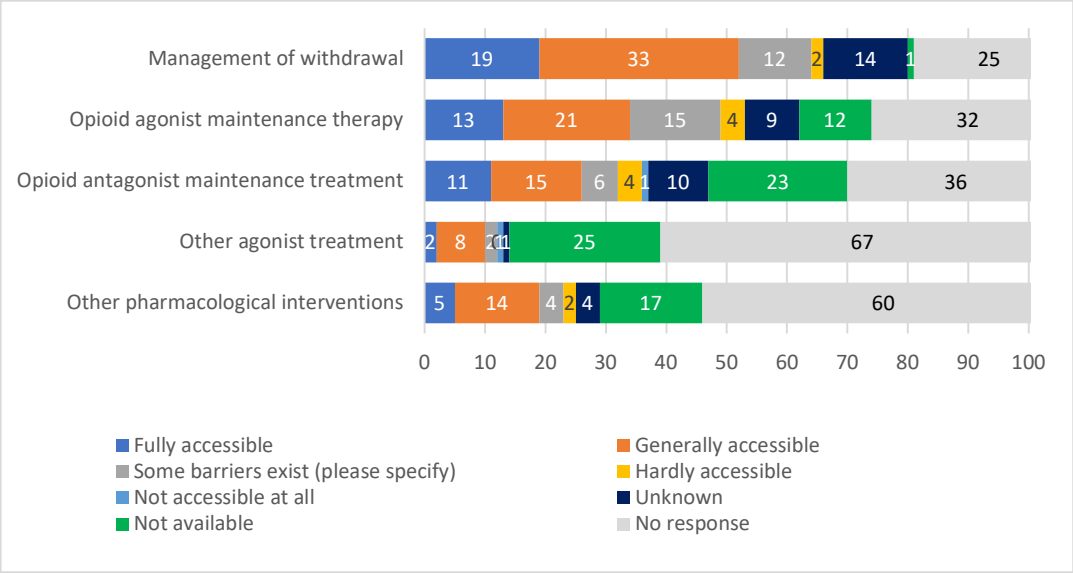


Figure 11: Number of countries reporting the accessibility of different pharmacological treatment types

The next most accessible type of pharmacological treatment was **opioid agonist maintenance therapy** (OAMT). Of the 106 countries in this study, 74 countries (70%) responded to this item and just under half of these (46%) reported that this type of treatment was either fully accessible (13 countries) or generally accessible (21 countries). Of the remainder, 15 reported some barriers to access existed, four that this type of treatment was hardly accessible, nine that accessibility was unknown and 12 that it was not available.

Twenty-four countries provided some information on the barriers to accessing OAMT in their country. Geographical constraints were again the most frequently reported, being mentioned by 11 countries, organisational or structural barriers (6 countries), cost or financial issues (5 countries – two of them specifically mentioning these in relation to buprenorphine), and human resources issues (4 countries). Countries sometimes highlight more than one barrier, and there was also overlap between different types of barriers. For example, *'partial take-home, only in the addiction treatment network, the availability of narcologists is limited, it is not possible to receive it by GPs. Buprenorphine is at the patient's own expense (fee)'* and *'there are geographical accessibility and cost barriers (in the case of non-governmental services from the private sector or civil society)'.* As one country highlighted in their

comment, '*need to scale up number of locations where services can be accessed. Need to accelerate mobile dispensing for hard to reach key populations'*, it is necessary to consider not just geographical barriers but also the potential need for different types of service for specific groups. One or two countries mentioned a number of other barriers. Two countries mentioned difficulties with access to medication, one issue relating to the COVID pandemic, while one mentioned stigma and discrimination as an issue, and another reported there were barriers to providing opioid agonist therapy (OAT) in prison settings. One country mentioned that this type of treatment was available but that no cases had been registered.

Opioid antagonist treatment appears to be considerably less accessible: 36 countries did not answer to this question and of those that did respond, 23 countries (33%) reported it was not available in their country. A little over a third of responding countries (37%) reported it was either fully accessible (11 countries) or generally accessible (15 countries), while six countries reported that some barriers to access existed, four that such treatment was hardly accessible and one that it was not accessible at all. In 10 countries, accessibility of this intervention was unknown.

Some comments on accessibility of opioid antagonist treatment were made by 14 countries. These mainly described financial, geographical or organisational constraints on access similar to those mentioned above. It appears that this type of treatment is often only available in certain types of services which may reduce access. Four countries also mentioned difficulties obtaining these medications, mentioning cost and limited suppliers.

Other agonist treatments were even less likely to be reported: only 39 countries responded to this question, and 25 of these reported that this type of treatment was not available in their country. The majority of those indicating it was available (71%, 10 countries, or 26% of all respondents) rated accessibility as good; two countries reported it was fully accessible, and eight that it was generally accessible. Two countries reported that some barriers to access existed, one that it was not accessible at all, and one that accessibility was unknown. There were only five comments on accessibility of this sort of treatment, but two of these mentioned eligibility restrictions.

Non-response to the question on **other pharmacotherapy interventions** was also high, with only 46 countries providing information, including 17 who reported these were not available. It was not specified what other interventions were to be included here, which is likely to have greatly influenced responses and hampered their interpretation. Most of those providing an accessibility assessment were positive about it, with five countries saying these interventions were fully accessible and 14 saying that they were generally accessible. However, four countries reported some barriers to access existed, two that they were hardly accessible and four that accessibility was not known. Only 10 countries commented on this question, including four that provided insight into the very different types of other pharmacotherapy that countries may be referring to when answering this question. These were: '*traditional medicine*', '*methylphenidate for methamphetamine users'*, '*alcohol pharmacological treatment'*, and '*Hepatitis and TB and HIV services for people who use drugs*'.

3.2.3.2 Accessibility of different psychosocial and behavioural interventions

As discussed earlier, psychosocial and behavioural interventions are the category of intervention that are most likely to be reported as being available. Within this group, the types of psychosocial and behavioural interventions that were reported as being most accessible overall were cognitive

behavioural therapy (CBT) and motivational interviewing (MI), with community reinforcement approaches (CRA) and mutual-help groups not far behind, and contingency management (CM) less accessible (*Figure 12*).

Other psychosocial interventions were not often reported, and it is unclear what those who responded to this question included in it. Some countries provided information about this in their comments, reporting counselling (individual and group), psychotherapy, relapse prevention, life skills training, employment, education and other forms of social integration, family therapies, and integrated comorbidity treatment. However, most of these are probably more relevant to other intervention categories.

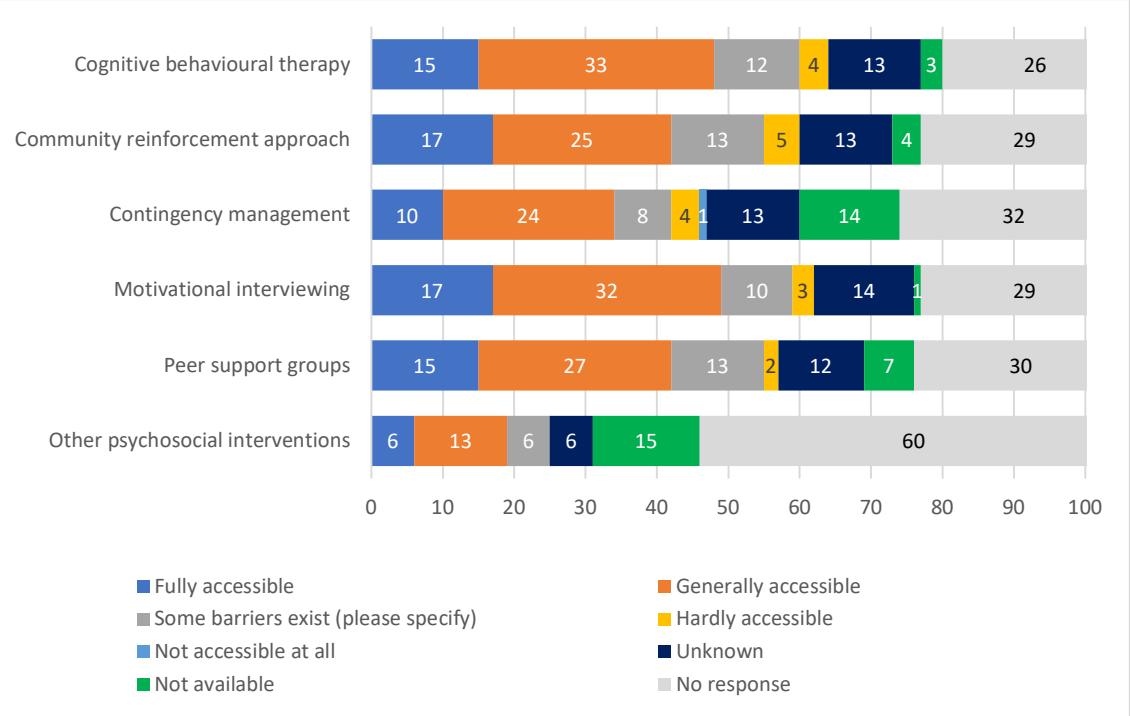


Figure 12: Number of countries reporting the accessibility of different psychosocial and behavioural interventions

In total, 80 countries (75% of countries included in this study) responded to the questions on **cognitive behavioural therapy** (CBT), of which 60% reported that this type of therapy was either fully accessible (15 countries) or generally accessible (33 countries). Twelve countries reported that some barriers to access existed, four countries assessed CBT as hardly accessible, while three countries reported it was not available, and in 13 countries, the level of accessibility was unknown. Nineteen (19) countries provided information about barriers to accessing CBT. The barriers mentioned were similar to those described for psychological and behavioural interventions generally (see section 3.2.2.2). The two main groups of concern raised were a lack of trained staff (seven countries) and geographical constraints, such as insufficient services and patchy provision (six countries).

Slightly fewer countries (77) responded to the questions about the accessibility of **motivational interviewing** (MI)**.** Of these, almost two-thirds (64%) reported that MI was either fully accessible (17 countries) or generally accessible (32 countries), while 10 countries reported some barriers to access

existed, three countries that these interventions were hardly accessible, and 14 did not know. Only one country reported MI was not available in their country. Nineteen (19) countries provided descriptive information on the barriers to access to MI. These were similar to those described earlier in section 3.2.2.2, largely around shortage of trained staff, lack of services and financial constraints. Specific to MI, one country reported that '*even though motivational interviewing training is widely used, the structured method is not that widely used as general motivational approach*' and another described a positive development: '*there has been extensive drives by ATTC to provide social workers and others involved in the treatment area with MI training. This has been well implemented over the last 5 years*'.

The questions on access to the **community reinforcement approach** (CRA) were also responded to by 77 countries, and, of these, 55% reported that this approach was either fully accessible (17 countries) or generally accessible (25 countries). Some barriers to accessing this type of intervention were the assessment given by 13 countries; five countries reported they were hardly accessible, and four countries reported they were not available at all. Thirteen countries indicated that accessibility was unknown. Comments on barriers to access were made by 19 countries and mainly covered similar issues to those mentioned earlier. However, issues specific to CRA include challenges around family engagement in some communities and the lack of coverage by insurance companies for this sort of care, in one case, a distinction was highlighted between family involvement and a structured CRA approach, saying: '*Although most services effectively involve family members and others, few are practising CRA*'.

Responses to the questions on **peer support groups** were received from 76 countries. Of these, 55% reported that peer support groups were either fully accessible (15 countries) or generally accessible (27 countries). 13 countries reported some barriers to access, only two countries reported peer support groups were hardly accessible, but seven reported they were not available at all, while for 12 countries accessibility was not known. 16 countries provided comments on barriers, many were as discussed earlier. Ones specific to peer support groups include: '*narcotic analysis is not popular in* [our country]. *Groups are mainly provided in treatment centers under the supervision of a staff member*' and another which highlights the need to provide support to such groups: '*These services are offered by the private sector and civil society; however, there is little training of non-professional staff, lack of knowledge of current regulations and limited infrastructure*.' Another country highlighted the issue of stigma, which may hinder the operation of these groups and people's engagement with them, while on a more positive note, another country mentioned: '*the emergence of online programs (due to COVID) improves accessibility*'.

Slightly fewer countries (74) responded to the questions on **contingency management** (CM), and 14 countries (19% of respondents) reported that this was not available, with a similar number (13 countries, 18% of respondents) saying accessibility was unknown. Less than half of respondents (46%) reported CM was either fully accessible (10 countries) or generally accessible (24 countries), eight countries reported some barriers to access existed, four countries reported them to be hardly accessible, and one that they were not accessible at all. Fourteen countries left comments specific to CM, with one country pointing out that CM is '*not generally specified as a treatment type, therefore we are uncertain of the coverage*' and another reported that '*despite national guidance recommending it, CM is little implemented in* [our country] *as it is liable to generate negative media coverage*'.

3.2.3.3 Accessibility of different rehabilitation and aftercare (recovery and social support services)

The broad intervention category of rehabilitation and aftercare (recovery and social support services) was subdivided into two more specific intervention types: recovery and social integration, and evidence-based rehabilitation-focused interventions, alongside an 'other rehab and aftercare services' question. However, these more specific intervention types were not defined in the instructions for the ARQ and from the text comments in this section and the comparatively high non-response, it appears this may have created uncertainty for people completing the questionnaire.

Although recovery and social reintegration services are a little more likely to have been reported as available than evidence-based rehabilitation-focused interventions, they were slightly less likely to be reported to be fully or generally accessible (*Figure 13*). Few countries (only 40) answered the question on 'Other rehab and aftercare services', and 16 responding countries reported they were not available. However, where they are reported, they appear to be quite accessible – one country indicated in comments that the other services they were referring to were social and probation services.

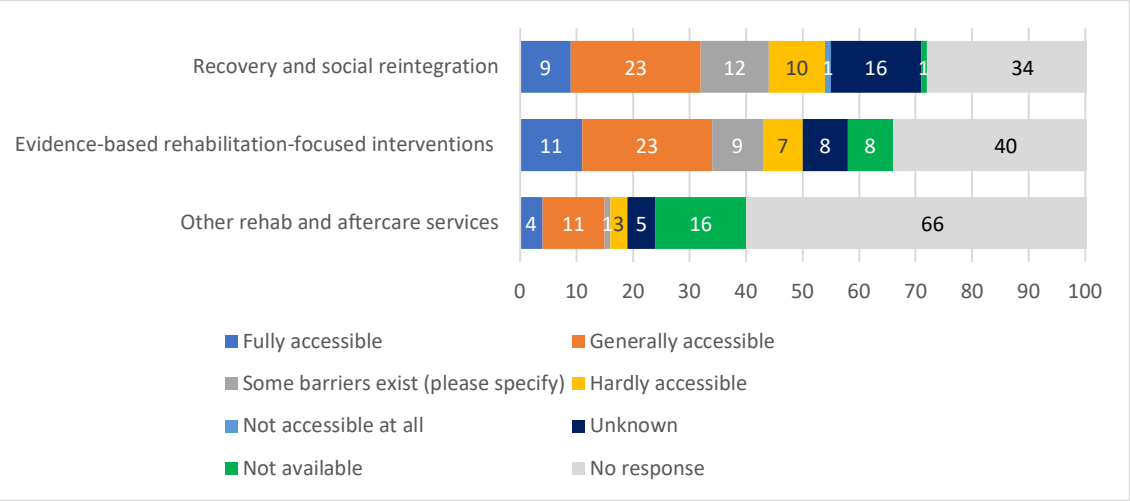


Figure 13: Number of countries reporting the accessibility of different rehabilitation and aftercare (recovery management and social support) services

Slightly more countries responded to the question relating **to recovery and social reintegration** support (72 countries, 68% of the countries in this study) than to the other questions in this group, and only one country reported this support was not available. However, less than half (44%) of responding countries reported that this type of intervention was either fully accessible (nine countries) or generally accessible (23 countries), while 12 countries reported that some barriers to access existed, 10 reported this support was hardly accessible and one country that it was not accessible at all. A fifth of respondents (16 countries) reported that accessibility was not known.

The question about **evidence-based rehabilitation-focused interventions** was answered by 66 countries, and just over half (52%) reported that these were either fully accessible (11 countries) or generally accessible (23 countries). Nine countries reported some barriers to access, and seven countries

reported these interventions were hardly accessible, while eight countries indicated accessibility was not known and another eight countries reported these interventions were not available.

The barriers described in the open questions were described earlier (in section 3.2.2.3) and did not show much variation between the specific intervention types.

3.2.3.4 Accessibility of other interventions

As discussed earlier, the availability of the two specified 'other types of treatment', i.e., the treatment of psychiatric comorbidities and medical comorbidities, was generally similar. However, the accessibility of treatment of medical comorbidities appeared to be somewhat better overall than treatment for psychiatric comorbidities (*Figure 14*).

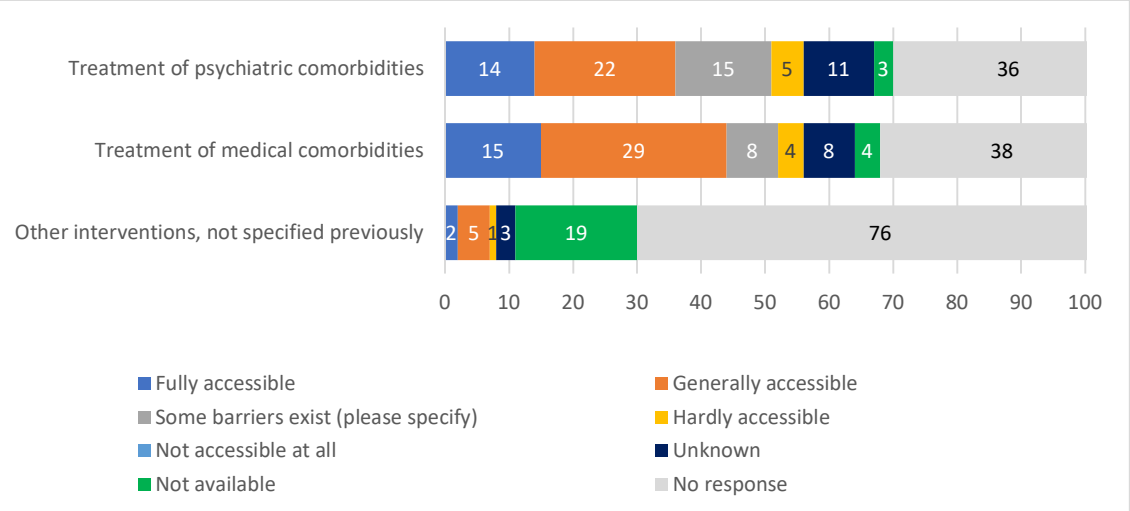


Figure 14: Number of countries reporting the accessibility of other types of interventions

Of the 70 countries who responded to the questions about the **treatment of psychiatric comorbidities**, about half (51%) reported that these services were either fully accessible (14 countries) or generally accessible (22 countries), while 15 countries (21%) reported that some barriers to access existed, five countries reported these services were hardly accessible, 11 did not know, and three countries reported they were not available. In addition to the issues of financial/economic constraints, geographical accessibility, and concerns about the cost of and access to medicines etc., mentioned in relation to other types of service generally, several countries made comments specifically relating to a lack of psychiatrists, while others mentioned the problem of a lack of coordination between addiction and mental health services and service gaps for people with dual diagnosis.

A total of 68 countries provided a response to the questions on accessibility of **treatment for medical comorbidities**. Of these, about two-thirds (65%) reported that these services were either fully accessible (15 countries) or generally accessible (29 countries). Only eight countries reported that some barriers to access existed, four countries reported these services were hardly accessible, eight countries did not know, and four countries reported they were not available. In the comments about barriers to access stigmatisation (within physical health services) and poor referral processes stand out in comments

relating to barriers to treatment of medical comorbidities, e.g., '*stigma issues when it comes to seeking other medical care hampers access*' and '*some people dependent on drugs, including on OAT, still report poor treatment by acute physical healthcare services*'.

Few countries gave any response to the question about 'Other interventions, not previously specified'; only 30 countries of which 19 responded that they were not available, and in three cases, accessibility was not known. Only four countries gave comments relating to other interventions not specified previously. Two of these related to the services being referred to here: one was '*services of civil society organizations*' and the other was '*treatment in churches and convents (informal)*'.

3.3 Affordability of services

Treatment services for drug use disorders should be affordable for patients from different socio-economic groups and levels of income. Ideally, treatment for drug use disorders should be provided free of charge so that the costs do not become a barrier to treatment. Additionally, there is a need to make treatment systems for drug and other substance use disorders affordable for the health and social system in order to sustain treatment services.

As indicated above, financial constraints and the cost of treatment were identified as barriers to treatment access in the comments from many countries. These are related to costs limiting the provision of treatment services and the requirement for payment for treatment being a barrier to access for people with substance use disorders.

A key aspect of affordability from an individual's perspective is whether they will be charged for using drug treatment services and the ARQ module R12.12 (national policies/strategies on drug treatment) included a question that sought to provide some insights on this topic. This asked whether in their country:

- All treatment is covered by the public health system;
- Treatment is covered only by private insurance;
- Mixed coverage (some treatment covered by the public system and others by the private system or
- Other.

If they responded that there was mixed coverage or other arrangements, they were asked to specify these.

Just over half the countries included in this study, 54 in total, responded to this question. As shown in *Figure 15*, half of these indicated that the public health system covered all drug treatment services and none reported that treatment was only available when covered by private insurance. Most of the remaining countries (43%, 23 countries) reported mixed coverage, and the descriptions provided by the 14 countries who provided more information highlight the variety of situations that may occur and the difficulty of obtaining a picture of the complex arrangements that may be in place. For example, "*substance use treatment services are delivered in a variety of settings and operate both publicly and privately, including mixed funding models. Constructing a national picture of treatment centres and services is challenging, as prevention, treatment, and recovery are not defined uniformly across the country",* and "*the health system has a mixed, decentralised structure composed of three subsystems: the public subsystem, the social security subsystem and the private subsystem. It is based on financial*

protection mechanisms financed by different sources: the national and provincial budgets, the world of work and the economic resources of individuals."

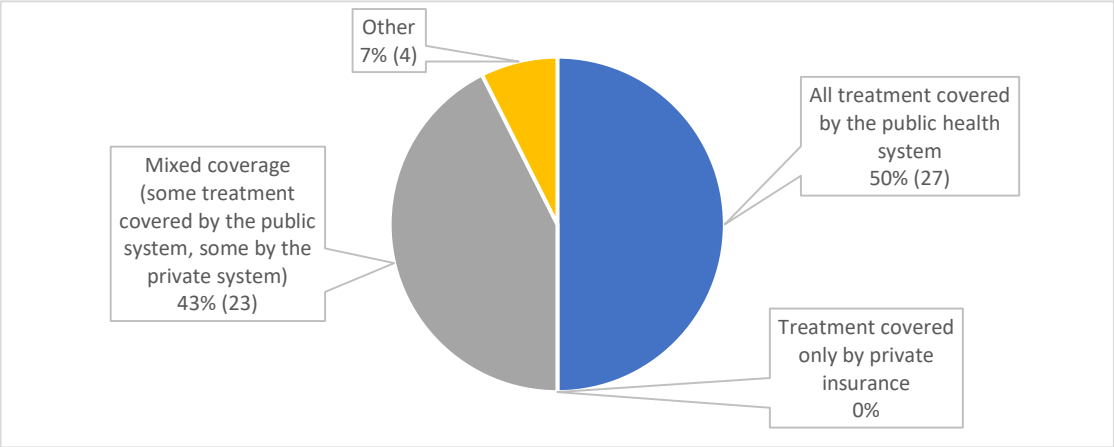


Figure 15: Overview of the reported payment mechanisms for drug treatment

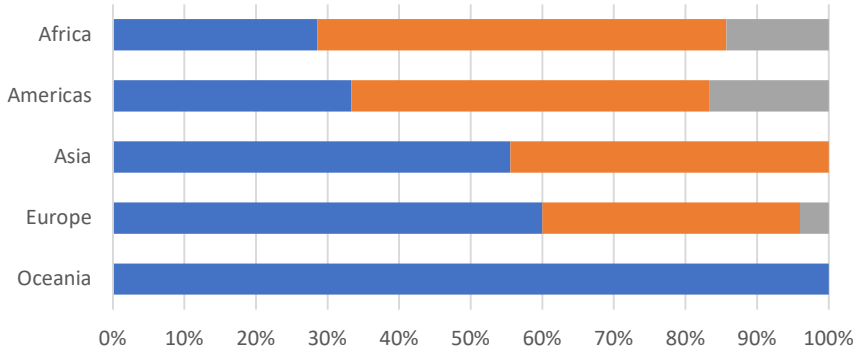
Several other countries also highlighted the role of social insurance schemes that underpin eligibility for health care more generally and for drug treatment services, which may provide for only some specific types of treatment. One such example is the response from a country stating, "*in a region, the regulations on addiction care and support services provide for the following: Free consultations can be given on the basis of an internal regulation that sets out the modalities. For services provided under the Compulsory Health Care and Benefits Insurance Act, the financial contribution from the insurance company is claimed either on the basis of payment per service or on the basis of a lump sum. For non-medical services, the terms of the financial contribution and a maximum rate are set by the Government.*" Similarly, in another country "*the services offer an anonymous and free reception. With anonymity, people who are in an irregular situation are also treated. Addiction services in hospitals are covered like any insured person, with certain drugs (e.g. methadone) being covered. All general practitioners can prescribe buprenorphine at the correct dosage. The consultation is paid for in the same way as any insured person with possible additional coverage by complementary mutual insurance companies."*

Private clinics may make a significant contribution to drug treatment provision, or some patients and their families may be required to pay for these services even if they are provided in public clinics. For example, "*publicly funded out-patient services are ensured by a narcologist, who is a directly accessible specialist and who provides healthcare services to patients (diagnoses coded as mental and behavioural disorders due to psychoactive substance use (F10-F19) or habit and impulse disorders (F63.0)) in accordance with the International Classification of Diseases (ICD-10). Treatment of patients with substance use disorders is also provided by private institutions and private narcologist's practices*" and, *"the Government has 440 outpatient addiction care units and 51 residential care units, most of which provide treatment free of charge or with an affordable recovery fee. However, there is a significant proportion of treatment services offered by the private sector or Civil Society Organisations, mainly in the residential modality, and 2,129 establishments were registered in 2020."*

Sometimes, eligibility for treatment in the public system is restricted, as in this example: "*the treatment provided by the public system is for those clients who are apprehended by the law for the offence of*

substance abuse and those referred by the schools and institutes. The other treatment seekers (voluntary clients) are treated by private system and NGOs."

There was also variability between regions in how drug treatment services are paid for, as shown in *Figure 16*. These data need to be viewed as indicative only since the number of countries responding varies considerably by region. For example, only one country in **Oceania** responded to this question in which drug treatment was covered by the public health system, but it cannot be assumed that this is the case everywhere in the region. Nevertheless, it does appear that in general, provision of treatment through the public health system may be lower in Africa and the Americas than in Asia and Europe, although a considerable proportion (over two-thirds) of the countries in Asia included in this study did not respond to this question.



	Oceania	Europe	Asia	Americas	Africa
All treatment covered by the public health system	1	15	5	4	2
Mixed coverage (some treatment covered by the public system, some by the private system)	0	9	4	6	4
Other	0	1	0	2	1

[Note: Proportion of the 106 countries included in the study responding to the question was: Africa 47%, Americas 57%, Asia 31%, Europe 64% and Oceania 50%]

Figure 16: Proportion of countries responding who reported different payment mechanisms for drug treatment by region (Source ARQ module R12.12, 2020)

4 Promoting quality assurance at the system level

The development and dissemination of *the Standards* (UNODC and WHO, 2020) is supported by a number of international documents, including CND resolution 59/4 on the "Development and dissemination of international standards for the treatment of drug use disorders", the Outcome Document of the 2016 United Nations General Assembly Special Session On The World Drug Problem (UNGASS) and, more recently, CND resolution 64/3 on "Promoting scientific evidence-based, quality, affordable and comprehensive drug prevention, treatment, sustained recovery and related support services". This resolution also reaffirmed the importance of developing quality assurance mechanisms for drug use disorders treatment in order to promote its continuous improvement and prevent cruel, inhuman or degrading treatment or punishment in accordance with national legislation and applicable international law.

In 2022, UNDOC launched two quality assurance (QA) tools based on *the Standards* (UNODC and WHO, 2020)*:* one dedicated to quality assurance at the services level (Services QA Toolkit) and another focused on quality assurance at the systems level (System QA Toolkit). In collaboration with other relevant stakeholders, UNODC has also developed a set of "Key Quality Standards for Service Appraisal" based on *the Standards* (UNODC and WHO, 2020), and that are (a) drawn from existing sets of regional and international standards and (b) are thought to be of key importance to assure the quality of drug use disorder treatment services.

The System QA Toolkit is designed to help stakeholders reflect on their current approach to the planning, resourcing and delivery of treatment and care systems for people with drug use disorders and identify gaps and areas for further improvement in line with the *the Standards* (UNODC and WHO, 2020). It specifies five standards for local drug use disorder treatment systems, each with detailed criteria and recommended evidence required to demonstrate compliance. A summary of the System QA standards and criteria is given in *Table 4*.

The information collected in the ARQ module R12.12 (national policies/strategies on drug treatment) covers some of the standards in the System Toolkit, and consideration of the data provided within these items can provide some insights into the quality of services within responding countries and, in particular, the mechanisms for quality assurance currently available in their drug treatment systems. The responses provided by the countries included in this study relevant to each of the five (5) System Standards are reviewed below. However, the limitations of the data discussed earlier must be borne in mind when considering these findings and they must be viewed as a first overview of the types of insights that might be obtained from this module and how it could be developed in the future.

Table 4: Summary of Drug Treatment Systems Standards and Criteria

Table 2: Summary of systems standards and criteria	
Standard Sys1: The area has a mechanism that co-ordinates and oversees the planning, funding, monitoring and review of the drug use disorder treatment system	
A	The area has a mechanism for the co-ordination, planning, funding and review of the drug use disorder treatment system
B	The mechanism has multi-sectorial representatives at a senior level to ensure drug use disorder treatment is linked with health, social care, criminal justice systems and communities
C	The co-ordination, planning of the DUD treatment system is led by public health or health authorities.
Sys2: The area has a recent comprehensive needs assessment that informs drug use disorder treatment system planning	
A	The area has a recent comprehensive needs assessment, preferably led by public health authorities
B	There is a national drug information system and observatory (national data centre)
Standards statement: Sys3: The drug use disorder treatment system features a tiered or 'pyramid' model, settings, modalities and interventions outlined in *'The Standards' (WHO/UNODC 2020)*	
A	The system is organised in a tiered or pyramid model to provide treatment for a range of drug use disorders (in terms of substance type, severity and complexity)
B	The system is designed to have health and social care interventions in non-specialised settings (such as primary health care) as recommended by *'The Standards' (WHO/UNODC 2020)*
C	The system is designed to have specialised drug use disorder treatment in all settings as recommended in *'The Standards' (WHO/UNODC 2020)*
D	The system is designed to have the core evidence-based specialised drug use disorder treatment modalities and interventions recommended in *'The Standards' (WHO/UNODC 2020)* (to meet local needs)
E	The system is designed to provide continuity of care and recovery management for people with drug use disorders
Standards statement SyS4: The area has a funded plan to develop and sustain its drug use disorder treatment system in line with *'The Standards' (WHO/UNODC 2020)*	
A	The area has a current plan for its drug use disorder treatment system functioning and development in line with *'The Standards' (WHO/UNODC 2020)*
B	The plan has adequate resources to fund the drug use disorder treatment system development and functioning
C	The plan has priorities and indicators that are monitored, including system capacity, access and quality
D	The plan is regularly reviewed and updated
E	The system has mechanisms to ensure specialised drug use disorder treatment services are accountable and help meet the plan
Standards statement SyS5: The system has planned and monitored mechanisms to enable and improve quality, including addressing inhuman or degrading treatment, stigma and discrimination	
A	There is a system-wide drug use disorder treatment data system
B	The system has standards and a quality improvement mechanism that includes protecting people from inhumane or degrading treatment
C	The system has planned and funded activities to support workforce development including training
D	The system has planned and funded activities to reduce stigma and discrimination faced by people with drug use disorders and their families

Source: Systems QA Toolkit, Table 2

4.1 Standards Statement SyS1: The area has a mechanism that co-ordinates and oversees the planning, funding, monitoring and review of the drug use disorder treatment system

This first standard has three criteria specified within the Toolkit. These are:

A. The area has a mechanism for the co-ordination, planning, funding and review of the drug use disorder treatment system.
B. The mechanism has multi-sectorial representatives at a senior level to ensure drug use disorder treatment is linked with health, social care, criminal justice systems and communities.
C. The co-ordination and planning of the drug use disorder treatment system is led by public health or health authorities.

One item in the ARQ module R12.12 (national policies/strategies on drug treatment) is a free text question that asks countries to provide information on the "Central co-ordinating entity and other

institutions involved in the implementation and management of treatment services (including NGOs, if applicable)". A total of 43 of the countries included in this study responded to this item. *Figure 17* shows that, of these, just over half indicated that the central co-ordinating entity was the ministry of health or other health department or agency, with only two countries indicating this was undertaken by the ministry of justice/department or agency. A drug-specific body, often created within the drug legislation, was reported to be the central co-ordinating entity by 12 countries (28% of those providing a response), while seven countries described some other arrangement. These included countries where co-ordination of drug treatment provision was developed to local areas/states and some where other ministries, such as social development or citizenship, took the lead.

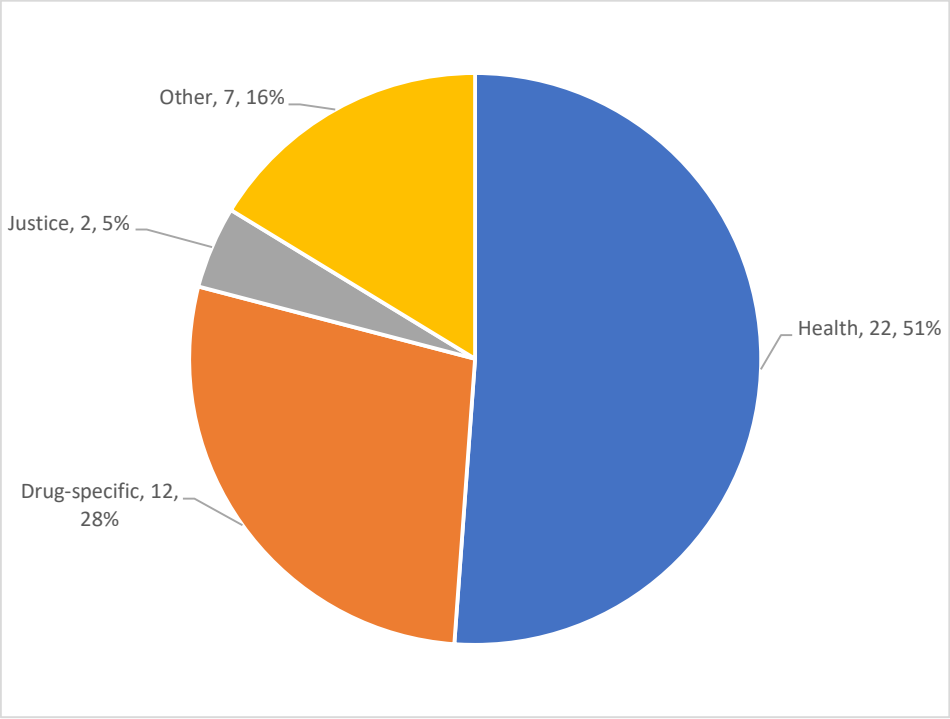


Figure 17: Overview of the ministry/department/agency leading the central co-ordinating entity in those countries answering this question (n=43)

The small number of countries responding to this question makes consideration of regional differences unreliable. However, it appears that in Europe, a health-led approach dominates, with 17 of the 23 countries responding to the question reporting that a health ministry or department was the lead in the central co-ordinating entity. In the Americas, in contrast, six of the nine responding countries reported a drug-specific ministry/department in the lead. In other regions, responses were more varied.

Some countries also provided more information about the different ministries or agencies that were involved in the implementation and management of treatment services in their country, which included a wide range of ministries, treatment services, NGOs, professional bodies, academic institutions.

4.2 Standards Statement SyS2: The area has a recent comprehensive needs assessment that informs drug use disorder treatment system planning

The second standard has two criteria specified within the Toolkit. These are:

A. The area has a recent comprehensive needs assessment, preferably led by public health authorities.

B. There is a national drug information system and observatory (national data centre).

One item in the ARQ module R12.12 (national policies/strategies on drug treatment) sheds some light on criterion B. This is a question that asks countries to provide information on the "Availability of mechanism(s) to map available interventions and/or to monitor treatment interventions". Answer categories provided were: Yes (please specify); No; Unknown. Just over half of the countries (54) included in this study provided a response to this question, and most of these, 46 (85% of those who provided a response to the question, 43% of all the countries covered by this study) reported that such a mechanism existed (*Figure 18*). Only four countries reported there was not one, and four reported they did not know. Free text descriptions of the mechanisms available were provided by 34 countries. These were very variable and showed the range of ways in which the question could be interpreted, in some cases, people described referral arrangements or gave a description of their treatment system, with only a few describing a monitoring system.

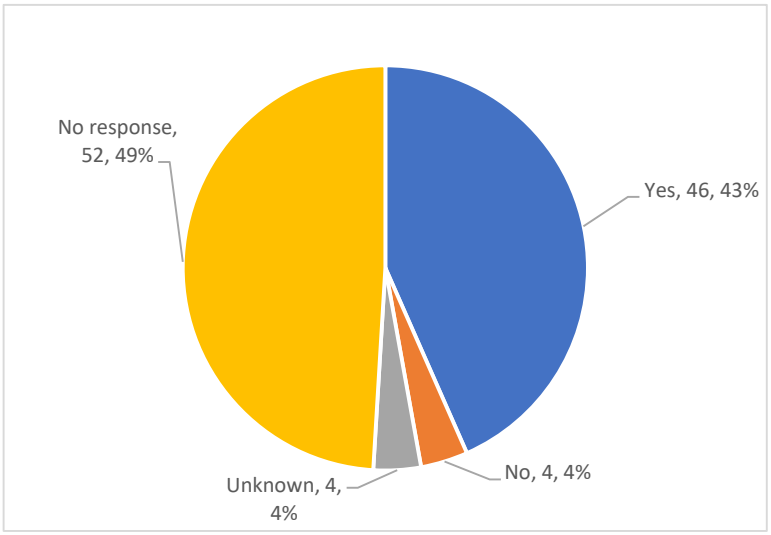


Figure 18: Overview of responses to the question on the availability of mechanisms to map and/or monitor treatment interventions

4.3 Standards statement SyS3: The drug use disorder treatment system features a tiered or 'pyramid' model, settings, modalities and interventions outlined in *the Standards* (UNODC and WHO, 2020)

The third standard has five criteria specified within the Toolkit. These are:

A. The system is organised in a tiered or pyramid model to provide treatment for a range of drug use disorders (in terms of substance type, severity and complexity).
B. The system is designed to have health and social care interventions in non-specialised settings (such as primary health care) as recommended by *the Standards* (UNODC and WHO, 2020).
C. The system is designed to have specialised drug use disorder treatment in all settings as recommended in *the Standards* (UNODC and WHO, 2020).
D. The system is designed to have the core evidence-based specialised drug use disorder treatment modalities and interventions recommended in *the Standards* (UNODC and WHO, 2020) (to meet local needs).
E. The system is designed to provide continuity of care and recovery management for people with drug use disorders.

The information on the availability of different categories and types of interventions provided in the section 3.1 of this report is relevant to this standard. Also relevant is the item in ARQ R12.12 (national policies/strategies on drug treatment), in which countries are asked about the range of treatment interventions covered in legal provisions or strategies.

4.3.1 Categories of treatment interventions covered in legal provisions or strategy

Countries were asked to indicate which categories of treatment interventions covered in legal provisions or strategies. The categories asked about were:

- Pharmacological: detoxification, opioid antagonist maintenance;
- Psychosocial: counselling, cognitive behavioural therapy (CBT), social support;
- Rehabilitation and aftercare: interventions based on scientific evidence and focused on the process of rehabilitation;
- Recovery and social reintegration;
- Other (please specify).

In total, 62 countries provided some information in response to this question, but in one case, the types of categories covered were not known. Over three-quarters of responding countries (48) reported that all four of the broad categories of treatment asked about were covered in their legal provisions or drug strategy (*Figure 19*). Most of the remainder (19%, 12 countries) reported that three of the categories were covered, while two countries reported their legal provisions or strategy covered two.

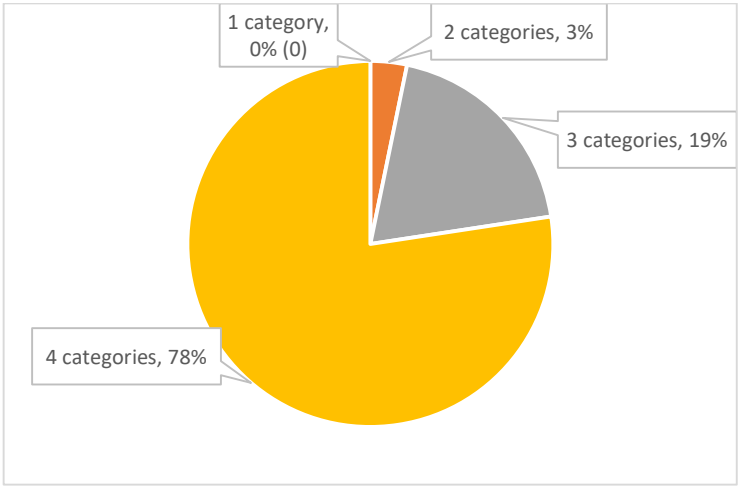


Figure 19: Number of categories of drug treatment interventions covered in legal provisions or strategy reported by countries who responded to this question

As would be expected, given that most responding countries reported their legislation or strategy covered three or four of the categories of treatment specified in the question, there was little difference between the different categories in terms of coverage. However, pharmacological treatment, recovery and social reintegration were reported as covered slightly less often than psychosocial interventions, rehabilitation and aftercare (*Figure 20*).

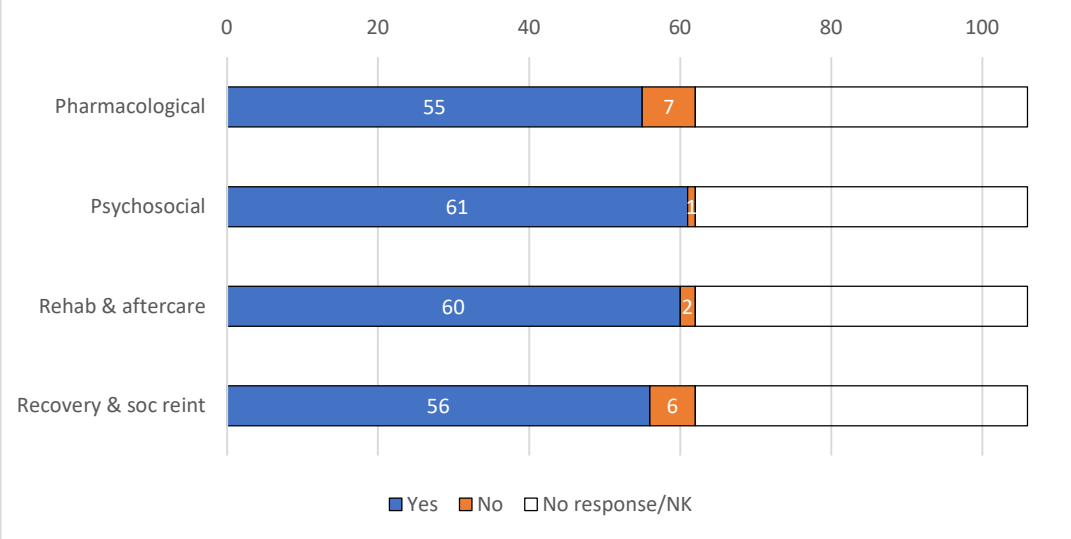


Figure 20: Number of countries reporting the coverage of different categories of drug treatment interventions in their legal provisions or strategy

In addition, nine countries answered 'Yes' to the question about other interventions covered in their legal provisions or strategy and seven provided more information about these. These included, for example, harm reduction and programs administered by the courts, while others related to mental health

treatment including, such as *"Individual Placement Support [which] is an employment support service integrated within community mental health teams for people who experience severe mental health conditions. It is an evidence-based programme that aims to help people in drug recovery find and retain employment"*. One country highlighted Community Intervention which they described as: *"... a particular type of strategy called community intervention. It is framed within the Human Rights approach and within the framework of the Mental Health Law and is conceived as a dynamic and participatory process that proposes to place the problems associated with substance use in a collective dimension, involving the population in the development of preventive, promotional and assistance responses. Conceptually, community intervention is based on the notion that people live in a community and in a territory where they participate and interact with different groups that are part of their history, identity and subjectivity. The premise of this strategy is to improve the living conditions of people, groups and populations who are often far from health and social services by providing greater levels of accessibility and permanence in the support strategies and devices of the Federal Network."*

4.4 Standards statement SyS4: The area has a funded plan to develop and sustain its drug use disorder treatment system in line with '*the Standards*' (UNODC and WHO, 2020)

The fourth standard has five criteria associated with it:

A. The area has a current plan for its drug use disorder treatment system functioning and development in line with *the Standards* (UNODC and WHO, 2020).
B. The plan has adequate resources to fund the drug use disorder treatment system development and functioning.
C. The plan has priorities and indicators that are monitored, including system capacity, access and quality.
D. The plan is regularly reviewed and updated.
E. The system has mechanisms to ensure specialised drug use disorder treatment services are accountable and help meet the plan.

The ARQ module R12.12 on National policies/strategies on the treatment of people using drugs asks respondents to list the policies and/or strategies in place on the provision of treatment interventions for people using drugs in their country and to provide links or upload relevant documents. It then asks whether there are specific policies and/or strategies for the provision of such treatment to specific population groups. Both these elements are relevant to Standard Sys4.

4.4.1 Availability of national policies or strategies for the treatment of people with drug problems

In total, 52 countries included in this study provided information about national policies or strategies relevant to the treatment of people using drugs in their country and most of these provided links to relevant documents. Only seven countries reported such policies did not exist and the remainder did not respond to this item (*Figure 21*).

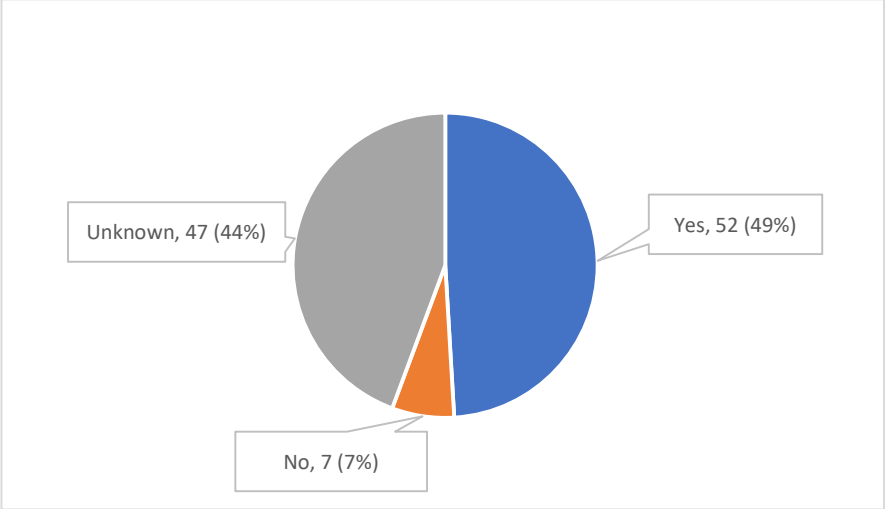


Figure 21 : Number of countries reporting national policies or strategies on the treatment of people using drugs

However, there was considerable variation in the types of documents referenced by those providing positive responses to this question. In some countries these were overall national drug, addiction, mental health or general health strategies, which included drug treatment as one element. In a few cases, treatment guidelines were referenced, while some countries referred to decrees or national legislation. A considerable amount of information was therefore potentially available, but generally only in the national language and it was beyond the scope of this study to analyse it.

4.4.2 Availability of a specific policy/strategy for particular groups of the population

The ARQ question on the availability of a specific policy/strategy for specific groups of the population asked about the following specific groups:

- Persons with disabilities
- Persons living in rural areas
- Indigenous persons
- Persons with a migrant background
- Homeless persons
- People who engage in sex work
- Persons with severe mental illness
- Other groups (specify).

The response categories given were Yes (please provide link/attachment), No, and Unknown. However, responses were not mandatory, and it appears countries took varying approaches to responding. Some countries that did not have specific policies for these groups answered "No" to all groups, while others appear to have just left the questions blank. Some countries responded for all population groups with a mix of "Yes" or "No" responses, while others have responded "Yes" for some groups and left others without any response, so it is not clear if such non-response equates to a "No" response or an "Unknown". A few countries responded "Unknown" for all groups, but it is likely that some of the

countries who have not responded to the question may have done so because the answer was not known. Finally, in a few cases, a response '...' was made against one or two groups – these have been replaced with the response "Unknown". All this uncertainty limits the analysis that is possible and needs to be considered when interpreting the findings. It should also be noted that it appears from comments made as part of this question that countries may have interpreted the question in different ways. For example, some viewed it as asking about whether or not there are separate policy/strategies for individual population groups while others responded "Yes" if mention of specific groups was made in the overall drug policy/strategy.

Figure 22 shows that **people with mental illness** was the population group that was most often reported as having a specific policy or strategy for their treatment; 31 countries reported they had one, while 13 reported they did not, and two were unsure. However, while having a clear strategy is an important starting point for the development of quality services, it is worth noting that, in the module on availability and accessibility of drug treatment, many countries reported problems with both coverage and accessibility of treatment for psychiatric comorbidities. Problems highlighted in comments in that module included a lack of sufficient psychiatrists and psychologists reported, as well as referral problems and geographical and cost concerns.

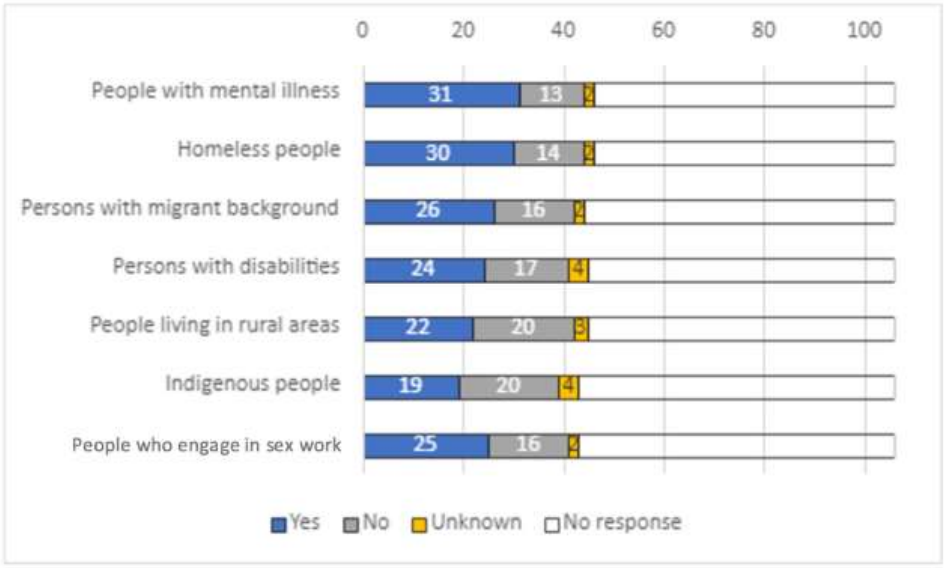


Figure 22 : Number of countries reporting the availability of specific policies/strategies for particular population groups

Having a policy or strategy for the provision of treatment interventions to **homeless people** was next most commonly reported, with 30 countries saying they had one, 14 saying they did not, and two saying they did not know. Slightly fewer countries reported having policies/strategies relating to provision for **people with a migrant background** (26 countries), **people who engage in sex work** (25 countries), and **people with disabilities** (24 countries). Least commonly reported were policies/strategies for drug treatment provision for **people living in rural areas** (22 countries) and **indigenous people** (19 countries). However, it should be noted that not all countries have indigenous population groups requiring specific provisions.

4.5 Standards statement SyS5: The system has planned and monitored mechanisms to enable and improve quality, including addressing inhuman or degrading treatment, stigma and discrimination

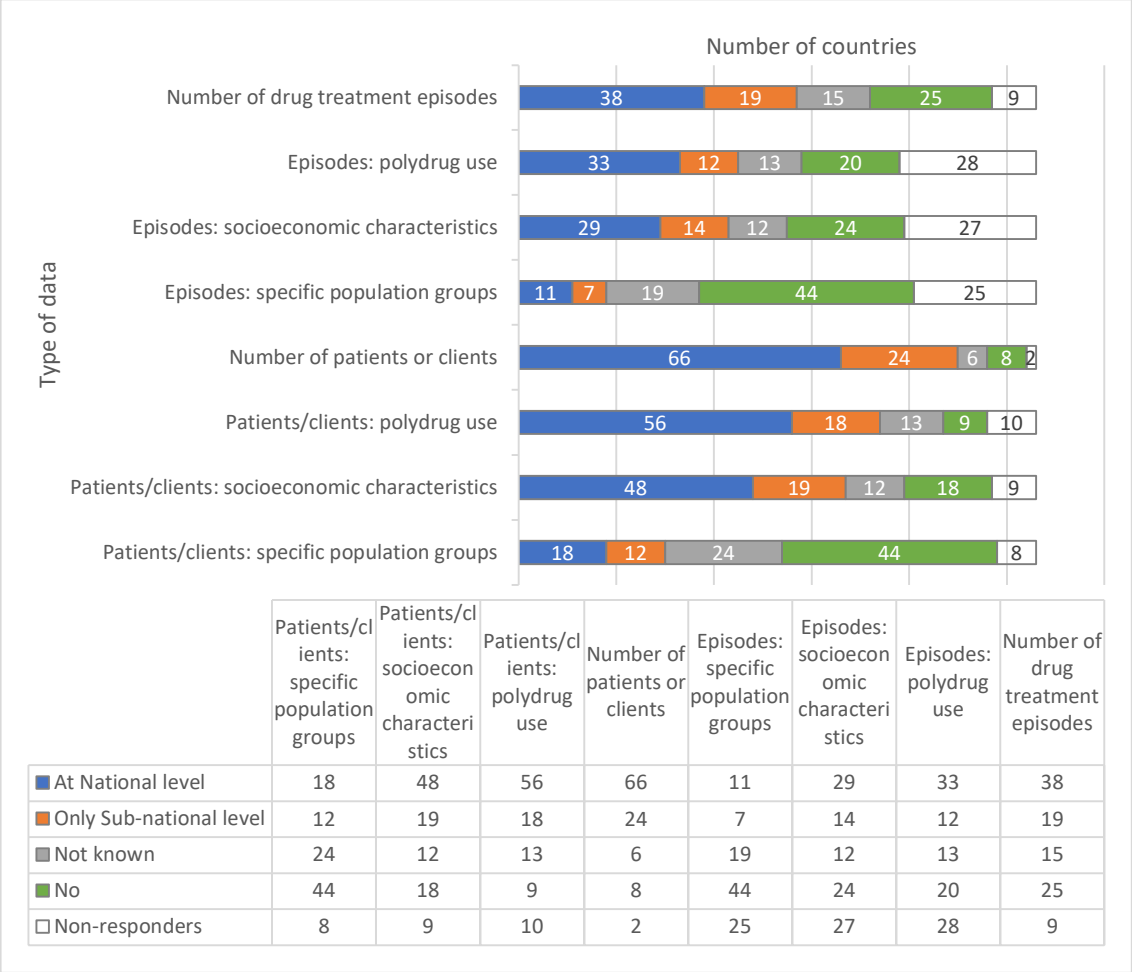
The fifth standard is: The system has planned and monitored mechanisms to enable and improve quality, including addressing inhuman or degrading treatment, stigma and discrimination. The ARQ datasets available for this study included two elements relating to this standard:

- In relation to criterion A: There is a system-wide drug use disorder treatment data system, Module A06.08 asks about the availability of data on drug-related treatment at the national or sub-national level based on number of clients and number of episodes (response options: Yes (national); Yes (only sub-national); No; Unknown). It also asks whether these data are able to be disaggregated by specific groups of the population; socioeconomic groups; polydrug or single drug use as the reason for entering treatment.
- For criterion B: The system has standards and a quality improvement mechanism that includes protecting people from inhumane or degrading treatment, Module R12.12 (national policies/strategies on drug treatment) includes a question on the existence of standard operating procedures on treatment interventions and to assess their quality (response options: Yes (please specify); No; Unknown; Other (please specify)) with more information collected in a free text field.

4.5.1 Availability of a system-wide drug use disorder treatment data system

The majority of countries provided some information in response to items in the ARQ module A06.08 (availability of data on drug-related treatment). Only two countries included in this study left the item on availability of data on the numbers of patients or clients in drug treatment blank, and only nine gave no response to the one relating to the number of drug treatment episodes. There were non-response higher rates to the items about whether these data also provided information on polydrug use, socioeconomic status and specific population groups. There were also a few cases (between 1 and 4, depending on the item) where instead of one of the standard response options a response '...' appeared in the database. It is unclear if these represent "Unknown", "No" or non-response. For the present, these have been combined with "Unknown" responses in the category "Not known".

The data that was most commonly reported as being available was data on the number of patients/clients in drug treatment (*Figure 23*). This type of data was reported to be available at the national level by 66 countries (62% of all the countries included in this study), and at the sub-national level by 24 countries (23% of countries in this study).



	Patients/clients: specific population groups	Patients/clients: socioeconomic characteristics	Patients/clients: polydrug use	Number of patients or clients	Episodes: specific population groups	Episodes: socioeconomic characteristics	Episodes: polydrug use	Number of drug treatment episodes
At National level	18	48	56	66	11	29	33	38
Only Sub-national level	12	19	18	24	7	14	12	19
Not known	24	12	13	6	19	12	13	15
No	44	18	9	8	44	24	20	25
Non-responders	8	9	10	2	25	27	28	9

Figure 23: Number of countries reporting the availability of data on the number of drug treatment use

4.5.2 Standard operating procedures on treatment interventions and to assess their quality

A little under half of the countries included in this analysis (50 out of 106 countries) provided an answer to the question about the availability of standard operating procedures on treatment interventions and to assess their quality. Of those responding to the question, almost three-quarters (74%) of respondents (37 countries, 35% of all the countries in this study) reported they had standard operating procedures in place for their drug treatment services, five countries (10% of respondents) reported they had other things in place, six (12%) reported they had no such procedures and two countries reported they did not know (*Figure 24*).

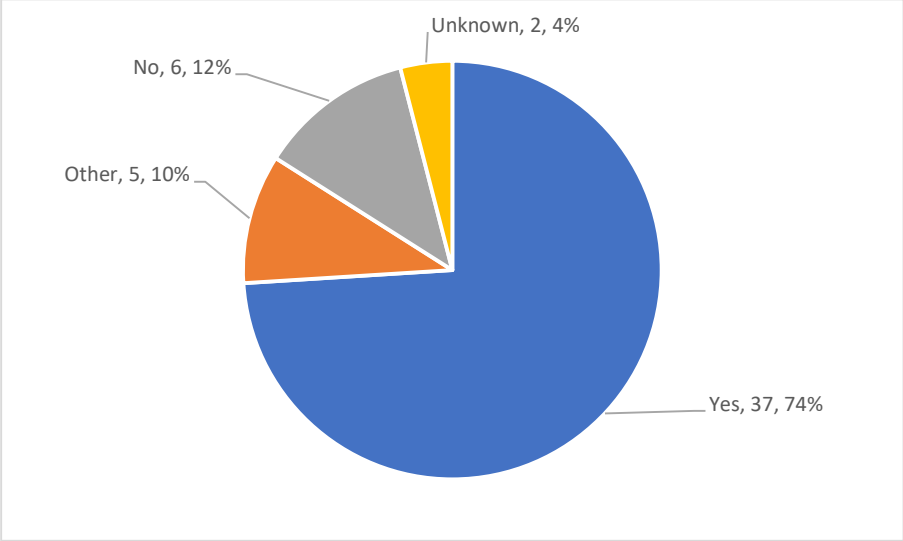


Figure 24 : Existence of Standard Operating Procedures for Drug Use Treatment among those responding to this question

In addition, 27 countries provided additional qualitative information on their quality assurance mechanisms. This included discussion of and in some cases links to, *the Standards* (UNODC and WHO, 2020) or other Guidelines for those providing treatment services. Some responses mentioned the processes or bodies with responsibility for monitoring adherence to these standards or guidelines, which included the specification of quality measures, such as outcomes, within contracts for services, having accreditation requirements for treatment providers, and inspection or supervision processes. Some responses also highlighted the role of training for those providing care in assuring quality services.

5 Concluding remarks

As part of its efforts to support Member States in developing effective drug dependence treatment services and systems and to address the associated health and social consequences of drug use disorders, UNODC, in collaboration with the WHO, has published the International Standards for the Treatment of Drug Use Disorders (2020). In addition, in 2021, CND resolution 64/3 on "Promoting scientific evidence-based, quality, affordable and comprehensive drug prevention, treatment, sustained recovery and related support services" called upon UNODC, in collaboration with Member States and other relevant stakeholders, to prepare a comprehensive report on the quality of drug prevention, treatment, sustained recovery and related support services, as well as other health-related measures, in line with those standards. In this context, the study reported here sought to investigate the potential of ARQ data on treatment for people using drugs to provide insight into the quality of drug treatment services worldwide and identify areas for further development of this work.

A new online ARQ data collection process has been developed to improve the data generated from the process and reduce the burden on Member States. As with any such major change, some issues that impact data quality have emerged. These include high non-response rates and uncertainty about what non-response indicates, variable understandings of the questions being asked or their scope, and inconsistencies within answers to related questions. As these issues are addressed, the usefulness of the ARQ data will grow. In addition, other occasional modules relevant to the treatment quality issue had not yet been utilised during this study. Thus, in the longer term, the ARQ can become an increasingly useful source of information on treatment quality.

In interpreting the data available at the time of writing, it is also important to recognise that countries differ with respect to the extent and nature of drug use disorders in their populations, which will impact the types of services they will require to address them. The differing social and economic situations and cultural contexts will also affect the level and type of provision. Nevertheless, the information collected in the ARQ does provide a variety of indications relating to the key principles for the delivery of high-quality and effective treatment for people with drug use disorders set out in the Standards (UNODC and WHO, 2020) and the associated quality assurance toolkits, which can help to identify issues that may require greater focus and areas that would benefit from greater support.

For example, the data described in this report shows that although some form of the main broad types of drug treatment (i.e., psychosocial and behavioural interventions and pharmacological treatment) are reported to be available in most countries, coverage could be limited, and there are still gaps in provision. Even for the most basic pharmacological treatment to manage withdrawal, only half of the responding countries assessed coverage as adequate or fully adequate. It also indicates that the availability and coverage of interventions to support rehabilitation and aftercare are more limited, as they were reported to be available in fewer countries. This was also the case for other more specialised interventions, such as psychiatric and medical comorbidity treatment.

The analysis also highlighted potential regional differences. For example, the number of countries in Africa that responded was lower than in other regions, and coverage was reported to be more limited for all of the broad categories of treatment, suggesting this region could benefit from increased support.

Another key aspect of quality is the accessibility of services, and the ARQ provides some insights on this issue, with accessibility to different interventions being generally similar to coverage. Overall, psychosocial and behavioural interventions were reported to be the most accessible of the broad treatment categories, although the reported accessibility of pharmacological interventions was very similar. As was the case for coverage, the accessibility of rehabilitation and aftercare services appears to be slightly lower than is the case for clinical interventions. Despite limitations in the sample, data also suggested that the accessibility of pharmacological treatment generally appears lower in Africa and the Americas, with less than half of the countries who responded reporting this broad type of treatment as being fully or generally accessible. In other regions, well over half of the countries reported full or general accessibility. However, a considerable proportion still reported that these interventions were unavailable or that accessibility was unknown.

The ARQ data also highlights which specific interventions within each broad category of intervention are most accessible to people. For example, within the category of psychosocial and behavioural interventions, the types of interventions that were reported as being most accessible overall were cognitive behavioural therapy (CBT) and motivational interviewing (MI), with community reinforcement approaches (CRA) and peer support groups not far behind, and contingency management (CM) less accessible. Interestingly, while the availability of the two specified 'other types of treatment', i.e. the treatment of psychiatric comorbidities and of medical comorbidities, was generally similar, the accessibility of treatment of medical comorbidities appeared to be somewhat better overall than treatment for psychiatric comorbidities.

In addition to the insights that can be gleaned from these questions in which countries are asked to self-report the level of provision and accessibility of their services, respondents to the ARQ have also provided a lot of other information in response to open questions and uploaded a wide range of documents. While the response rate has been low for the years analysed, the additional information could, in principle, help provide insights into other aspects of the quality of drug use disorder treatment. Only a very basic analysis of some of this information was possible within this project, but they could prove valuable in the future. For example, it might be possible to use them alongside other data to develop country profiles that could underpin bilateral discussions between UNODC and Member States. Documents, such as treatment protocols, guidelines, laws, and policies, might provide examples for other countries less advanced in the development of their treatment system. Building and maintaining a database or catalogue of these documents would make it easier to use them in this way.

Any new data collection system will have initial problems, and it is especially challenging to develop a questionnaire appropriate to the circumstances and context of every country in the world. Analysis of the data, therefore, inevitably highlights issues, such as questions that are open to widely different interpretations and questions that people struggle to answer, which limit the findings from the analysis. Despite these limitations, the report has highlighted a number of these; nevertheless, useful information has been obtained, and analyses such as these will allow the ARQ to be developed and improved over time with UN Member States.

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