



INDICATOR ANALYSIS

REPORTED TREATMENT COVERAGE FOR ALCOHOL AND DRUG DEPENDENCE

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<p>Overview</p>	<p><i>Reported Treatment Coverage for Substance Dependence</i> is defined as “the proportion of people with alcohol or drug dependence (including those who are not seeking treatment) that are in contact with treatment services, i.e. currently receiving treatment or in remission or relapse, but still in contact with treatment services” (1).</p>
<p>How is the indicator calculated?</p>	<p>The indicator is a fraction. Numerator: number of people with alcohol or drug dependence in contact with treatment services, i.e. currently receiving treatment or in remission or relapse, but still in contact with treatment services. Denominator: number of people with alcohol or drug dependence (including those who are not seeking treatment).</p> <p><i>Method of estimation:</i> The national authorities of a given country respond to the WHO ATLAS survey on resources for the prevention and treatment of substance use disorders. Substance dependence is defined as a dependence to cocaine, cannabis, opioid, and alcohol. Treatment services is not defined. This indicator is expressed as a percentage.</p>

<p>GLOBAL TRENDS</p>	
<p>What are the global patterns for this indicator? Trends, geographic patterns etc.</p>	<p>Rates of access to substance abuse treatment (measured in 2016 for alcohol and 2019 for drugs) are highest in Central and Eastern Europe and Central Asia. Countries with highest rates of treatment access (above 40%) include Russia, France, Ukraine, Belarus, Kazakhstan, Turkmenistan, Uzbekistan, and Iceland. Outside of Europe, the DRC, Cote d’Ivoire, Zimbabwe, Cuba, and Brazil have equal rates of treatment coverage (1).</p> <p>The countries with over 40% of treatment access (all list above) are of varying contexts thus making it difficult to compare geographic regions and health systems. However, the following observations were made:</p> <ul style="list-style-type: none"> - All European and Central Asian countries listed above benefit from universal health care access - All African countries list above received “above 40%” based solely on their treatment access for alcohol; access to treatment for opioids, cannabis, and cocaine was either “severely limited (less than 1-10%)” or marked as “data not available” <p>In regard to countries with the lowest scores of access (around 1-10%)</p> <ul style="list-style-type: none"> - Developed countries make up only eight of the 30 lowest scores (United States, Switzerland, Denmark, Latvia, Estonia, Netherlands, Belgium, Czech Republic) - 12 of the lowest scored countries are in Africa - The majority of countries with no available data are in the Middle East or Africa

	<p>These findings suggest that access to drug treatment may not be prioritized in high conflict settings, in regions where primary health care systems are significantly underdeveloped, or where alcohol may be prohibited.</p> <p>These findings also suggest that access to universal health care shares a positive relationship with access to treatment services and that countries with higher rates of alcohol use (Russia) may prioritize access to treatment services.</p>
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RELEVANCE TO UNDERSTANDING RELATIONSHIPS AMONG GENDER, HEALTH, FRAGILITY/PEACE	
<p>How could this indicator contribute to our understanding of how gender, health and fragility and peace influence one another?</p>	<p>High access rates in developed country contexts demonstrates that rates of access to treatment may be dependent upon the sophistication and capacity of a country's health system.</p> <p>High access rates in countries with universal health care access demonstrates that rates of access to treatment may be positively correlated with one's access to financial resources and/or availability of free treatment services.</p> <p>Low access rates in developing country contexts suggests that low rates of access to treatment may be a result of poor health infrastructure and health system capacity of a country.</p> <p>Low access rates in high conflict settings suggest that treatment services for substance abuse may not be a prioritized provision of health care during wartime or civil conflict. This is supported by evidence that substance use in humanitarian settings has always been a neglected area of public health with very limited information available in both published and grey literature on this matter (2).</p>

UTILITY	
<p>What does the indicator measure?</p>	<p>The proportion of people with substance dependence in a certain geographical region who are accessing drug dependency treatment.</p>
<p>What does it NOT measure - what does it miss?</p>	<p>This indicator does not measure actual availability of treatment services in any one geographical area. Rather, this indicator measures those who identify as having a substance dependence and who are accessing treatment. This distinction is important as the latter measure provides little insight into the totality of services available at the national or global level. Rather, this indicator provides more knowledge into who is accessing treatment and the specificities of treatment users on an individual level.</p>

	<p>This indicator does not measure the types of (nor clearly defines) “treatment services” being accessed and therefore provides little context into the most accessed types of treatment. This indicator also therefore equally weighs all types of treatment.</p> <p>Substance abuse is a mental health disorder. Because this indicator only measures drug dependency treatment, it may underreport those who are seeking treatment for mental health disorders not exclusive to substance abuse disorders. This is important because significant scientific evidence indicates that individuals with substance use disorders often access the health care system for reasons other than their substance use disorder (3), which may provide mental health benefits that have a positive impact on drug dependence.</p>
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AVAILABILITY	
Sources for indicator (CRVS, DHS etc.);	<p>Estimation of treatment coverage in populations is based on the data from global surveys of key informants in national health authorities implemented by WHO periodically (WHO ATLAS survey on prevention and treatment resources for substance use disorders – ATLAS SU; WHO Global Survey on Alcohol and Health) and supported by available data on prevalence of substance use disorders and treatment coverage.</p> <p>Preferred data sources included household surveys, health system data on treatment provision, sentinel surveillance site.</p> <p>Indicator data are available from the following sources:</p> <ol style="list-style-type: none"> 1. WHO's Global Health Observatory (country level 2014 and 2016) https://www.who.int/data/gho/data/indicators/indicator-details/GHO/reported-treatment-coverage-for-substance-dependence 2. UN's SDG indicator database (country level 2015-2017) https://unstats.un.org/sdgs/indicators/database/
Most recent date available;	Most recent data available are from 2017.
Availability across geographic areas;	All countries are included in the WHO's GHO, though over 70 countries are listed as having “no available data”.
Availability in conflict affected settings;	Data is available for Afghanistan in both the WHO's GHO and the UN's SDG indicator database for the DRC, South Sudan, Somalia and Yemen.

GRANULARITY	
<i>Disaggregation at national level</i>	
Data disaggregated by sex;	While some constituent tracer indicators are disaggregated by sex, data of the final output of the coverage index is not disaggregated by sex (2).
Data disaggregated by identity group (race, ethnicity);	No.
Data disaggregated by income	No.
<i>Disaggregation at sub-national level</i>	
Data disaggregated by geographic region;	No.
Data disaggregated by identity group (race, ethnicity);	No.
Data disaggregated by income.	No.

SOURCES OF BIAS	
What bias can exist with these data?	<p><i>Selection bias:</i> Surveys don't account for those receiving services outside of "substance dependence treatment services" as defined by the indicator, subsequently leaving out those who may be receiving mental health services in another form that may have health benefits for substance dependency. Similarly, relying on health system surveys only includes those seeking treatment through specific health authorities and may exclude community health programming, private clinic programming, and anonymous treatment programming. Estimates are also likely to overlook those with substance abuse disorders that have not presented for treatment or care, thus overestimating treatment access.</p> <p><i>Response Bias:</i> Given the stigma attached to alcohol abuse in some contexts, respondents may be inclined to report accessing treatment. This may be most significant in contexts where those with addictions face serious social stigma or criminal charges. This may be a more significant factor in women respondents as gender norms can place a higher stigma on female addicts. Respondents may refrain from answering truthfully in hospital surveys for a variety of reasons, including improper/insensitive screening techniques, power dynamics, and harmful attitudes held by medical professionals that may influence the desire to respond honestly. This may be most significant in contexts where</p>

	<p>drug and alcohol use have criminal implications and/or where health authorities share close relationships with police authorities.</p> <p>The lack of a clear definition of treatment services may imply that such services include a wide variety of treatment methodologies subject to the interpretation of respondents or interviewers.</p>
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VALIDITY	
<p>Clear and accepted international standards for indicator;</p>	<p>Because of the use of a self-reported method with no clear definition of what treatment services include, this indicator may not reflect the amount of people in any geographical context that are accessing treatment services. This indicator may only retrieve data from people who have access to health services and who openly reported using a health intervention that they consider to be a treatment service for drug dependency.</p>
<p>Validity of measurement of indicator generally accepted;</p>	<p>No other indicators measuring the proportion of a population accessing drug treatment services were found. As such, the WHO's method of measuring appears to be the acceptable standard of measurement</p>

RELIABILITY	
<p>Reliability of indicator generally accepted;</p>	<p>This indicator relies on self-reported measures and is not based on a clear definition of treatment services, which limits its reliability.</p>

COMPLEXITY	
<p>Enables analysis across time and location.</p>	<p>Yes, this indicator does enable for analysis across time and location as there is no geographic or time-related limitation explicitly identified within its definition.</p>

OTHER REFLECTIONS	
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<p>Are indicator values imputed/modelled?</p>	<p>The Global Health Observatory notes that values for this indicator may be estimated or modelled but offers no further detail (1). <i>Data are given in ranges and should be used with caution when comparing values across time and space.</i></p> <p>Methods used to derive values provided by the SDG indicator database differ for drug use and alcohol. For drug use, no data is imputed or modelled at the national level. For alcohol use, they note that "several approaches will be used to produce estimates based on all available pieces of contextual service capacity data in the country and regionally" (4). <i>Uncertainty bounds are not included with indicator data which may be based on estimated values for alcohol. As such, caution should be exercised when comparing indicator values across time and space.</i></p>
<p>Other reflections/debates?</p>	<p>The indicator is lacking in specificity; not explaining what treatment services constitute means this indicator is vulnerable to various interpretations which would decrease its comparability across contexts.</p> <p>Relying only on open disclosure as the singular form of data collection may overestimate the figure of those accessing treatment services, especially in countries where drug and alcohol use is criminalized and/or stigmatized.</p> <p>The limited data available (or capacity to gather data) in conflict or developing settings suggests that the humanitarian community may be best suited to gather data within these contexts. This is most crucial in areas of civil conflict and disaster, as increasing use of substances is reported among combatants and ex-combatants as a means of coping with stress. The humanitarian principles of neutrality and impartiality might also be important tools used to capture adequate statistics, specifically inside contexts with heavy social stigma and/or criminalization.</p> <p><i>Final Thoughts:</i> The indicator should explicitly define treatment services and should include other mental health and/or community programming; the indicator should not rely on self-reported data; the indicator should be used to capture data in regard to race, gender, and socio economic status; researchers using this indicator should code and categorize the types of treatment accessed to understand treatment impact and where exactly what type of treatment needs to be scaled up; in contexts where stigma and criminalization of drug use is a known problem, third/neutral parties may be best suited to collate data as many of these countries currently have no statistics on this indicator.</p>

References

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