WFTC

WORLD FEDERATION OF THERAPEUTIC COMMUNITIES

WORLD SOCIAL REPORT

Nº 2 - 2023

Coordination of the Report

Coordinator
Pablo Kurlander (Brazil)

Deputy coordinators
Sergio Di Paolo (Italy)
Oriol Esculies (Spain)

International advisors

Augusto Nogueira (Macao SAR)
Garth Popple (Australia)
Gerard Byrne (Australia)
Jesús Mullor (Spain)
Jorge Olivares (Chile)
José Manoel Bertolote (Brazil)
Phaedon Kaloterakis (Greece)
Richard Steinberg (USA)
Selva Careaga (Chile)
Sushma Taylor (USA)
Wouter Vanderplasschen (Belgium)

Communication and Knowledge Management Committee

Ann Tucker (USA)
Edward Carlson, chair (USA)
Enrico Costa (Italy)
Lonnie Granier (USA)
Lucía Goberna (Spain)
Martín Infante (Philippines)
Miguel Garibay (USA)
Natalia Zachartzi (Greece)
Quetzalli Manzano (Mexico)
Robert Budsock (USA)

Acknowledgments to
Sonja Phutachad Neef (New Zealand)

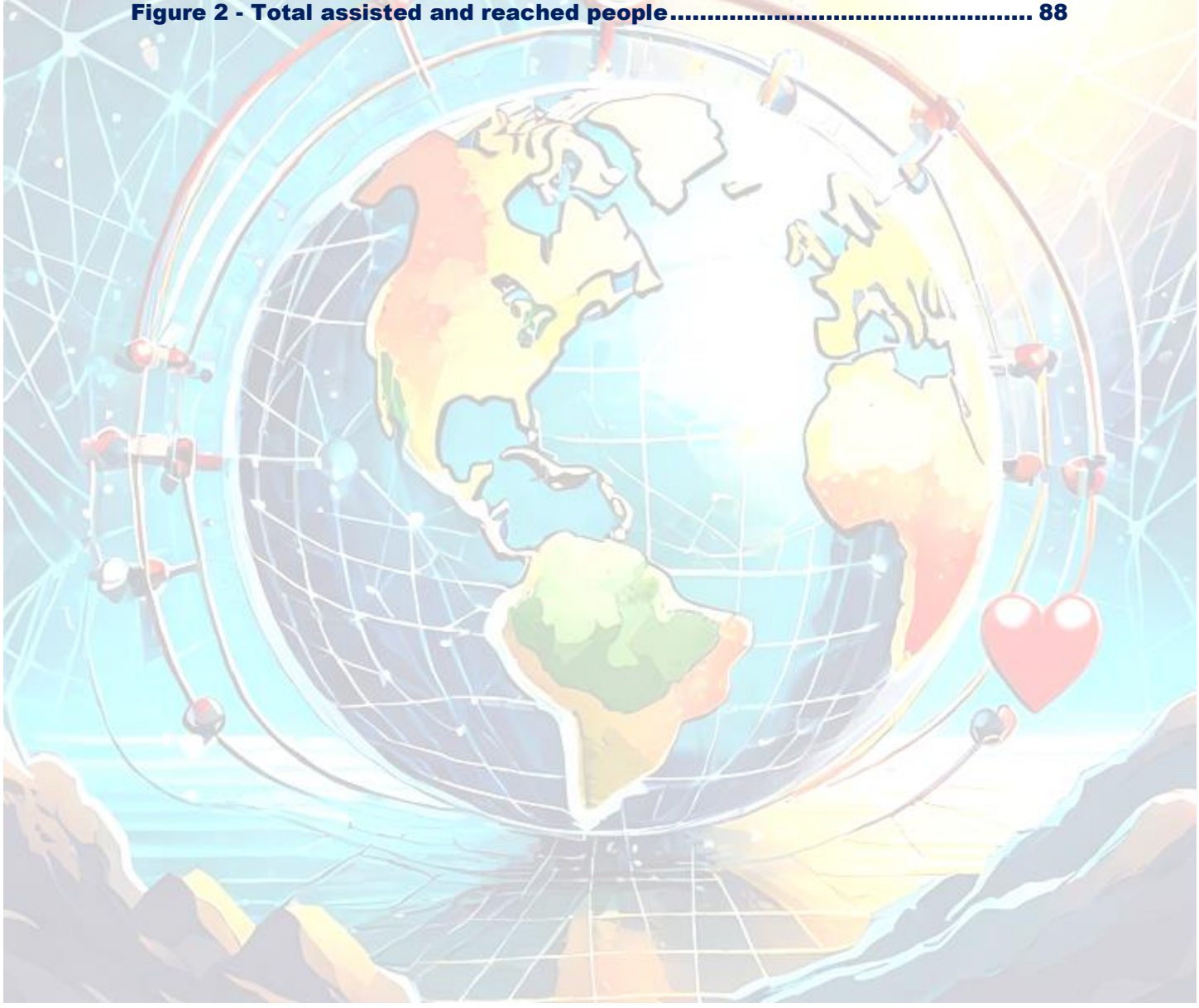
World Federation of Therapeutic Communities – WFTC
World Social Report, n. 2, Dec. 2023

SUMMARY

TABLES SUMMARY

GRAPHS SUMMARY

FIGURES SUMMARY



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 regions 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 urban and rural. 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 TC.
- 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%

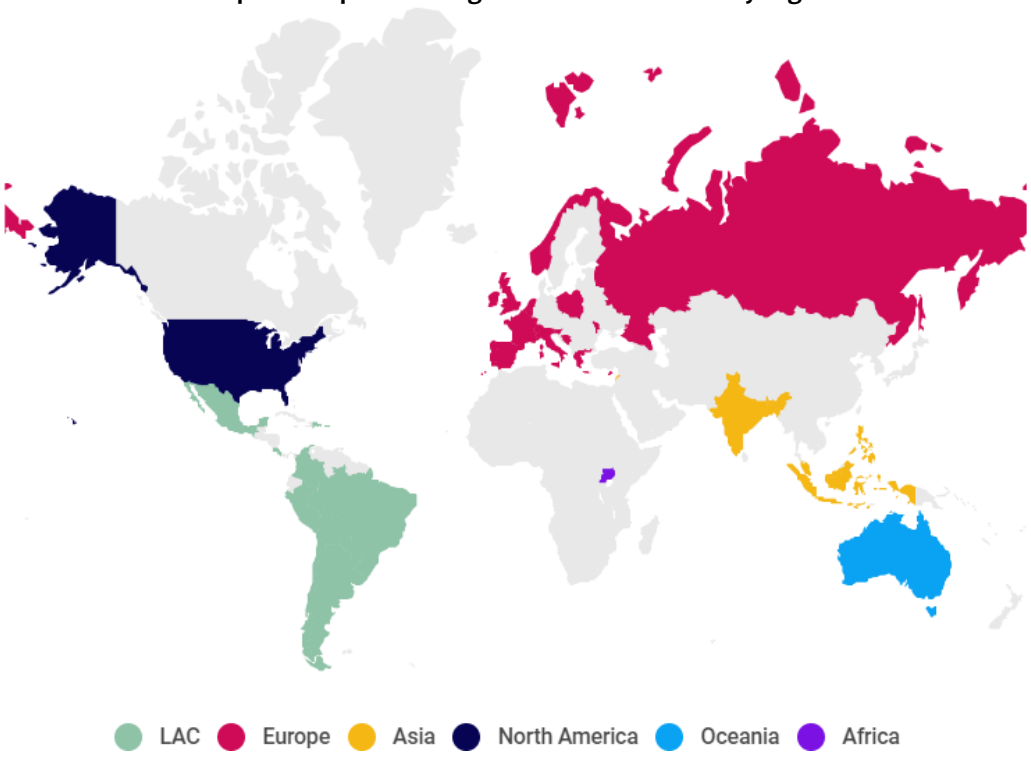
The regions with more impressive increases were Latin America and the Caribbean (308%) and Europe (250%). In the first edition Africa didn't participate, and in this edition, Africa had only one respondent TC. It's a kick-off for the African continent, and we'll try to further disseminate in the regions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

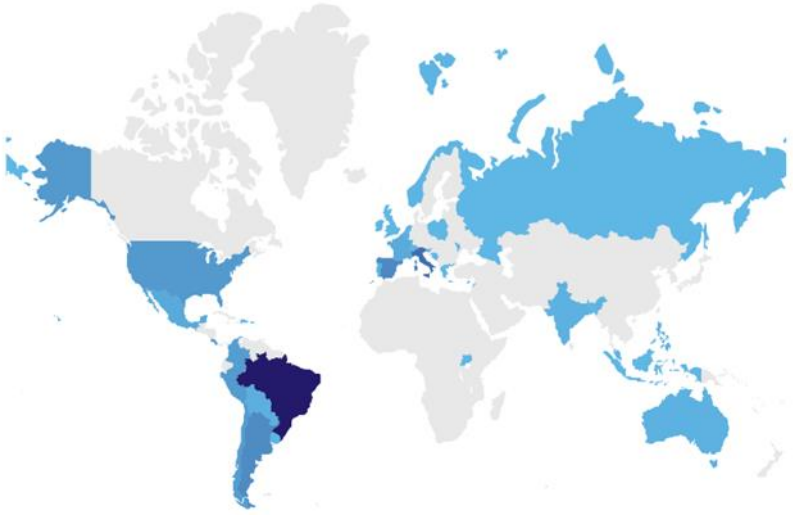
Region	2023		2022		Increase	
	n	%	n	%	n	%
Europe	17	42.5%	9	34.6%	8	188.9%
LAC	12	30.0%	7	26.9%	5	171.4%
Asia	8	20.0%	8	30.8%	0	0.0%
North America	1	2.5%	1	3.8%	0	0.0%
Oceania	1	2.5%	1	3.8%	0	0.0%
Africa	1	2.5%	0	0.0%	1	-
Total	40	100%	26	100%	14	153.8%

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%

Related to the respondent organizations countries, below we could see the distribution by region and country.

In LAC, after data updates, Brazil leads the list, with more than 110 respondent TCs (almost 50% of the total in LAC), and with an increase of more than 300%.

The most impressive increases were in Chile (850%) and in Peru (450%).

In total, LAC had a great increase of respondent TCs of 326%.

The difference in the 2022 total countries (total 73, not 72) is because in 2022 Ecuador had 1 respondent TC, and none in 2023, due to this it has not been included in the table below.

Table 4 - Total TCs by Country in Latin America and the Caribbean (2023-2022) after update

Country	2023		2022		Increase	
	n	%	n	%	n	%
Brazil	113	47.5%	36	49.3%	77	313.9%
Argentina	28	11.8%	19	26.0%	9	147.4%
Chile	17	7.1%	2	2.7%	15	850.0%
Costa Rica	18	7.6%	0	0.0%	18	-
Peru	18	7.6%	4	5.5%	14	450.0%
Colombia	17	7.1%	11	15.1%	6	154.5%
Mexico	9	3.8%	0	0.0%	9	-
Bolivia	6	2.5%	0	0.0%	6	-
Paraguay	5	2.1%	0	0.0%	5	-
Puerto Rico	3	1.3%	0	0.0%	3	-
Dominican Republic	2	0.8%	0	0.0%	2	-
Uruguay	2	0.8%	0	0.0%	2	-
Total	238	100%	73	100%	165	326.0%

In Europe, after the update, the countries with more respondent TCs were Italy (n=47; 44.3%) and Spain (n=30; 28.3%), with large increases for both (Italy 1567%; Spain 1500%). In total, Europe had an impressive increase of 681%.

The difference in the 2022 total countries (total 16, not 15) is because in 2022 Czech Republic had 1 respondent TC, and none in 2023, due to this it is not included in the table below.

Table 5 - Total TCs by Country in Europe (2023-2022) after update

Country	2023		2022		Increase	
	n	%	n	%	n	%
Italy	47	43.1%	3	18.8%	44	1566.7%
Spain	30	27.5%	2	12.5%	28	1500.0%
France	8	7.3%	0	0.0%	8	-
Belgium	6	5.5%	2	12.5%	4	300.0%
Portugal	3	2.8%	3	18.8%	0	0%
Norway	2	1.8%	0	0.0%	2	-
Netherlands	2	1.8%	0	0.0%	2	-
Slovenia	2	1.8%	1	6.3%	1	200.0%
Bosnia and Herzegovina	1	0.9%	0	0.0%	1	-
Cyprus	1	0.9%	0	0.0%	1	-
Greece	1	0.9%	2	12.5%	-1	-50.0%
Ireland	1	0.9%	1	6.3%	0	0%
Poland	1	0.9%	0	0.0%	1	-
Moldova	1	0.9%	1	6.3%	0	0%
Switzerland	1	0.9%	0	0.0%	1	-
UK	1	0.9%	0	0.0%	1	-
Russia	1	0.9%	0	0.0%	1	-
Total	109	100%	16	100%	93	681.3%

In Asia, there were a decrease of 29% in total respondent TCs, due to difficulties in the communication with the TCs of the region, which couldn't fill the form before the deadline.

India had more respondent TCs (n=4; 33.3%), with an increase of 133%.

Table 6 - Total TCs by Country in Asia (2023-2022)

Country	2023		2022		Increase	
	n	%	n	%	n	%
India	4	33.3%	3	17.6%	1	133.3%
Bangladesh	2	16.7%	3	17.6%	-1	-33.3%
Hong Kong SAR	1	8.3%	0	0.0%	1	-
Philippines	1	33.3%	4	17.6%	1	33.3%
Indonesia	1	8.3%	2	11.8%	-1	-50.0%
Malaysia	1	8.3%	2	11.8%	-1	-50.0%
Lebanon	1	8.3%	1	5.9%	0	0.0%
Macao SAR	1	8.3%	0	0.0%	1	-
Total	12	100%	17	100%	-5	-29.4%

In North America, Oceania and Africa there were only one country for each region (USA, Australia, Uganda), hence why there is no table to show.

USA had a decrease in respondent TCs of 9.5% (19 in 2023; 21 in 2022). Australia had a decrease of 20% (4 in 2023; 5 in 2022). Uganda was not included in the 2022 survey.

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.

Table 7 - Scope of work by region (2023)

Region	Local		National		International	
	n	%	n	%	n	%
Europe	8	20.0%	28	70.0%	4	10.0%
LAC	81	36.0%	139	61.8%	5	2.2%
North America	14	73.7%	4	21.1%	1	5.3%
Asia	2	16.7%	8	66.7%	2	16.7%
Oceania	2	50.0%	2	50.0%	0	0.0%
Africa	0	0.0%	1	100%	0	0.0%
Total	**107**	**35.5%**	**182**	**60.5%**	**12**	**4.0%**

Related to the respondent organizations countries, below we could see the distribution of scope of work by region and country.

Table 8 - Scope of work by country in Latin America and the Caribbean

Country	Local		National		International	
	n	%	n	%	n	%
Argentina	4	14.3%	22	78.6%	2	7.1%
Bolivia	2	33.3%	4	66.7%	0	0.0%
Brazil	49	49.0%	51	51.0%	0	0.0%
Chile	12	70.6%	5	29.4%	0	0.0%
Colombia	5	29.4%	11	64.7%	1	5.9%
Costa Rica	0	0.0%	18	100.0%	0	0.0%
Dominican Republic	1	50.0%	1	50.0%	0	0.0%
Mexico	3	33.3%	5	55.6%	1	11.1%
Paraguay	0	0.0%	5	100%	0	0.0%
Peru	4	22.2%	14	77.8%	0	0.0%

Puerto Rico	1	33.3%	1	33.3%	1	33.3%
Uruguay	0	0.0%	2	100%	0	0.0%
Total	81	36.0%	139	61.8%	5	2.2%

Table 9 - Scope of work by country in Europe

Country	Local		National		International	
	n	%	n	%	n	%
Belgium	2	33.3%	4	66.7%	0	0.0%
Bosnia and Herzegovina	0	0.0%	1	100%	0	0.0%
Cyprus	0	0.0%	1	100%	0	0.0%
France	1	12.5%	7	87.5%	0	0.0%
Greece	1	100%	0	0.0%	0	0.0%
Ireland	0	0.0%	1	100%	0	0.0%
Italy	2	40.0%	2	40.0%	1	20.0%
Moldova	0	0.0%	1	100%	0	0.0%
Netherlands	0	0.0%	2	100%	0	0.0%
Norway	0	0.0%	2	100%	0	0.0%
Poland	0	0.0%	1	100%	0	0.0%
Portugal	0	0.0%	2	66.7%	1	33.3%
Russia	0	0.0%	0	0.0%	1	100%
Slovenia	1	50.0%	1	50.0%	0	0.0%
Spain	1	33.3%	2	66.7%	0	0.0%
Switzerland	0	0.0%	0	0.0%	1	100%
UK	0	0.0%	1	100%	0	0.0%
Total	8	20.0%	28	70.0%	4	10.0%

Table 10 - Scope of work by country in Asia

Country	Local		National		International	
	n	%	n	%	n	%
Bangladesh	1	50.0%	1	50.0%	0	0.0%
Hong Kong SAR	0	0.0%	0	0.0%	1	100%
India	0	0.0%	4	100%	0	0.0%
Indonesia	1	100%	1	100%	0	0.0%
Lebanon	0	0.0%	1	100%	0	0.0%
Macao SAR	1	100%	0	0.0%	0	0.0%
Malaysia	0	0.0%	1	100%	0	0.0%
Philippines	0	0.0%	1	25.0%	0	0.0%
Total	3	23.1%	9	69.2%	1	7.7%

In the comparison between the 2022 and 2023 data, we could see an increase of national works in Europe (50% to 70%) and Oceania (40% to 50%), a greater increase of local works in LAC (22% to 36%) and North America (52% to 74%), and a visible decrease of international works in LAC (10% to 2%) and North America (19% to 5%).

In this comparison data, Africa was not included because there were no participants in the first survey.

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

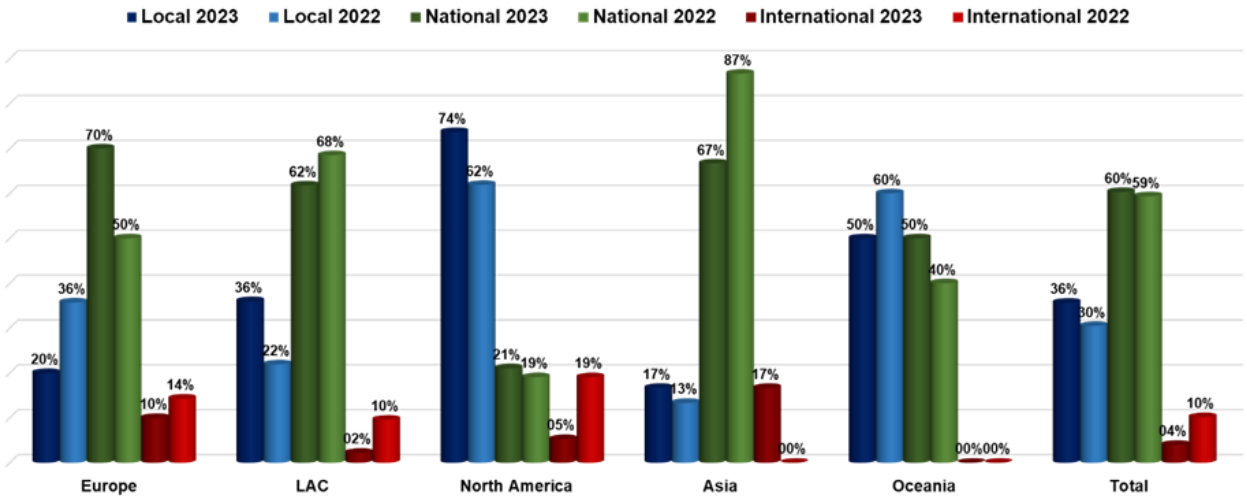


Table 11 - Scope of work by region (2023-2022)

Region	Local				National				International			
	2023		2022		2023		2022		2023		2022	
	n	%	n	%	n	%	n	%	n	%	n	%
Europe	8	20.0%	5	35.7%	28	70.0%	7	50.0%	4	10.0%	2	14.3%
LAC	81	36.0%	16	21.9%	139	61.8%	50	68.5%	5	2.2%	7	9.6%
North America	14	73.7%	13	61.9%	4	21.1%	4	19.0%	1	5.3%	4	19.0%
Asia	2	16.7%	2	13.3%	8	66.7%	13	86.7%	2	16.7%	0	0.0%
Oceania	2	50.0%	3	60.0%	2	50.0%	2	40.0%	0	0.0%	0	0.0%
Total	107	35.7%	39	30.5%	181	60.3%	76	59.4%	12	4.0%	13	10.2%

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 12 - 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%**

Related to the respondent organizations countries, below we could see the distribution of type of work by region and country.

Table 13 - Type of work by country in Latin America and the Caribbean

Country	Grassroots		Advocacy		Grassroots and Advocacy	
	n	%	n	%	n	%
Argentina	23	82.1%	0	0.0%	5	17.9%
Bolivia	6	100%	0	0.0%	0	0.0%
Brazil	88	88.0%	3	3.0%	9	9.0%
Chile	16	94.1%	0	0.0%	1	5.9%
Colombia	13	76.5%	1	5.9%	3	17.6%
Costa Rica	2	11.1%	0	0.0%	16	88.9%
Dominican Republic	2	100%	0	0.0%	0	0.0%
Mexico	8	88.9%	0	0.0%	1	11.1%
Paraguay	5	100%	0	0.0%	0	0.0%
Peru	18	100%	0	0.0%	0	0.0%
Puerto Rico	2	66.7%	0	0.0%	1	33.3%
Uruguay	2	100%	0	0.0%	0	0.0%
Total	185	82.2%	4	1.8%	36	16.0%

Table 14 - Type of work by country in Europe

Country	Grassroots		Advocacy		Grassroots and Advocacy	
	n	%	n	%	n	%
Belgium	1	16.7%	1	16.7%	4	66.7%
Bosnia and Herzegovina	1	100%	0	0.0%	0	0.0%
Cyprus	0	0.0%	0	0.0%	1	100%
France	6	75.0%	0	0.0%	2	25.0%
Greece	1	100%	0	0.0%	0	0.0%
Ireland	0	0.0%	0	0.0%	1	100%
Italy	1	20.0%	1	20.0%	3	60.0%
Moldova	0	0.0%	0	0.0%	1	100%
Netherlands	1	50.0%	0	0.0%	1	50.0%
Norway	2	100%	0	0.0%	0	0.0%
Poland	1	100%	0	0.0%	0	0.0%
Portugal	1	33.3%	0	0.0%	2	66.7%
Russia	1	100%	0	0.0%	0	0.0%
Slovenia	2	100%	0	0.0%	0	0.0%
Spain	1	33.3%	0	0.0%	2	66.7%
Switzerland	0	0.0%	1	100%	0	0.0%
UK	0	0.0%	0	0.0%	1	100%
Total	19	47.5%	3	7.5%	18	45.0%

Table 15 - Type of work by country in Asia

Country	Grassroots		Advocacy		Grassroots and Advocacy	
	n	%	n	%	n	%
Bangladesh	1	50.0%	0	0.0%	1	50.0%
Hong Kong SAR	0	0.0%	0	0.0%	1	100%
India	1	25.0%	0	0.0%	3	75.0%
Indonesia	1	100%	0	0.0%	1	100%
Lebanon	0	0.0%	0	0.0%	1	100%
Macao SAR	0	0.0%	0	0.0%	1	100%
Malaysia	1	100%	0	0.0%	0	0.0%
Philippines	0	0.0%	0	0.0%	1	25.0%
Total	4	30.8%	0	0.0%	9	69.2%

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)

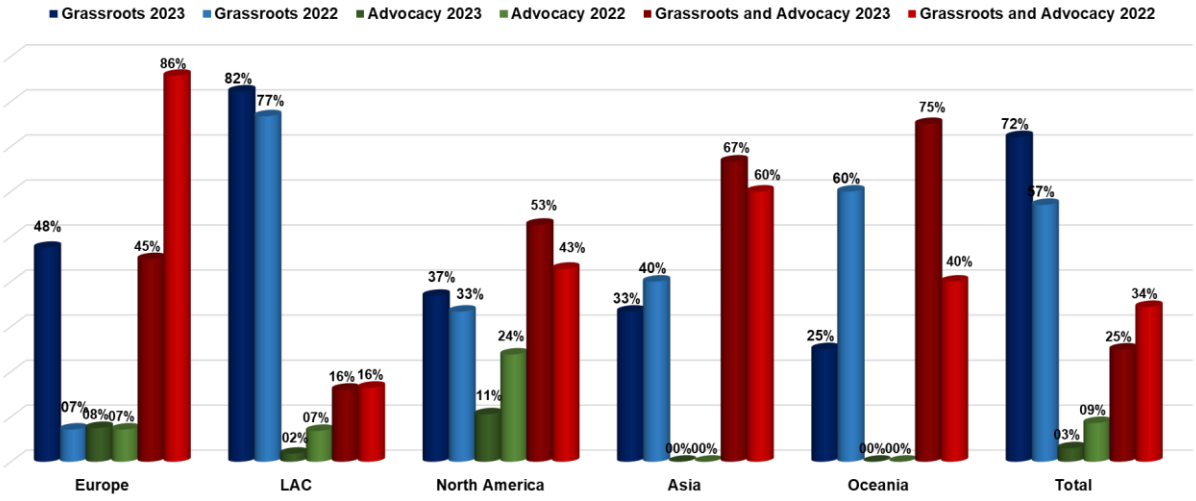


Table 16 - Type of work by region (2023-2022)

Region	Grassroots				Advocacy				Grassroots and Advocacy			
	2023		2022		2023		2022		2023		2022	
	n	%	n	%	n	%	n	%	n	%	n	%
Europe	19	47.5%	1	7.1%	3	7.5%	1	7.1%	18	45.0%	12	85.7%
LAC	185	82.2%	56	76.7%	4	1.8%	5	6.8%	36	16.0%	12	16.4%
North America	7	36.8%	7	33.3%	2	10.5%	5	23.8%	10	52.6%	9	42.9%
Asia	4	33.3%	6	40.0%	0	0.0%	0	0.0%	8	66.7%	9	60.0%
Oceania	1	25.0%	3	60.0%	0	0.0%	0	0.0%	3	75.0%	2	40.0%
Total	**217**	**72.1%**	**73**	**57.0%**	**9**	**3.0%**	**11**	**8.6%**	**75**	**24.9%**	**44**	**34.4%**

5.4 Number of employees

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

- <10
- 10 to 50
- >50

As the question about the scope of work, this information could be related to the size of the organization, considering that bigger organizations have more 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.

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.

Considering that LAC had almost the half of the TCs of this survey, it is important to stress the relevance of the region in the TCs world scenario. So, the human and financial investment in LAC TCs by the governments, international organizations and international bodies, is an urgent step to move forward.

Table 17 - Number of employees by region (2023)

Region	<10		10 to 50		>50	
	n	%	n	%	n	%
Europe	8	20.0%	17	42.5%	15	37.5%
LAC	108	48.0%	100	44.4%	17	7.6%
North America	0	0.0%	1	5.3%	18	94.7%
Asia	1	8.3%	4	33.3%	7	58.3%
Oceania	0	0.0%	3	75.0%	1	25.0%
Africa	0	0.0%	1	100%	0	0.0%
Total	**217**	**72.1%**	**9**	**3.0%**	**75**	**24.9%**

Related to the respondent organizations countries, below we could see the distribution of number of employees by region and country.

Table 18 - Number of employees by country in Latin America and the Caribbean

Country	<10		10 to 50		>50	
	n	%	n	%	n	%
Argentina	4	14.3%	20	71.4%	4	14.3%
Bolivia	5	83.3%	1	16.7%	0	0.0%
Brazil	53	53.0%	43	43.0%	4	4.0%
Chile	8	47.1%	6	35.3%	3	17.6%
Colombia	7	41.2%	7	41.2%	3	17.6%
Costa Rica	10	55.6%	8	44.4%	0	0.0%
Dominican Republic	1	50.0%	1	50.0%	0	0.0%
Mexico	7	77.8%	2	22.2%	0	0.0%
Paraguay	3	60.0%	2	40.0%	0	0.0%
Peru	9	50.0%	9	50.0%	0	0.0%
Puerto Rico	0	0.0%	1	33.3%	2	66.7%
Uruguay	1	50.0%	0	0.0%	1	50.0%
Total	108	49.8%	100	46.1%	17	7.8%

Table 19 - Number of employees by country in Europe

Country	<10		10 to 50		>50	
	n	%	n	%	n	%
Belgium	1	16.7%	3	50.0%	2	33.3%
Bosnia and Herzegovina	0	0.0%	1	100%	0	0.0%
Cyprus	0	0.0%	1	100%	0	0.0%
France	0	0.0%	4	50.0%	4	50.0%
Greece	0	0.0%	1	100%	0	0.0%
Ireland	0	0.0%	0	0.0%	1	100%
Italy	1	20.0%	0	0.0%	4	80.0%
Moldova	0	0.0%	1	100%	0	0.0%
Netherlands	2	100%	0	0.0%	0	0.0%
Norway	0	0.0%	2	100%	0	0.0%
Poland	1	100%	0	0.0%	0	0.0%
Portugal	0	0.0%	2	66.7%	1	33.3%
Russia	1	100%	0	0.0%	0	0.0%
Slovenia	1	50.0%	1	50.0%	0	0.0%
Spain	0	0.0%	1	33.3%	2	66.7%
Switzerland	1	100%	0	0.0%	0	0.0%
UK	0	0.0%	0	0.0%	1	100%
Total	8	20.0%	17	42.5%	15	37.5%

Table 20 - Number of employees by country in Asia

Country	<10		10 to 50		>50	
	n	%	n	%	n	%
Bangladesh	0	0.0%	1	50.0%	1	50.0%
Hong Kong SAR	0	0.0%	0	0.0%	1	100%
India	0	0.0%	2	50.0%	2	50.0%
Indonesia	0	0.0%	1	100%	1	100%
Lebanon	0	0.0%	0	0.0%	1	100%
Macao SAR	0	0.0%	1	100%	0	0.0%
Malaysia	1	100%	0	0.0%	0	0.0%
Philippines	0	0.0%	0	0.0%	1	25.0%
Total	1	7.7%	5	38.5%	7	53.8%

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)

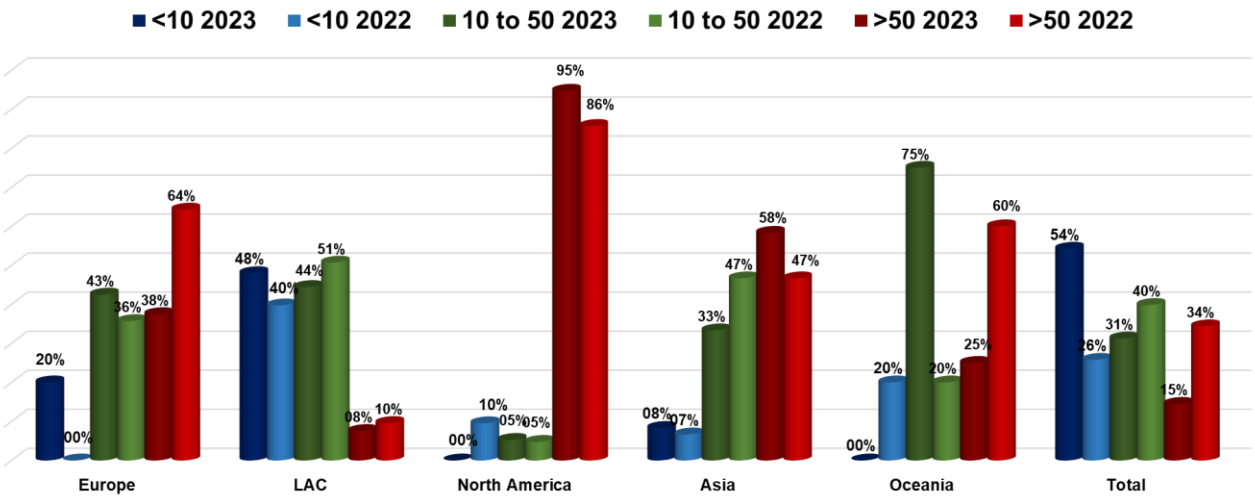


Table 21 - Number of employees by region (2023-2022)

Region	<10				10 to 50				>50			
	2023		2022		2023		2022		2023		2022	
	n	%	n	%	n	%	n	%	n	%	n	%
Europe	8	20.0%	0	0.0%	17	42.5%	5	35.7%	15	37.5%	9	64.3%
LAC	108	48.0%	29	39.7%	100	44.4%	37	50.7%	17	7.6%	7	9.6%
North America	0	0.0%	2	9.5%	1	5.3%	1	4.8%	18	94.7%	18	85.7%
Asia	1	8.3%	1	6.7%	4	33.3%	7	46.7%	7	58.3%	7	46.7%
Oceania	0	0.0%	1	20.0%	3	75.0%	1	20.0%	1	25.0%	3	60.0%
Total	217	54.3%	33	25.8%	125	31.3%	51	39.8%	58	14.5%	44	34.4%

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 so many other financial possibilities, making the work insecure, unstable, and unsustainable especially for long term projects.

The region which presented bigger quantities 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

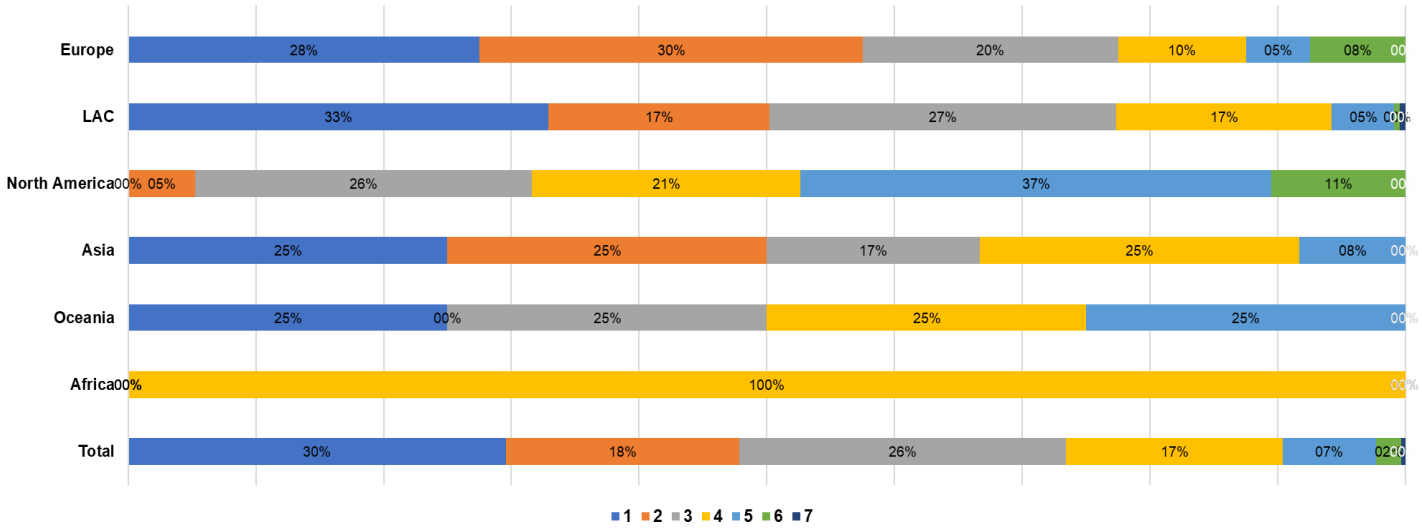


Table 22 - Number of sources of funding by region

Region	1		2		3		4		5		6		7	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Europe	11	27.5%	12	30.0%	8	20.0%	4	10.0%	2	5.0%	3	7.5%	0	0.0%
LAC	74	32.9%	39	17.3%	61	27.1%	38	16.9%	11	4.9%	1	0.4%	1	0.4%
North America	0	0.0%	1	5.3%	5	26.3%	4	21.1%	7	36.8%	2	10.5%	0	0.0%
Asia	3	25.0%	3	25.0%	2	16.7%	3	25.0%	1	8.3%	0	0.0%	0	0.0%
Oceania	1	25.0%	0	0.0%	1	25.0%	1	25.0%	1	25.0%	0	0.0%	0	0.0%
Total	**89**	**29.6%**	**55**	**18.3%**	**77**	**25.6%**	**51**	**16.9%**	**22**	**7.3%**	**6**	**2.0%**	**1**	**0.3%**

As we can see in the graph and table above, only one TC in this survey reported having all the 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

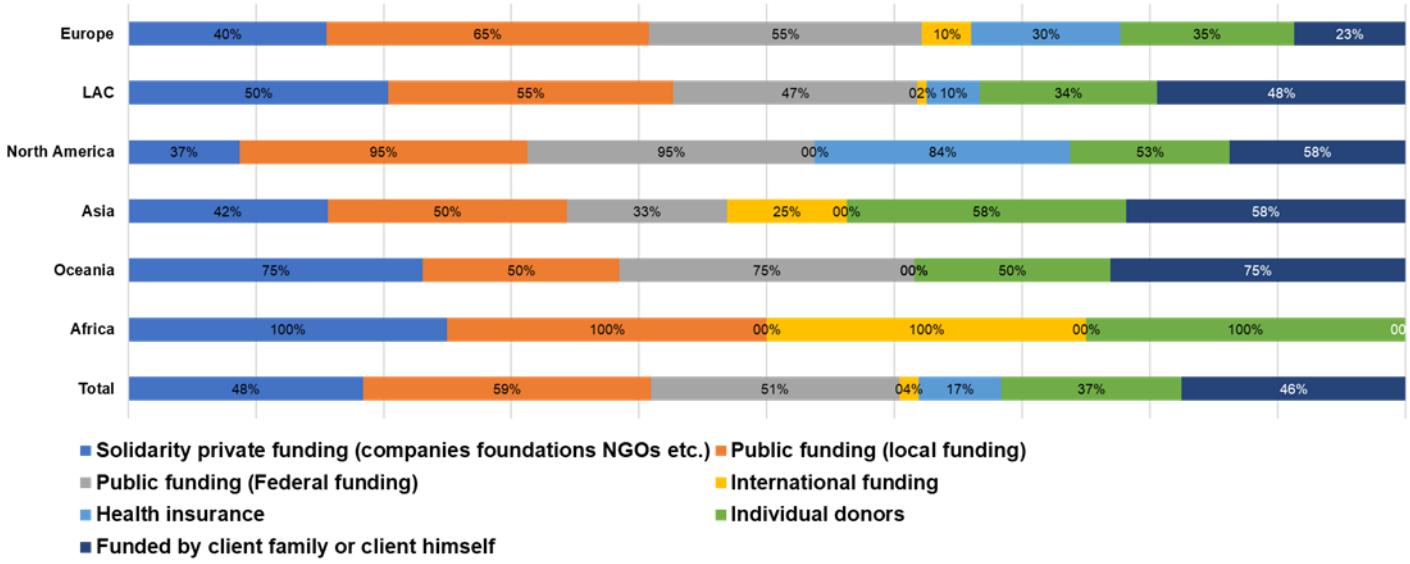
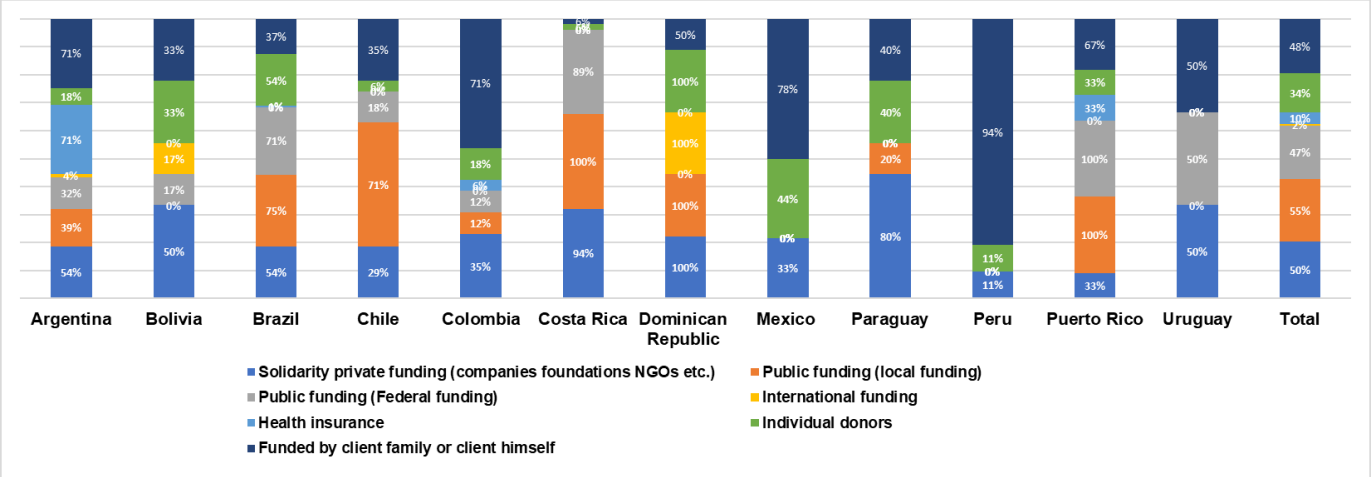


Table 23 - Sources of funding by region

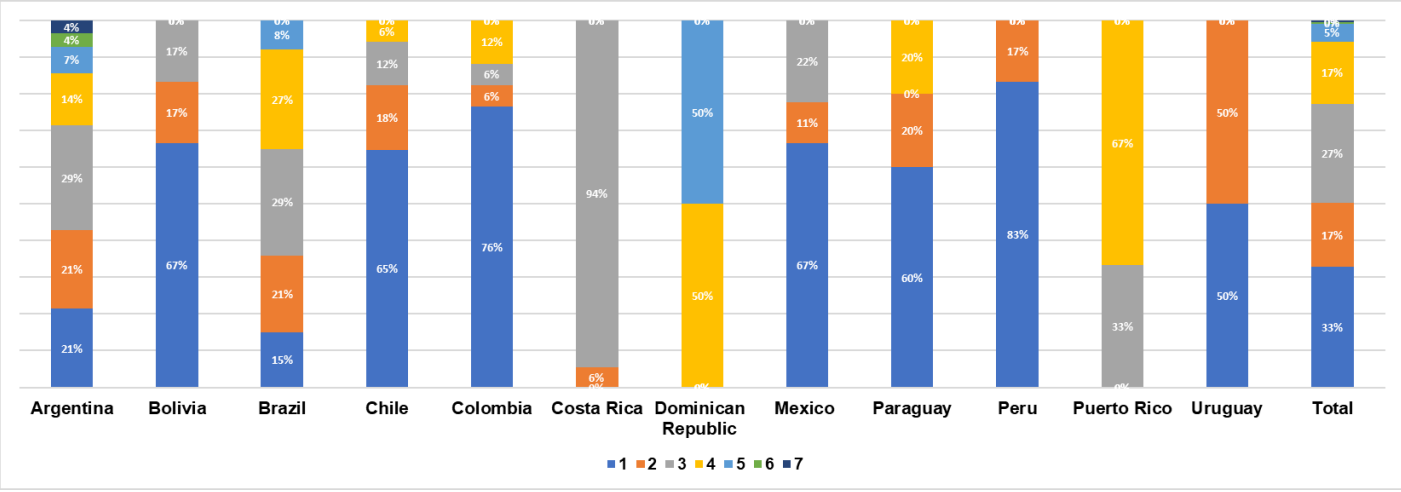
Region	Solidarity private funding (companies foundations NGOs etc.)		Public funding (local funding)		Public funding (Federal funding)		International funding		Health insurance		Individual donors		Funded by client family or client himself	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Europe	16	40.0%	26	65.0%	22	55.0%	4	10.0%	12	30.0%	14	35.0%	9	22.5%
LAC	113	50.2%	124	55.1%	106	47.1%	4	1.8%	23	10.2%	77	34.2%	108	48.0%
North America	7	36.8%	18	94.7%	18	94.7%	0	0.0%	16	84.2%	10	52.6%	11	57.9%
Asia	5	41.7%	6	50.0%	4	33.3%	3	25.0%	0	0.0%	7	58.3%	7	58.3%
Oceania	3	75.0%	2	50.0%	3	75.0%	0	0.0%	0	0.0%	2	50.0%	3	75.0%
Total	**145**	**48.2%**	**177**	**58.8%**	**153**	**50.8%**	**12**	**4.0%**	**51**	**16.9%**	**111**	**36.9%**	**138**	**45.8%**

Related to the respondent organizations countries, in the table below we can see the distribution of source of funding and number of sources of funding by region and country.

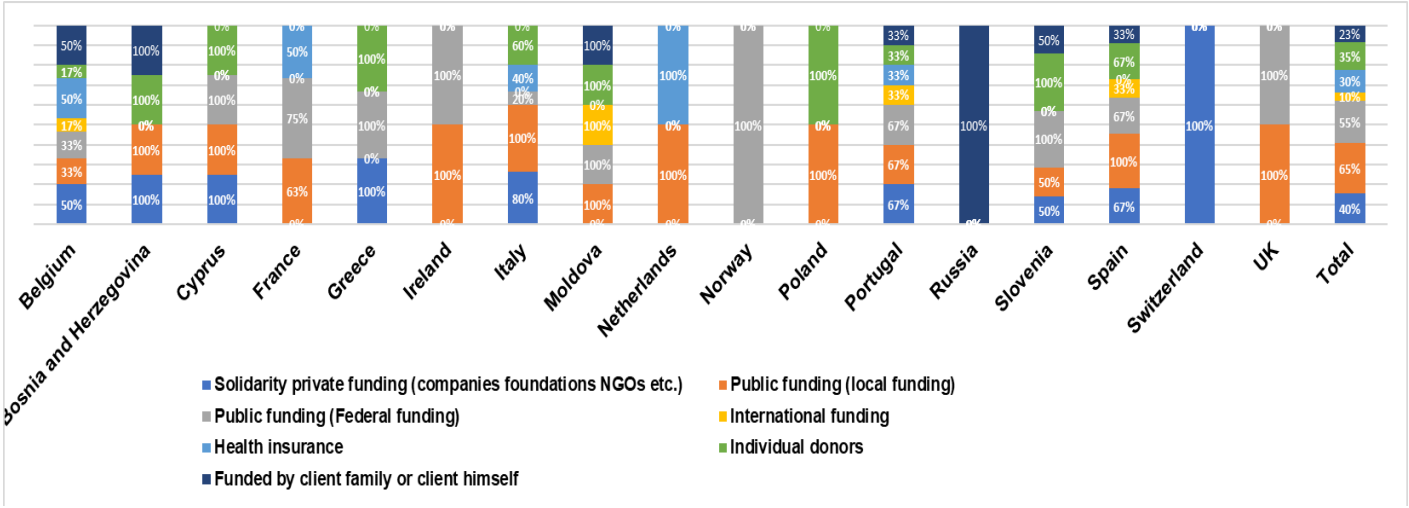
Graph 8 - Source of funding by country in Latin America and the Caribbean



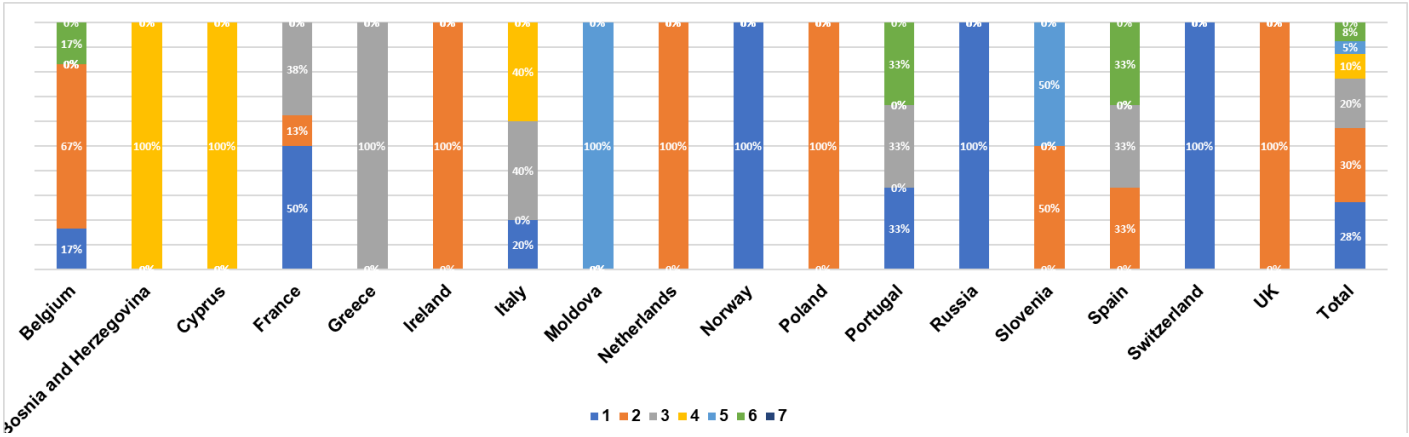
Graph 9 - Number of sources of funding by country in Latin America and the Caribbean



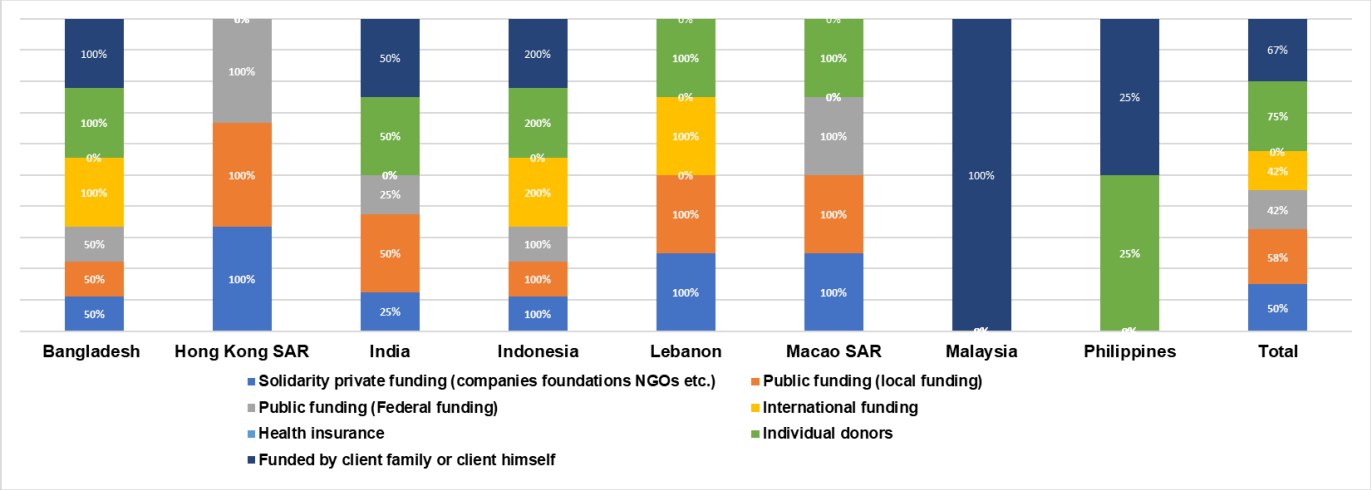
Graph 10 - Source of funding by country in Europe



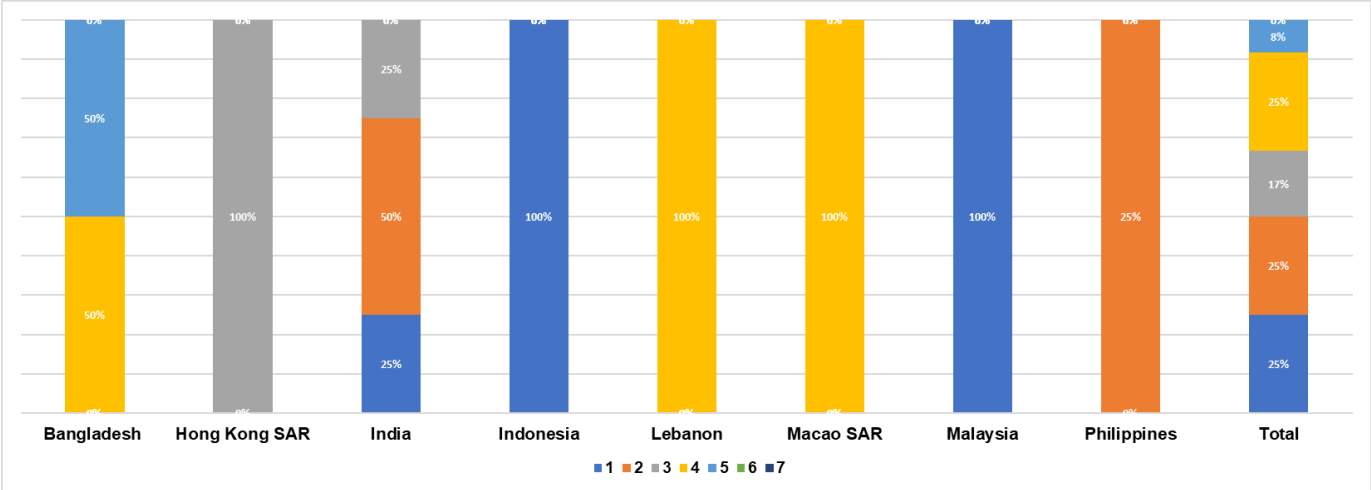
Graph 11 - Number of sources of funding by country in Europe



Graph 12 - Source of funding by country in Asia



Graph 13 - Number of sources of funding by country in Asia



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 and table 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 regions 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 14 - Target population by region

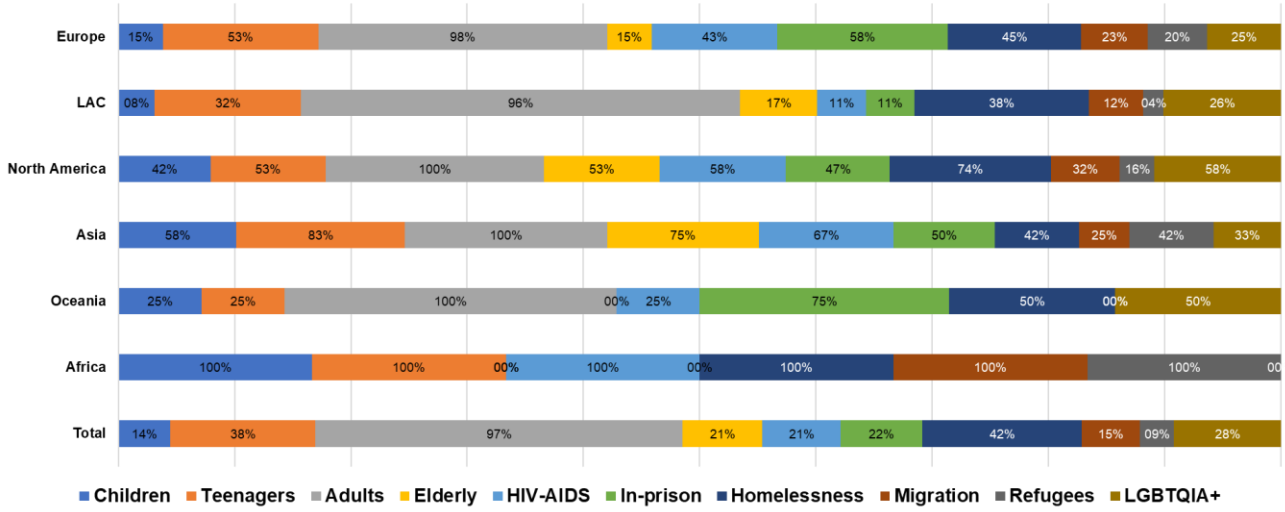


Table 24 - Target population by region

Target population		Region						Total
		Europe	LAC	North America	Asia	Oceania	Africa	
Children	n	6	18	8	7	1	1	41
	%	15.0%	8.0%	42.1%	58.3%	25.0%	100%	13.6%
Teenagers	n	21	72	10	10	1	1	115
	%	52.5%	32.0%	52.6%	83.3%	25.0%	100%	38.2%
Adults	n	39	217	19	12	4	0	291
	%	97.5%	96.4%	100%	100%	100%	0.0%	96.7%
Elderly	n	6	38	10	9	0	0	63
	%	15.0%	16.9%	52.6%	75.0%	0.0%	0.0%	20.9%
HIV-AIDS	n	17	24	11	8	1	1	62
	%	42.5%	10.7%	57.9%	66.7%	25.0%	100%	20.6%
In-prison	n	23	24	9	6	3	0	65
	%	57.5%	10.7%	47.4%	50.0%	75.0%	0.0%	21.6%
Homeless	n	18	86	14	5	2	1	126
	%	45.0%	38.2%	73.7%	41.7%	50.0%	100%	41.9%
Immigrants	n	9	27	6	3	0	1	46
	%	22.5%	12.0%	31.6%	25.0%	0.0%	100%	15.3%
Refugees	n	8	10	3	5	0	1	27
	%	20.0%	4.4%	15.8%	41.7%	0.0%	100%	9.0%
LGBTQIA+	n	10	58	11	4	2	0	85
	%	25.0%	25.8%	57.9%	33.3%	50.0%	0.0%	28.2%

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 15 - Number of target populations by region

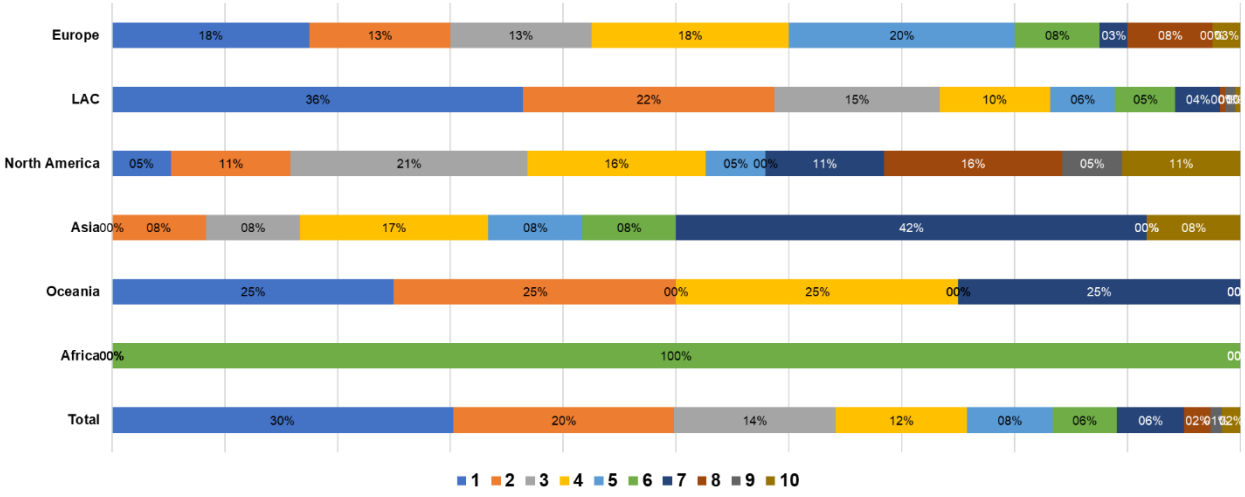


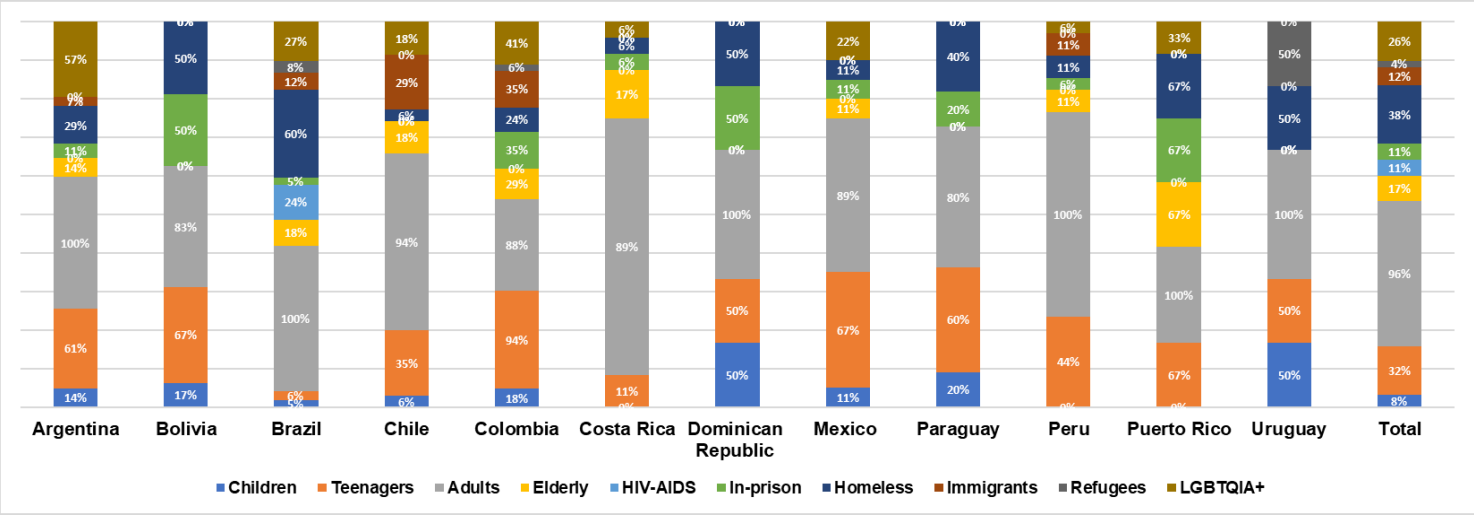
Table 25 - Number of target populations by region

N. of Target population		Region						Total
		Europe	LAC	North America	Asia	Oceania	Africa	
1	n	7	82	1	0	1	0	91
	%	17.5%	36.4%	5.3%	0.0%	25.0%	0.0%	30.2%
2	n	5	50	2	1	1	0	59
	%	12.5%	22.2%	10.5%	8.3%	25.0%	0.0%	19.6%
3	n	5	33	4	1	0	0	43
	%	12.5%	14.7%	21.1%	8.3%	0.0%	0.0%	14.3%
4	n	7	22	3	2	1	0	35
	%	17.5%	9.8%	15.8%	16.7%	25.0%	0.0%	11.6%
5	n	8	13	1	1	0	0	23
	%	20.0%	5.8%	5.3%	8.3%	0.0%	0.0%	7.6%
6	n	3	12	0	1	0	1	17
	%	7.5%	5.3%	0.0%	8.3%	0.0%	100%	5.6%
7	n	1	9	2	5	1	0	18
	%	2.5%	4.0%	10.5%	41.7%	25.0%	0.0%	6.0%

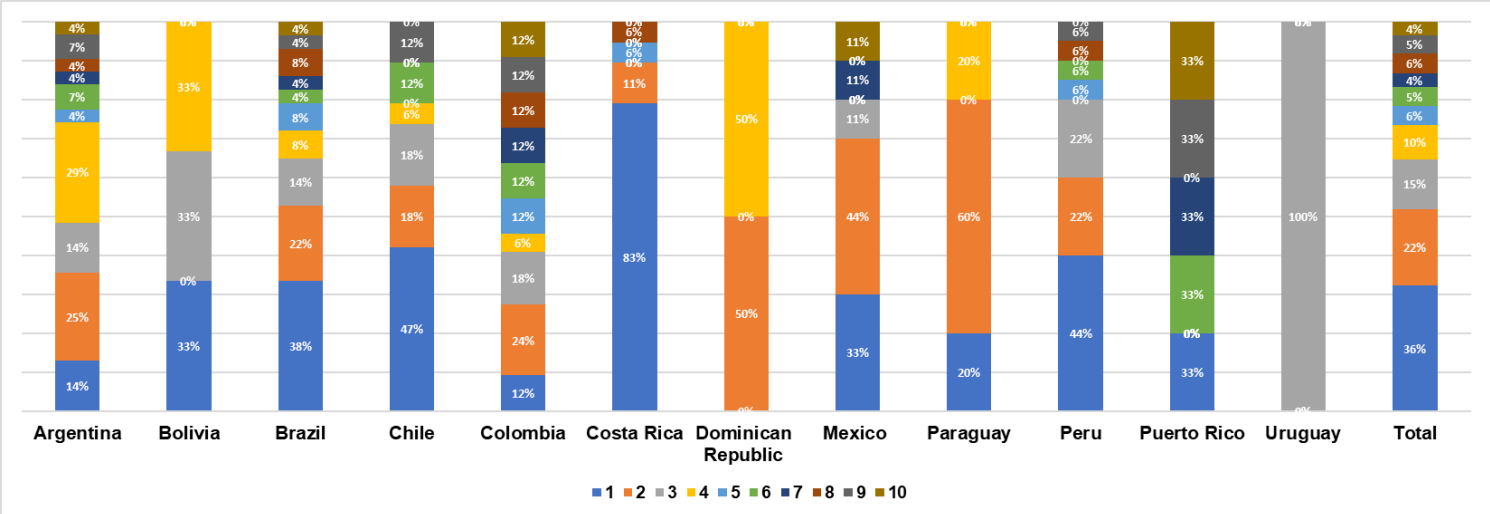
8	n	3	1	3	0	0	0	7
	%	7.5%	0.4%	15.8%	0.0%	0.0%	0.0%	2.3%
9	n	0	2	1	0	0	0	3
	%	0.0%	0.9%	5.3%	0.0%	0.0%	0.0%	1.0%
10	n	1	1	2	1	0	0	5
	%	2.5%	0.4%	10.5%	8.3%	0.0%	0.0%	1.7%

Related to the respondent countries, below we could see the distribution of target population and number of target population by region and country.

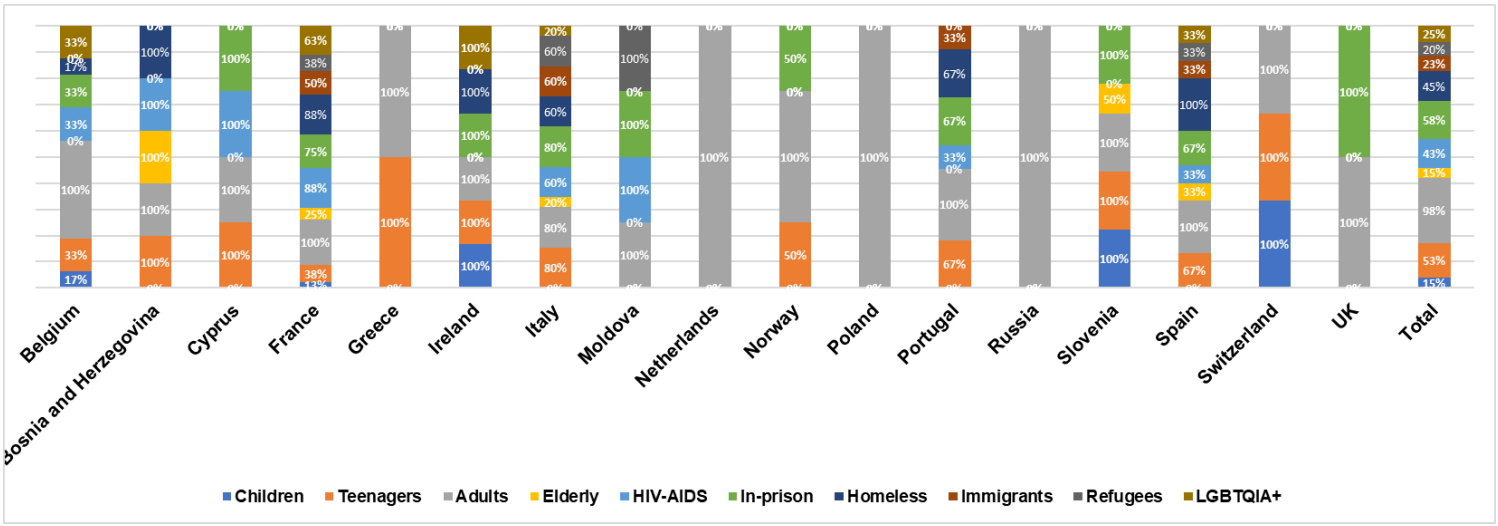
Graph 16 - Target population by region and country in Latin America and the Caribbean



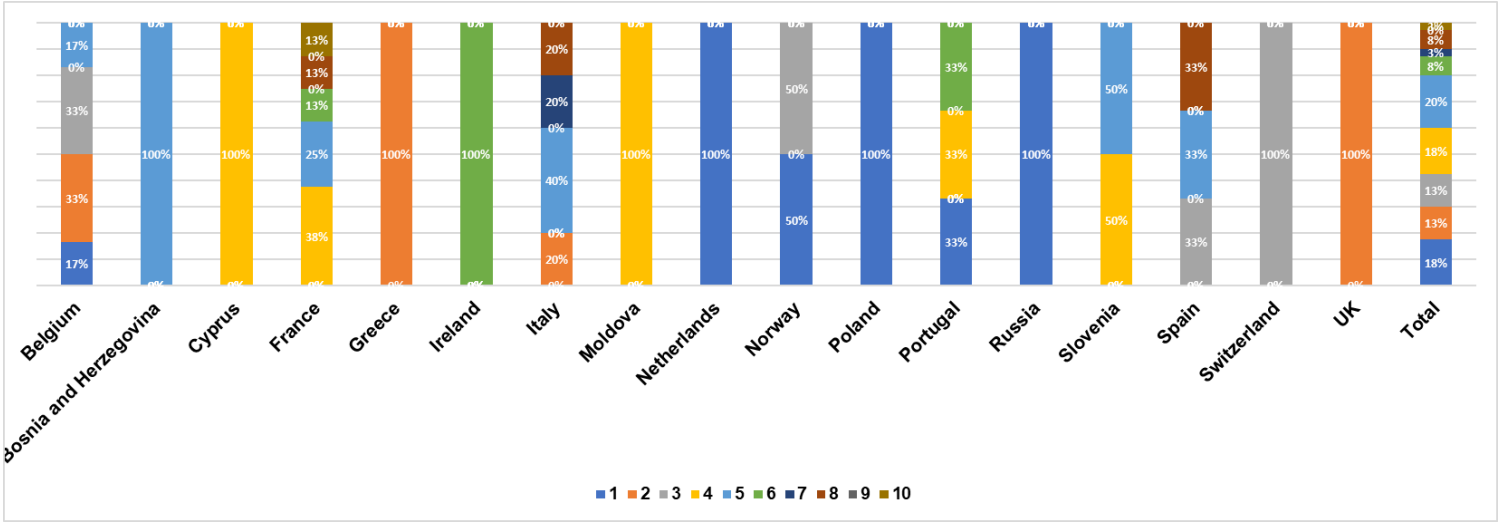
Graph 17 - Number of target population by region and country in Latin America and the Caribbean



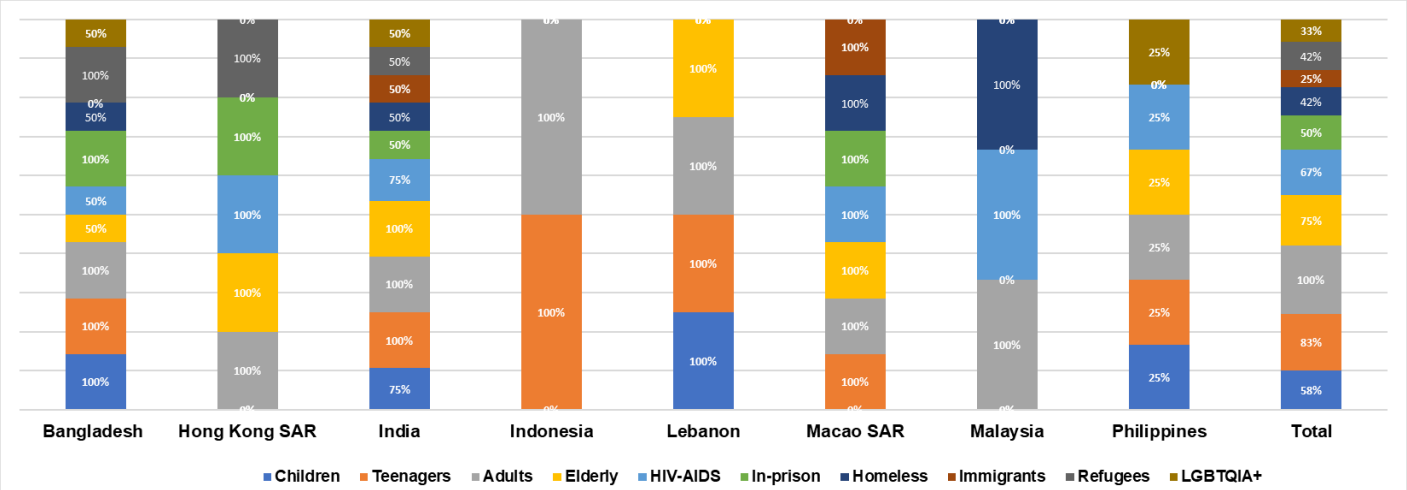
Graph 18 - Target population by region and country in Europe



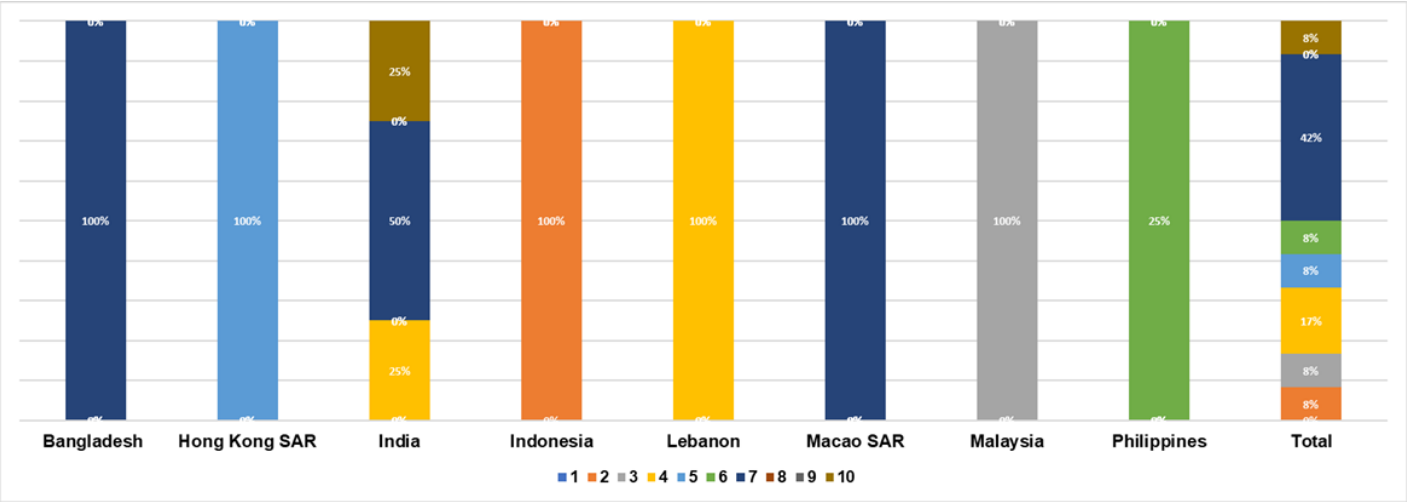
Graph 19 - Number of target population by region and country in Europe



Graph 20 - Target population by region and country in Asia



Graph 21 - Number of target population by region and country in Asia



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 and table 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 22 - Target population gender by region

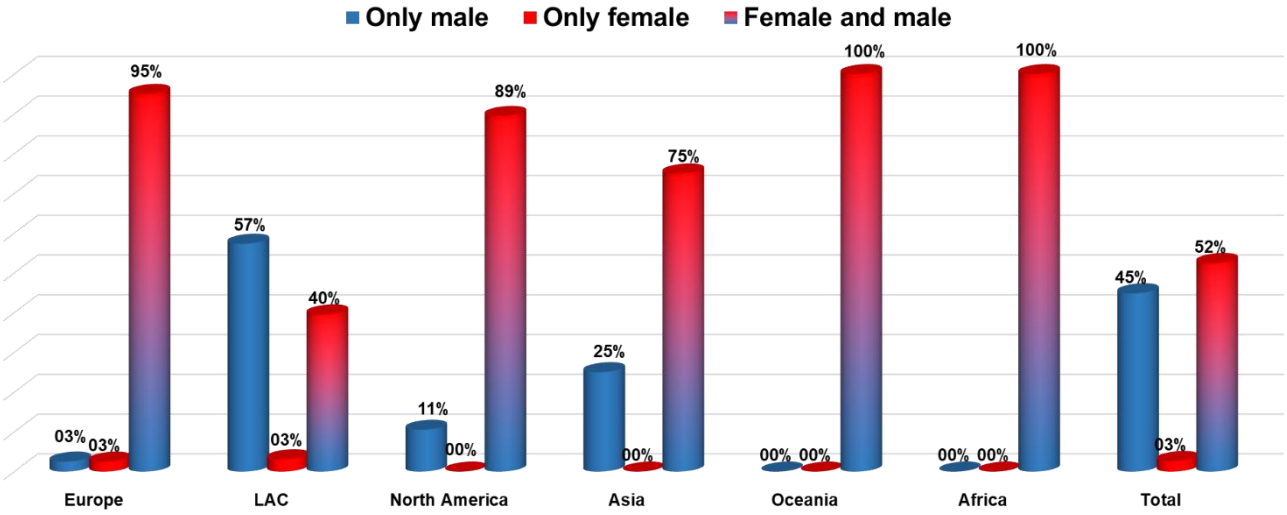


Table 26 - Target population gender by region

Region	Only male		Only female		Female and male	
	n	%	n	%	n	%
Europe	1	2.5%	1	2.5%	38	95.0%
LAC	129	57.3%	7	3.1%	89	39.6%
North America	2	10.5%	0	0.0%	17	89.5%
Asia	3	25.0%	0	0.0%	9	75.0%
Oceania	0	0.0%	0	0.0%	4	100%
Africa	0	0.0%	0	0.0%	1	100%
Total	135	44.9%	8	2.7%	158	52.5%

Related to the respondent organizations countries, below we could see the distribution of target population gender by region and country.

Table 27 - Target population gender by country in Latin America and the Caribbean

Country	Only male		Only female		Female and male	
	n	%	n	%	n	%
Argentina	4	14.3%	0	0.0%	24	85.7%
Bolivia	1	16.7%	0	0.0%	5	83.3%
Brazil	70	70.0%	7	7.0%	23	23.0%
Chile	7	41.2%	0	0.0%	10	58.8%
Colombia	6	35.3%	0	0.0%	11	64.7%
Costa Rica	9	50.0%	0	0.0%	9	50.0%
Dominican Republic	1	50.0%	0	0.0%	1	50.0%
Mexico	8	88.9%	0	0.0%	1	11.1%
Paraguay	4	80.0%	0	0.0%	1	20.0%
Peru	17	94.4%	0	0.0%	1	5.6%
Puerto Rico	1	33.3%	0	0.0%	2	66.7%
Uruguay	1	50.0%	0	0.0%	1	50.0%
Total	108	49.8%	100	46.1%	17	7.8%

Table 28 - Target population gender by country in Europe

Country	Only male		Only female		Female and male	
	n	%	n	%	n	%
Belgium	0	0.0%	0	0.0%	6	100%
Bosnia and Herzegovina	0	0.0%	1	100%	0	0.0%
Cyprus	0	0.0%	0	0.0%	1	100%
France	0	0.0%	0	0.0%	8	100%
Greece	0	0.0%	0	0.0%	1	100%
Ireland	0	0.0%	0	0.0%	1	100%
Italy	1	20.0%	0	0.0%	4	80.0%
Moldova	0	0.0%	0	0.0%	1	100%
Netherlands	0	0.0%	0	0.0%	2	100%
Norway	0	0.0%	0	0.0%	2	100%
Poland	0	0.0%	0	0.0%	1	100%
Portugal	0	0.0%	0	0.0%	3	100%
Russia	0	0.0%	0	0.0%	1	100%
Slovenia	0	0.0%	0	0.0%	2	100%
Spain	0	0.0%	0	0.0%	3	100%
Switzerland	0	0.0%	0	0.0%	1	100%
UK	0	0.0%	0	0.0%	1	100%
Total	1	2.5%	1	2.5%	38	95.0%

Table 29 - Target population gender by country in Asia

Country	Only male		Only female		Female and male	
	n	%	n	%	n	%
Bangladesh	0	0.0%	0	0.0%	2	100%
Hong Kong SAR	0	0.0%	0	0.0%	1	100%
India	2	50.0%	0	0.0%	2	50.0%
Indonesia	0	0.0%	0	0.0%	2	200.0%
Lebanon	0	0.0%	0	0.0%	1	100%
Macao SAR	0	0.0%	0	0.0%	1	100%
Malaysia	1	100%	0	0.0%	0	0.0%
Philippines	0	0.0%	0	0.0%	1	25.0%
Total	**3**	**23.1%**	**0**	**0.0%**	**10**	**76.9%**

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 23 – Settings by region

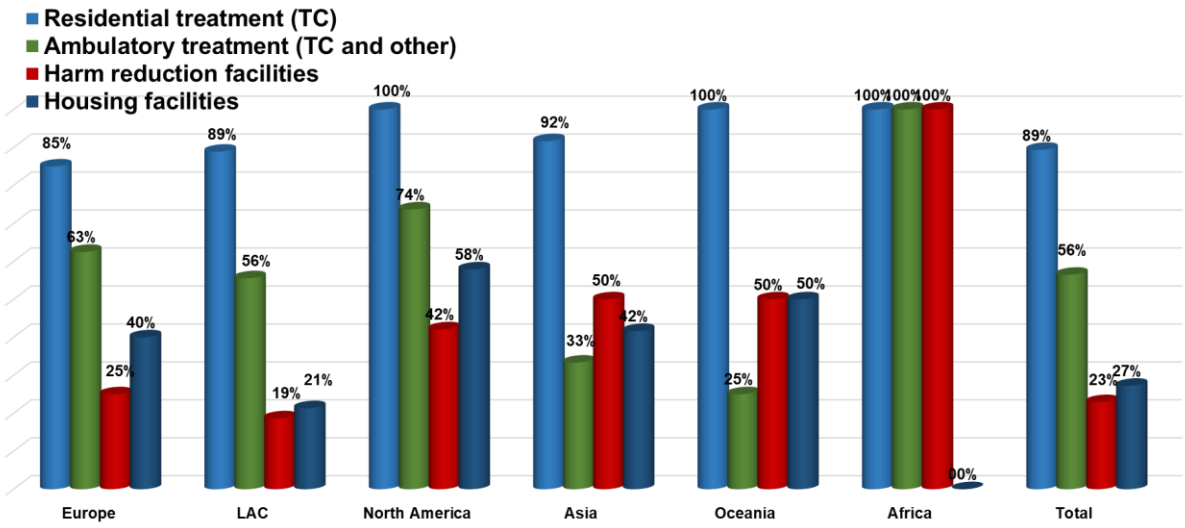


Table 30 - Settings by region

Region	Residential treatment (TC)		Ambulatory treatment (TC and other)		Harm reduction facilities		Housing facilities	
	n	%	n	%	n	%	n	%
Europe	34	85.0%	25	62.5%	10	25.0%	16	40.0%
LAC	200	88.9%	125	55.6%	42	18.7%	48	21.3%
North America	19	100%	14	73.7%	8	42.1%	11	57.9%
Asia	11	91.7%	4	33.3%	6	50.0%	5	41.7%
Oceania	4	100%	1	25.0%	2	50.0%	2	50.0%
Africa	1	100%	1	100%	1	100%	0	0.0%
Total	269	89.4%	170	56.5%	69	22.9%	82	27.2%

Relating to the respondent countries, below we could see the distribution of settings by region and country.

Table 31 - Settings by country in Latin America and the Caribbean

Country	Residential treatment (TC)		Ambulatory treatment (TC and other)		Harm reduction facilities		Housing facilities	
	n	%	n	%	n	%	n	%
Argentina	25	89.3%	27	96.4%	15	53.6%	8	28.6%
Bolivia	5	83.3%	4	66.7%	1	16.7%	2	33.3%
Brazil	92	92.0%	25	25.0%	7	7.0%	19	19.0%
Chile	12	70.6%	12	70.6%	0	0.0%	0	0.0%
Colombia	15	88.2%	14	82.4%	9	52.9%	7	41.2%
Costa Rica	17	94.4%	15	83.3%	1	5.6%	1	5.6%
Dominican Republic	1	50.0%	1	50.0%	0	0.0%	2	100%
Mexico	8	88.9%	4	44.4%	2	22.2%	2	22.2%
Paraguay	3	60.0%	5	100%	2	40.0%	0	0.0%
Peru	17	94.4%	15	83.3%	2	11.1%	6	33.3%
Puerto Rico	3	100%	2	66.7%	2	66.7%	1	33.3%
Uruguay	2	100%	1	50.0%	1	50.0%	0	0.0%
Total	200	88.9%	125	55.6%	42	18.7%	48	21.3%

Table 32 - Settings by country in Europe

Country	Residential treatment (TC)		Ambulatory treatment (TC and other)		Harm reduction facilities		Housing facilities	
	n	%	n	%	n	%	n	%
Belgium	4	66.7%	6	100%	0	0.0%	2	33.3%
Bosnia and Herzegovina	1	100%	1	100%	0	0.0%	1	100%
Cyprus	1	100%	0	0.0%	0	0.0%	0	0.0%
France	8	100%	3	37.5%	3	37.5%	3	37.5%
Greece	0	0.0%	1	100%	0	0.0%	0	0.0%
Ireland	1	100%	1	100%	1	100%	0	0.0%
Italy	4	80.0%	3	60.0%	1	20.0%	3	60.0%
Moldova	1	100%	1	100%	1	100%	1	100%
Netherlands	2	100%	1	50.0%	0	0.0%	1	50.0%
Norway	2	100%	0	0.0%	0	0.0%	1	50.0%
Poland	1	100%	0	0.0%	0	0.0%	0	0.0%
Portugal	3	100%	3	100%	2	66.7%	1	33.3%
Russia	1	100%	0	0.0%	0	0.0%	0	0.0%
Slovenia	1	50.0%	1	50.0%	0	0.0%	0	0.0%
Spain	3	100%	3	100%	1	33.3%	2	66.7%
Switzerland	0	0.0%	0	0.0%	0	0.0%	0	0.0%
UK	1	100%	1	100%	1	100%	1	100%
Total	34	85.0%	25	62.5%	10	25.0%	16	40.0%

Table 33 - Settings by country in Asia

Country	Residential treatment (TC)		Ambulatory treatment (TC and other)		Harm reduction facilities		Housing facilities	
	n	%	n	%	n	%	n	%
Bangladesh	1	50.0%	0	0.0%	2	100%	1	50.0%
Hong Kong SAR	1	100%	1	100%	1	100%	0	0.0%
India	4	100%	2	50.0%	2	50.0%	2	50.0%
Indonesia	1	100%	0	0.0%	0	0.0%	0	0.0%
Lebanon	1	100%	1	100%	0	0.0%	0	0.0%
Macao SAR	1	100%	0	0.0%	1	100%	0	0.0%
Malaysia	1	100%	0	0.0%	0	0.0%	1	100%
Philippines	1	25.0%	0	0.0%	0	0.0%	1	25.0%
Total	11	91.7%	4	33.3%	6	50.0%	5	41.7%

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 24 - Number of settings by region

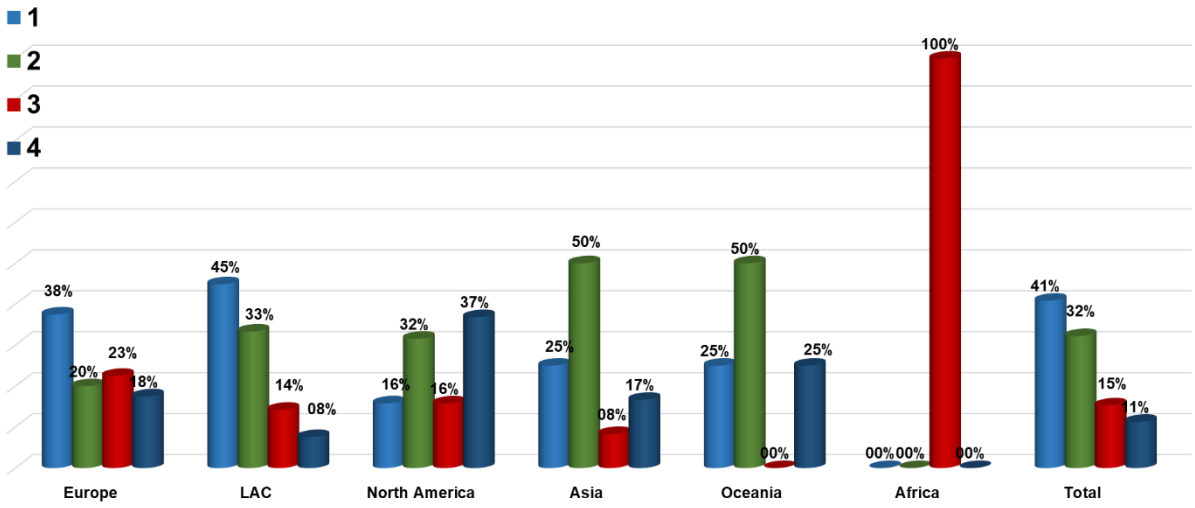


Table 34 - Number of settings by region

Region	1		2		3		4	
	n	%	n	%	n	%	n	%
Europe	15	37.5%	8	20.0%	9	22.5%	7	17.5%
LAC	101	44.9%	75	33.3%	32	14.2%	17	7.6%
North America	3	15.8%	6	31.6%	3	15.8%	7	36.8%
Asia	3	25.0%	6	50.0%	1	8.3%	2	16.7%
Oceania	1	25.0%	2	50.0%	0	0.0%	1	25.0%
Africa	0	0.0%	0	0.0%	1	100%	0	0.0%
Total	123	40.9%	97	32.2%	46	15.3%	34	11.3%

Related to the respondent organizations countries, below we could see the distribution of number of settings by region and country.

Table 35 - Number of settings by country in Latin America and the Caribbean

Country	1		2		3		4	
	n	%	n	%	n	%	n	%
Argentina	2	7.1%	9	32.1%	13	46.4%	4	14.3%
Bolivia	3	50.0%	1	16.7%	1	16.7%	1	16.7%
Brazil	70	70.0%	21	21.0%	5	5.0%	4	4.0%
Chile	10	58.8%	7	41.2%	0	0.0%	0	0.0%
Colombia	3	17.6%	5	29.4%	4	23.5%	5	29.4%
Costa Rica	3	16.7%	14	77.8%	1	5.6%	0	0.0%
Dominican Republic	0	0.0%	2	100%	0	0.0%	0	0.0%
Mexico	5	55.6%	2	22.2%	1	11.1%	1	11.1%
Paraguay	0	0.0%	5	100%	0	0.0%	0	0.0%
Peru	3	16.7%	9	50.0%	5	27.8%	1	5.6%
Puerto Rico	1	33.3%	0	0.0%	1	33.3%	1	33.3%
Uruguay	1	50.0%	0	0.0%	1	50.0%	0	0.0%
Total	101	44.9%	75	33.3%	32	14.2%	17	7.6%

Table 36 - Number of settings by country in Europe

Country	1		2		3		4	
	n	%	n	%	n	%	n	%
Belgium	2	33.3%	2	33.3%	2	33.3%	0	0.0%
Bosnia and Herzegovina	0	0.0%	0	0.0%	1	100%	0	0.0%
Cyprus	1	100%	0	0.0%	0	0.0%	0	0.0%
France	4	50.0%	1	12.5%	1	12.5%	2	25.0%
Greece	1	100%	0	0.0%	0	0.0%	0	0.0%
Ireland	0	0.0%	0	0.0%	1	100%	0	0.0%
Italy	2	40.0%	1	20.0%	1	20.0%	1	20.0%
Moldova	0	0.0%	0	0.0%	0	0.0%	1	100%
Netherlands	1	50.0%	0	0.0%	1	50.0%	0	0.0%
Norway	1	50.0%	1	50.0%	0	0.0%	0	0.0%
Poland	1	100%	0	0.0%	0	0.0%	0	0.0%
Portugal	0	0.0%	1	33.3%	1	33.3%	1	33.3%
Russia	1	100%	0	0.0%	0	0.0%	0	0.0%
Slovenia	1	50.0%	1	50.0%	0	0.0%	0	0.0%
Spain	0	0.0%	1	33.3%	1	33.3%	1	33.3%
Switzerland	0	0.0%	0	0.0%	0	0.0%	0	0.0%
UK	0	0.0%	0	0.0%	0	0.0%	1	100%
Total	15	38.5%	8	20.5%	9	23.1%	7	17.9%

Table 37 - Number of settings by country in Asia

Country	1		2		3		4	
	n	%	n	%	n	%	n	%
Bangladesh	0	0.0%	2	100%	0	0.0%	0	0.0%
Hong Kong SAR	0	0.0%	0	0.0%	1	100%	0	0.0%
India	2	50.0%	0	0.0%	0	0.0%	2	50.0%
Indonesia	1	100%	0	0.0%	0	0.0%	0	0.0%
Lebanon	0	0.0%	1	100%	0	0.0%	0	0.0%
Macao SAR	0	0.0%	1	100%	0	0.0%	0	0.0%
Malaysia	0	0.0%	1	100%	0	0.0%	0	0.0%
Philippines	0	0.0%	1	25.0%	0	0.0%	0	0.0%
Total	3	25.0%	6	50.0%	1	8.3%	2	16.7%

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

Early, original TCs used to have long term programs, with periods around one to two years. However, during the last decades, facing new challenges, new drugs, new technologies and a different public, TCs needed to adapt to these new shifts which led to introducing shorter programs. This adaptation was called "modified TC", and some research shows that shorter programs have better client adherence and less client dropout, which is very useful and meaningful data and information to consider.

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 and table 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 25 - Average proposed time for treatment by region

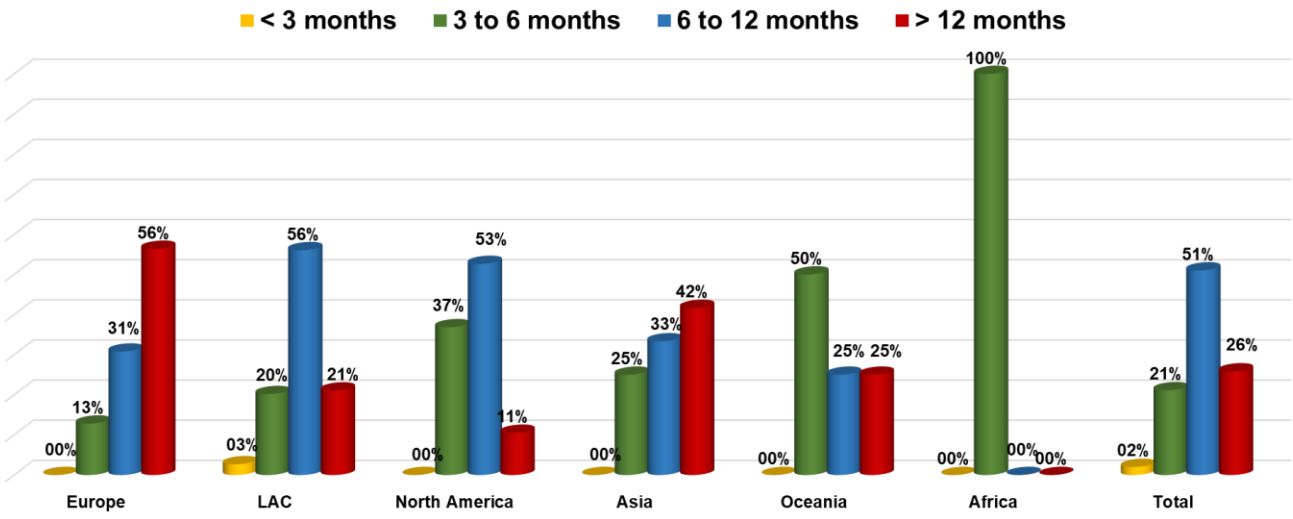


Table 38 - Average proposed time for treatment by region

Region	< 3 months		3 to 6 months		6 to 12 months		> 12 months	
	n	%	n	%	n	%	n	%
Europe	0	0.0%	5	12.8%	12	30.8%	22	56.4%
LAC	6	2.7%	45	20.2%	125	56.1%	47	21.1%
North America	0	0.0%	7	36.8%	10	52.6%	2	10.5%
Asia	0	0.0%	3	25.0%	4	33.3%	5	41.7%
Oceania	0	0.0%	2	50.0%	1	25.0%	1	25.0%
Africa	0	0.0%	1	100%	0	0.0%	0	0.0%
Total	**6**	**2.0%**	**63**	**21.1%**	**152**	**51.0%**	**77**	**25.8%**

There is a difference in the table above in the total TCs in Europe and in Latin America and the Caribbean, due to not all the TCs filling out this information in the survey.

Related to the respondent organizations countries, below we can see the distribution of average proposed time for treatment by region and country.

Table 39 - Average proposed time for treatment by country in Latin America and the Caribbean

Country	< 3 months		3 to 6 months		6 to 12 months		> 12 months	
	n	%	n	%	n	%	n	%
Argentina	0	0.0%	5	17.9%	18	64.3%	4	14.3%
Bolivia	0	0.0%	1	16.7%	3	50.0%	2	33.3%
Brazil	0	0.0%	29	29.0%	65	65.0%	6	6.0%
Chile	0	0.0%	0	0.0%	10	58.8%	7	41.2%
Colombia	1	5.9%	3	17.6%	7	41.2%	6	35.3%
Costa Rica	5	27.8%	4	22.2%	5	27.8%	3	16.7%
Dominican Republic	0	0.0%	0	0.0%	1	50.0%	1	50.0%
Mexico	0	0.0%	1	11.1%	7	77.8%	1	11.1%
Paraguay	0	0.0%	1	20.0%	3	60.0%	1	20.0%
Peru	0	0.0%	0	0.0%	4	22.2%	14	77.8%
Puerto Rico	0	0.0%	1	33.3%	1	33.3%	1	33.3%
Uruguay	0	0.0%	0	0.0%	1	50.0%	1	50.0%
Total	6	2.7%	45	20.2%	125	56.1%	47	21.1%

Table 40 - Average proposed time for treatment by country in Europe

Country	< 3 months		3 to 6 months		6 to 12 months		> 12 months	
	n	%	n	%	n	%	n	%
Belgium	0	0.0%	2	33.3%	2	33.3%	2	33.3%
Bosnia and Herzegovina	0	0.0%	0	0.0%	1	100%	0	0.0%
Cyprus	0	0.0%	0	0.0%	0	0.0%	1	100%
France	0	0.0%	0	0.0%	0	0.0%	8	100%
Greece	0	0.0%	0	0.0%	1	100%	0	0.0%
Ireland	0	0.0%	1	100%	0	0.0%	0	0.0%
Italy	0	0.0%	0	0.0%	0	0.0%	5	100%
Moldova	0	0.0%	0	0.0%	1	100%	0	0.0%
Netherlands	0	0.0%	0	0.0%	0	0.0%	2	100%
Norway	0	0.0%	0	0.0%	1	50.0%	1	50.0%
Poland	0	0.0%	0	0.0%	1	100%	0	0.0%
Portugal	0	0.0%	0	0.0%	3	100%	0	0.0%
Russia	0	0.0%	1	100%	0	0.0%	0	0.0%
Slovenia	0	0.0%	0	0.0%	0	0.0%	2	100%
Spain	0	0.0%	0	0.0%	2	66.7%	1	33.3%
Switzerland	0	0.0%	0	0.0%	0	0.0%	0	0.0%
UK	0	0.0%	1	100%	0	0.0%	0	0.0%
Total	0	0.0%	5	12.8%	12	30.8%	22	56.4%

Table 41 - Average proposed time for treatment by country in Asia

Country	< 3 months		3 to 6 months		6 to 12 months		> 12 months	
	n	%	n	%	n	%	n	%
Bangladesh	0	0.0%	2	100%	0	0.0%	0	0.0%
Hong Kong SAR	0	0.0%	0	0.0%	0	0.0%	1	100%
India	0	0.0%	1	25.0%	2	50.0%	1	25.0%
Indonesia	0	0.0%	0	0.0%	1	100%	0	0.0%
Lebanon	0	0.0%	0	0.0%	0	0.0%	1	100%
Macao SAR	0	0.0%	0	0.0%	0	0.0%	1	100%
Malaysia	0	0.0%	0	0.0%	1	100%	0	0.0%
Philippines	0	0.0%	0	0.0%	0	0.0%	1	25.0%
Total	**0**	**0.0%**	**3**	**25.0%**	**4**	**33.3%**	**5**	**41.7%**

5.10 TC location

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

- Urban
- Rural
- Urban and Rural

Originally, many TCs used to be located mostly in rural facilities, however after the TCs modification, increasing numbers of TCs started to prefer urban locations or, in many cases, both 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 rural environments it is possible to develop some specific rural activities, like farming, vegetable gardens, plantations, etc. However, it's more difficult for the staff to access, so many other professional activities could be prejudged and challenging due to this. In rural areas, the access to the health care network is more difficult too, which is another reason why TCs have increasingly preferred urban locations in the last few decades.

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 26 - TC location by region

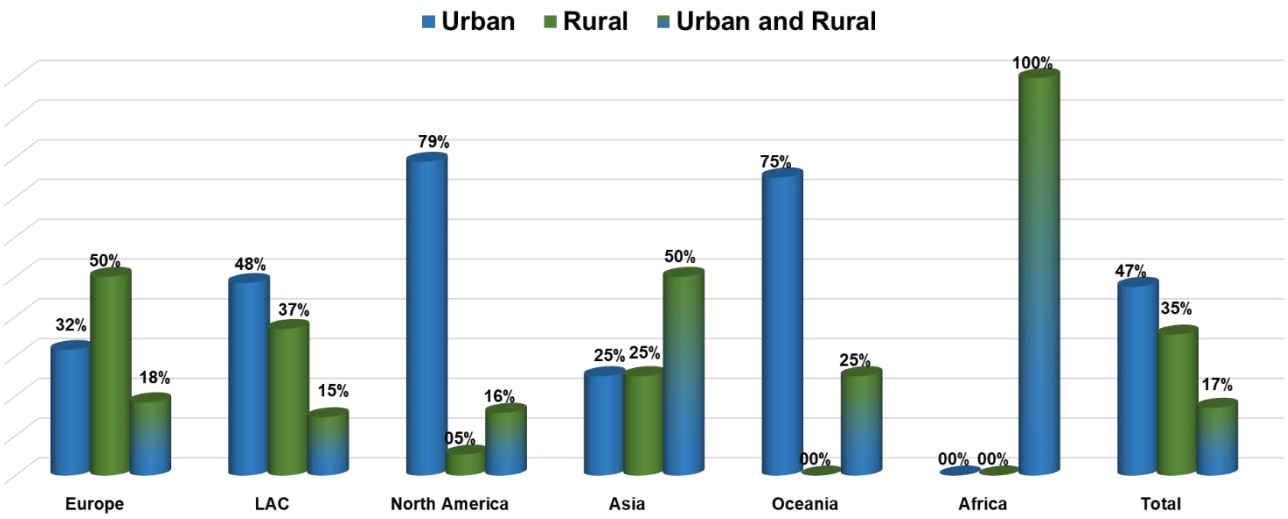


Table 42 - TC location by region

Region	Urban		Rural		Urban and Rural	
	n	%	n	%	n	%
Europe	12	31.6%	19	50.0%	7	18.4%
LAC	109	48.4%	83	36.9%	33	14.7%
North America	15	78.9%	1	5.3%	3	15.8%
Asia	3	25.0%	3	25.0%	6	50.0%
Oceania	3	75.0%	0	0.0%	1	25.0%
Africa	0	0.0%	0	0.0%	1	100%
Total	**6**	**2.0%**	**63**	**21.1%**	**152**	**51.0%**

There is a difference in the table above in the total TCs in Europe, due to not all the TCs filling out this information in the survey.

Related to the respondent organizations countries, below we can see the distribution of TC location by region and country.

Table 43 - TC location by country in Latin America and the Caribbean

Country	Urban		Rural		Urban and Rural	
	n	%	n	%	n	%
Argentina	21	75.0%	4	14.3%	3	10.7%
Bolivia	3	50.0%	0	0.0%	3	50.0%
Brazil	28	28.0%	58	58.0%	14	14.0%
Chile	11	64.7%	3	17.6%	3	17.6%
Colombia	6	35.3%	8	47.1%	3	17.6%
Costa Rica	16	88.9%	1	5.6%	1	5.6%
Dominican Republic	2	100%	0	0.0%	0	0.0%
Mexico	8	88.9%	1	11.1%	0	0.0%
Paraguay	2	40.0%	3	60.0%	0	0.0%
Peru	12	66.7%	3	16.7%	3	16.7%
Puerto Rico	0	0.0%	1	33.3%	2	66.7%
Uruguay	0	0.0%	1	50.0%	1	50.0%
Total	109	48.4%	83	36.9%	33	14.7%

Table 44 - TC location by country in Europe

Country	Urban		Rural		Urban and Rural	
	n	%	n	%	n	%
Belgium	3	60.0%	2	40.0%	0	0.0%
Bosnia and Herzegovina	0	0.0%	1	100%	0	0.0%
Cyprus	0	0.0%	0	0.0%	1	100%
France	2	25.0%	6	75.0%	0	0.0%
Greece	1	100%	0	0.0%	0	0.0%
Ireland	0	0.0%	0	0.0%	1	100%
Italy	1	20.0%	2	40.0%	2	40.0%
Moldova	0	0.0%	1	100%	0	0.0%
Netherlands	2	100%	0	0.0%	0	0.0%
Norway	0	0.0%	2	100%	0	0.0%
Poland	0	0.0%	1	100%	0	0.0%
Portugal	1	33.3%	1	33.3%	1	33.3%
Russia	0	0.0%	1	100%	0	0.0%
Slovenia	1	50.0%	1	50.0%	0	0.0%
Spain	1	33.3%	1	33.3%	1	33.3%
Switzerland	0	0.0%	0	0.0%	0	0.0%
UK	0	0.0%	0	0.0%	1	100%
Total	12	31.6%	19	50.0%	7	18.4%

Table 45 - TC location by country in Asia

Country	Urban		Rural		Urban and Rural	
	n	%	n	%	n	%
Bangladesh	0	0.0%	0	0.0%	2	100%
Hong Kong SAR	0	0.0%	0	0.0%	1	100%
India	2	50.0%	0	0.0%	2	50.0%
Indonesia	1	100%	0	0.0%	0	0.0%
Lebanon	0	0.0%	0	0.0%	1	100%
Macao SAR	0	0.0%	1	100%	0	0.0%
Malaysia	0	0.0%	1	100%	0	0.0%
Philippines	0	0.0%	1	100%	0	0.0%
Total	3	25.0%	3	25.0%	6	50.0%

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

The use of religious and/or spiritual practices in TCs is a sensitive issue in the TCs worldwide movement, since in some regions, like Latin America and the Caribbean and Asia, most of TCs were founded and are funded by religious groups.

Religious and spiritual practices are related to better outcomes in many types of treatment, not only in substance use disorders, so here, in this report, we are not discussing if these practices are recommended or not.

The concern regarding this question is the wrong use of these concepts or practices, which could resemble religious proselytism and violation of human rights.

That's why we decided to include these three categories, considering that there are non-religious TCs, and the other one's with religious activities, which could be carried out in a mandatory or non-mandatory way.

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 27 - Religious by region

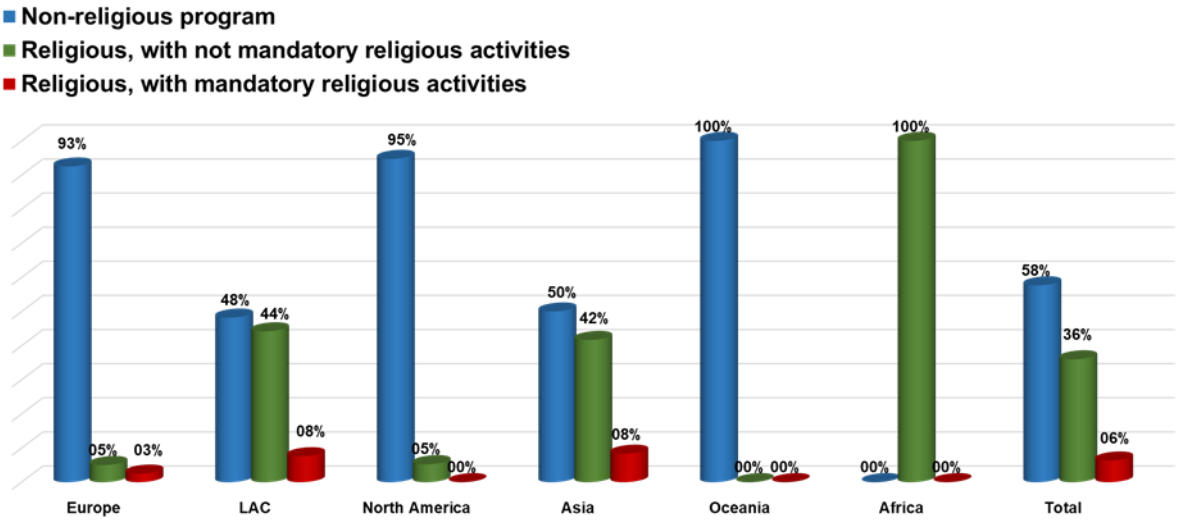


Table 46 - Religious by region

Region	Non-religious program		Religious, with not mandatory religious activities		Religious, with mandatory religious activities	
	n	%	n	%	n	%
Europe	37	92.5%	2	5.0%	1	2.5%
LAC	108	48.2%	99	44.2%	17	7.6%
North America	18	94.7%	1	5.3%	0	0.0%
Asia	6	50.0%	5	41.7%	1	8.3%
Oceania	4	100%	0	0.0%	0	0.0%
Africa	0	0.0%	1	100%	0	0.0%
Total	**173**	**57.7%**	**108**	**36.0%**	**19**	**6.3%**

There is a difference in the table above in the total TCs in Latin America and the Caribbean, due to not all the TCs having filled out this information in the survey.

Related to the respondent organizations countries, below we can see the distribution of religious by region and country.

Table 47 - Religious by country in Latin America and the Caribbean

Country	Non-religious program		Religious, with not mandatory religious activities		Religious, with mandatory religious activities	
	n	%	n	%	n	%
Argentina	24	88.9%	3	11.1%	0	0.0%
Bolivia	3	50.0%	3	50.0%	0	0.0%
Brazil	31	31.0%	62	62.0%	7	7.0%
Chile	14	82.4%	3	17.6%	0	0.0%
Colombia	9	52.9%	8	47.1%	0	0.0%
Costa Rica	10	55.6%	2	11.1%	6	33.3%
Dominican Republic	2	100%	0	0.0%	0	0.0%
Mexico	4	44.4%	3	33.3%	2	22.2%
Paraguay	0	0.0%	4	80.0%	1	20.0%
Peru	8	44.4%	9	50.0%	1	5.6%
Puerto Rico	2	66.7%	1	33.3%	0	0.0%
Uruguay	1	50.0%	1	50.0%	0	0.0%
Total	109	48.4%	83	36.9%	33	14.7%

Table 48 - Religious by country in Europe

Country	Non-religious program		Religious, with not mandatory religious activities		Religious, with mandatory religious activities	
	n	%	n	%	n	%
Belgium	6	100%	0	0.0%	0	0.0%
Bosnia and Herzegovina	0	0.0%	0	0.0%	1	100%
Cyprus	0	0.0%	1	100%	0	0.0%
France	8	100%	0	0.0%	0	0.0%
Greece	1	100%	0	0.0%	0	0.0%
Ireland	1	100%	0	0.0%	0	0.0%
Italy	5	100%	0	0.0%	0	0.0%
Moldova	0	0.0%	1	100%	0	0.0%
Netherlands	2	100%	0	0.0%	0	0.0%
Norway	2	100%	0	0.0%	0	0.0%
Poland	1	100%	0	0.0%	0	0.0%
Portugal	3	100%	0	0.0%	0	0.0%
Russia	1	100%	0	0.0%	0	0.0%
Slovenia	2	100%	0	0.0%	0	0.0%
Spain	3	100%	0	0.0%	0	0.0%
Switzerland	1	100%	0	0.0%	0	0.0%
UK	1	100%	0	0.0%	0	0.0%
Total	37	92.5%	2	5.0%	1	2.5%

Table 49 - Religious by country in Asia

Country	Non-religious program		Religious, with not mandatory religious activities		Religious, with mandatory religious activities	
	n	%	n	%	n	%
Bangladesh	1	50.0%	1	50.0%	0	0.0%
Hong Kong SAR	1	100%	0	0.0%	0	0.0%
India	3	75.0%	1	25.0%	0	0.0%
Indonesia	0	0.0%	1	100%	0	0.0%
Lebanon	0	0.0%	1	100%	0	0.0%
Macao SAR	1	100%	0	0.0%	0	0.0%
Malaysia	0	0.0%	0	0.0%	1	100%
Philippines	0	0.0%	1	25.0%	0	0.0%
Total	**6**	**50.0%**	**5**	**41.7%**	**1**	**8.3%**

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 and table 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 28 - Staff by region

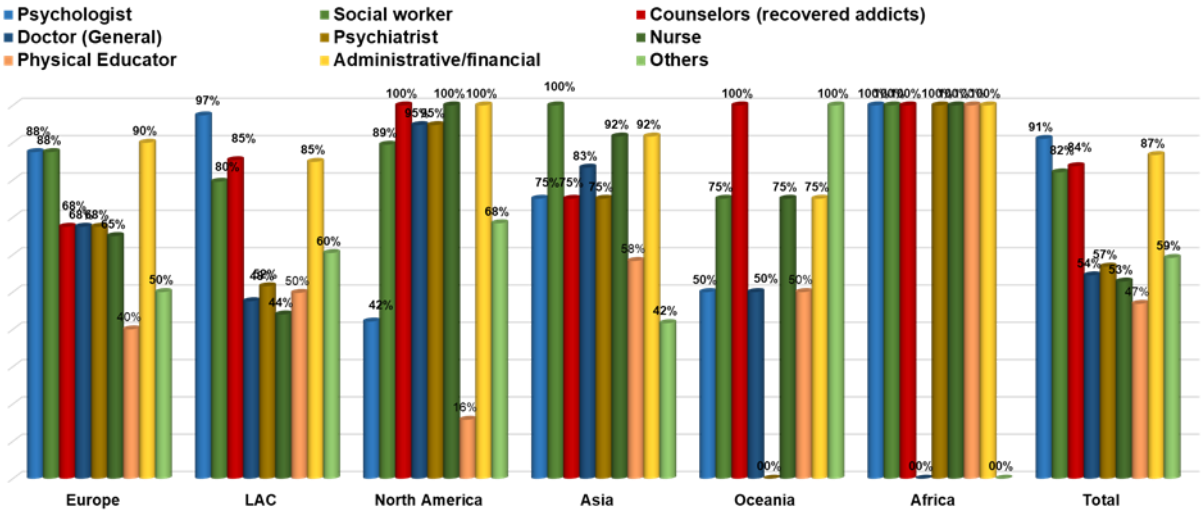


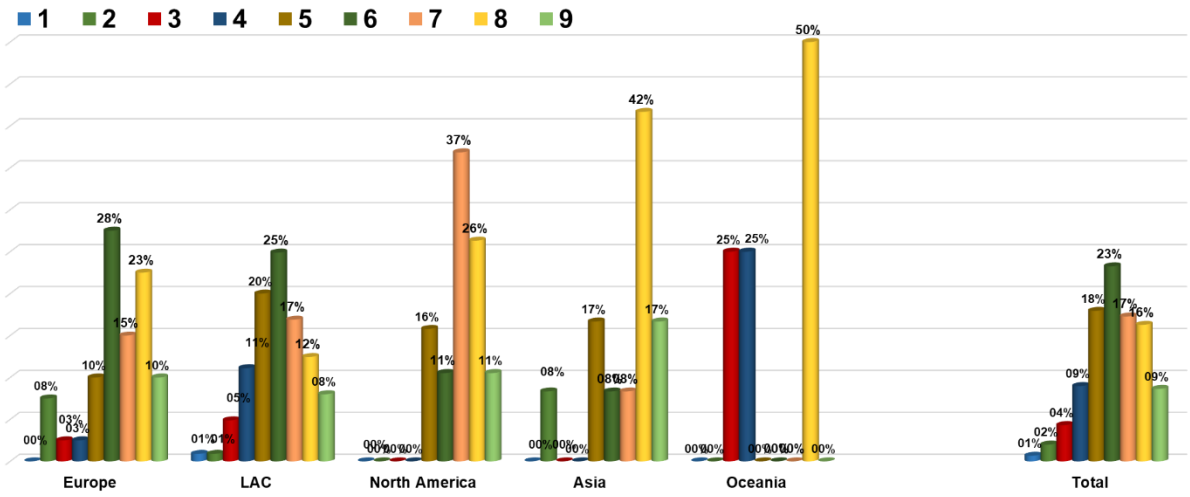
Table 50 - Staff by region

Staff		Region						Total
		Europe	LAC	North America	Asia	Oceania	Africa	
Psychologist	n	35	219	8	9	2	1	274
	%	87.5%	97.3%	42.1%	75.0%	50.0%	100%	91.0%
Social worker	n	35	179	17	12	3	1	247
	%	87.5%	79.6%	89.5%	100%	75.0%	100%	82.1%
Counselors (recovered addicts)	n	27	192	19	9	4	1	252
	%	67.5%	85.3%	100%	75.0%	100%	100%	83.7%
Doctor (General)	n	27	107	18	10	2	0	164
	%	67.5%	47.6%	94.7%	83.3%	50.0%	0.0%	54.5%
Psychiatrist	n	27	116	18	9	0	1	171
	%	67.5%	51.6%	94.7%	75.0%	0.0%	100%	56.8%
Nurse	n	26	99	19	11	3	1	159
	%	65.0%	44.0%	100%	91.7%	75.0%	100%	52.8%
Physical Educator	n	16	112	3	7	2	1	141
	%	40.0%	49.8%	15.8%	58.3%	50.0%	100%	46.8%
Administrative/financial	n	36	191	19	11	3	1	261
	%	90.0%	84.9%	100%	91.7%	75.0%	100%	86.7%
Others	n	20	136	13	5	4	0	178
	%	50.0%	60.4%	68.4%	41.7%	100%	0.0%	59.1%

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 29 – Number of staff by region



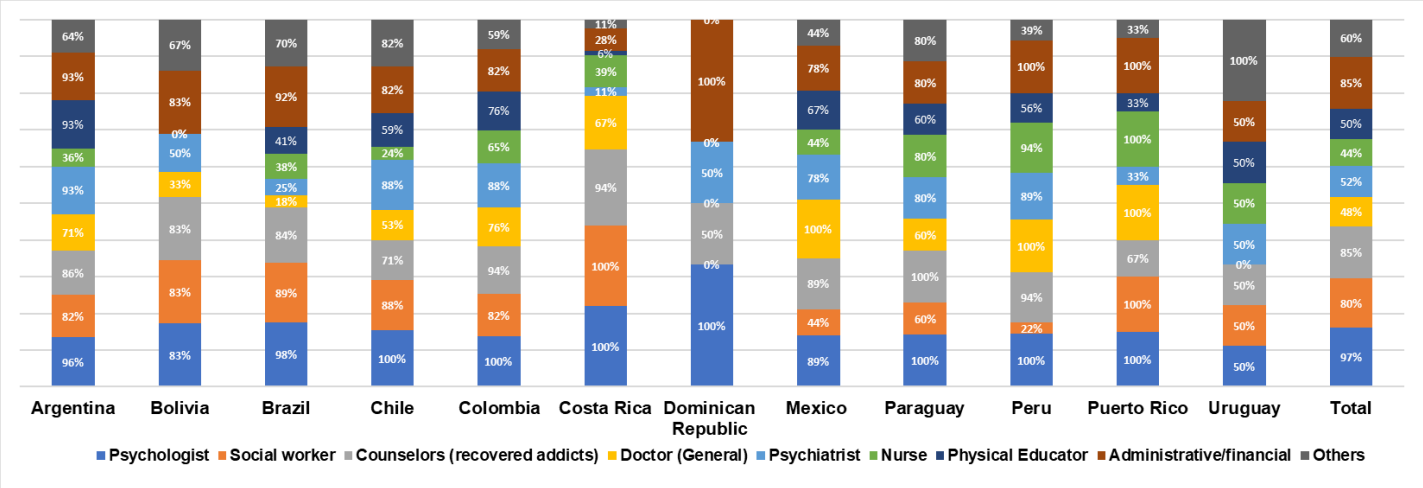
Africa is not in this graph to be clearer, but its data is in the table below.

Table 51 - Number of staff by region

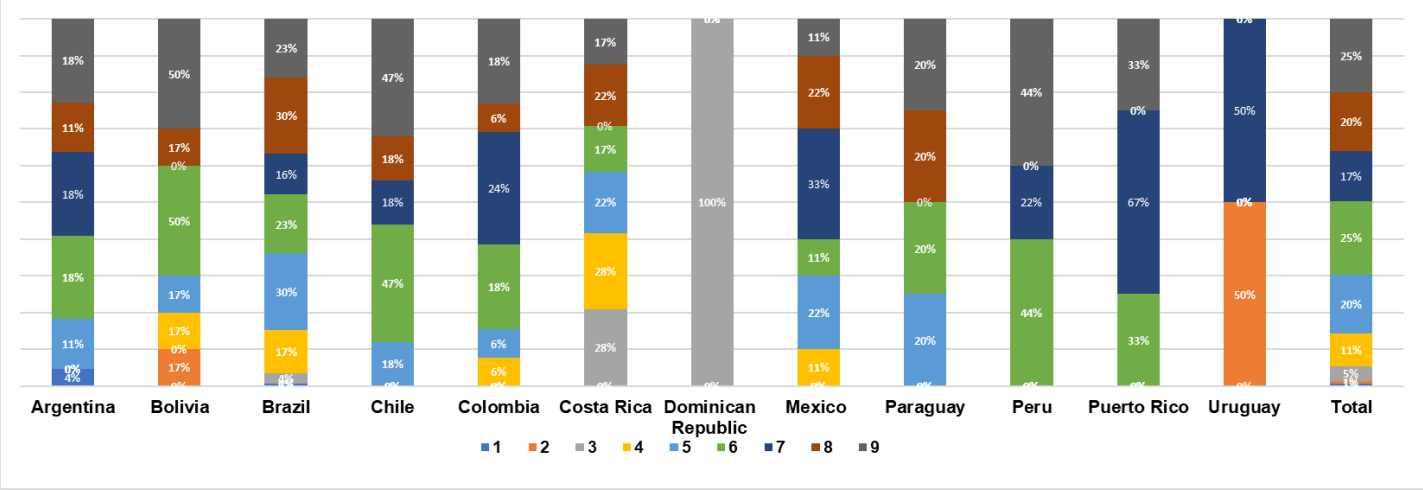
N. of staff		Region						Total
		Europe	LAC	North America	Asia	Oceania	Africa	
1	n	0	2	0	0	0	0	2
	%	0.0%	0.9%	0.0%	0.0%	0.0%	0.0%	0.7%
2	n	3	2	0	1	0	0	6
	%	7.5%	0.9%	0.0%	8.3%	0.0%	0.0%	2.0%
3	n	1	11	0	0	1	0	13
	%	2.5%	4.9%	0.0%	0.0%	25.0%	0.0%	4.3%
4	n	1	25	0	0	1	0	27
	%	2.5%	11.1%	0.0%	0.0%	25.0%	0.0%	9.0%
5	n	4	45	3	2	0	0	54
	%	10.0%	20.0%	15.8%	16.7%	0.0%	0.0%	17.9%
6	n	11	56	2	1	0	0	70
	%	27.5%	24.9%	10.5%	8.3%	0.0%	0.0%	23.3%
7	n	6	38	7	1	0	1	53
	%	15.0%	16.9%	36.8%	8.3%	0.0%	100%	17.6%
8	n	9	28	5	5	2	0	49
	%	22.5%	12.4%	26.3%	41.7%	50.0%	0.0%	16.3%
9	n	4	18	2	2	0	0	26
	%	10.0%	8.0%	10.5%	16.7%	0.0%	0.0%	8.6%

Related to the respondent organizations countries, below we can see the distribution of staff and number of staff by region and country.

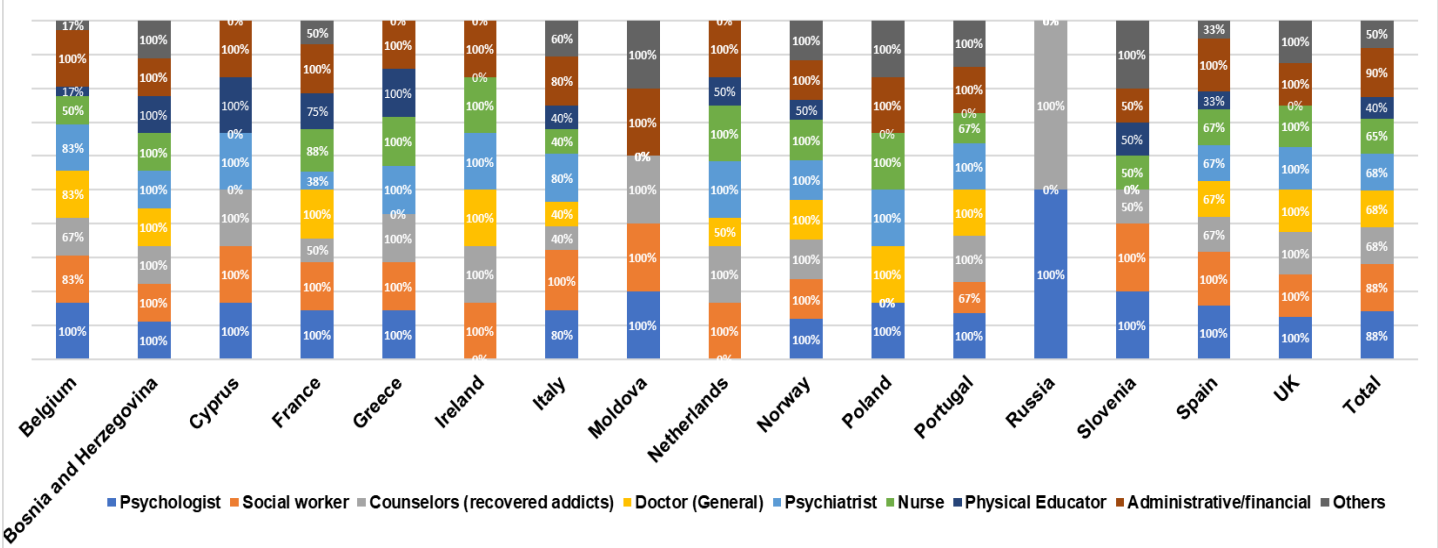
Graph 30 - Staff by country in Latin America and the Caribbean



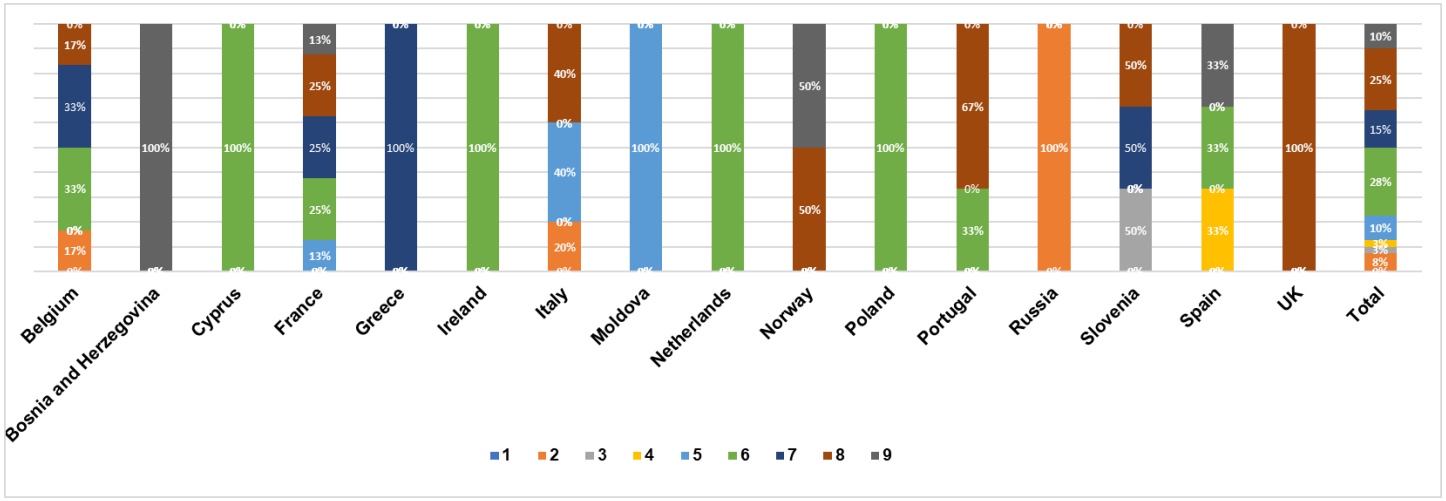
Graph 31 - Number of staff by country in Latin America and the Caribbean



Graph 32 - Staff by country in Europe

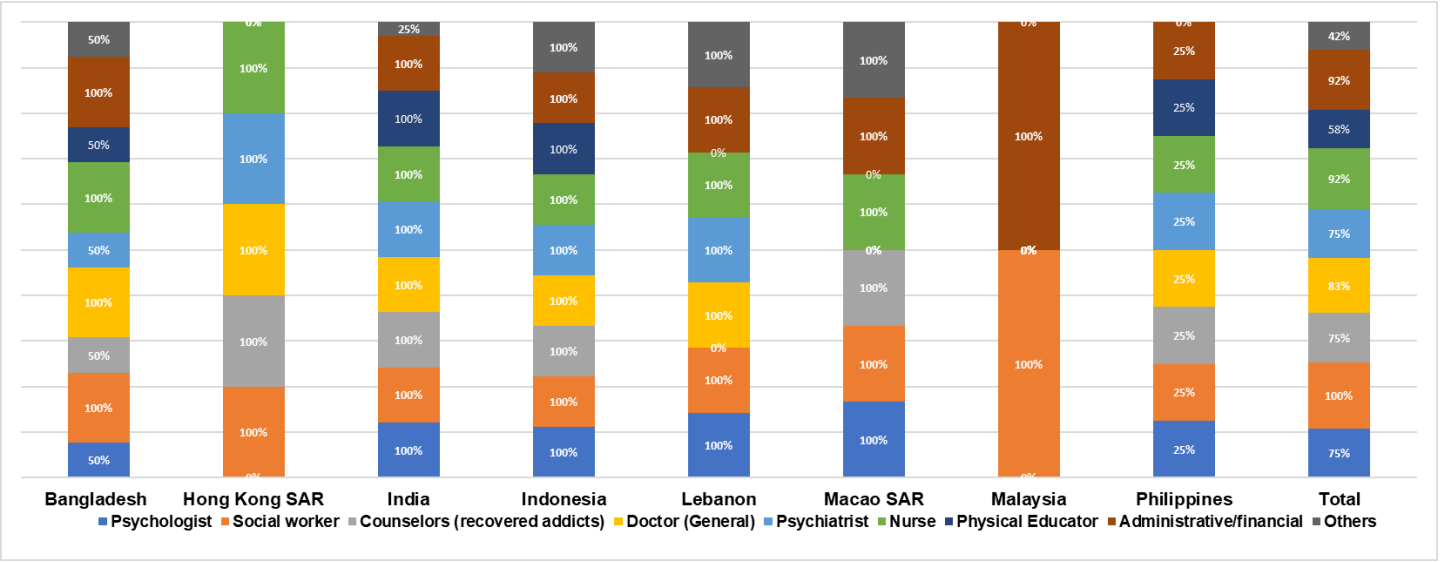


Graph 33 - Number of staff by country in Europe

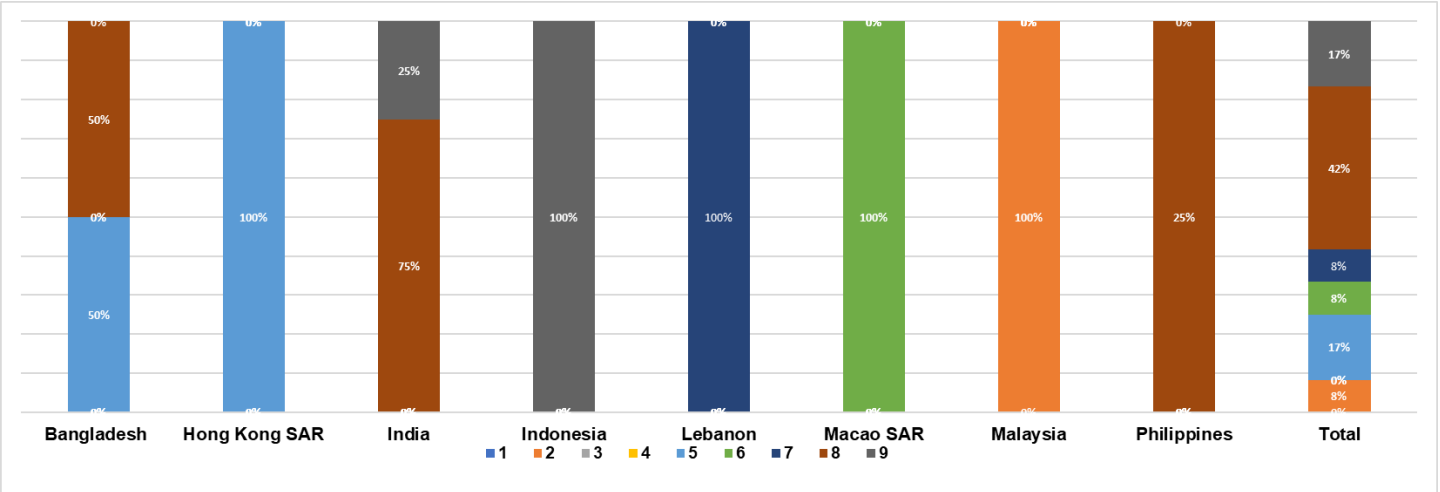


Switzerland is not present in these graphs because there was no data for this question.

Graph 34 - Staff by country in Asia



Graph 35 - Number of staff by country in Asia



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 52 - 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%).

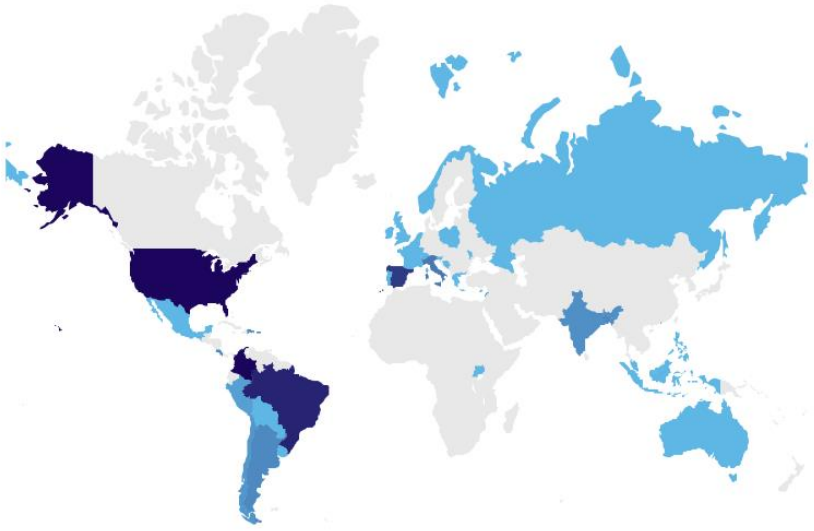
In total we had an increase of 1,184,965 assisted and reached people, that means an impressive increase of 302.3%.

Table 53 - 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%

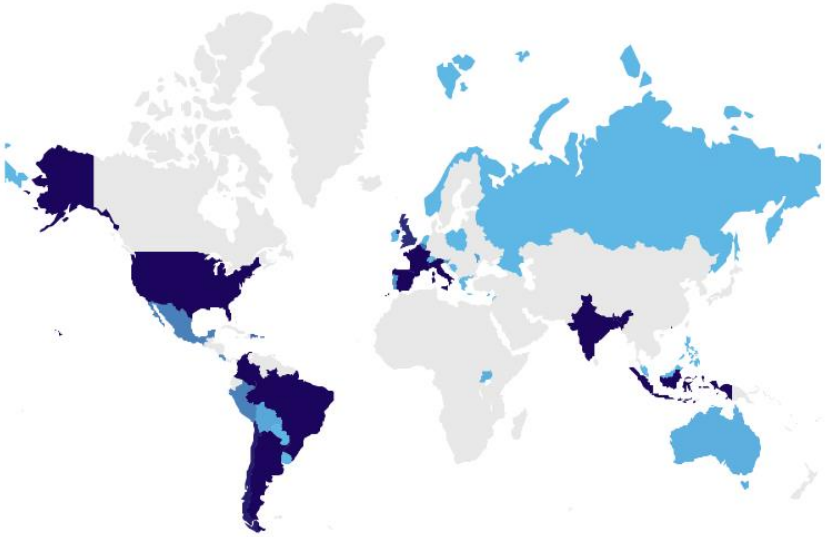
Related to the respondent organizations countries, below we could see the graph about the total individuals who received services (assisted people), where the darker the country, the more assisted people.

Graph 36 - 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 37 - Total individuals reached by country



Below we could see the distribution of assisted and reached people by region and country, and the comparison with the last survey.

Table 54 - Total assisted and reached people by country in Latin America and the Caribbean

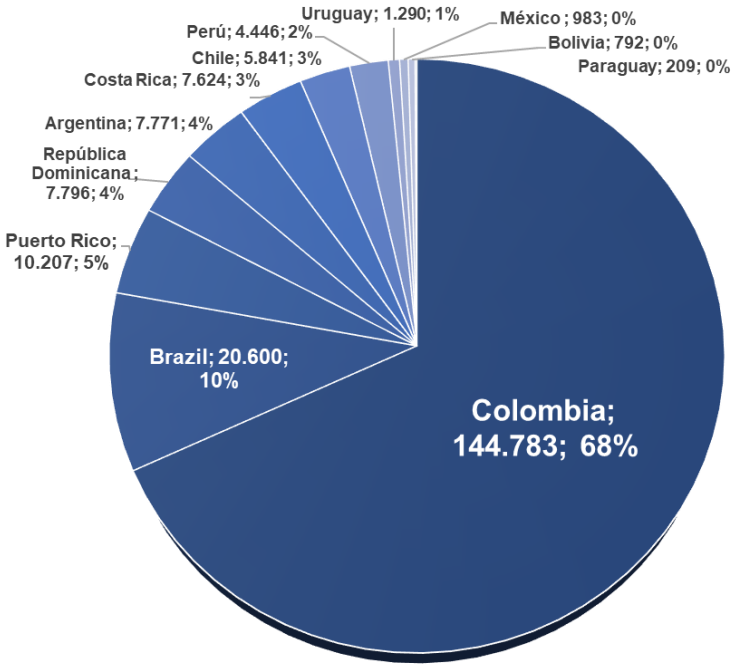
Country	Total individuals who received services		Total individuals reached	
	n	%	n	%
Argentina	7,771	3.7%	40,060	14.3%
Bolivia	792	0.4%	3,866	1.4%
Brazil	20,600	9.7%	113,290	40.5%
Chile	5,841	2.8%	21,070	7.5%
Colombia	144,783	68.2%	52,037	18.6%
Costa Rica	7,624	3.6%	7,856	2.8%
Dominican Republic	7,796	3.7%	12,470	4.5%
Mexico	983	0.5%	8,760	3.1%
Paraguay	209	0.1%	960	0.3%
Peru	4,446	2.1%	8,951	3.2%
Puerto Rico	10,207	4.8%	8,793	3.1%
Uruguay	1,290	0.6%	1,936	0.7%
Total	**212,342**	**100%**	**280,049**	**100%**

Table 55 - Total assisted and reached people by country in Latin America and the Caribbean (2023-2022)

Country	2023		2022		Increase	
	n	%	n	%	n	%
Argentina	47,831	9.7%	36,850	32.6%	10,981	129.8%
Bolivia	4,658	0.9%	-	-	-	-
Brazil	133,890	27.2%	33,949	30.0%	99,941	394.4%
Chile	26,911	5.5%	5,882	5.2%	21,029	457.5%
Colombia	196,820	40.0%	24,635	21.8%	172,185	798.9%
Costa Rica	15,480	3.1%	-	-	-	-
Dominican Republic	20,266	4.1%	-	-	-	-
Mexico	9,743	2.0%	-	-	-	-
Paraguay	1,169	0.2%	-	-	-	-
Peru	13,397	2.7%	4,885	4.3%	8,512	274.2%
Puerto Rico	19,000	3.9%	-	-	-	-
Uruguay	3,226	0.7%	6,152	5.4%	-2,926	-47.6%
Total	**492,391**	**100%**	**113,063***	**100%**	**379,328**	**435.5%**

***** Ecuador had 710 assisted and reached people in the last survey.

Graph 38 - Total assisted people by country in Latin America and the Caribbean



Graph 39 - Total reached people by country in Latin America and the Caribbean

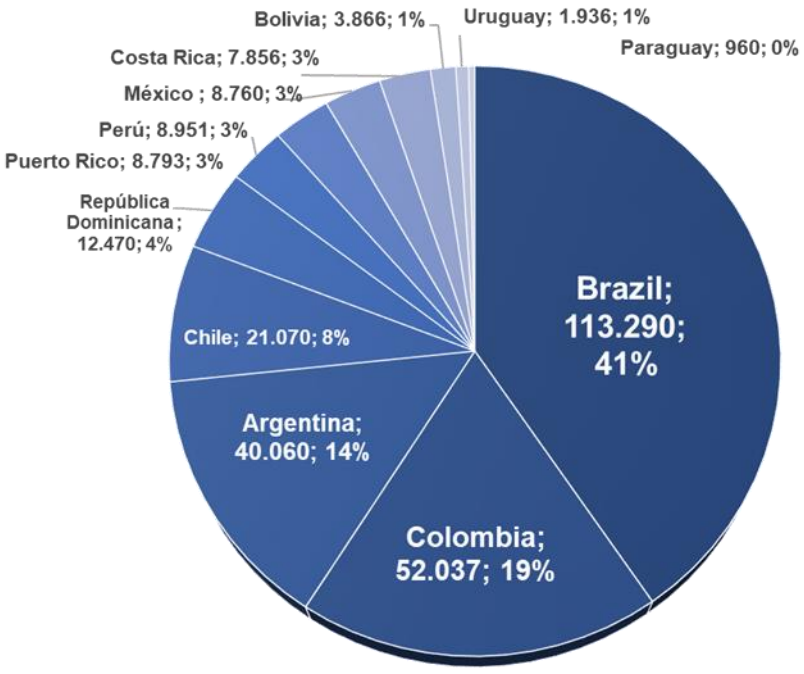


Table 56 - Total assisted and reached people by country in Europe

Country	Total individuals who received services		Total individuals reached	
	n	%	n	%
Belgium	1,530	4.5%	10,266	1.56%
Bosnia and Herzegovina	96	0.3%	1,500	0.23%
Cyprus	120	0.4%	150	0.02%
France	1,707	5.0%	334,408	50.83%
Greece	306	0.9%	308	0.05%
Ireland	250	0.7%	1,850	0.28%
Italy	9,818	28.6%	124,042	18.85%
Moldova	41	0.1%	4,000	0.61%
Netherlands	126	0.4%	131	0.02%
Norway	65	0.2%	210	0.03%
Poland	1,200	3.5%	1,000	0.15%
Portugal	272	0.8%	5,400	0.82%
Russia	10	0.0%	15	0.00%
Slovenia	711	2.1%	5,658	0.86%
Spain	17,644	51.5%	149,831	22.77%
Switzerland	0	0.0%	125	0.02%
UK	380	1.1%	19,000	2.89%
Total	34,276	100%	657,894	100%

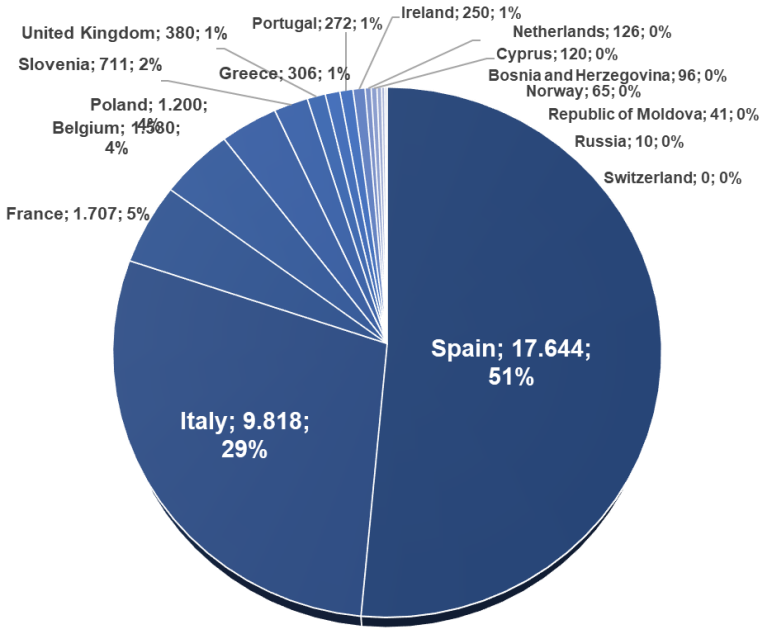
Table 57 - Total assisted and reached people by country in Europe (2023-2022)

Country	2023		2022		Increase	
	n	%	n	%	n	%
Belgium	11,796	1.7%	4,967	6.3%	6,829	237.5%
Bosnia and Herzegovina	1,596	0.2%	-	-	-	-
Cyprus	270	0.0%	-	-	-	-
France	336,115	48.6%	-	-	-	-
Greece	614	0.1%	22,665	28.6%	-22,051	-97.3%
Ireland	2,100	0.3%	1,885	2.4%	215	111.4%
Italy	133,860	19.3%	12,398	15.7%	121,462	1079.7%
Moldova	4,041	0.6%	3,000	3.8%	1,041	134.7%
Netherlands	257	0.0%	-	-	-	-
Norway	275	0.0%	-	-	-	-
Poland	2,200	0.3%	-	-	-	-
Portugal	5,672	0.8%	3,261	4.1%	2,411	173.9%
Russia	25	0.0%	-	-	-	-
Slovenia	6,369	0.9%	1,726	2.2%	4,643	369.0%
Spain	167,475	24.2%	21,708	27.4%	145,767	771.5%
Switzerland	125	0.0%	-	-	-	-

UK	19,380	2.8%	-	-	-	-
Total	692,170	100%	79,210*	100%	612,960	873.8%

* Czech Republic had 7,600 assisted and reached people in the last survey.

Graph 40 - Total assisted people by country in Europe



Graph 41 - Total reached people by country in Europe

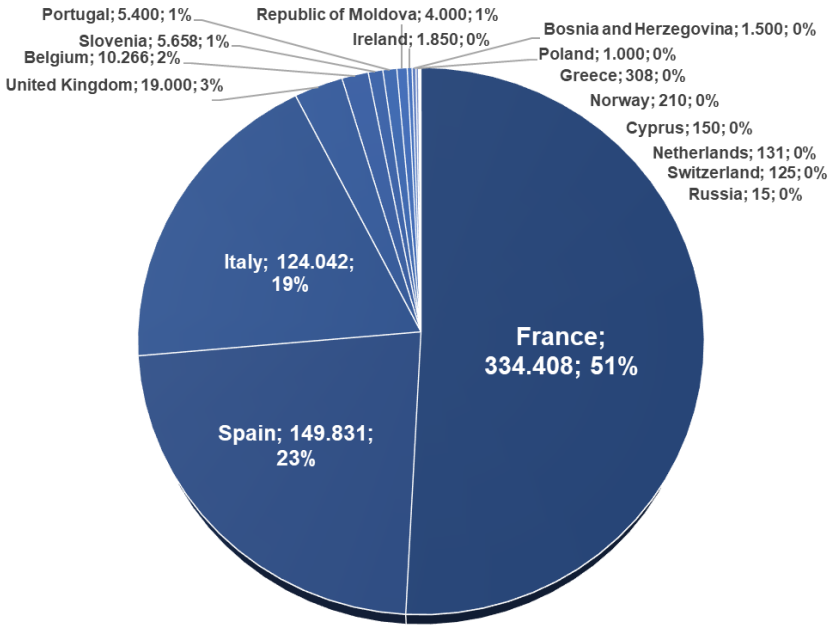


Table 58 - Total assisted and reached people by country in Asia

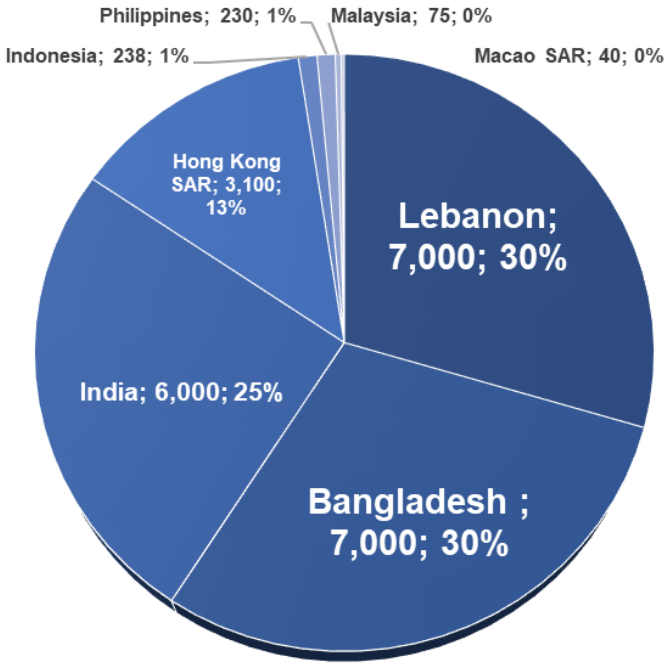
Country	Total individuals who received services		Total individuals reached	
	n	%	n	%
Bangladesh	7,000	29.6%	51,200	31.6%
Hong Kong SAR	3,100	13.1%	30,000	18.5%
India	6,000	25.3%	26,359	16.3%
Indonesia	238	1.0%	51,200	31.6%
Lebanon	7,000	29.6%	2,500	1.5%
Macao SAR	40	0.2%	407	0.3%
Malaysia	75	0.3%	250	0.2%
Philippines	230	1.0%	200	0.1%
Total	**23,683**	**100%**	**162,116**	**100%**

Table 59 - Total assisted and reached people by country in Asia (2023-2022)

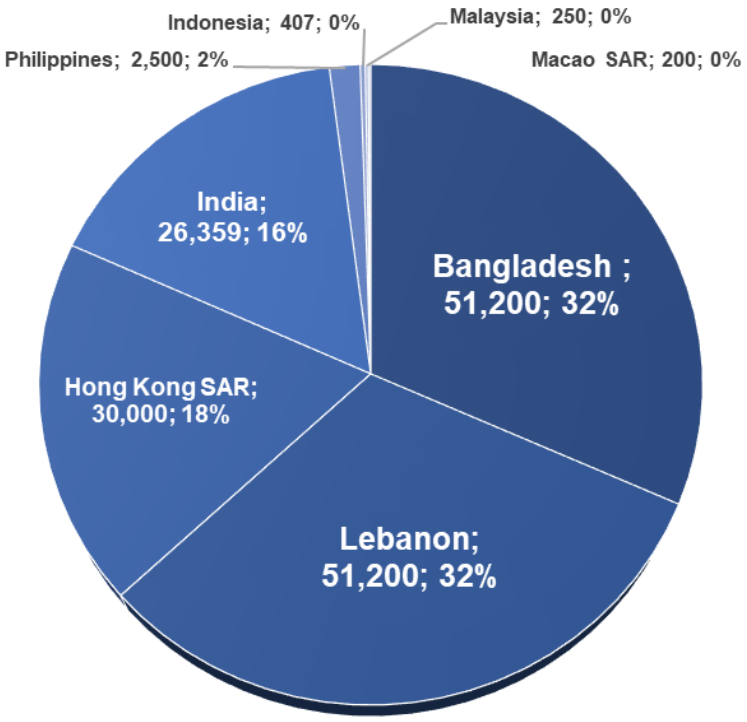
Country	2023		2022		Increase	
	n	%	n	%	n	%
Bangladesh	52,410	30.1%	10,419	11.8%	41,991	503.0%
Hong Kong SAR	33,100	19.0%	-	-	-	-
India	32,359	18.6%	28,410	32.1%	3,949	113.9%
Indonesia	645	0.4%	950	1.1%	-305	-32.1%
Lebanon	52,410	30.1%	21,338	11.8%	41,991	403.0%
Macao SAR	240	0.1%	-	-	-	-
Malaysia	325	0.2%	950	1.1%	-625	-65.8%
Philippines	2,730	1.6%	530	0.6%	2,200	515.1%
Total	**174,219**	**100%**	**88,532***	**100%**	**85,687**	**196.8%**

* Nepal had 500 and Pakistan 25,435 assisted and reached people in the last survey.

Graph 42 - Total assisted people by country in Asia



Graph 43 - Total reached people by country in Asia



5.13.1 Assisted people by target population gender

Knowing the distribution of assisted people by gender is important to figure out if the balanced number of female and male TCs in the world means a balanced number of assisted women and men.

Historically, female services are less common, and women accessed treatment less compared to men. Furthermore, in general, female TCs are smaller than male TCs, so even with a balanced number, it is highly probable that women still have less access to treatment than men.

As we saw in section 5.6, in this survey we asked if the organizations have treatment facilities only for male, only female, or both. In the case of both, it doesn't mean that the same facility deliver treatment for men and women. It means that the organization have different facilities for each gender.

In the case of the TC having both kinds of facilities, we did not separate the total of assisted people for each gender, so we cannot know exactly, in these cases, how specific female services are represented in the total.

As we can see in the graph and table below, more than 90% (n=311,780; 91.9%) of the assisted people were in TCs with both 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.

Graph 44 - Total assisted people by target population gender

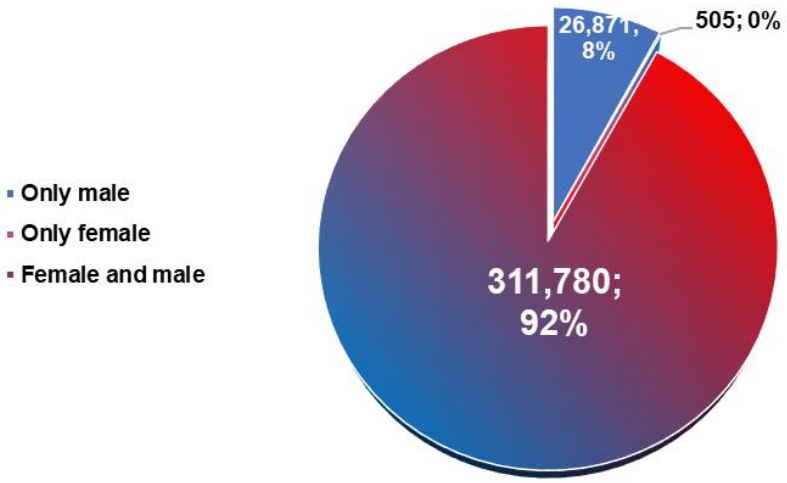


Table 60 - Total assisted people by region and target population gender

Region	Only male		Only female		Female and male	
	n	%	n	%	n	%
Europe	1	0.0%	96	0.3%	34,179	99.7%
LAC	23,570	11.1%	409	0.2%	188,363	88.7%
North America	225	0.3%	0	0.0%	72,376	99.7%
Asia	3,075	17.2%	0	0.0%	14,818	82.8%
Oceania	0	0.0%	0	0.0%	1,844	100%
Africa	0	0.0%	0	0.0%	200	100%
Total	**26,871**	**7.9%**	**505**	**0.1%**	**311,780**	**91.9%**

Related to the respondent organizations countries, below we can see the distribution of total assisted people by target population gender, region and country.

Table 61 - Total assisted people by target population gender in Latin America and the Caribbean

Country	Only male		Only female		Female and male	
	n	%	n	%	n	%
Argentina	410	5.3%	0	0.0%	7,361	94.7%
Bolivia	70	8.8%	0	0.0%	722	91.2%
Brazil	13,726	66.6%	409	2.0%	6,465	31.4%
Chile	361	6.2%	0	0.0%	5,480	93.8%
Colombia	1,399	1.0%	0	0.0%	143,384	99.0%
Costa Rica	2,289	30.0%	0	0.0%	5,335	70.0%
Dominican Republic	49	0.6%	0	0.0%	7,747	99.4%
Mexico	683	69.5%	0	0.0%	300	30.5%
Paraguay	159	76.1%	0	0.0%	50	23.9%
Peru	4,346	97.8%	0	0.0%	100	2.2%
Puerto Rico	78	0.8%	0	0.0%	10,129	99.2%
Uruguay	0	0.0%	0	0.0%	1,290	100%
Total	**23,570**	**11.1%**	**409**	**0.2%**	**188,363**	**88.7%**

Table 62 - Total assisted people by target population gender in Europe

Country	Only male		Only female		Female and male	
	n	%	n	%	n	%
Belgium	0	0.0%	0	0.0%	1,530	100%
Bosnia and Herzegovina	0	0.0%	96	100%	0	0.0%
Cyprus	0	0.0%	0	0.0%	120	100%
France	0	0.0%	0	0.0%	1,707	100%
Greece	0	0.0%	0	0.0%	306	100%
Ireland	0	0.0%	0	0.0%	250	100%
Italy	1	0.0%	0	0.0%	9,817	100%
Moldova	0	0.0%	0	0.0%	41	100%
Netherlands	0	0.0%	0	0.0%	126	100%
Norway	0	0.0%	0	0.0%	65	100%
Poland	0	0.0%	0	0.0%	1,200	100%
Portugal	0	0.0%	0	0.0%	272	100%
Russia	0	0.0%	0	0.0%	10	100%
Slovenia	0	0.0%	0	0.0%	711	100%
Spain	0	0.0%	0	0.0%	17,644	100%
Switzerland	0	0.0%	0	0.0%	0	0.0%
UK	0	0.0%	0	0.0%	380	100%
Total	**1**	**0.0%**	**96**	**0.3%**	**34,179**	**99.7%**

Table 63 - Total assisted people by target population gender in Asia

Country	Only male		Only female		Female and male	
	n	%	n	%	n	%
Bangladesh	0	0.0%	0	0.0%	1,210	100%
Hong Kong SAR	0	0.0%	0	0.0%	3,100	100%
India	3,000	50.0%	0	0.0%	3,000	50.0%
Indonesia	0	0.0%	0	0.0%	238	100%
Lebanon	0	0.0%	0	0.0%	7,000	100%
Macao SAR	0	0.0%	0	0.0%	40	100%
Malaysia	75	100%	0	0.0%	0	0.0%
Philippines	0	0.0%	0	0.0%	230	100%
Total	**3,075**	**9.0%**	**0**	**0.0%**	**14,818**	**43.2%**

5.13.2 Assisted people by location

As we said in section 5.10, urban locations are the mainstream in modern TCs, with increased access to the health care network, being very important especially in more severe cases.

In the case of selecting urban and rural, we did not ask how many people were assisted in each one, so in these cases we do not know exactly the number of people assisted in rural and in urban facilities.

In total, 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.

If we consider that only 35.5% of the respondent TCs reported having only rural locations, and 43.9% were assisted in rural facilities, we could possibly conclude that rural facilities are bigger than the urban ones. This characteristic of urban facilities (less people) could suggest that urban treatments could be more individualized than rural ones.

Graph 45 - Total assisted people by location

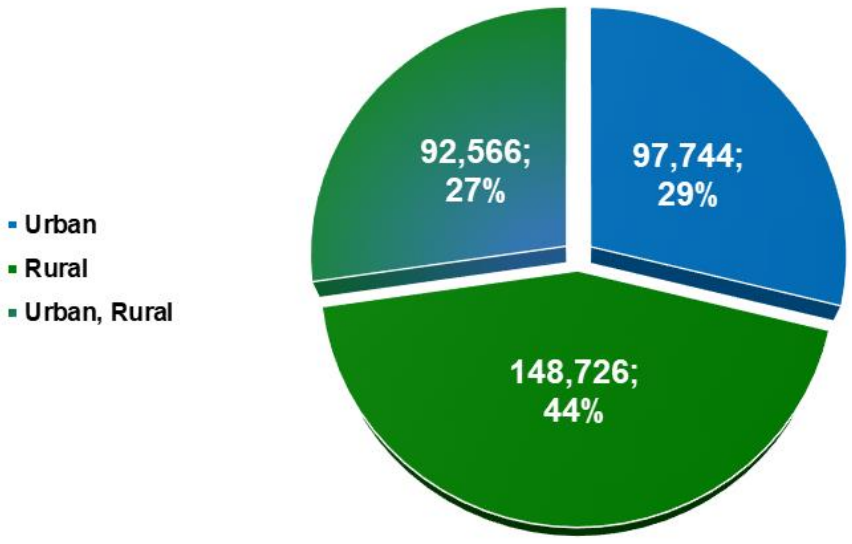


Table 64 - Total assisted people by region and location

Region	Urban		Rural		Urban and Rural	
	n	%	n	%	n	%
Europe	6,885	20.2%	4,251	12.4%	23,020	67.4%
LAC	32,003	15.1%	143,953	67.8%	36,386	17.1%
North America	55,274	76.1%	177	0.2%	17,150	23.6%
Asia	3,238	18.1%	345	1.9%	14,310	80.0%
Oceania	344	18.7%	0	0.0%	1,500	81.3%
Africa	0	0.0%	0	0.0%	200	100%
Total	**97,744**	**28.8%**	**148,726**	**43.9%**	**92,566**	**27.3%**

Related to the respondent organizations countries, below we could see the distribution of total assisted people by location, region and country.

Table 65 - Total assisted people by location in Latin America and the Caribbean

Country	Urban		Rural		Urban and Rural	
	n	%	n	%	n	%
Argentina	4,037	51.9%	445	5.7%	3,289	42.3%
Bolivia	250	31.6%	0	0.0%	542	68.4%
Brazil	4,863	23.6%	10,571	51.3%	5,166	25.1%
Chile	3,735	63.9%	180	3.1%	1,926	33.0%
Colombia	1,252	0.9%	131,928	91.1%	11,603	8.0%
Costa Rica	5,303	69.6%	200	2.6%	2,121	27.8%
Dominican Republic	7,796	100%	0	0.0%	0	0.0%
Mexico	893	90.8%	90	9.2%	0	0.0%
Paraguay	124	59.3%	85	40.7%	0	0.0%
Peru	3,750	84.3%	376	8.5%	320	7.2%
Puerto Rico	0	0.0%	78	0.8%	10,129	99.2%
Uruguay	0	0.0%	0	0.0%	1,290	100%
Total	**32,003**	**15.1%**	**143,953**	**67.8%**	**36,386**	**17.1%**

Table 66 - Total assisted people by location in Europe

Country	Urban		Rural		Urban and Rural	
	n	%	n	%	n	%
Belgium	1,190	84.4%	220	15.6%	0	0.0%
Bosnia and Herzegovina	0	0.0%	96	100%	0	0.0%
Cyprus	0	0.0%	0	0.0%	120	100%
France	402	23.6%	1,305	76.4%	0	0.0%
Greece	306	100%	0	0.0%	0	0.0%
Ireland	0	0.0%	0	0.0%	250	100%
Italy	3,778	38.5%	801	8.2%	5,239	53.4%
Moldova	0	0.0%	41	100%	0	0.0%
Netherlands	126	100%	0	0.0%	0	0.0%
Norway	0	0.0%	65	100%	0	0.0%
Poland	0	0.0%	1,200	100%	0	0.0%
Portugal	153	56.3%	59	21.7%	60	22.1%
Russia	0	0.0%	10	100%	0	0.0%
Slovenia	657	92.4%	54	7.6%	0	0.0%
Spain	273	1.5%	400	2.3%	16,971	96.2%
Switzerland	0	0.0%	0	0.0%	0	0.0%
UK	0	0.0%	0	0.0%	380	100%
Total	**6,885**	**20.2%**	**4,251**	**12.4%**	**23,020**	**67.4%**

Table 67 - Total assisted people by location in Asia

Country	Urban		Rural		Urban and Rural	
	n	%	n	%	n	%
Bangladesh	0	0.0%	0	0.0%	1,210	100%
Hong Kong SAR	0	0.0%	0	0.0%	3,100	100%
India	3,000	50.0%	0	0.0%	3,000	50.0%
Indonesia	238	100%	0	0.0%	0	0.0%
Lebanon	0	0.0%	0	0.0%	7,000	100%
Macao SAR	0	0.0%	40	100%	0	0.0%
Malaysia	0	0.0%	75	100%	0	0.0%
Philippines	0	0.0%	230	100%	0	0.0%
Total	**3,238**	**18.1%**	**345**	**1.9%**	**14,310**	**80.0%**

5.13.3 Assisted people by religious

As we saw in the 5.11 section, religion is a sensitive point in the TC world movement, so it could be interesting to know how many people were treated in religious and non-religious programs.

As we can see in the graph and table below, the vast majority of the assisted people (n=292,208; 86.2%) was treated in non-religious programs. This information opposes the common idea that TCs are associated with religious places and practices, in which there are no technical treatment.

Only in Asia there were more assisted people in religious programs (n=9,973; 55.7%), but the fact of having religious activities does not mean that there were no technical staff and technically oriented activities.

Graph 46 - Total assisted people by religious

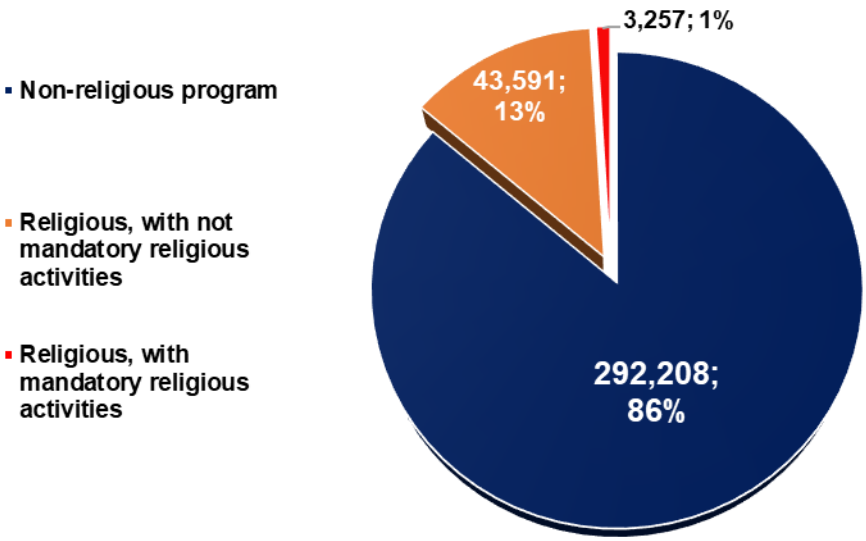


Table 68 - Total assisted people by region and religious

Region	Non-religious program		Religious, with not mandatory religious activities		Religious, with mandatory religious activities	
	n	%	n	%	n	%
Europe	34,019	99.3%	161	0.5%	96	0.3%
LAC	176,066	83.0%	33,090	15.6%	3,086	1.5%
North America	72,359	99.7%	242	0.3%	0	0.0%
Asia	7,920	44.3%	9,898	55.3%	75	0.4%
Oceania	1,844	100%	0	0.0%	0	0.0%
Africa	0	0.0%	200	10.8%	0	0.0%
Total	**292,208**	**86.2%**	**43,591**	**12.9%**	**3,257**	**1.0%**

Related to the respondent organizations countries, below we can see the distribution of total assisted people by religious, region and country.

Table 69 - Total assisted people by religious in Latin America and the Caribbean

Country	Non-religious program		Religious, with not mandatory religious activities		Religious, with mandatory religious activities	
	n	%	n	%	n	%
Argentina	7,301	95.2%	370	4.8%	0	0.0%
Bolivia	525	66.3%	267	33.7%	0	0.0%
Brazil	7,390	35.9%	12,212	59.3%	998	4.8%
Chile	2,239	38.3%	3,602	61.7%	0	0.0%
Colombia	142,024	98.1%	2,759	1.9%	0	0.0%
Costa Rica	5,450	71.5%	392	5.1%	1,782	23.4%
Dominican Republic	7,796	100%	0	0.0%	0	0.0%
Mexico	607	61.7%	200	20.3%	176	17.9%
Paraguay	0	0.0%	135	64.6%	74	35.4%
Peru	1,220	27.4%	3,170	71.3%	56	1.3%
Puerto Rico	224	2.2%	9,983	97.8%	0	0.0%
Uruguay	1,290	100%	0	0.0%	0	0.0%
Total	**176,066**	**83.0%**	**33,090**	**15.6%**	**3,086**	**1.5%**

Table 70 - Total assisted people by religious in Europe

Country	Non-religious program		Religious, with not mandatory religious activities		Religious, with mandatory religious activities	
	n	%	n	%	n	%
Belgium	1,530	100%	0	0.0%	0	0.0%
Bosnia and Herzegovina	0	0.0%	0	0.0%	96	0.0%
Cyprus	0	0.0%	120	100%	0	0.0%
France	1,707	100%	0	0.0%	0	0.0%
Greece	306	100%	0	0.0%	0	0.0%
Ireland	250	100%	0	0.0%	0	0.0%
Italy	9,818	100%	0	0.0%	0	0.0%
Moldova	0	0.0%	41	100%	0	0.0%
Netherlands	126	100%	0	0.0%	0	0.0%
Norway	65	100%	0	0.0%	0	0.0%
Poland	1,200	100%	0	0.0%	0	0.0%
Portugal	272	100%	0	0.0%	0	0.0%
Russia	10	100%	0	0.0%	0	0.0%
Slovenia	711	100%	0	0.0%	0	0.0%
Spain	17,644	100%	0	0.0%	0	0.0%
Switzerland	0	0.0%	0	0.0%	0	0.0%
UK	380	100%	0	0.0%	0	0.0%
Total	15,274	98.3%	161	1.0%	96	0.6%

Table 71 - Total assisted people by religious in Asia

Country	Non-religious program		Religious, with not mandatory religious activities		Religious, with mandatory religious activities	
	n	%	n	%	n	%
Bangladesh	780	64.5%	430	35.5%	0	0.0%
Hong Kong SAR	3,100	100%	0	0.0%	0	0.0%
India	4,000	66.7%	2,000	33.3%	0	0.0%
Indonesia	0	0.0%	238	100%	0	0.0%
Lebanon	0	0.0%	7,000	100%	0	0.0%
Macao SAR	40	100%	0	0.0%	0	0.0%
Malaysia	0	0.0%	0	0.0%	75	100%
Philippines	0	0.0%	230	100%	0	0.0%
Total	7,920	44.3%	9,898	55.3%	75	0.4%

5.13.4 Assisted people by average proposed time for treatment

In the section 5.9 we saw that "modified TCs" started to develop shorter programs, which could lead to better adherence and less dropouts.

In the graph and table below, we can see that 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.

Only in Asia there were more assisted people in longer programs of more than 12 months (n=11,370; 63.5%), and in Europe 39.9% (n=13,684) of the assisted people were in these longer programs.

As mentioned, longer programs do not necessarily imply longer internments, as a program could offer both residential and ambulatory treatments, and depend on the phase.

Graph 47 - Total assisted people by average proposed time for treatment

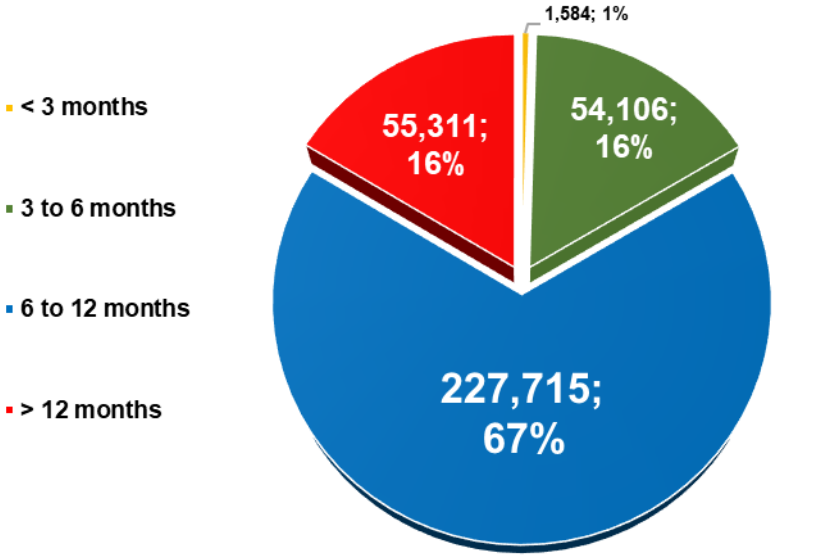


Table 72 - Total assisted people by region and average proposed time for treatment

Region	< 3 months		3 to 6 months		6 to 12 months		> 12 months	
	n	%	n	%	n	%	n	%
Europe	0	0.0%	880	2.6%	19,712	57.5%	13,684	39.9%
LAC	1,584	0.7%	11,849	5.6%	168,612	79.6%	29,857	14.1%
North America	0	0.0%	37,897	52.2%	34,454	47.5%	250	0.3%
Asia	0	0.0%	1,710	9.6%	4,813	26.9%	11,370	63.5%
Oceania	0	0.0%	1,570	85.1%	124	6.7%	150	8.1%
Africa	0	0.0%	200	100%	0	0.0%	0	0.0%
Total	1,584	0.5%	54,106	16.0%	227,715	67.2%	55,311	16.3%

Related to the respondent organizations countries, below we can see the distribution of total assisted people by average proposed time for treatment, region and country.

Table 73 - Total assisted people by average proposed time for treatment in Latin America and the Caribbean

Country	< 3 months		3 to 6 months		6 to 12 months		> 12 months	
	n	%	n	%	n	%	n	%
Argentina	0	0.0%	1,050	13.9%	6,186	81.7%	335	4.4%
Bolivia	0	0.0%	150	18.9%	525	66.3%	117	14.8%
Brazil	0	0.0%	4,889	23.7%	14,619	71.0%	1,092	5.3%
Chile	0	0.0%	0	0.0%	3,585	61.4%	2,256	38.6%
Colombia	50	0.0%	1,570	1.1%	132,303	91.4%	10,860	7.5%
Costa Rica	1,534	20.8%	3,958	53.6%	1,275	17.3%	617	8.4%
Dominican Republic	0	0.0%	0	0.0%	7,747	99.4%	49	0.6%
Mexico	0	0.0%	80	8.1%	603	61.3%	300	30.5%
Paraguay	0	0.0%	74	35.4%	85	40.7%	50	23.9%
Peru	0	0.0%	0	0.0%	248	5.6%	4,198	94.4%
Puerto Rico	0	0.0%	78	0.8%	146	1.4%	9,983	97.8%
Uruguay	0	0.0%	0	0.0%	1,290	100%	0	0.0%
Total	1,584	0.7%	11,849	5.6%	168,612	79.6%	29,857	14.1%

Table 74 - Total assisted people by average proposed time for treatment in Europe

Country	< 3 months		3 to 6 months		6 to 12 months		> 12 months	
	n	%	n	%	n	%	n	%
Belgium	0	0.0%	240	15.7%	401	26.2%	889	58.1%
Bosnia and Herzegovina	0	0.0%	0	0.0%	96	100%	0	0.0%
Cyprus	0	0.0%	0	0.0%	0	0.0%	120	100%
France	0	0.0%	0	0.0%	0	0.0%	1,707	100%
Greece	0	0.0%	0	0.0%	306	100%	0	0.0%
Ireland	0	0.0%	250	100%	0	0.0%	0	0.0%
Italy	0	0.0%	0	0.0%	0	0.0%	9,818	100%
Moldova	0	0.0%	0	0.0%	41	100%	0	0.0%
Netherlands	0	0.0%	0	0.0%	0	0.0%	126	100%
Norway	0	0.0%	0	0.0%	25	38.5%	40	61.5%
Poland	0	0.0%	0	0.0%	1,200	100%	0	0.0%
Portugal	0	0.0%	0	0.0%	272	100%	0	0.0%
Russia	0	0.0%	10	100%	0	0.0%	0	0.0%
Slovenia	0	0.0%	0	0.0%	0	0.0%	711	100%
Spain	0	0.0%	0	0.0%	17,371	98.5%	273	1.5%
Switzerland	0	0.0%	0	0.0%	0	0.0%	0	0.0%
UK	0	0.0%	380	100%	0	0.0%	0	0.0%
Total	**0**	**0.0%**	**880**	**2.6%**	**19,712**	**57.5%**	**13,684**	**39.9%**

Table 75 - Total assisted people by average proposed time for treatment in Asia

Country	< 3 months		3 to 6 months		6 to 12 months		> 12 months	
	n	%	n	%	n	%	n	%
Bangladesh	0	0.0%	1,210	100%	0	0.0%	0	0.0%
Hong Kong SAR	0	0.0%	0	0.0%	0	0.0%	3,100	100%
India	0	0.0%	500	8.3%	4,500	75.0%	1,000	16.7%
Indonesia	0	0.0%	0	0.0%	238	100%	0	0.0%
Lebanon	0	0.0%	0	0.0%	0	0.0%	7,000	100%
Macao SAR	0	0.0%	0	0.0%	0	0.0%	40	100%
Malaysia	0	0.0%	0	0.0%	75	100%	0	0.0%
Philippines	0	0.0%	0	0.0%	0	0.0%	230	100%
Total	**0**	**0.0%**	**1,710**	**9.6%**	**4,813**	**26.9%**	**11,370**	**63.5%**

5.13.5 Assisted people by number of Staff

We saw in section 5.12, more than 80% of TCs reported having 5 or more different professionals in their staff. Now we can see how many people were assisted according to the number of different professionals the TCs had.

As we can see in the graph and table below, the majority of the people (n=198,579; 58.6%) were assisted in TCs with 8 different professionals in their staffs.

The rate of 95.6% (n=324,076) for people assisted in TCs with 5 or more different professionals in their staffs is notable.

Graph 48 - Total assisted people by number of staff

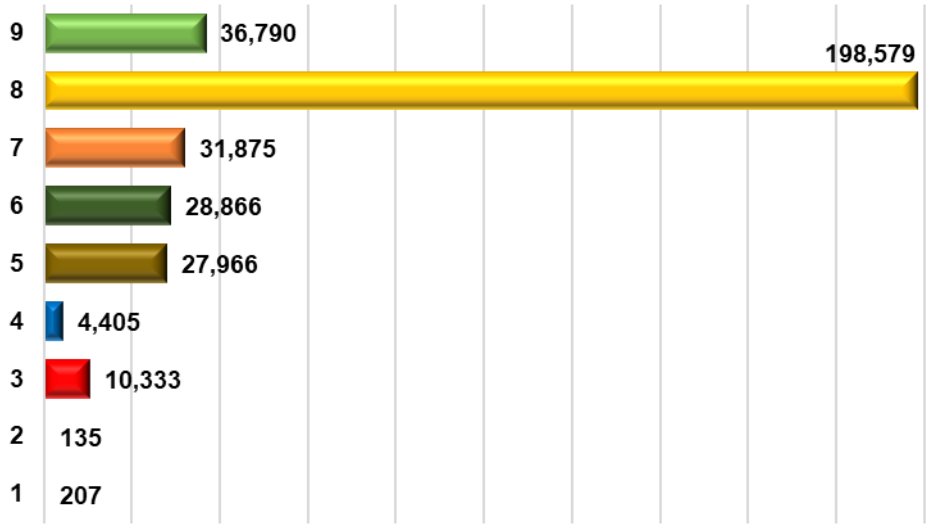
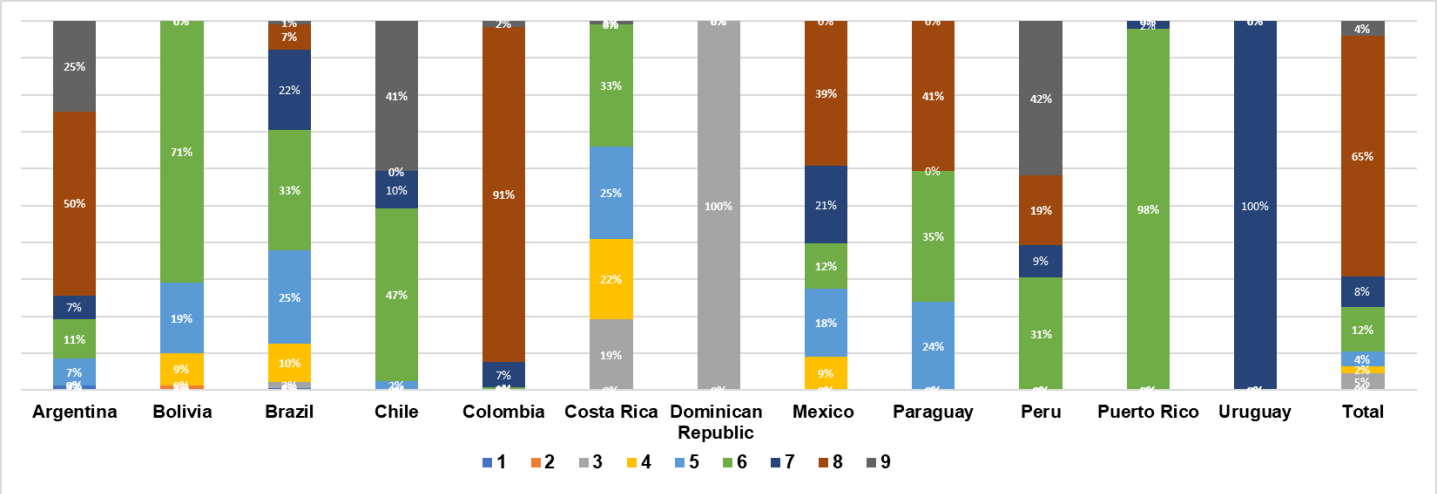


Table 76 - Total assisted people by region and number of staff

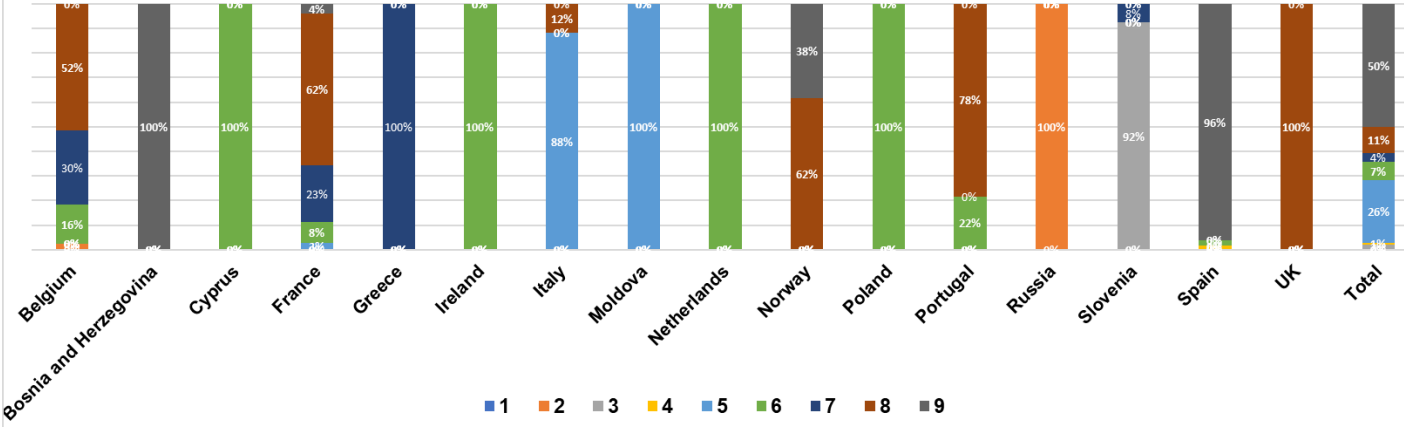
N. of staff		Region						Total
		Europe	LAC	North America	Asia	Oceania	Africa	
1	n	0	207	0	0	0	0	207
	%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.1%
2	n	50	10	0	75	0	0	135
	%	0.1%	0.0%	0.0%	0.4%	0.0%	0.0%	0.0%
3	n	657	9,606	0	0	70	0	10,333
	%	1.9%	4.5%	0.0%	0.0%	3.8%	0.0%	3.0%
4	n	273	3,982	0	0	150	0	4,405
	%	0.8%	1.9%	0.0%	0.0%	8.1%	0.0%	1.3%
5	n	8,743	8,243	7,100	3,880	0	0	27,966
	%	25.5%	3.9%	9.8%	21.7%	0.0%	0.0%	8.2%
6	n	2,539	26,012	275	40	0	0	28,866
	%	7.4%	12.3%	0.4%	0.2%	0.0%	0.0%	8.5%
7	n	1,213	17,430	6,032	7,000	0	200	31,875
	%	3.5%	8.2%	8.3%	39.1%	0.0%	100%	9.4%
8	n	3,639	138,139	51,017	4,160	1,624	0	198,579
	%	10.6%	65.1%	70.3%	23.2%	88.1%	0.0%	58.6%
9	n	17,162	8,713	8,177	2,738	0	0	36,790
	%	50.1%	4.1%	11.3%	15.3%	0.0%	0.0%	10.8%

Related to the respondent organizations countries, below we can see the distribution of total assisted people by number of staff, region and country.

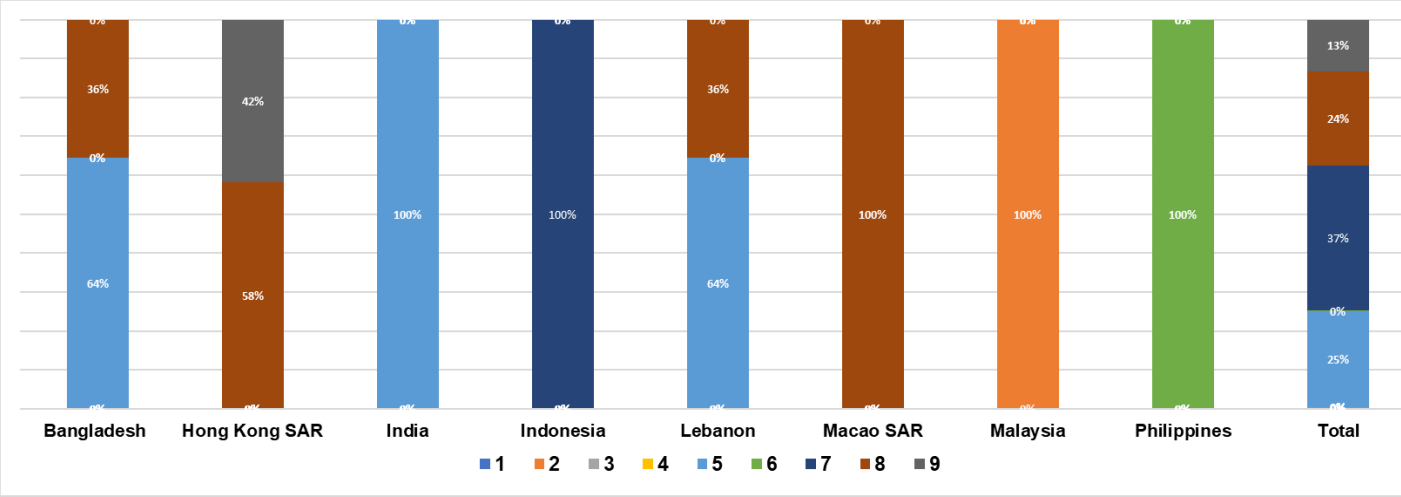
Graph 49 - Total assisted people by region and number of staff in Latin America and the Caribbean



Graph 50 - Total assisted people by region and number of staff in Europe



Graph 51 - Total assisted people by region and number of staff in Asia



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 problems, 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.

ANNEX 1 – QUESTIONAIRE

SECTION 1 – INSTITUTIONAL DATA

1. Person's name submitting the information

2. Name of Organization

3. Country Base

4. Institutional Affiliation (multiple option)

- World Federation of Therapeutic Communities (WFTC)
- Australasian Therapeutic Communities Association (ATCA)
- European Federation of Therapeutic Communities (EFTC)
- Federation of Therapeutic Communities in Asia (FTCA)
- Latin-American Federation of Therapeutic Communities (FLACT)
- Treatment Communities of America (TCA)
- Others: (Local Federations)

5. Scope of work (single answer)

- Local
- National
- International

5.1 If international: in which other countries the Organization maintain TC services?

6. Type of work conducted (single answer)

- ***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***

7. Number of employees (single answer)

- <10
- 10-50
- >50

8. Source of funding (multiple option)

- 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

SECTION 2 – SERVICE DATA

9. Target population (multiple option)

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

10. Target population gender (single answer)

- Only female
- Only male
- Female and male

11. 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.

12. 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.

13. Settings (multiple option)

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

SECTION 3 - ONLY FOR TCs

14. Average proposed time for treatment (single answer)

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

15. TC location (multiple option)

- Urban
- Rural

16. Religious (single answer)

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

17. Staff (multiple option)

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

ANNEX 2 – RESPONDENT TCs LIST

Europe

Table 77 - Respondent TCs from Europe

Country	Name of Organization
Belgium	De Kiem
	De Sleutel vzw Organisatie Brothers of Charity
	Phoenix House Bulgaria
	Solidarnost ARAP Association
	Trempoline ASBL
	Vassilev
Bosnia and Herzegovina	Public Instituion Center for rehabilitation addicts of psychoactive substances
Cyprus	Therapeutic Community "Agia Skepi"
France	Association Montjoie Communauté Thérapeutique
	Association RIMBAUD
	CEID-Addictions
	Fédération Addiction
	SATO Picardie
	Sauvegarde du nord
	Association Montjoie Communauté Thérapeutique
	Association RIMBAUD
Greece	ARGO Alternative Therapeutic Program for Drug Addicted Individuals
Ireland	Coolmine Therapeutic Community
Italy	CEIS Genova
	Comunità San Patrignano
	Dianova Cooperativa Sociale ARL
	Federazione Italiana Comunità Terapeutiche F.I.C.T.
	Lycos
Moldova	Initiativa Pozitiva (Positive Initiative)
Netherlands	Stichting De Stam
	TC De Stam
Norway	Stiftelsen Phoenix
	Stiftelsen Renåvangen
Poland	Polish Federation of Therapeutic Communities
Portugal	Ares do Pinhal
	Associação Dianova Portugal
	Centro de Solidariedde de Braga / Projecto Homem
Russia	Clinic of Dr.Isaev
Slovenia	Društvo Projekt Človek
	UP Society Slovenia

Spain	AAT Associació d'Acollida i Acció Terapèutica
	Association Proyecto Hombre
	Dianova España
Switzerland	Dianova International
United Kingdom	Phoenix Futures

Latin America and the Caribbean

Table 78 - Respondent TCs from Latin America and the Caribbean

Country	Name of Organization
Argentina	ACIAR - El Reparo
	ANANKE
	asoc PROGRAMAANDRES
	Asociación civil Del Prado
	Asociación Civil Programa Guadalupe
	Asociacion Modelo Minnesota
	Asociación Rumen
	Asociación SEDRO
	Cades
	Centro Shoc
	CETRAQ
	El Palomar
	Fundación Aprendiendo a Vivir
	Fundación Aylen
	Fundación Creando la Libertad
	Fundacion Creer es Crear
	Fundación Luz de Vida
	Fundacion Nocka Munayki (yo te quiero)
	Fundacion Viviré
	grupo del Oeste salud mental y adicciones
	La Libertad
	La Misión
	La Urdimbre asoc civil
	Los Naranjos Comunidad Terapeutica
	Posada del Inti
	Programa Delta
	Proyecto U.N.O Asociación Civil
	Segunda Oportunidad

Bolivia	Centro Boliviano de Solidaridad Vida
	Centro de reintegracion para Teenagers con responsabilidad penal
	E.D.I.T.O. Espacio de Diagnóstico e Intervención Terapéutica Oportuna
	El alto sin alcohol y drogas
	Fundación Enda El Alto
Brazil	ARAD - Associação de Recuperação e Prevenção do Alcoolismo e Outras Drogas
	Associação Acolher
	Associação Amor Exigente de Torres (Comunidade Terapêutica Renovar)
	Associação Beneficente Novo Amanhã
	Associação Bom Samaritano
	Associação Cearense de Inclusão e Assistência Social
	Associação Comunitária de Recuperação Novo Caminho
	Associação Crença
	Associação de Assistência aos dependentes Químicos-toxicológicos - Casa do Amor Fraterno
	Associação de Promoção Humana - Grupo AMA
	Associação fazenda do Senhor Jesus
	Associação Mãe Admirável
	Associação Missionária Para Vidas
	Associação Nova Vida
	Associação Padre Leonardo Nunes
	Associação Promocional Sol Nascente
	Associação Promocional Vida Nova
	Associação Prudentina para Prevenção dos Vícios e Recuperação de Vidas - Esquadrão da Vida
	Associação Reeducação Social Jaboque
	Associação Resgate a vida de Mogi Mirim
	Associação Terapêutica Novo Amanhecer - ATENA
	Associação Terra Santa / Astes
	Associação TESHUVA / Comunidade Terapêutica TESHUVA/Nossa Senhora de Guadalupe
	Associação Vida Plena Amor Exigente /AVIPAE
	Caritas Projeto Mãe que Acolhe
	Casa de Apoio Pe. Aloísio Boeing
	Casa de Reintegração Social Nova Vida
	Casa do Sol Azul
	CAUDEQ
	Centro de Atenção Urbana a Dependência Química
	Centro de Apoio e recup. de toxic. e alcoolat de Rio Pardo

Brazil	Centro Terapêutico Cristão Salva Vidas
	Centro Terapêutico São Francisco
	Comunidade Bethania
	Comunidade Só Por Hoje
	Comunidade Solidariedade SOL
	Comunidade Terapêutica Acolhedora Filhos da Luz
	Comunidade Terapêutica Amigos da Vida
	Comunidade Terapêutica Atos
	Comunidade Terapêutica Beth Hayotser
	Comunidade Terapêutica Bom Pastor
	Comunidade Terapêutica Cáritas Nossa Senhora do Perpétuo Socorro
	Comunidade terapêutica Casa Marta e Maria
	Comunidade terapêutica conquista
	Comunidade Terapêutica do Maranhão- CTM
	Comunidade Terapeutica Ebenezer
	Comunidade Terapêutica Emanuel - Coterem
	Comunidade Terapêutica Esquadrão Resgate
	Comunidade Terapêutica Essência de Vida
	Comunidade Terapêutica Fazenda Padre Réus
	Comunidade Terapêutica Fazenda Renascer
	Comunidade Terapêutica Fazenda Santo Expedito
	Comunidade Terapêutica Fazenda Senhor Jesus Cristo Rei
	Comunidade Terapêutica Feminina Florescer
	Comunidade Terapêutica Kairos
	Comunidade terapêutica Maranata
	Comunidade Terapêutica Nova Jerusalem
	Comunidade Terapêutica Nova Jornada
	Comunidade Terapêutica para Dependentes Químicos e de Álcool - Associação Santana
	Comunidade Terapêutica Peniel
	Comunidade Terapêutica Renascer
	Comunidade Terapêutica Rosa de Saron
	Comunidade Terapeutica Santa Mãe da Providência
	Comunidade Terapeutica Sao Francisco
	Comunidade Terapêutica Vida Nova
	Comunidade Terapêutica Viver
	Comunidade Terapêutica Andradinense Recanto do Senhor Jesus
	CRAVI - Casa de Recuperação Água da Vida
	CRER Comunidade Terapêutica Fazenda São Francisco
	Desafio Jovem de Santo André
	Fundação de Ribeirão Preto Apoiando a Recuperação de Vidas - RAREV

Brazil	Fundação Padre Gabriel Correr
	G. T. Goiás sem Drogas
	GRAAUS - Grupo de Recuperação de Alcoólicos Augusto Silva
	Grupo Nova Aurora Feminino e Masculino de Atenção à Dependência Química
	Instituição Padre Haroldo Rahm
	Instituto Amor e Vida
	Instituto Bambu
	Instituto El Shaddai
	Instituto Redenção
	Instituto Ruach CT DEJOB
	Instituto Social Beneficente Ebenézer
	Instituto vale viver
	IVVI- Instituto Valorização da Vida de Ituverava
	Missão Desafio Peniel
	Missão Resgate da Paz
	NAREV
	Obras Sociais Água Viva
	Obras Sociais da Diocese de Goiás
	Obras Sociais da Diocese de Uruaçu
	OSC Projeto WIDA - CT Nossa Senhora de Fátima
	PACTO N/B
	PATNA - Pastoral de Apoio ao Toxicômano Nova Aurora
	PATRE - Associação Amor Exigente de Antônio Prado
	Pia união das irmãs da Copiosa Redenção
	PROVITA - Projeto Vida Itapema
	Recanto "Rogério de Souza"
	Servos - Sociedade no Empenho na Recuperação de Vidas
	SOPROH Sociedade de Promoção Humana
	Terra da Sobriedade - Associação de Atenção à Dependência Química
Chile	CEPAS
	Comunidad TABOR
	Comunidad Terapéutica PEULLA
	Comunidad Terapéutica Colina
	Comunidad Terapéutica Joven Levántate
	Comunidad Terapéutica Liwen
	Comunidad Terapéutica Manquehue
	Comunidad Terapéutica Renovaciòn
	CREA
	CT El Ruco
	CT INTA
	CT La Roca
	Dianova Chile

Chile	Fundación Despertar
	Fundación Hogar Volver a Nacer
	Org. de tratamiento y prevención de drogas "OTPD"
	PAI Licanantay
Colombia	Alma cad
	Alma Cad Cali
	Casa Fenix, Tú Oportunidad de Renacer
	Corporación creando vida
	Corporacion Gestora de Paz Kairós
	Corporación nueva vida
	Corporación Raíces, Alas y Sentido
	Fundación criar
	Fundacion Familiar Faro
	Fundación Hogares Claret
	Fundacion La Luz IPS
	Fundación Revivir con Cristo que me fortalece
	Fundación Semillas de Amor
	Fundación Vive La Vida IPS
	Valle de Guerreros
Costa Rica	Fundación Kañïr
	Albergue Adulto Mayor
	Clinia patricio Perez
	Hogar Limon Salvando al Adicto
	Adepea
	Hogar CREA
	Hogar Salvando Alcohólico Guadalupe
	CLINICA nueva vida
	Proyecto Equilibrio
	Hogar salvando Alcohólico
	Asociación Minesterio Casa de Paz Sucot Shalon
	Hogar San José
	Centro Restauración Vigias de Amor
	Hogar Zoe
	Residencia Terapéutica Eliasit
	Rostro de Jesus
	Centro de restauración para hombres famacodependientes
	Asociación R.E.N.A.C.ER.
Dominican Republic	Asociación Casa Abierta
	Guarabi inc

Mexico	Arca de Noé A.C
	Casa de la Esperanza Comunidad Terapéutica
	Comunidad de restauración familiar semilla
	Comunidad Terapéutica en Adiciones para Mujeres A.C. (SECUOYA)
	Comunidad Terapéutica Guerreros de San Miguel
	Comunidad terapéutica in lak ech a c
	FEMEXCOT
	Fundación México Me Necesita A. C.
	Tu decides como vivir
Paraguay	Centro Terapeutico El Nazareno
	Comunidad Terapéutica "TALLER DEL MAESTRO"
	Comunidad Terapéutica Mahanaim
	Con Pasion
	Padres Unidos en el Amor y la Fe. PUAFE
Peru	Asociación A.T.A.
	Asociacion Comunidad Terapéutica Fuente de Agua Viva
	Asociacion Vereda Libre
	ATP VIDA (Asociación Terapéutica profesional Vida)
	C.T. Lugar de Restauración LIFE
	Centro de Desarrollo Humano y Rehabilitacion Psicosocial Amarse
	Centro Takiwasi Centro de Rehabilitación de Toxicómanos y de Investigación de Medicinas Tradicionales.
	Comunidad Terapéutica Ayuda en Acción
	Comunidad Terapéutica Cristiana Divino Salvador
	Comunidad Terapéutica Cristiana Enséñame el Camino
	Comunidad Terapéutica Programa San José
	CT Talita Kumi
	CT Villa Angela
	De Nuevo A La Vida
	Esperanza de vida
	Novo World
	Programa Terapéutico Ayudémonos
	Solidaridad Vida
Puerto Rico	APCT, Inc.
	Guara Bi, Inc.
	Hogar Santisima Trinidad, Inc.
Uruguay	Comunidad terapéutica Diente de león
	Fundación Dianova Uruguay

Asia

Table 79 - Respondent TCs from Asia

Country	Name of Organization
Bangladesh	Dhaka Ahsania Mission
	KOTHOWAIN (Vulnerable Peoples Development Organization)
Hong Kong SAR	SARDA
India	Angels in the Field
	Sabrr Foundation
	Shafa Home
	SPYM
Indonesia	Kasih Mulia Foundation
Lebanon	CDLL
Macao SAR	ARTM
Malaysia	Rumah Hijrah
Philippines	Self Enahancement for Life Foundation, Inc.

North America

Table 80 - Respondent TCs from North America

Country	Name of Organization
USA	Acacia Network, Inc.
	Bridges International
	Camelot of Staten Island
	Center Point, Inc.
	Center Point, Inc.
	Dynamic Youth Community Inc.
	Gateway Foundation, Inc.
	Hospitality House TC, inc.
	Integrity House
	NOVA Treatment Community
	NYTC - Stay'n Out
	Odyssey House Louisiana, Inc.
	Odyssey House of Utah
	Outreach Development Corporation
	Samaritan Daytop Village
	Tarzana Treatment Centers
	Treatment Trends, Inc
	VIP Community Services
	WestCare Foundation, Inc.

Oceania

Table 81 - Respondent TCs from Oceania

Country	Name of Organization
Australia	DASA
	Goldbridge Rehabilitation Services
	Karralika Programs
	WHOS (We Help Ourselves)

Africa

Table 82 - Respondent TCs from Africa

Country	Name of Organization
Uganda	Uganda Youth Development Link (UYDEL)