WFTC

WORLD FEDERATION OF THERAPEUTIC COMMUNITIES

WORLD SOCIAL REPORT
Nº 2 – 2023
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EXECUTIVE SUMMARY

This second edition of the WFTC Social Report had a significant increase of 153% in countries (26 in 2022 to 40 in 2023) and 290% in respondent organizations (132 in 2022 to 383 in 2023) and included Africa, which was not present in the first edition.

Most of the respondent organizations were from Latin America and the Caribbean (n=238; 62.1%), followed by Europe (n=109; 28.5%). These regions had the most impressive increase in respondent organizations, respectively 326.0% (n=165) and 681.3% (n=93).

Assisted and reached people

In 2022, WFTC respondent TCs assisted 339,156 people and reached 1,431,639 people, which combined represented a great increase of 302.3% (n=1,184,965) in assisted and reached people, compared with 2022.

More than 90% (n=311,780; 91.9%) of the assisted people were in TCs with female and male facilities. Only 7.9% (n=26,781) were in only male TCs, and a non-representative total of 0.1% (n=505) were in only female services.

Almost the half of the population (n= 148,726; 43.9%) were assisted in only rural facilities, and the other half were assisted equally in urban (n=97,744; 28.8%) and rural and urban (n=95,566; 27.3%) facilities.

The vast majority of the assisted people (n=292,208; 86.2%) was treated in non-religious programs.

Most of the people were assisted in programs from 6 to 12 months (n=227,715; 67.2%), and only 0.5% (n=1,584) were treated in programs of less than 3 months.

The majority of the people (n=198,579; 58.6%) were assisted in TCs with 8 different professionals in their staffs.

Scope of work

Most of the organizations had national scope of work (n=182; 60.5%), but in North America most of the organizations had local scope of work (n=14; 73.7%). Only 4.0% (n=12) of the organizations had international scope of work.

Type of work

Only grassroot type of work was the most prevalent (n=217; 72.1%), especially in Latin America and the Caribbean (n=185; 82.2%). Only 3.0% (n=9) of the organizations had only Advocacy type of work, and there were only in Europe, North America and Latin America and the Caribbean. Both grassroots and advocacy type of work were more prevalent in Asia (n=8; 66.7%) and in North America (n=10; 52.6%).

Number of employees

North America (n=18; 94.7%) and Asia (n=7; 58.3%) had most bigger organizations, with more than 50 employees. Latin America and the Caribbean had most of smaller organizations (n=108; 48%), with less than 10 employees.

Source of funding

Almost 30% of the total (n=89; 29.6%) had only one source of funding, 18.3% (n=55) had two and 25.6% (n=77) had three sources of funding. It means that 3/4 of the TCs (n=177; 73.4%) had few sources of funding.

Target population

Adults were the most reported target population (n=291; 96.7%). The others more frequent target populations were Teenagers (n=115; 38.2%) and Homelessness (n=126; 41.9%).

Children services were only 13.6% (n=41), having only one target population below (Refugees: n=27; 9.0%). The region with the biggest rate of Children services were Asia (n=7; 58.3%) and North America (n=8; 42.1%).

Teenagers services had bigger rates in Asia (n=10; 83.3%), North America (n=10; 52.6%) and Europe (n=21; 52.5%). LGBTQIA+ could have care in 28.2% (n=85) of the respondent TCs, which is a promising number, considering that it's a new specific population for TCs.

Target population gender

Except in Latin America and the Caribbean (n=89; 39.6%), in all regions the vast majority of TCs offered male and female treatment. Only female services were non-representative (n=8; 2.7%) and only offered in Europe and in Latin America and the Caribbean.

Settings

In total, 89.4% (n=269) offered residential settings, 56.5% (n=170) ambulatory settings, 22.9% (n=69) harm reduction facilities and 27.2% (n=82) housing facilities.

Ambulatory treatment was more common in North America (73.7%; n=14) and Europe (62.5%; n=25). Housing facilities were more common in North America (57.9%; n=11).

Average proposed time for treatment

Most of the TCs had treatment programs of 6 to 12 months (n=152; 51.0%), and this proposed time was the most reported in Latin America and the Caribbean (n=125; 56.1%) and in North America (n=10; 52.6%).

Longer programs (more than 12 months) were more frequently reported in Europe (n=22; 56.4%), and Asia (n=5; 41.7%). Shorter programs (less than 3 months) appeared only in Latin America and the Caribbean, with only 2% (n=6) of the total (2.7% in LAC).

TC location

Almost the half of the TCs (n=142; 47.5%) reported having urban locations and 17.1 % (n=51) both. Only 35.5% (n=106) of the respondent TCs reported having only rural locations.

Only urban locations were more common in North America (n=15; 78.9%) and in Oceania (n=3; 75.0%). Europe was the only region with most rural locations (n=19; 50.0%).

Religious

More than half of TCs reported having non-religious programs (n=173; 57.7%). The regions with more religious programs were Latin America and the Caribbean (n=116; 51.8%) and Asia (n=6; 50.0%), considering TCs with mandatory and not mandatory activities.

In Oceania there were no TCs with religious programs, in Europe there were only 3 TCs (7.5%) and in North America only one (5.3%), considering TCs with mandatory and not mandatory religious activities.

Staff

The more present professionals were Psychologist (n=274; 91.0%); Administrative/financial (n=261; 86.7%), Counselors (n=252; 83.7%) and Social workers (n=247; 82.1%).

Psychologist were less present in North America (n=8; 42.1%) and in Oceania (n=2; 50.0%). Doctors and Psychiatrists were more present in North America (n=18; 64.7% both) and in Asia (n=10; 83.3%; n=9; 75.0%).

MESSAGE FROM THE PRESIDENT

The problems associated with illicit drug use impact every aspect of society. Drug dependence is not just the chronic use of a substance but includes a loss of control and a compulsion to continue use in spite of adverse consequences. These consequences can include impairments in cognitive, psychological, physical, and emotional health.

Science has documented the fact that prolonged use of substances results in changes in brain chemistry in fundamental and long-lasting ways. Neurotransmitters, which are essential to the healthy functioning of emotions, thinking, perception, and behavior are impacted by substance use.

The biological and behavioral aspects of dependence are complementary and interchangeable. Dependence may begin volitionally, but continued use leads to habituation and chronicity, which adversely impact cognitive, behavioral, emotional, family, social, cultural, and bio-physiological domains.

The demographics of those with substance use disorders are ever-changing. The new clients are complex and experience multiple problems including homelessness, poverty, malnutrition, and acute mental distress. These are individuals who seek medication for relief of their symptoms as well as those who are psychologically impaired due to overmedicating.

Member organizations of the World Federation of Therapeutic Communities have successfully engaged in the development of effective program models to treat substance dependence disorders for over 63 years. Our services are based upon a fundamental perspective that addiction occurs within a broader framework, which includes economic, social, and moral disaffiliation.

Therapeutic communities have been described as constructs, as a specific approach, a movement, a strategy, and a philosophy. All of these characteristics are fundamental within the therapeutic community model.

Early therapeutic communities developed a sociological belief system in order to survive and thrive. Fundamental to each was the belief that each member of the group or community was valued and in turn was responsible for the well-being of the group. The group was seen as a healing force, which provided each member with opportunities, challenges, role models, encouragement, hope, and structure in an effort to promote individual change.

Over the years, therapeutic communities have maintained the basic assumptions that were the underlying causal forces for their development. They have, however, adjusted to fit current patterns and current challenges. The effectiveness of the therapeutic community has been addressed in numerous outcome studies.

The World Federation of Therapeutic Communities' programs address the domains which are critical to treatment - these include education, the family, recreation, medical services, behavioral change, vocational development, mental health, stable housing, employment, and social responsibility.

Our programs provide a comprehensive array of services which include wellness promotion, health services, educational, social, and vocational services, housing, mental health counseling, and comprehensive psycho-social rehabilitation. Our programs serve the homeless, the victims of abuse and domestic violence, delinquent and dependent youth, runaway youth, mothers with dependent children, pregnant women, children of incarcerated parents, military veterans, individuals with mental illness, and those who are involved with the corrections and criminal justice system.

Our programs provide counseling, education, vocational support, and job training. We teach prosocial values. We encourage civic and personal responsibility.

We operate programs and deliver services in community clinics, residential centers, jails, prisons, homeless shelters, schools, outpatient settings, and crisis/triage centers. The conceptual frameworks for our methodology utilize cognitive, behavioral, and clinical interventions designed to foster pro-social

responsibility while new values, attitudes, and behaviors are internalized. Treatment and recovery are seen as a developmental process.

The perception of what therapeutic communities do among those who have not taken a closer look remains dated and less than complete. Perhaps this is due to the fluctuating nature of our field and the challenge to revise, adjust, and to refine our services. We have met this challenge head-on. When faced with new, more toxic drugs - we responded.

The trend to incarcerate rather than rehabilitate was responded to by creating treatment programs in jails and prisons. The increasing numbers of youth in foster care, child welfare, and juvenile justice systems was yet another challenge that was answered by our members. Our active service military and veterans return home with battle and psychic fatigue. We are proud to say that our member agencies have yet again faced this challenge and are offering veteran-specific services in our communities.

We have continued to question, to seek solutions, to learn, to grow, adapt, change, and adjust. Adjust to changing client demographics, fluctuating financial support, shifts in public policy, complexities of consumption patterns, and new population sectors created by social, economic, political, and environmental factors.

The course of social change is limited only by our vision and by our commitment to see that vision through.

The World Federation of Therapeutic Community members will continue to strive to make a difference.

Sushma D. Taylor, Ph.D.
President

1. SITUATION OF THE WORLD DRUG PHENOMENON IN 2022

Drug use continues to be very prevalent worldwide. According to the ***2022 World Drug Report*** (click here) published by UNODC (United Nations Office on Drugs and Crime)[1], around 296 million people worldwide (5.8% of the global population - 1 in every 17 people - aged 15–64), had used drugs at least once in 2021, a 23% increase over the previous decade (partly due to population growth).

Of these, about 39.5 million (around 13%) experience drug use disorders. Opioids continue to be the main drug that impacts the global burden of disease whereas cannabis is reported by a large share of countries as the drug of most concern for drug use disorders.

There are, however, clear regional differences in the primary drug reported by people entering drug treatment. In Europe and most of the Asian sub-regions, the most frequent primary drug of people in drug treatment are opioids. In Latin America, the most frequent primary is cocaine, whereas in parts of Africa it is cannabis, and in East and South-East Asia it is methamphetamine.

It is clear that opioids remain the leading cause of premature deaths in fatal overdoses (500,000 in 2019 - 17.5% increase since 2009) and an important factor in years of "healthy" life lost due to disability.

Only 1 in 5 people with drug use disorders received drug treatment in 2021. The treatment gap worsened due to the Covid-19 pandemic. Since the pandemic started, 40% of the countries reporting regularly to UNODC, reported a decrease in the number of people seeking drug treatment, number that declined even more in 2021.

There are numerous barriers in accessing treatment and women are most affected. Only 1 in 4 people in treatment are women.

1 https://www.unodc.org/unodc/en/data-and-analysis/world-drug-report-2022.html

Women account for over 40 percent of people using pharmaceutical drugs for non-medical purposes, and nearly one in two people using amphetamine-type stimulants (ATS), but only one in five in treatment for ATS is a woman.

Young people are also highly represented when it comes to drug use. In 2021, 5.3% of 15 to 16-year-olds worldwide (13.5 million individuals) had used cannabis in the past year.

In addition, the latest Office of the High Commissioner Report on ***"Human rights challenges in addressing and countering all aspects of the world drug problem"***[2] (click here) published in September on 2023, the UN identified the lack of and unequal access to treatment and harm reduction as one of the main challenges (additional information here).

At the same time, it is critical to reduce inequalities and gaps in accessing treatment and broad and inclusive health services to minimize the social consequences of drug use, especially for vulnerable and marginalized populations. Also, there needs to be a significant focus and increase in prevention policies and programs, especially for young people.

Drug use disorders and other mental health conditions are closely interconnected: mental health conditions increase the risk of developing drug use disorders, and drugs pose the risk of exacerbating mental health problems if taken outside medical supervision. With an estimated one in eight people globally living with a diagnosed mental health condition, the need to address mental health issues in drug use prevention and treatment has increasingly become a priority (additional information here).

2 https://www.dianova.org/wp-content/uploads/2023/10/A-HRC-54-53-EN.pdf

2. ABOUT WFTC

The World Federation of Therapeutic Communities (WFTC) is an international nongovernment association that engages in building collaborative coalitions and networks of social, education, and therapeutic systems that support the therapeutic community model of care.

The WFTC is a broad global membership-based association which advocates for and promotes the understanding of principles and methodologies that govern the therapeutic community methodology.

The WFTC seeks to establish social learning initiatives, inter-country forums, cross- cultural collaboration and regional networks. In addition, WFTC promotes the exchange of information, data, research, clinical trends, and emerging innovative strategies.

The WFTC promotes standards of care for practice, quality of programs and practitioners, while interfacing with other professional disciplines and providing information about the therapeutic community model of treatment and recovery.

3. WFTC ORGANIZATION

The World Federation of Therapeutic Communities is divided into 5 large geographical areas and operates through 4 operational Committees.

GEOGRAPHICAL AREAS

1. Australasian Therapeutic Communities Association (ATCA)
2. European Federation of Therapeutic Communities (EFTC)
3. Federation of Therapeutic Communities of Asia (FTCA)
4. Latin-American Federation of Therapeutic Communities (FLACT)
5. Treatment Communities of America (TCA)

OPERATIONAL COMMITTEES

1. Communications Committee
2. International Relations Committee
3. Membership Committee
4. Standards Committee

To view countries where Therapeutic Community centers operate, please visit the link: wftc.org → OFFICERS & MEMBERS

3.1 The Australasian Therapeutic Communities Association (ATCA)

President: Gerard Byrne (Australia)
Website: atca.com.au

The Australasian Therapeutic Communities Association (ATCA) formed in 1986 to represent the collective views and interests of not-for-profit organizations providing alcohol and other drugs treatment utilizing the Therapeutic Community Model in Australia and New Zealand. The ATCA has 32 member organizations who provide 61 Therapeutic Communities (TCs) and Residential Rehabilitation services.

In 2022 the ATCA held some promotional events to bring our membership together. The ATCA Symposium was held on 23 November 2022 in Brisbane. Presentation topics included building community-based Recovery Capital and the ATCA TC Training. In May 2022, the ATCA Board also met in person with Brisbane members and potential members to discuss the work of the ATCA.

The ATCA continues to focus on training, which our members continue to identify as vital to workforce development. The ATCA TC Training contributes to strengthening the AOD workforce, allowing participants to expand their skills and knowledge in TC theory and evidence-based practice. This year, 111 people have completed the ATCA TC Training course with staff from 11 TC's completing the course. This brings the total number of people who have participated in the ATCA TC Training course to 548.

The theme of the 34th Conference of the ATCA in 2023 in Sydney was *Inclusion. Innovation. Impact. Sustainability.* The conference provided the opportunity for participants to hear from leaders in the areas of research, clinical practice, advocacy and commissioning. Site visits to local and regional members took place on 31 October, with the Conference held on 1 and 2 November at the Mercure Sydney. Details can be found on our website at: https://atca.com.au/event/atca-conference-2023/.

3.2 The European Federation of Therapeutic Communities (EFTC)

President: Phaedon Kaloterakis (Greece)
Website: eftc.ngo

The EFTC was founded in 1981 in Dusseldorf, Germany.

Its mission includes supporting and developing the psychopedagogical approach to help problem drug abusers, and their families reclaim a life free of drugs, where possible. The members are pledged to assist and enable each community or project participant to become contributing members of society and role models for the local communities in whatever social and political climate they reside within.

Maximise the involvement and participation of each person in their recovery from substance abuse. This self-help and community as method approach enhances the self-respect and dignity of all clients.

All federation members across Europe provide equal opportunity to treatment services which are non-political, non-racist, non-exploitive and non-violent. The integrity of each programme member is valued within this extended European community and the EFTC Standards and Code of Ethics. Recently in 2022, the EFTC was granted Special Consultative Status with the United Nations Economic and Social Council.

The Therapeutic Community is one of the most effective models in treating addictions. For the past few decades and through rigorous research, increasing evidence proving this point has come to light. Part of the effectiveness of the Therapeutic Communities can be attributed to their ability to adapt to different cultural settings and meet the needs of vulnerable populations.

The 2023 WFTC Report manifests these foundational truths in a profound and methodical manner.

Lastly, I invite all of you to participate to the 19th European Conference of Therapeutic Communities that will be held in the amazing city of Gdansk, Poland, in September 2024, organized by the Polish Federation of Therapeutic Communities and the EFTC.

3.3 The Federation of Therapeutic Communities of Asia (FTCA)

President: Martin Infante (Philippines)
Website: ftca.info

Over the three years of the pandemic, the FTCA was able to fulfill in the Asian region its mission of "Helping Each Other Help Others" by running a total of six online gatherings via Zoom. The last three were a called "Consultation Hours".

Questions about the challenges in running TC programs were solicited from the members and a panel of experts responded. The sessions were presided by the FTCA president Martin Infante and moderated by the FTCA advisor Phaedon Kaloterakis.

FTCA Consultation Hour Series

- 1st Consultation Hour – TC Practices | October 30, 2021

  The premiere edition addressed queries regarding TC Practices. It featured a videotaped address by Dr. George De Leon.

- 2nd Consultation Hour – TC Program and the Families | February 12, 2022

  The second of the series addresses questions on the modifications in the TC tools, along with the role of the families in the recovery of residents.

- 3rd Consultation Hour – Dual Diagnosed in the TC | July 23, 2022

  The third addressed queries regarding dual diagnosed patients with mental health conditions. Psychiatrists with extensive involvement in the TC discussed the conditions while some TC graduates with co-morbidities shared their journey of recovery.

2nd FTCA Conference

The FTCA plans to hold its 2nd International Conference in February 2024 in Manila, Philippines. Announcement for this conference is expected within the coming months.

3.4 The Latin-American Federation of Therapeutic Communities (FLACT)

President: Jorge Olivares Calderón (Chile)
Website: federacionlatinoamericanaCT

The Latin American Federation of Therapeutic Communities, known as FLACT by its acronym, is a non-profit, private interest foundation, created in 1987 in Campinas-Brazil.

The following objectives are stated:

- Bring together the National Federations of Therapeutic Communities (TCs) of the member countries that adhere to the codes and standards of ethics of the WFTC and the TC model.
- Collaborate with affiliated federations in the consolidation and expansion of their programs, providing them with assistance when necessary and in accordance with the available means and always promoting the exchange of experiences among its members.
- Encourage the training of human resources at all levels, through the training and training of professionals, non-professionals and volunteers.
- Promote and/or stimulate the holding of events of different kinds such as: congresses, conferences, symposiums, meetings, scientific meetings and others, in order to disseminate, share and deepen their experiences regarding the practice of the model of the CT.
- Encourage and strengthen research into problems related to the consumption of psychoactive substances, disseminating relevant information among its members.
- Manage financial resources in order to meet its objectives and promote the idea of self-management in each of its members.

- Collaborate with international, governmental and/or individual organizations in comprehensive prevention, rehabilitation and social reintegration programs and policies related to the use and abuse of psychoactive substances and related disorders.
- Influence the study and proposals of national and international policies related to the prevention and treatment of drug dependence in all affected populations and especially referring to children and their social environment.

It currently has 12 active member countries; that through their federations gather more than 500 Therapeutic Communities. The study called "Mapping and diagnosis of the current technical situation and resources of the therapeutic communities affiliated with the Latin American Federation of Therapeutic Communities (FLACT, 2023)" has the participation of 12 countries and 444 associated TCs. Withal, it is important to emphasize that FLACT is providing support so that inactive Latin American countries can form and/or reactivate their national federations.

The Board of Directors 2022 -2024, in its strategic framework and in order to respond to current needs, proposes:

- Validate the CT model, through the establishment of quality management processes in treatments.
- Strengthen and support the accreditation processes of the TCs in the respective countries.
- Ensure respect for human rights in each of the affiliated TCs.

And take on the challenges of:

- Prepare, translate and disseminate the "Guide to good practice standards for drug treatment service providers in the CT model".

- Prepare and disseminate the study "Mapping and diagnosis of the current technical situation and resources of the TCs affiliated with FLACT".
- Strengthen networking with the Proyecto Hombre Association and other organizations.
- Hold the TC World Congress in Brazil 2024.

3.5 Treatment Communities of America (TCA)

President: Edward C. Carlson (USA)
Website: treatmentcommunitiesofamerica.org

TCA is a consortium of over 600 programs sites providing an array of integrated services which include primary and preventive care, outreach; education, assessment, referral and follow-up; detoxification and crisis management; residential treatment with aftercare support; outpatient services; family therapy; mental health services; vocational assistance and job placement; emergency, transitional and permanent housing with supportive services.

TCA Federal Advocacy: Substance Use Disorder Treatment Funding and Policy

In 2022, TCA worked to educate lawmakers of the need and urgency to expand access to comprehensive, evidence-based substance use disorder (SUD) and co-occurring treatment services that are based on the full continuum of care.

TCA continued to make the case for significant investments in the Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant as the United States experienced record levels of opioid overdose deaths and a new wave of fatalities related to the proliferation of illicit fentanyl.

TCA continued to build its reputation as a trusted and knowledgeable resource on SUD treatment and policy on Capitol Hill, especially related to the proliferation of fentanyl and stimulants across the United States which increases the urgency of providing and expanding access to care. TCA also continues to host a monthly Public Policy meeting which allows members to get real time updates on Capitol Hill and Administration activities and legislation.

TCA Conducted Virtual Meetings with Congressmembers, Staff

TCA conducted robust outreach and education efforts as part of its federal advocacy work on Capitol Hill, holding two rounds of virtual Hill visits over four days during 2022, in June and November.

The virtual Hill Days offered TCA programs the opportunity to meet with Members and staff to advocate for enhancements to the Block Grant, and consideration of the MIND Act and other relief from the Medicaid IMD Exclusion, providing support for the SUD treatment workforce, and other priority issues.

TCA Produces White Papers on Telehealth and SUD Workforce

TCA formed two new working groups to investigate, update, and put forth position papers on two issues that have been high priorities, which were also affected profoundly by the COVID pandemic.

The working groups met regularly throughout 2022 and developed white papers along the following themes of *Substance Use Disorder Treatment Workforce* and *Telehealth Use in SUD Treatment*.

TCA explains the use and practical applications and best practices of telehealth in the substance use disorder (SUD) field to date, and explores future directions for telehealth policy, including challenges facing its expanded use, the impact on client care, and effects on the U.S. healthcare system.

Congressmember Honored with Charlie Devlin Award at TCA Event Keynoted by National Drug Policy Director

In September 2022, TCA members gathered for a virtual reception to celebrate decades of federal advocacy in support of people overcoming substance use disorders as well as to honor a deserving legislator with the Charlie Devlin Award for

Excellence, an award given each year to a legislator who has exemplified what it means to serve and contribute to the SUD field.

This award is named after former TCA President Charlie Devlin, who had more than 50 years in recovery and worked tirelessly on behalf of the millions of individuals and family members whose lives had been impacted by addiction to alcohol and other drugs. Rep. David Trone of Maryland received the award for all his hard work and leadership in promoting the SUD field, and Dr. Rahul Gupta, Director of the Office of National Drug Control Policy, was the keynote speaker.

TCA Honors Legacy of Richard Pruss with Workforce Development Scholarships

As a means of supporting our workforce and honoring the great work of Richard Pruss, in 2019, TCA established the Richard Pruss Professional Development Scholarship.

Each year the scholarship is awarded to up to 5 individuals who work in the SUD field, which TCA believes will make a profound difference and will support the professional development of talented individuals working to advance their careers in the SUD treatment field.

Scholarships were announced and presented during the Fall Legislative Reception in September 2022, where TCA members heard from recipients about the impact of the scholarship in helping to advance them in their professions.

TCA Members Present at WFTC Conference in New Delhi, India

In December 2022, several TCA Members, including both the TCA President and Executive Director, attended the World Federation of Therapeutic Communities (WFTC) 28th World Conference on Therapeutic Communities: A View Towards the Future.

Several TCA members, including Amity Foundation, Centerpoint, Integrity House, Odyssey House Louisiana, Odyssey House New York, and Stay'N Out/NYTC also presented at the conference on the TC Model.

4. THIS REPORT

The WFTC Communications Committee has been brainstorming ways to highlight the positive work of our federations and all our individual member programs so that we can showcase the impact our programs have worldwide.

The "WFTC Social Report" constitutes an indication of our identity and function, an outline of our goals, aims and objectives, a clarification of our service provision, an identification of who are the users of these services and a presentation of the results achieved.

The WFTC Social Report aims to communicate:

- **Our vision:** to join together in a worldwide association of sharing, understanding and cooperation within the global TC Movement.
- **Our aim:** to widen recognition and acceptance of the Therapeutic Community approach among health organizations and health delivery systems of international and national bodies.
- **Our universality and inclusivity:** representation from all 5 continents and providing information from a large number of countries and services.
- **Our ethics and principles.**
- **Our holistic approach:** we draw upon all the disciplines, including medical, psychiatric, and social services, as well as TC trained professional service providers.
- **Our professional reliability:** provision of sharing, understanding, guidance and cooperation to our members and the broader society.

This report is a work that depends solely to the priceless contribution and experience received from the Federations and their members that work tirelessly to improve the health and wellbeing of people facing addictions.

At the WFTC World Conference in New Delhi, India in December 2022, we released the **first edition of the WFTC Social Report** (click here), which we were able to use for informational and promotional purposes.

This is the second edition of the WFTC Social Report, prepared and implemented in partnership with the 5 continental Federations that make up its functional structure.

After the great repercussion that the 1st Report had worldwide, we planned to carry out a more comprehensive and in-depth research this year, with the aim of getting closer to the real picture of the CTs members of the WFTC.

The elaboration of the new research was carried out in a joint effort by the members of the WFTC Communications Committee, aiming to cover the specificities of each region, as can be seen in Annex 1.

Some of the data collected were compared with the previous year, and many others are unprecedented data at a global level, which could be compared with future editions of this Report.

The research was carried out online, using a Google Forms interview questionnaire, so that filling out the data was simple for participants. This form, as well as all promotional and explanatory material, was made available in three languages: English, Spanish and Portuguese.

After released, a period of 45 days was given for each regional Federation to disseminate the form among its TCs member, so that they could fill in the requested data.

After the deadline, data from each region were sent to the respective regional Federations, to validate that all TCs that responded to the questionnaire belonged to the regional network, as well as to check for possible filling errors, repeated data or possible qualitative and quantitative divergences with the reality known to regional leaders.

After the process of validating the initial data, the regional Federations sent back the corrected and commented data, with which the final version of the data spreadsheet for analysis was prepared.

These data were descriptively analyzed, as will be seen below, comparing those data that were compatible with those from the 1st Report, separating the data by region and country.

After finishing the analysis, the preliminary outcomes were presented at a Communications Committee meeting and sent for validation to all members of the Board and Communications Committee. This data was also sent to International Advisors, for technical validation of the obtained results.

As we can see, this Report is the result of the joint effort of many actors from various countries and regions, who sought to highlight the monumental effort that TCs around the world make daily in search of a better world for those who suffer, directly or indirectly, from the drug use.

5. OUTCOMES

5.1 Total respondent organizations

After a great effort of all regional and local Federations, we had an impressive number of respondent organizations. There were **301 organizations**, from **40 countries** and from the **6 regions** of the whole world: Europe, North America, Latin America and the Caribbean (LAC), Asia, Oceania and Africa.

Figure 1 - Total respondent organizations worldwide

Comparing this survey with the last, in the first edition of this report we had 127 TCs from 26 countries and 5 regions, which represent a **great increase** of 228% for TCs and 153.8% for countries, as we can see in the table below.

Table 1 - Total respondent organizations by Region (2023-2022)

Region	2023		2022		Increase	
	n	%	n	%	n	%
LAC	225	74.8%	73	55.3%	152	308.2%
Europe	40	13.3%	16	12.1%	24	250.0%
North America	19	6.3%	21	15.9%	-2	-9.5%
Asia	12	4.0%	17	12.9%	-5	-29.4%
Oceania	4	1.3%	5	3.8%	-1	-20.0%
Africa	1	0.3%	0	0.0%	1	-
Total	301	100%	132	100%	169	228%

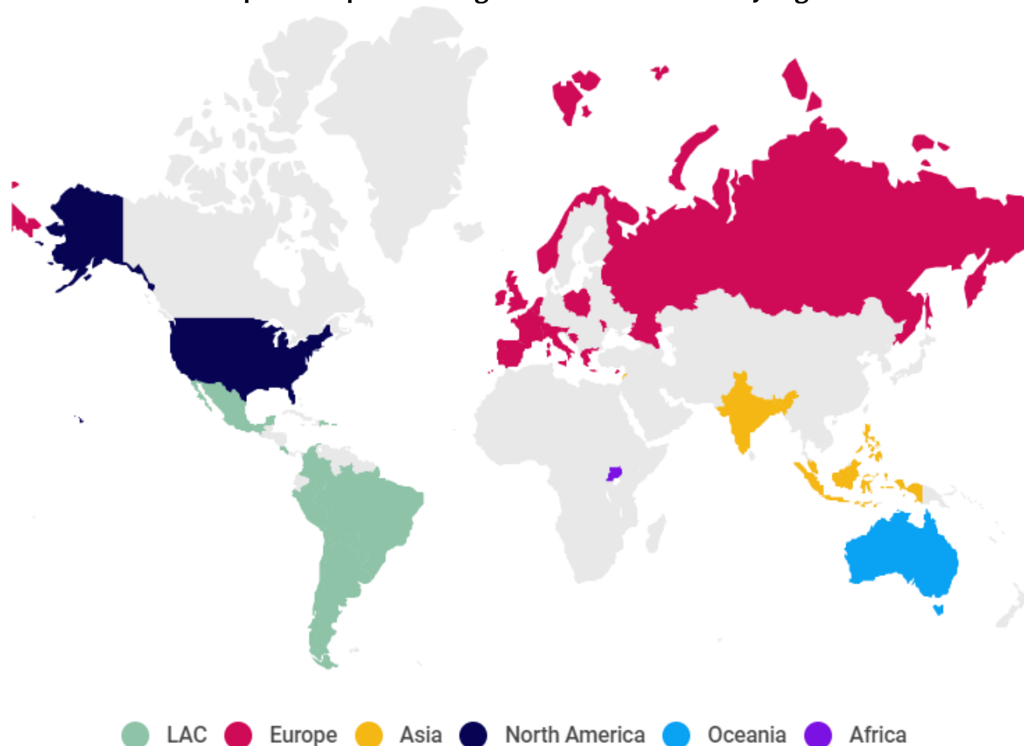
The regions with more impressive increases were Latin America and the Caribbean (308%) and Europe (250%). In the first edition Africa didn't participate, and in this edition, Africa had only one respondent TC. It's a kick-off for the African continent, and we'll try to further disseminate in the regions with lower representation next year.

Regarding the total countries by region, the greatest increase was in Europe (188.9%) and Latin America and the Caribbean (171.4%), as we could see in the table below.

Table 2 - Total countries by region (2023-2022)

Region	2023		2022		Increase	
	n	%	n	%	n	%
Europe	17	42.5%	9	34.6%	8	188.9%
LAC	12	30.0%	7	26.9%	5	171.4%
Asia	8	20.0%	8	30.8%	0	0.0%
North America	1	2.5%	1	3.8%	0	0.0%
Oceania	1	2.5%	1	3.8%	0	0.0%
Africa	1	2.5%	0	0.0%	1	-
Total	40	100%	26	100%	14	153.8%

Graph 1 - Respondent organizations - countries by region



In the graph below, we could see the total TCs by country. The darker the country, the more TCs it had.

Graph 2 - Total respondent organizations by country

As some of this organizations which responded as a single one had more than one specific TC service, we asked for them to share the total number of TC services, so we could show a real picture of the whole TCs services by region.

The ***Asociación Proyecto Hombre*** from Spain reported 28 services, the **Italian Federation of TCs (FICT)** reported 43 services, and some TCs from **Brazil** reported a total of 13 extra services.

After this update we had a total of **383 TCs**, which represents an impressive increase of **290%**, considering that our first expectation was an increase of 25% of organizations. In all the next descriptive analysis we use the first number of 301 TCs as total.

Table 3 - Total TCs by Region (2023-2022) after update

Region	2023		2022		Increase	
	n	%	n	%	n	%
LAC	238	62.1%	73	55.3%	165	326.0%
Europe	109	28.5%	16	12.1%	93	681.3%
North America	19	5.0%	21	15.9%	-2	-9.5%
Asia	12	3.1%	17	12.9%	-5	-29.4%
Oceania	4	1.0%	5	3.8%	-1	-20.0%
Africa	1	0.3%	0	0.0%	1	-
Total	**383**	**100%**	**132**	**100%**	**251**	**290.2%**

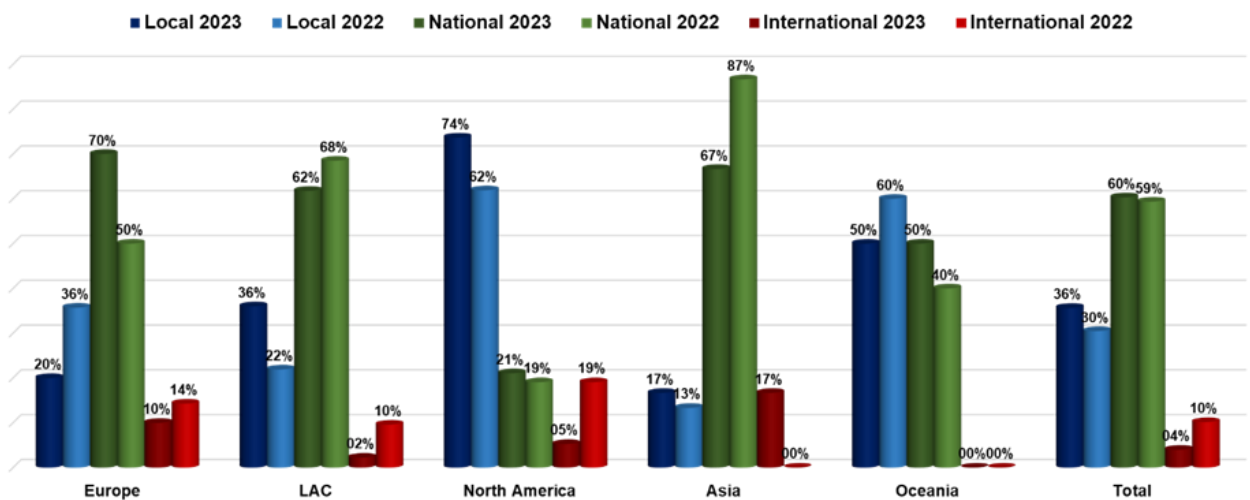
5.2 Scope of work

The scope of work was divided in three categories: local, national and international. This data was also collected in the first survey, so it was possible to compare the 2022 data with the current survey.

This information could be related to the size of the organization, considering that bigger organizations are more likely to carry out national and international work.

Most of the organizations had a national scope of work (n=182; 60.5%) and only 4% (n=12) had international scope of work.

Graph 3 - Scope of work by region (2023-2022)



5.3 Type of work conducted

In this question the organizations had to choose between three categories:

- ***Grassroots:*** the organization maintains and operates facilities or services that provide education, prevention, treatment, and supportive care which ameliorates addiction, poverty, homelessness, unemployment, and social dislocation.
- ***Advocacy:*** the organization maintains a relationship with policymakers, national and international governments, and other organizations in the field, represents other organizations in the regional and international context.
- ***Grassroots and Advocacy***

This data was also collected in the first survey, so it was possible to compare the 2022 data with the current survey.

Most of TCs (n=217; 72.1%) reported Grassroots work, especially in Latin America and the Caribbean (n=185; 82.2%). The region with more Advocacy work was North America (n=2; 10.5%), followed by Europe (n=3; 7.5%).

This picture shows the need of more political engagement by the TCs worldwide, focusing increasing the participation and the voice of the whole TC world movement.

Table 4 - Type of work by region (2023)

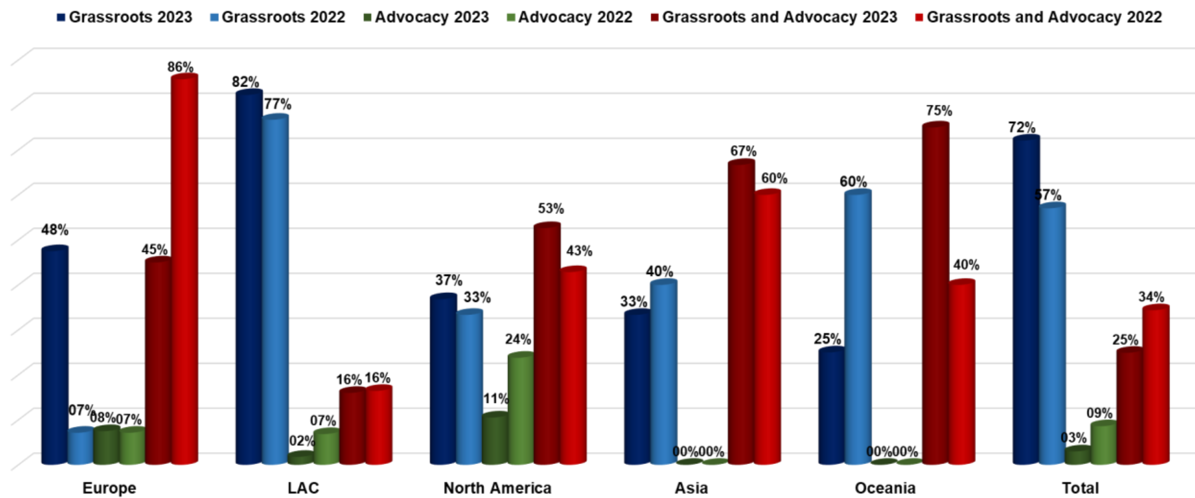
Region	Grassroots		Advocacy		Grassroots and Advocacy	
	n	%	n	%	n	%
Europe	19	47.5%	3	7.5%	18	45.0%
LAC	185	82.2%	4	1.8%	36	16.0%
North America	7	36.8%	2	10.5%	10	52.6%
Asia	4	33.3%	0	0.0%	8	66.7%
Oceania	1	25.0%	0	0.0%	3	75.0%
Africa	1	100%	0	0.0%	0	0.0%
Total	**217**	**72.1%**	**9**	**3.0%**	**75**	**24.9%**

In the comparison between the 2022 and 2023 data, we could see an increase of Grassroots works in Total (57% to 72%), in Europe (07% to 48%) and LAC (77% to 82%).

There was a greater decrease of Grassroots and Advocacy works in Europe (86% to 45%) while there was an increase in North America (43% to 53%), Asia (60% to 67%) and Oceania (40% to 75%).

In this comparison data Africa was not included because it did not participate in the first survey.

Graph 4 - Type of work by region (2023-2022)



5.4 Number of employees

In this issue, the organizations had to choose between three categories:

- <10
- 10 to 50
- >50

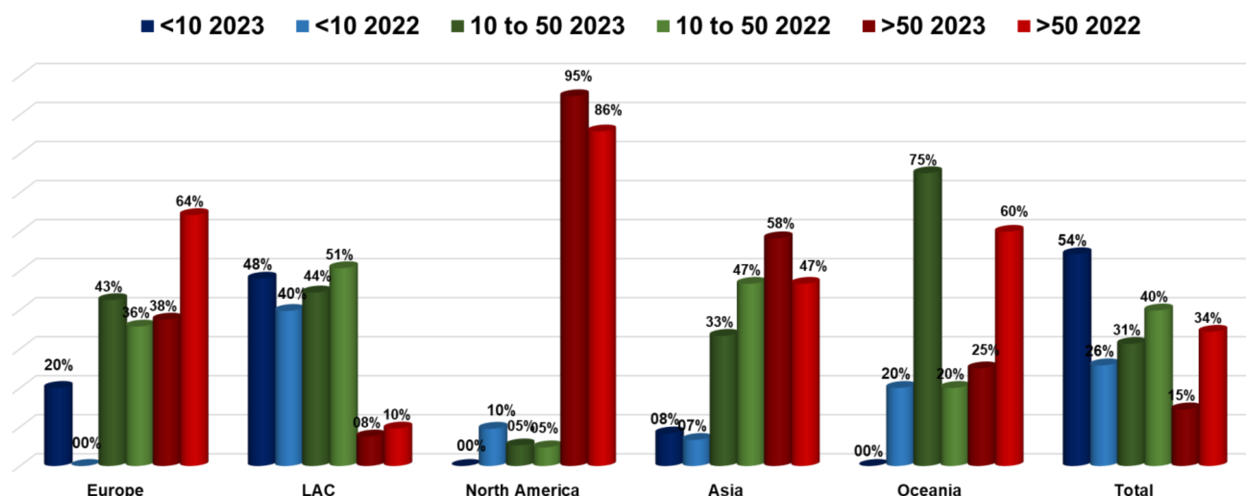
North America (n=18; 94.7%) and Asia (n=7; 58.3%) had most bigger organizations, with more than 50 employees. Latin America and the Caribbean had most of smaller organizations (n=108; 48%), with less than 10 employees.

This data shows something that already appeared in the last survey, which is that LAC has less developed organizations. In section 5.3, we could see that LAC had more grassroot work (n=185; 82.2%), which could also explain this.

In the comparison between the 2022 and 2023 data, we could see an increase of bigger TCs in North America (86% to 95%) and in Asia (47% to 58%), but it could be due to the decrease of respondent organizations in these regions.

It is evident that there were fewer larger organizations in Total (34% to 15%), in Europe (64% to 38%) and in Oceania (60% to 25%) in this survey. In Latin America and the Caribbean, the rates of all categories were maintained.

Graph 5 - Number of employees by region (2023-2022)



5.5 Source of funding

In this question the organizations had to select one or more of these seven categories:

- Solidarity private funding (companies, foundations, NGOs, etc.)
- Public funding (local funding)
- Public funding (Federal funding)
- International funding
- Health insurance
- Individual donors
- Funded by client family or client himself

The objective of this question is to know how TCs worldwide get resources to fund their work, since financial problems are one of the most common threats and setbacks that makes the work very challenging and, in some cases, unfeasible.

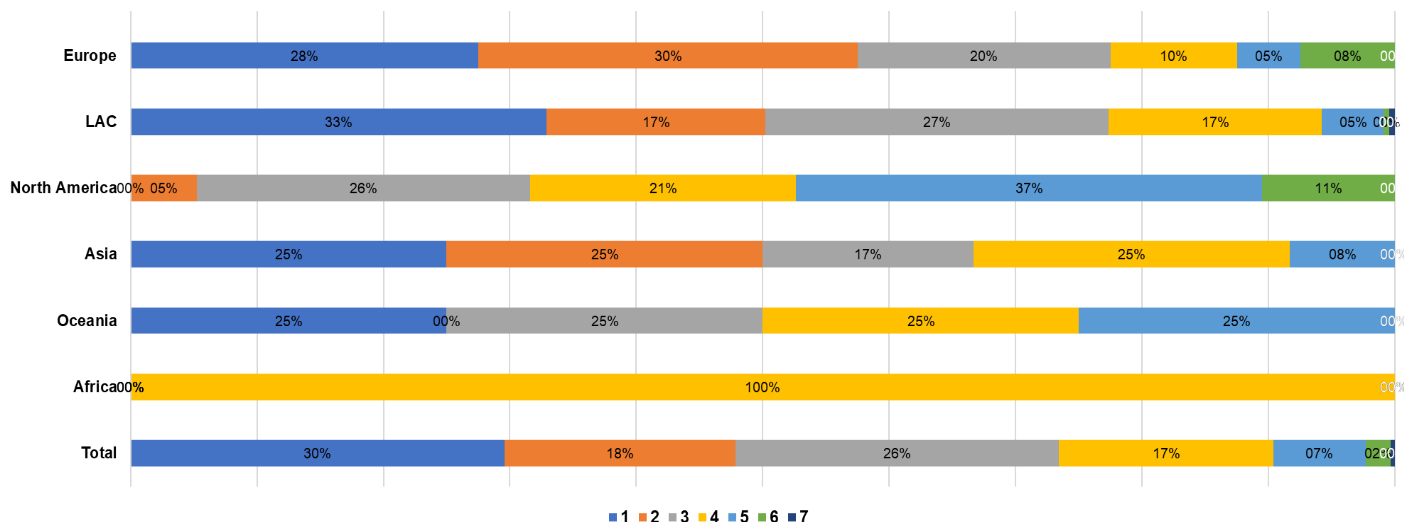
In the graph below, we could see how many sources of funding, of the seven above, the TCs selected.

Almost 30% of the total (n=89; 29.6%) had only one source of funding, 18.3% (n=55) had two and 25.6% (n=77) had three sources of funding. It means that 3/4 of the TCs (n=177; 73.4%) had few sources of funding.

It is clear that less sources of funding leads to greater likelihoods of financial problems that the TC has. If the TC loses one of these financial sources, it will not remain, making the work insecure, unstable, and unsustainable especially for long term projects.

The only region which presented increased rate of sources of funding was North America, where no TC had only one source of funding, and 48% had 4 or 5 sources of funding.

Graph 6 - Number of sources of funding by region

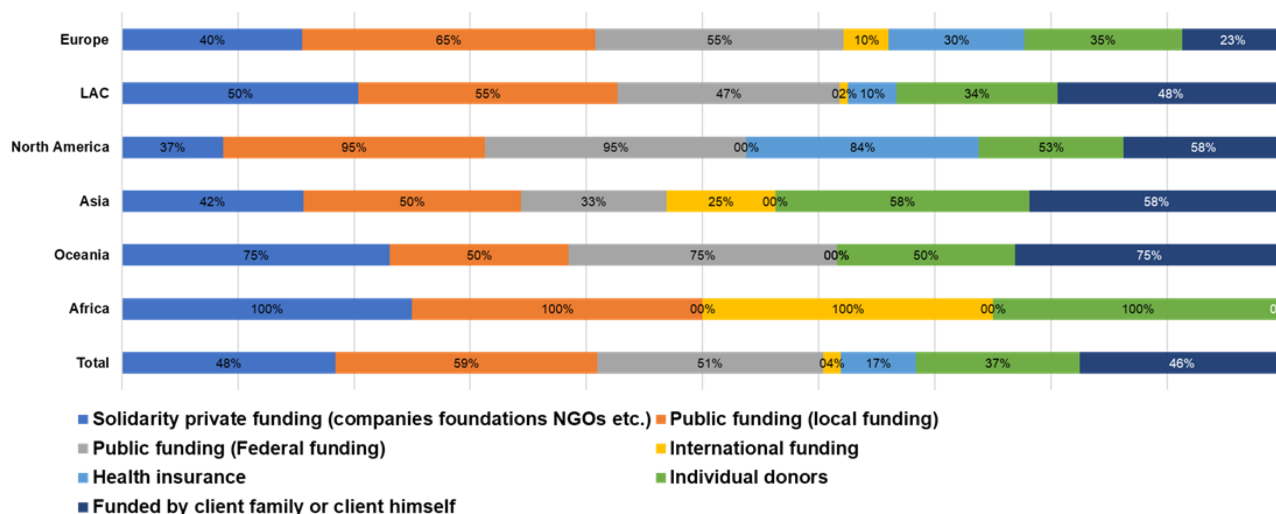


As we can see in the graph above, only one TC in this survey reported having 7 sources of funding (in LAC), and less than 10% of the total (n=29; 9.6%) reported 5 or more sources of funding.

About the specific sources of funding, in the graph below we can see that the main sources were: Public funding (local funding) (n=177; 58.8%); Public funding (federal funding) (n=153; 50.8%); Solidarity private funding (companies, foundations, NGOs, etc.) (n=145; 48.2%) and Funded by client family or client himself (n=138; 45.8%).

Health insurance source of funding was more common in North America (n=16; 84.2%) and Europe (n=12; 30.0%).

Graph 7 - Sources of funding by region



5.6 Target population

In this question the organizations had to select one or more of these ten categories, considering the target population reached by their programs:

- Children
- Teenagers
- Adults
- Elderly
- HIV-AIDS
- In-prison
- Homelessness
- Migration
- Refugees
- LGBTQIA+

It is important to know where and how the minorities and specific populations could reach appropriate care and treatment. Historically, was more common for TCs to deliver treatment only for male adults.

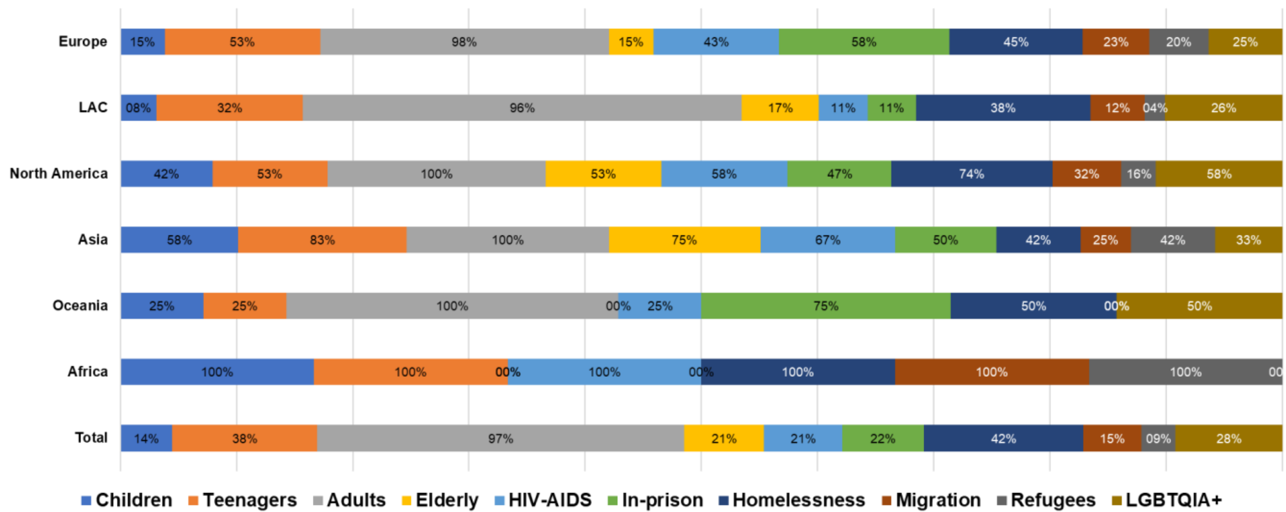
As we can see in the graph below, in total, adults were the most reported target population (n=291; 96.7%). The others more frequent target populations were Teenagers (n=115; 38.2%) and Homelessness (n=126; 41.9%).

Children services were only 13.6% (n=41), having only one target population below (Refugees: n=27; 9.0%). The region with the biggest rate of Children services were Asia (n=7; 58.3%) and North America (n=8; 42.1%).

Teenagers services had bigger rates in Asia (n=10; 83.3%), North America (n=10; 52.6%) and Europe (n=21; 52.5%).

LGBTQIA+ could have care in 28.2% (n=85) of the respondent TCs, which is a promising number, considering that it's a new specific population for TCs. This shows the progress of the TC worldwide movement in reaching out to specific populations responding to the rapid and evolving changes of the drug related problems scenario.

Graph 8 - Target population by region

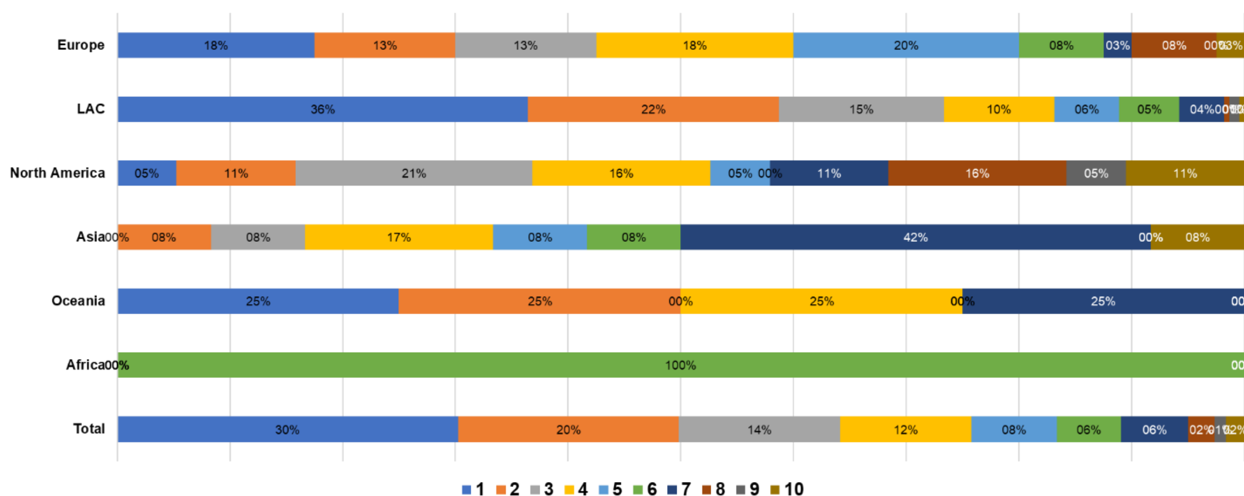


As each TC could select more than one target populations assisted by their services, we could see that half of the respondent TCs reported having only one (n=91; 30.2%) or two (n=59; 19.6%) target populations.

North America, Asia and Europe had more well distributed rates of number of target populations. In Asia none of the TCs had only one target population, in North America only 5.3% (n=1) and in Europe 17.5% (n=7).

Only 5 TCs (1.7%) reported having all the 10 target populations.

Graph 9 - Number of target populations by region



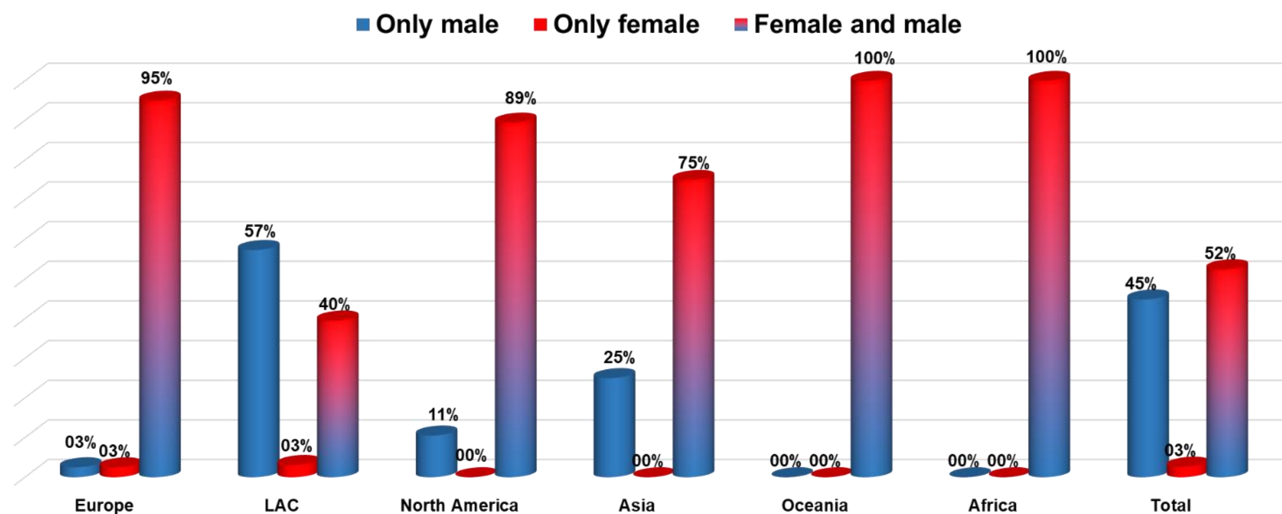
5.7 Target population gender

In this issue, the organizations had to answer if they have only male, only female or both treatment facilities. In the case of both, it does not mean that the same facility delivers treatment for men and women. Rather it means that the organization have different facilities for each gender.

As we could see in the graph below, except in Latin America and the Caribbean, in all regions the vast majority of TCs offered male and female treatment. Although, as we already highlight in Section 1, the UNODC 2022 World Drug Report showed that there are barely female services, compared to male.

Only female services were non-representative (n=8; 2.7%) and only offered in Europe and in Latin America and the Caribbean.

Graph 10 - Target population gender by region



5.8 Settings

In this issue, the organizations had to select one or more of these four categories:

- Residential treatment (TC)
- Ambulatory treatment (TC and other)
- Harm reduction facilities
- Housing facilities

At an early stage, original TCs used to deliver only residential treatment, in most of the countries where they were present. However, during the past few decades, modified TCs have been established, with different programs and varied time of treatment.

In this process of modification, TCs started to deliver other kinds of care, like ambulatory programs, harm reduction and housing programs.

Hence, why in this question we asked about these other kinds of settings. It's important to explain that in this issue the question is about having specific facilities for these kinds of programs. For example, if the organization delivers harm reduction care in outreach programs, but did not have a specific facility for this, the organization could not select the harm reduction setting in this question.

In total, 89.4% (n=269) offered residential settings, 56.5% (n=170) ambulatory settings, 22.9% (n=69) harm reduction facilities and 27.2% (n=82) housing facilities.

It's important to stress that **almost a quarter of the respondent TCs had harm reduction facilities**. This data shows that global TCs services are evolving to be person-centered and adapt to their needs in a continuum of care logic.

Due to this, TCs had been developing their programs, in order to adapt itself to the more urgent needs of their target populations, beyond ideological and political boundaries.

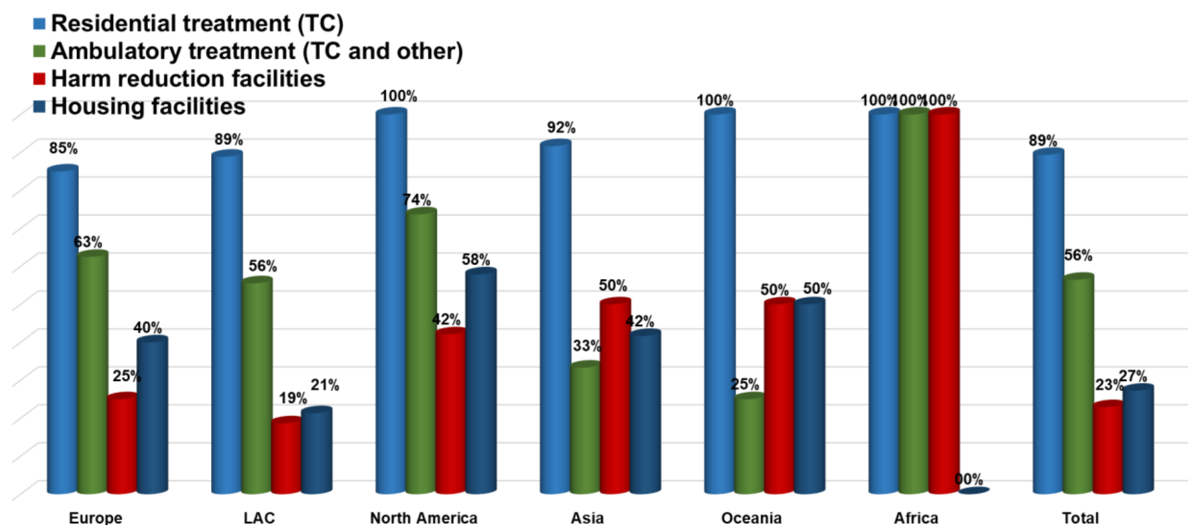
These harm reduction facilities were more reported in Asia (50.0%; n=6) and North America (42.1%; n=8). Even with lower rates in Latin America and the Caribbean (18.7%), we could find a great number of 42 TCs with harm reduction facilities, even in

a less developed region, and even the primary drug used not being heroine, which is the most associated drug with harm reduction programs.

Ambulatory treatment was more common in North America (73.7%; n=14) and Europe (62.5%; n=25).

Housing facilities were more common in North America (57.9%; n=11).

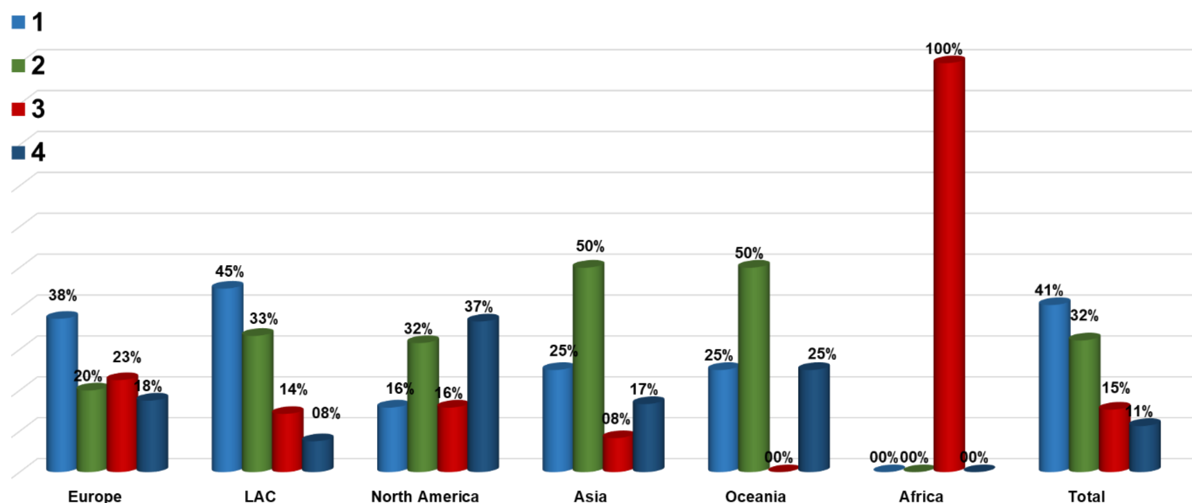
Graph 11 – Settings by region



As each TC could select more than one setting, we could how many different settings the respondent organization had.

Most of the organizations had only one setting (n=123; 40.9%), 32.2% (n=97) had two, 15.3% (n=46) had three and only 11.3% (n=34) had the four proposed settings.

Graph 12 - Number of settings by region



5.9 Average proposed time for treatment

In this question, the organizations had to select one of these four categories:

- < 3 months
- 3 – 6 months
- 6 – 12 months
- > 12 months

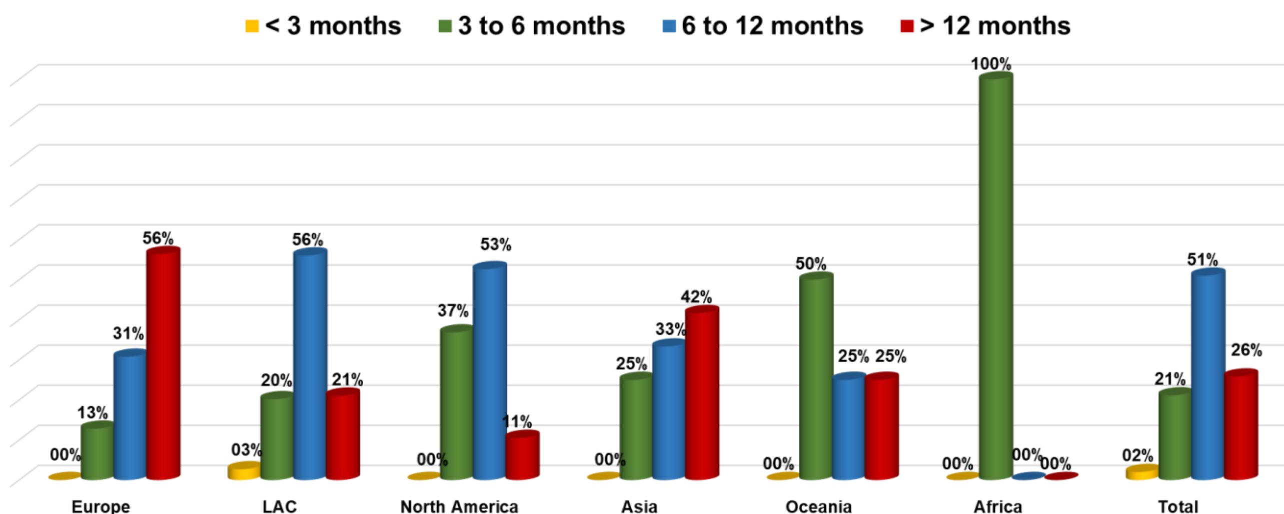
In this question we want to know how many TCs in each region had adapt their programs to this new trend.

As we can see in the graph below, most of the TCs had treatment programs of 6 to 12 months (n=152; 51.0%), and this proposed time was the most reported in Latin America and the Caribbean (n=125; 56.1%) and in North America (n=10; 52.6%).

Longer programs (more than 12 months) were more frequently reported in Europe (n=22; 56.4%), and Asia (n=5; 41.7%). It is important to highlight that longer programs do not necessarily entail longer internments, as a program could offer both residential and ambulatory treatment, depending on the phase.

Shorter programs (less than 3 months) appeared only in Latin America and the Caribbean, with only 2% (n=6) of the total (2.7% in LAC).

Graph 13 - Average proposed time for treatment by region



5.10 TC location

In this question, the organizations had to select one of these three categories:

- Urban
- Rural
- Urban and Rural

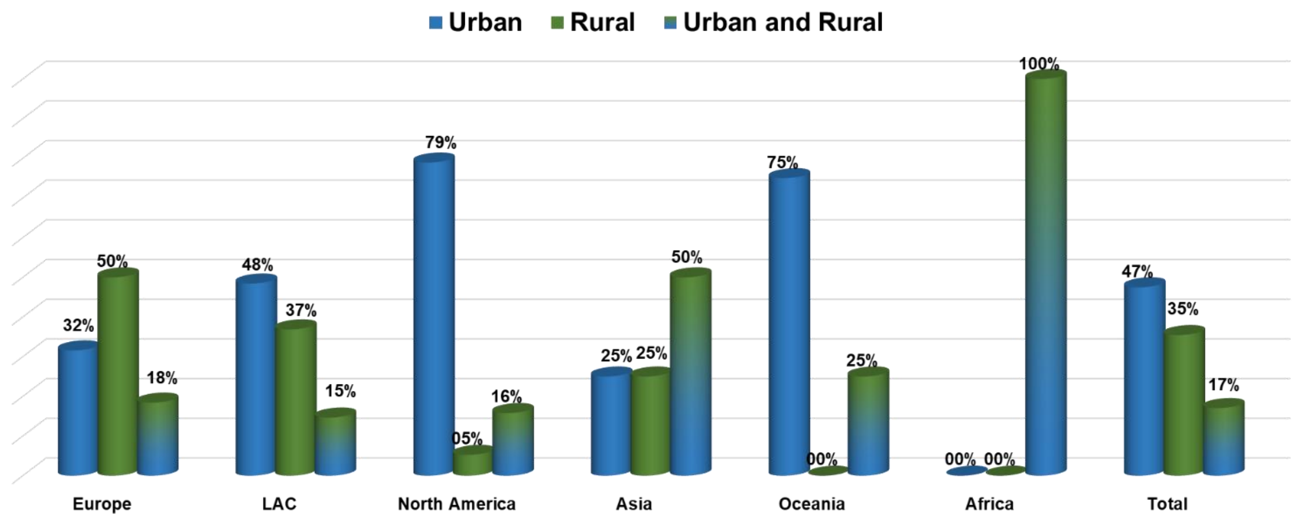
Here, we want to know how many TCs follow the mainstream of preferring urban facilities or, at least, having both locations to better assist their public.

In this question, we have an impressive result of almost the half of the TCs (n=142; 47.5%) reported having urban locations and 17.1 % (n=51) both. Only 35.5% (n=106) of the respondent TCs reported having only rural locations.

Only urban locations were more common in North America (n=15; 78.9%) and in Oceania (n=3; 75.0%).

Europe was the only region with most rural locations (n=19; 50.0%).

Graph 14 - TC location by region



5.11 Religious

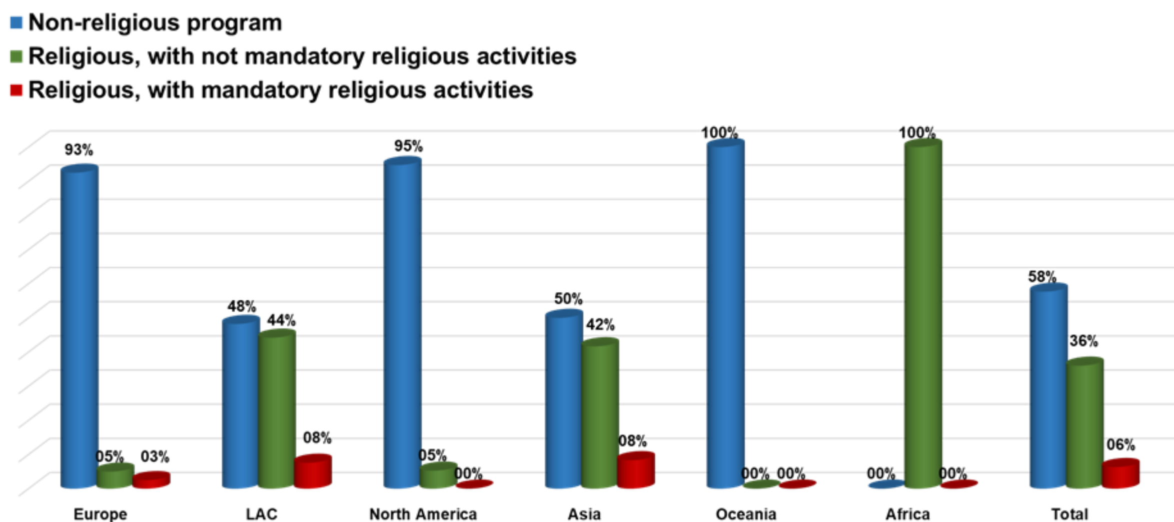
In this question, the organizations had to select one of these three categories:

- Non-religious program
- Religious, with not mandatory religious activities
- Religious, with mandatory religious activities

More than half of TCs reported having non-religious programs (n=173; 57.7%). The regions with more religious programs were Latin America and the Caribbean (n=116; 51.8%) and Asia (n=6; 50.0%), considering TCs with mandatory and not mandatory activities.

In Oceania there were no TCs with religious programs, in Europe there were only 3 TCs (7.5%) and in North America only one (5.3%), considering TCs with mandatory and not mandatory religious activities.

Graph 15 - Religious by region



5.12 Staff

In this issue, the organizations had to select one or more of these nine staff members:

- Psychologist
- Social Worker
- Counselors (recovered addicts)
- Doctor (General)
- Psychiatrist
- Nurse
- Physical Educator
- Administrative/financial
- Others

During the developing of TCs, mainly in the last two decades, different and more various professionals started to be part of the daily work and activities thus, enhancing the modern TCs programs.

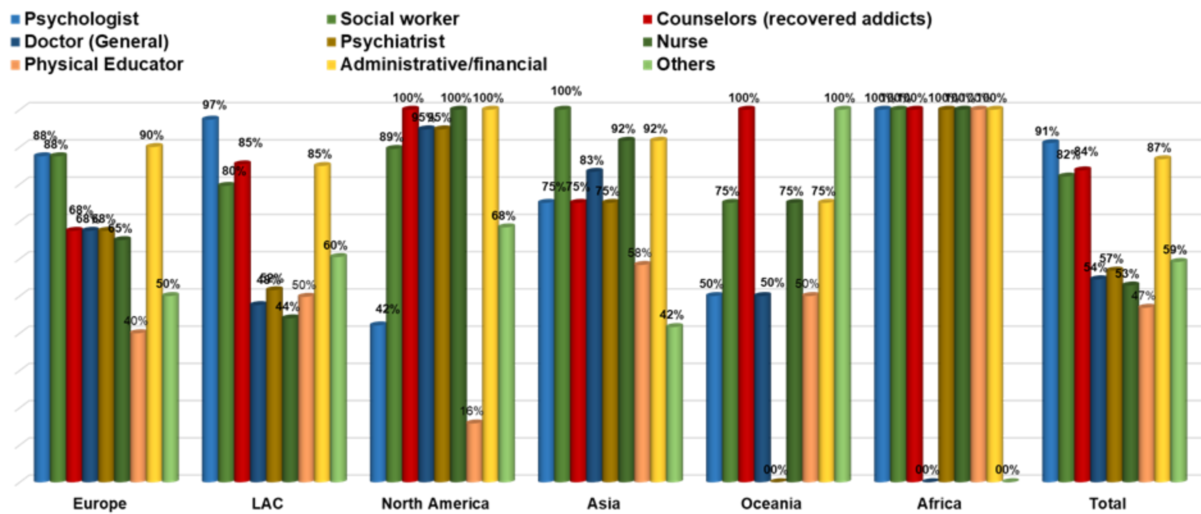
In order to simplify the filling of the form, we didn't ask how many of each professional the TCs had, so here they only have to select if they have these professionals or not.

As we can see in the graph below, the more present professionals were Psychologist (n=274; 91.0%); Administrative/financial (n=261; 86.7%), Counselors (n=252; 83.7%) and Social workers (n=247; 82.1%).

Psychologist were less present in North America (n=8; 42.1%) and in Oceania (n=2; 50.0%).

Doctors and Psychiatrists were more present in North America (n=18; 64.7% both) and in Asia (n=10; 83.3%; n=9; 75.0%).

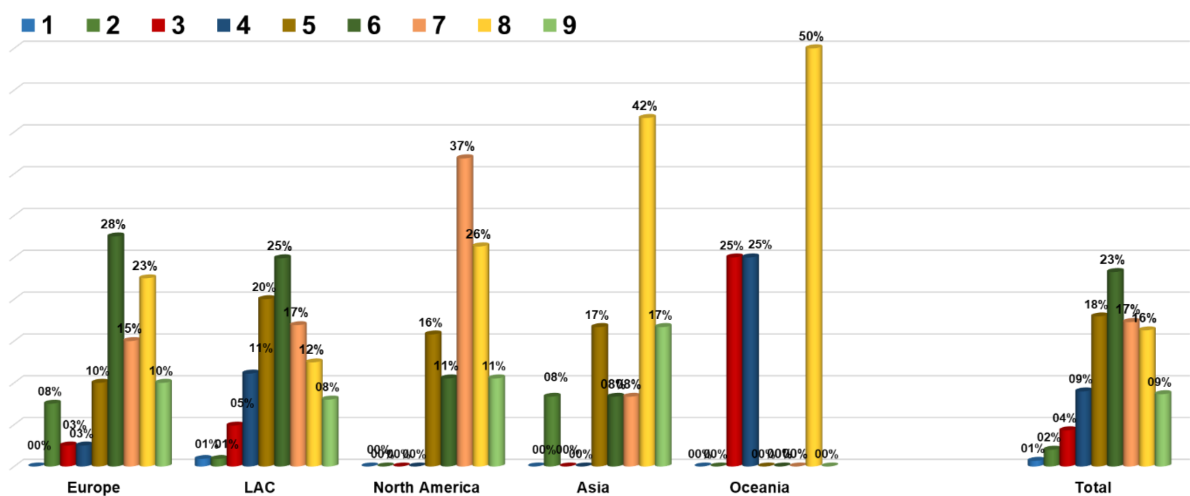
Graph 16 - Staff by region



As each TC could select more than one staff members, we could look at information on the number of different professionals the TCs had. We can see that more than 80% of TCs reported having 5 or more different professionals in their staff.

This is really impressive, considering that until recently and still to this day, TCs are sometimes seen as non-professional treatments by many groups associated with drug policies and health services.

Graph 17 – Number of staff by region



5.13 Assisted and reached people

In this last section we present the most important outcome, which is the number of assisted and reached people. To get this number we asked to the TCs about two different results:

a. **Number of individuals who received services in TC by your organization in 2022.**
   Number who received services include individuals directly cared by your organization in TC services.

b. **Number of individuals reached by your organization in 2022.**
   Number reached should include the number serviced along with individuals who have been "touched" by your organization. This can include prevention programs, street outreach, family members, educational activities and those who had one-time touch point of receiving food, shelter and clothing, as examples. It should, however, not include people reached through communication actions (social media, awareness campaigns, etc.) as these figures can alter the total number and blurry the data we would like to show.

In the first survey, we asked about assisted and reached people in a unique question. In this survey we had two different questions, in order to separate the direct work of the TC (question a = Assisted) and the complementary work (question b = Reached).

In total we had more than 300,000 assisted people, and almost a million and a half of people reached, totaling more than 1,700,000 assisted and reached people by WFTC TCs worldwide.

Figure 2 - Total assisted and reached people

As we can see in the table below, Latin America and the Caribbean was the region with most assisted people, making up more than 60% of the total (n=212,342; 62.6%). Europe was the region with most reached people, making up almost the half of the total (n=657,894; 46.0%).

Table 5 - Total assisted and reached people by region

Region	Total individuals who received services		Total individuals reached	
	n	%	n	%
LAC	212,342	62.6%	280,049	19.6%
North America	72,601	21.4%	366,968	25.6%
Europe	34,276	10.1%	657,894	46.0%
Asia	17,893	5.3%	121,916	8.5%
Oceania	1,844	0.5%	2,812	0.2%
Africa	200	0.1%	2,000	0.1%
Total	339,156	100%	1,431,639	100%

We compared these results with the last survey by summing both results and comparing it to that one result, which found promising and positive outcomes in this change in people reached and assisted.

The most notable increase was in Europe, with an increase of 612,960 assisted and reached people (increase of 873.8%), followed by Latin America and the Caribbean, with an increase of 379,328 assisted and reached people (increase of 435.5%).

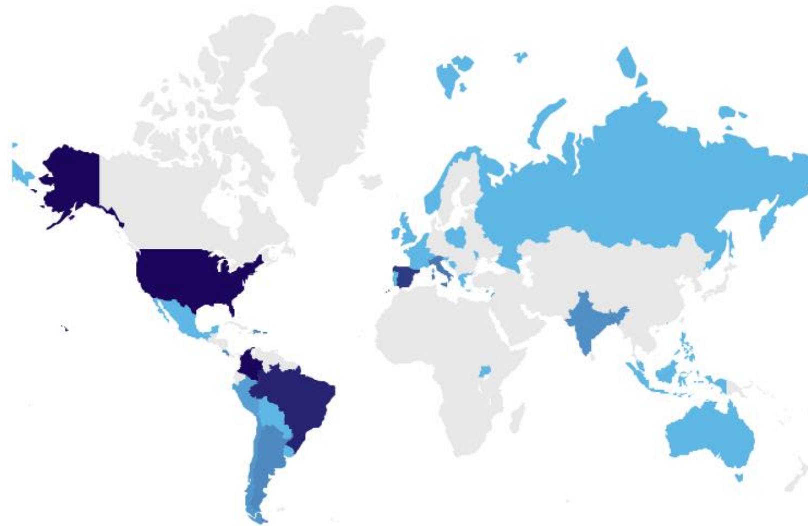
In total we had an increase of 1,184,965 assisted and reached people, that means an impressive increase of 302.3%.

Table 6 - Total assisted and reached people by region (2023-2022)

Region	2023		2022		Increase	
	n	%	n	%	n	%
Europe	692,170	39.1%	79,210	13.5%	612,960	873.8%
LAC	492,391	27.8%	113,063	19.3%	379,328	435.5%
North America	439,569	24.8%	276,795	47.2%	162,774	158.8%
Asia	139,809	7.9%	88,532	15.1%	51,277	157.9%
Oceania	4,656	0.3%	28,230	4.8%	-23,574	-83.5%
Africa	2,200	0.1%	0	0.0%	2,200	-
Total	1,770,795	100%	585,830	100%	1,184,965	302.3%

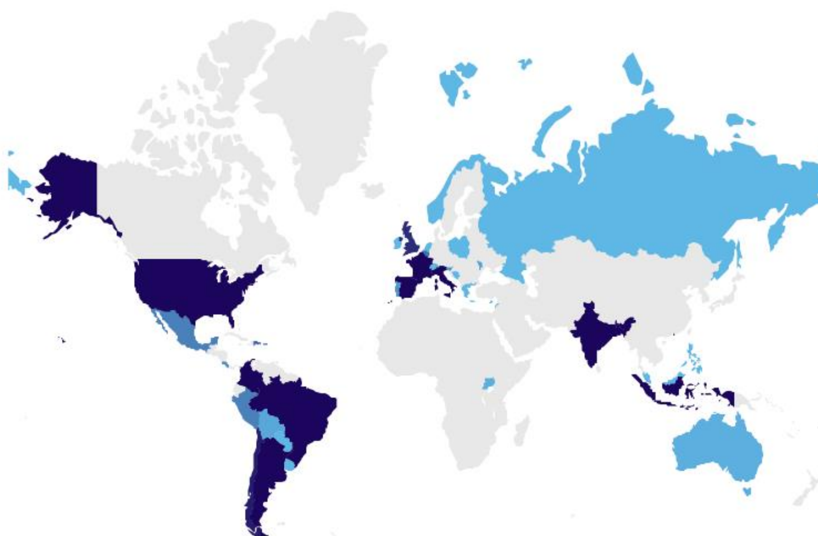
Related to the respondent organizations countries, below we could see the graph about the total individuals who received services (assisted people), where the darker the country, the more assisted people.

Graph 18 - Total assisted people by country



Now we could see the graph about the total individuals reached by the organizations, where the darker the country, the more reached people.

Graph 19 - Total individuals reached by country



CONCLUSIONS

This second edition of the WFTC Social Report had a significant increase of 153% in countries and 290% in respondent organizations and included Africa, which was not present in the first edition. In total, we had 383 participants from 40 countries of the six regions of the world. However, we still need to further circulate, advertise, and publicize this work to spread this survey more widely in the coming years.

In 2022, WFTC respondent TCs assisted more than 300,000 people and reached almost a million and a half, which was an encouraging indication of the relevance of the TC movement worldwide.

As we saw in the first report, there are bigger organizations in North America and Europe, but most of the respondent organizations were based in Latin America and the Caribbean.

These organizations mostly situated in less economically developed countries, may have less influence on the political scenario, as there tends to be less advocacy work and collaboration between non-government and government organizations. It is an urgent issue to support these organizations in gaining more political influence in their countries and regions.

Funding is another critical node in the field and is a significant challenge faced by many TCs in less economically developed countries. Advocacy work could enhance funding programs and help to ensure the continuation, improvement, and sustainability of program effectiveness.

Programs for children are still rare, and women remain underrepresented in the gender distribution of the programs. This is a critical point, and we call on the world TC movement to improve the availability of women-only programs to have a more comprehensive network of services.

Promisingly, almost a quarter of the respondent TCs had harm reduction facilities, which shows that TCs are developing their programs in order to adapt to the more urgent needs of their target populations beyond ideological and political boundaries.

Another encouraging sign is the significant, multidisciplinary presence of different professionals in the majority of TC staff, which shows that contemporary TCs are becoming more professionally oriented services.

To conclude, this second edition of the World TC Report highlights the continued, monumental efforts that TCs around the world make to work to create a better world to support those who experience drug use, directly or indirectly.

We are not the only solution. However, we are confident that TCs are making a difference for hundreds of thousands of people all around the world, and we will continue to adapt and improve our services so that we can carry on our work supporting people in the future.