Corruption in drug treatment systems, innovation against corrupt practices

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Acknowledgments:

We would like to thank Dr. Elizabeth Sáenz, Ivana Kohut, and Alice Uhl for their time and guidance throughout this research project. We are also very grateful to the RAUN coordinators, who organized this experience and provided the platform for us to conduct this important research.

We would also like to thank Dr. Carmen Albizu Garcia and Alexandra Plante for giving us direction when starting out, and the ISSUP and ICUDDR for helping us reach a larger audience.

Required citation: Cervantes Nieto, A. and Castaño Bonilla, C. 2023. *Corruption in drug treatment systems, innovation against corrupt practices.* Vienna. Regional Academy on the United Nations

Abstract

What makes drug treatment systems vulnerable to corruption and how can this be mitigated by innovation that promotes transparency? Research on corruption in health systems has been fundamental for policy-makers to identify the negative impact of this phenomenon on the healthcare sector overall. However, research on specific types of corruption in drug treatment services - a system with a unique constellation of stakeholders remains very limited. The following paper seeks to contribute to this knowledge gap by understanding how corruption weakens drug treatment systems per its nature, and provide recommendations that could help international organizations such as the UNODC and countries interested in implementing strategies to strengthen transparency in drug treatment services. The paper uses a multi-method research design that relies on a qualitative analysis of selected drug legislations (regulation of treatment) and a quantitative analysis driven by an online survey of professionals working in drug treatment. The paper concludes that mechanisms to combat corruption should strengthen data collection to include more criteria for assessing the quality of services provided to boost compliance and improve transparency levels of public and private providers. The digitalization of processes to reduce bureaucratic hurdles to access treatment and public-private partnerships with social media platforms would also facilitate communication about treatment, patient rights, and the duties of providers to vulnerable groups such as young people and people who use drugs (PWUDs) with lower income levels.

Keywords: Corruption, Drug Policy, Drug Treatment Systems, Transparency, Compliance, Innovation.

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1 Introduction

1.1 Corruption in drug treatment systems

What makes drug treatment systems vulnerable to corruption and how can this be mitigated by innovation[1] that promotes transparency? Previous research on corruption in health systems has been fundamental for policy-makers to identify the negative impact of this phenomenon on the healthcare sector overall (T. Vian 2007; Azfar and Gurgur 2008; M. Lewis 2006). Such research has highlighted the link between higher levels of good governance and transparency and lower instances of corruption in the provision of healthcare services (Brusca, Manes Rossi, and Aversano 2018; Hunter et al. 2020; Mackey and Liang 2012; Paschke et al. 2018; Taryn Vian 2020; 2008). Nonetheless, research on specific types of corruption in drug treatment systems, as well as the negative consequences produced by this phenomenon, has been limited to specific case studies with 1) a strong focus on human rights violations (i.e. case-study analysis of rehabilitation centers, with emphasis on issues like sexual abuse, human trafficking or forced labor) (UNODC 2021; Parker, Miranda-Miller, and Albizu-García 2022), and 2) mostly in using data from developed countries where there are reports of corrupt practices. Against this backdrop, international organizations such as the UNODC and WHO have voiced their concerns about the severe repercussions of entrenched corruption in drug treatments, and the need to further research to understand how it impacts the provision of treatment and rehabilitation services for people who use drugs (PWUDs), especially in developing countries.

Bearing in mind the particular nature of drug treatment systems and the number of stakeholders involved, it is necessary to understand how corruption impacts them. Drug treatment systems are regulated in different forms and they don't necessarily have the same goals (i.e. differences between health goals and criminalization/punishment). This heterogeneity in structures results in different vulnerabilities to corruption as well as different types of corruption in each drug treatment system. By undertaking this research we would be able not only to understand the way corruption affects specifically drug treatment systems but also contribute to the existing literature on corruption in the healthcare sector. On the policy-making level, our assessment would provide a much-needed contextualization of the issue of corruption affecting drug treatment as a core component of any country's drug policy. Therefore, initiatives resulting from this research would not only improve states' capacity to safeguard the rights of their citizens but also to achieve the goals of its drug policy concerning the reduction of drug use and harm associated with drug use.

[1] For this paper, by "innovation" the authors are not referring to the implementation of new IT solutions but rather to best practices that increase the availability of information concerning the quality of drug treatment services accountability from those stakeholders in the healthcare sector or in the government.

1.2 Justification

Drug treatment systems are not prioritized within the national drug policy and therefore suffer from constrained budgets and low availability of trained healthcare professionals (UNODC 2021)[2]. With this in mind, it is all the more relevant to use cost-efficient mechanisms such as the use of information tech and the digitalization of processes (which will be further detailed later on in this document). Certain innovative measures can be used alongside information technology and digitalization to guarantee access to information, accountability[3], and the communication and protection of PWIDs' rights. Moreover, cost-efficient and innovative anti-corruption mechanisms would be especially useful in low and middle-income countries where drug treatment systems have limited funding and are more affected by corruption (Fisman and Golden 2017).

The low prioritization of drug treatment systems in the overall drug policy in a country can leave clinics and rehabilitation centers with dangerously low levels of funding (Reuter 2006; Reuter and Caulkins 1996). As the literature on health systems shows, low funding renders the system and those who use it vulnerable to further levels of corruption. Additionally, in countries that implement a punitive approach to drugs, PWIDs are perceived and treated as criminals (UNODC 2021). They become re-victimized in the process, losing their rights and sense of agency, and ultimately become more vulnerable to abuse from officials or healthcare staff (Lunze et al. 2016).

Higher levels of corruption not only weaken the drug treatment systems but also result in less protection for PWUDs. It makes the system opaque, reducing accountability and the ability of governments and other actors (i.e., IOs, INGOs, and CSOs) to timely identify violations of the patient's rights. The increased vulnerability that drug treatment systems and PWUDs often find themselves in, makes it all the more urgent to identify the particular corruption risks that exist in different systems and provide the appropriate innovative solutions to address them.

1.3 Research aim and purpose

As explained in the previous sections, the aim of this research can be narrowed to the following objectives:

- Understand how corruption weakens different types of drug treatment systems.
- Identify the most common forms in which corruption affects the patients, with a special emphasis on the (lack of) safeguarding of their rights.
- Provide recommendations to design strategies that strengthen transparency in the provision of drug treatment services. Such strategies should focus on the quality of the service provided to improve top-down oversight and to give patients more agency and channels to inform about corruption instances.

The third component of the research would provide policy-makers with insights on how to best integrate possible anti-corruption strategies into the existing guidelines on drug treatment systems. This would help the UN, especially the UNODC and WHO, to build innovative tools to improve the work they already do together with member states in drug treatment systems.

[2] Information is taken from a drafted document by the UNODC on the issue of corruption in drug treatment systems. This fact sheet has not been officially published by the UNODC.

[3] By accountability, the authors refer to mechanisms designed to assure that funds for drug treatment are both allocated (by government) and used (by providers) as intended.

2 State of the Art

2.1 Drug Treatment Systems

2.1.1 Drug treatment systems as part of drug policy

Drug treatment systems and the services they comprise "vary considerably within and across societies, but they all share the assumption that individual-level change will translate into lower rates of drug use, drug-related infections, overdose deaths, unemployment, and criminal activity" (Babor et al. 2018, 143)[4]. The use of drug treatments is also prioritized by the provisions in the UN Conventions of drugs[5], with resolution II of the Single Convention on Narcotic Drugs emphasizing that the most "effective method[s] of treatment for addiction is treated in a hospital institution having a drug free atmosphere" (UNODC 2013b, 13)[6].

Although these definitions recognize the relevance of drug treatment systems to achieve the goals of any given drug legislation, they are the starting point for what is currently recognized as more integrated approaches to treating drug use disorders. Research on drug use disorders and advocacy in favor of PWUDs' rights understands drug treatment is not just dependent on the patient's commitment to recovery, but also heavily affected by the quality of the services provided and the implementation of evidence-based strategies for rehabilitation (Campello 2021). Additionally, their definition of services extends beyond medical (clinical) treatment, to include some additional psycho-social strategies -many of them included in the WHO guidelines for the treatment of drug use disorders (see Appendix I). The document provides a constellation of treatments combined with different types of interventions, summarized in Appendix II.

Notwithstanding the existence of these guidelines, the different types of drug policy[7] result in domestic legislation that frames the purpose of treatment and its subsequent regulation in different manners. The following subsections address two aspects by which drug treatment systems can be categorized: 1) compulsory and voluntary, and 2) controlled under the public health ministry or the criminal justice system.

2.1.2 Compulsory vs. voluntary

The distinction between compulsory and voluntary drug treatment systems is pertinent to this research because of two aspects. Firstly, research on the efficacy of drug treatments -including recidivism rates- evidence that compulsory rehabilitation [reclusion] presents higher levels of failure to treat addiction and higher rates of relapse after release (Bright and Martire 2013). Secondly, the vulnerability of patients considerably worsens in compulsory systems insofar as their rights and the safety of the treatments that they are forced to undergo (Kamarulzaman and McBrayer 2015).

[4] Although this individual-level approach might be the most commonly used by many countries, it often shifts the responsibility solely to PWUDs without acknowledging that societal structures and environmental causes might influence the individual's likelihood to use drugs (Babor et al. 2018, 17–18).

[5] Article 38 of the Single Convention on Narcotic Drugs

[6] Article 38 of the Single Convention "declared that one of the most effective methods of addiction treatment was treated in a hospital institution having a drug-free atmosphere [...]. The representative of the WHO expressed that the view that a 'drug-free environment' presupposed a 'closed institution'" (UN General Assembly 1973, 447)

[7] According to the International Drug Policy Consortium, the spectrum of drug policy options and their likely effects include legislations that contemplate drug control via ultra prohibition, legal regulation, or commercial promotion, with different results concerning social and health-related harms (IDCP 2018, 73).

Although compulsory treatments are being phased out in drug legislation, a number of developed countries[8] continue to force PWUDs to undergo treatment as means to avoid criminal sanction[9], and many developing countries make use of compulsory detention as the main form of treatment despite the precarity[10] in which most of these services are provided (Hall et al. 2012). Both efficacy of treatment and patients' vulnerability are two aspects closely related to corruption, with compulsory systems being more susceptible to corrupt practices such as patient brokerage (see more in section 3.2.5).

Patients that undergo treatment for drug use disorders are often stigmatized in a way that people suffering from other addiction disorders or chronic illnesses are not. They face the dichotomy of being considered ill and also criminals, particularly in the instances of compulsory rehabilitation. Although most research on coercive treatment has focused on its dehumanizing aspects and criminal recidivism (Pollack, Reuter, and Sevigny 2011; Hall et al. 2012), there are much fewer data about corruption exacerbating these problems in comparison to voluntary treatment.

2.1.3 Control under public health or the criminal justice system

Although international guidelines for drug treatment systems recommend their regulation under the health care system, many countries offer [coercive] treatment at the "intersection between substance use treatment and the Criminal Justice System [CJS]" (Bright and Martire 2013). Therefore, the participation of actors within the CJS presupposes the process of entering a treatment on drug use as a non-criminal punishment of a coercive nature. PWUDs, who are patients, are often perceived and treated as criminals that face the stages of arrest, trial, sentence, and conviction. This process not only increases the chances of re-victimization by having the already-vulnerable patients subject to criminal punishment, but also of instances where corruption directly impacts the well-being of the PWUDs, either through extortion or detention in jails that could be run for-profit. These compulsory detention centers, which fall under the CJS are run by law enforcement institutions, often employing treatment approaches with no evidence to support their success[11]. Those who end up receiving coerced treatment experience delayed or insufficient psychosocial support during treatment, and have higher recidivism rates in comparison to other types of voluntary treatments (D. Werb et al. 2016; Kamarulzaman and McBrayer 2015).

2.1.4 Lack of data on drug treatment system's performance

Factors such as hidden use, under-reporting, and non-standardized data collection methods, among others, result in the lack of up-to-date indicators related to drug use. Moreover, concerning drug treatment, there is even less capacity to obtain high-quality information[12] with countries requiring

[8] As of 2012, countries like Russia and Sweden detain PWUD in compulsory treatment. Its use remains a key strategy in developing countries despite evidence questioning the success of such strategies. (Hall et al. 2012).

[9] Such as involuntary civil commitment in the case of Puerto Rico (Parker, Miranda-Miller, and Albizu-García 2022)

[10] For example, treatment in compulsory detention centers, as evidenced by research in East and Southeast Asia, includes forced unmedicated detoxification, forced labor, and punishment for non-compliance. Designated centers also suffer from overcrowding and subpar sanitary facilities (Hall et al. 2012; Kamarulzaman and McBrayer 2015).

[11] Compulsory treatment, although mostly provided in inpatient settings, can also include some outpatient services such as group-based models (D. Werb et al. 2016).

[12] Lack of institutional capacity can be related to this problem, including the technical capacity to collect data in a timely manner, coordination of several stakeholders and access to gender-sensitive data (Expert Working Group on Improving Drug Statistics and Strengthening of the Annual Report Questionnaire (ARQ) 2018).

support in improving their data collection methodology. Strengthening institutional capacity on this level would require increasing the frequency and quality of surveys -especially in developing countries- to collect data not only on the absolute number of people in treatment but also on the quality of treatment services (Expert Working Group on Improving Drug Statistics and Strengthening of the Annual Report Questionnaire (ARQ) 2018).

The lack of standardized data about drug treatment systems, therefore, poses an obstacle to identifying patterns of misconduct or abuse of patients undergoing rehabilitation -all of these potential instances where corrupt practices might be more pervasive. Therefore, one of the earliest steps to improve transparency, and bolster accountability[13] with the purpose of reducing corruption- requires the need to standardize and improve data collection methodologies.

2.2 Corruption types and risks

2.2.1 Absenteeism

While training is more than adequate even in most developing countries, other aspects of human resources tend to be lacking (M. Lewis 2006). One of the most common problems in corrupt health systems is absenteeism on behalf of staff in health clinics, whether they be physicians or administrative staff (M. Lewis 2006). Staff might work reduced hours or skip entire work days[14], while still collecting their salaries, which causes a strain on the health system by reducing both funds and capacity, affecting all patients but especially the most vulnerable. While absenteeism rates vary wildly among and within countries, they average around 40% and can reach devastating levels such as 60% (M. Lewis 2006). In the most extreme examples, as a study in the Dominican Republic found, physicians only worked for 12% of their contracted time, nurses omitted outpatient services, and residents or interns worked for 4% of their contracted time (M. A. Lewis, La Forgia, and Sulvetta 1996). This bareboned reality of some health systems results in untrained workers providing a majority of care, resulting in subpar health outcomes and increased legal risk (M. A. Lewis, La Forgia, and Sulvetta 1996). Much of this is seen in publicly funded or subsidized systems, as most entities in the private sector would not tolerate such inefficiency and would enforce attendance.

2.2.2 Theft

Countries without well-designed inventory systems often see health clinics with insufficient levels of medical supplies (UNODC 2013a). Drugs are often siphoned out of the public sector to be sold in the black market (M. Lewis 2006). This could be either because of underpaid staff trying to supplement their sub-subsistence wages, or private actors maximizing their rents. The motives are not always monetary, however, as physicians and other staff in health clinics can also suffer from substance abuse disorders (Ross 2003). In its extreme, this situation can result in clinics not receiving medicines for years, leaving patients that require substance abuse medication (i.e.,

[13] "transparency and accountability can reduce vulnerability to corruption and unethical practices and improve public trust in government institutions" (Paschke et al. 2018, 782)

[14] These absences can sometimes be the result of staff having to work multiple jobs or poor road access that worsens daily commutes (M. Lewis 2006). Bearing this in mind, it is also common for staff to miss work because they were appointed in as a political favor. Some of the positions in health institutions are obtained through bribes, and staff therefore enjoy a significantly low level of accountability and scrutiny (Kirya 2020).

methadone or buprenorphine) or even basic medicine such as antibiotics (to treat infections related to injection drug use) to the mercy of black-market prices. When drugs are not stolen, they are often replaced with counterfeit or substandard medications, which creates its own consequences. Faced with reduced supplies, patients often resort to bringing or sharing their own supplies, be they bed sheets, bandages, needles, food, or medicine, creating a sub-optimal environment for their treatment and leaving the most vulnerable at the most risk (M. Lewis 2006). Such problems, together with the shortage of staff are not exclusive to the public sector, as private systems are also not immune to theft from employees, especially if their inventory systems are underfunded. To reduce this type of malfeasance, some providers have turned to automated dispensing cabinets, RFIDs, and the scanning of patient medical bands (Culbertson 2020).

2.2.3 Procurement

Publicly funded or subsidized systems are also particularly vulnerable to elevated procurement costs due to opaque contracting procedures or coordinated action by suppliers. This can be due both to suppliers attempting to increase their profits by inflating prices and to public officials wanting to get a cut off of public funds. The resulting increased costs from higher prices result in lower available funding for other health programs, affecting PWUDs (T. Vian 2007). While drug treatment systems that have been outsourced are also vulnerable, private enterprises tend to be less willing to overlook increased procurement costs. As the opioid epidemic in the United States has shown, physicians can sometimes be pressured to overprescribe opioids. A potential solution to this would be the implementation of programs such as the X waiver, which aims to reduce the number of opioids prescribed to patients and is a requirement for doctors to be able to prescribe buprenorphine (SAMHSA 2022).

2.2.4 Extortion

With health needs being highly inelastic, patients are often forced to resort to further victimization to access health services. With doctor's appointments and prescription medications in short supply, patients are often forced to bribe health workers for access or medication, even bribing nurses to be able to see their children (Gopakumar 1998; M. Lewis 2006). The increased power that some public officials find themselves with also allows for other types of victimization and other forms of extortion, such as the demanding of sexual favors in return for access or treatment in a practice known as sextortion, which tends to re-victimize minority groups, often women, low-income groups, members of the LGBTQ+ community, or patients with substance abuse issues (Kirya 2020). There have also been reports of drug planting by law enforcement agents in charge of monitoring compulsory detention centers (Csete et al. 2011). PWUDs already face high levels of stigmatization and these hurdles make it even more unlikely that they will seek out help. The increased power asymmetry seen in mandatory drug treatment regimes and those managed by the CJS leads us to believe that this sort of patient-level extortion will be more common in these types of systems when compared to the private sector.

2.2.5 Patient brokerage

Patient brokerage[15] is a practice that affects drug treatment systems in different forms according to their compulsory nature. Providers of services to treat drug use disorders, especially those managing private rehabilitation centers, employ practices to increase the number of patient referrals, including the bribing of officials or the payment of commissions per patient received (Enos 2015; Knopf 2015). The intricate network of patient brokerage includes stakeholders from both public and private sectors and takes advantage of the desperation of many people seeking to treat addiction. Concerning compulsory treatment, the patient brokerage is framed in the form of arbitrary patient referral without due process or trial (International Drug Policy Consortium 2016, 11). In most cases, compulsory rehabilitation centers obtain funding based on the number of patients that are in treatment. Instances where funding or income is tied to the number of patients in a treatment center -regardless of being compulsory or voluntary- shift the overall goal of the system away from the objective of successfully treating addiction disorders, and generate an environment where patients' recovery is hampered by corrupt practices that begin with patient brokerage.

2.3 The role of innovation in anti-corruption initiatives

The innovative use of tools to bolster transparency have had marked and demonstrated results in lowering corruption in the public and private sector. With that said, in this section the word "innovative" will not necessarily refer to technological innovation, but to novel initiatives that increase the availability of information to stakeholders in health settings or in the public sector.

2.3.1 Patient empowerment

Potential healthcare system users may be more vulnerable to the infringement of their rights should they not be fully aware of a healthcare provider's responsibility toward its patients. As mentioned in the previous section, patients in the healthcare system are sometimes subject to bribing workers or are charged for procedures that are supposed to be free, such as changing bed sheets (Lindelow, Serneels, and Lemma 2003). In this regard, public information campaigns that disseminate patients' rights would grant greater levels of protection to the wider public. An example of this was seen in Uganda, when the central government sponsored a newspaper campaign that published data on monthly transfers for public schools, in an effort to socialize the number of resources that were allocated (Reinikka and Svensson 2005). With local communities being aware of the transfers from the central government that were sent, the local officials were pressured to capture a lesser proportion of the funds, resulting in lower corruption, higher enrollment, and improved learning outcomes. A greater provision of information for the end user, along with programs promoting health literacy, would empower them to guarantee that their rights are respected and would allow the patients to complain through official channels should they have subpar healthcare due to absenteeism, theft, or extortion.

[15] Illegal practice employed by some healthcare providers with the purpose of procuring patients by means of bribing the third party (Florida Senate 2019).

2.3.2 Healthcare regulation

The widespread availability of information is not only beneficial for patients, but also for other stakeholders within the healthcare sector, particularly in procurement. With procurement contracts for medical services or supplies often being worth millions, it can be particularly tempting for public officials or private actors to inflate the reported prices for personal gain. The Ministry of Health in Argentina provides an example of how to limit the discretion of buyers and sellers to manipulate prices, having created a price monitoring system that tracked the prices paid by hospitals for common medication, and later sharing the data (T. Vian 2007). As a result of this intervention, the reported prices fell by an average of 12% almost immediately, resulting in benefits for the hospitals as well as the patients (T. Vian 2007). Public coffers, private healthcare institutions, and patients can also benefit from strong regulation and quality control in the accreditation of drug treatment organizations, as low levels of regulation can result in treatment centers that do not follow evidence-based treatment procedures or engage in unethical practices such as insurance overbilling and fraud (Plante 2018). Once treatment centers are approved and certified[16], it allows for the design of public-private partnerships or initiatives that further protect the healthcare system and its users from abuse, such as Google's decision to only allow certified healthcare providers to advertise on its platform.

3 Research Design and Strategy

3.1 Case selection

In order to have a representative sample of countries with different characteristics and drug policy strategies, the team did a systemic assessment of drug treatment systems in a group of countries from different regions: North America, South America, Europe, Africa, and East Asia. The countries selected as case studies have drug legislation and have established a plan of action or national strategy regulating the operation and purpose of their respective drug treatment systems. Therefore, they have a designated body of control, programs, and allocated budget available to offer drug treatment to their citizens. The country selection took into consideration geographic location (representing different regions) and income levels (including middle and high income). The complete list of countries is presented in Appendixes III and IV.

3.2 Data collection

3.2.1 Primary data

- Drug legislations and plans of action: section on drug treatment systems, looking at the definition of drug use and its framing (as illness, crime, or both). Appendix V includes the list of detailed criteria used for the legislation assessment.
- Survey: Online survey asking participants to rate a number of statements (using a Likert scale) related to transparency, compliance, and quality of drug treatment services in their countries (see section 3.3.3). The questions were grouped according to aspects identified in the literature review concerning the provision of treatment where corrupt practices are more likely to happen. Appendices VI and VIII include the full questionnaire and the respondent distribution according to region and income.

[16] There already exist some industry standards such as the ASAM criteria or the International standards for the treatment of drug use disorders (WHO and UNODC 2020; American Society of Addiction Medicine n.d.)

3.2.2 Secondary data

- Policy papers assessing drug legislation, country reports developed by regional organizations (i.e., the EMCDDA[17]), case studies of rehabilitation/treatment centers (looking at corruption and/or abuse of patients), and further research on corruption in the healthcare sector. This will be especially necessary for the development of innovative responses to counter corruption in drug treatment systems.

3.3 Methodology

3.3.1 General considerations

This research will use a multi-method approach relying on both quantitative and qualitative methods from social sciences. Firstly, it relies on an analysis of the drug legislations of selected countries (see 3.1.) to identify in textual production the instances where policymakers mention drug treatment systems and in what form is drug use understood (i.e., illness or crime). This is a necessary step to gauge the overall nature of the drug legislation of a given country (Appendixes III and IV include the list of selected countries). More concisely, it aims at identifying the different perceptions that governments have on PWUDs and how this translates to the regulation of drug treatment.

Based on the findings from the assessment of drug legislation as well as the key issues identified by the literature review, the research makes use of quantitative analysis to identify where within the drug treatment infrastructure corruption is more likely to occur. It does so by looking at areas where a lack of transparency or compliance is most prominent. For this purpose, we developed an online survey that asks questions related to the aforementioned aspects. For more information about the survey design and targeted groups, please refer to Appendix VI. The following sections detail the application of each method.

3.3.2 Analysis of Drug legislations - Qualitative Analysis

The purpose of this type of analysis is to identify two aspects related to drug treatment systems: corruption instances and attitudes toward drug treatment systems. The primary sources used for this analysis include

- Drug legislation: provisions concerning drug treatment, and specific legislative acts on treatment or rehabilitation services (if the country has one).
- Plans of action/strategy for drug treatment: country's document compiling the guidelines designed to offer drug treatment services (if the country has one)
- Self-assessment reports: country's evaluation of results from their drug treatment strategy (if the country has one).

The authors decided to include these documents since each country has developed its drug treatment strategy to different levels in accordance with its institutional capacity. The authors searched for the documents on the official government sites as well as UNODC's Sherloc database and converted them to .docx documents. After the standardization of the documents' formatting, the authors read each document looking for the specific segments pertaining to drug treatment, and identifying the following categories:

[17] European Monitoring Centre for Drugs and Drug Addiction

- Definition of drug use: framing it as a crime, illness, or both, and whether it is subject to criminal or non-criminal sanctions.
- Points of entry into treatment: voluntary/spontaneous or compulsory, with the latter being a coerced measure used as punishment.
- Degree of availability: where the legislation has defined a threshold for the number of providers (i.e., centers, outpatient programs, etc.) for drug treatment, as well as the purpose of this services (i.e., the well-being of the patient, successful reintegration into society, etc.)
- Financing of treatment: funding options and costs for the patient (if it applies)
- Quality assurance: whether legislations have defined an official body and mechanisms to assure quality and compliance with guidelines on drug treatment.
- Language: how drug use is represented in the legislation and what provisions are too vague or left for interpretation of officials (i.e., the difference between possession with intention of use and with the initiation of distribution is not specific enough, relying on what the law enforcement officer decides).

After identifying the information that falls into these categories, the authors designed a matrix compiling the data in order to undertake a comparative analysis across countries' strategies. For more details on the matrix consolidating the findings please refer to Appendix VII.

3.3.3 Survey - quantitative analysis

The purposes of this questionnaire survey are:

- Gather data on trends concerning practices in the provision of drug treatment services that might affect patients' rights and that could be associated with a lack of transparency and governance in drug treatments
- Find empirical evidence to complement existing research on mechanisms to strengthen transparency and accountability in drug treatment systems

The estimated time for completion is 15-20 minutes on average. The survey groups several statements to be ranked in accordance with a Likert scale from 1 (strongly disagree) to 5 (strongly agree). These issues addressed are

- Data reporting
- Measures of quality in services
- Patient's rights and agency
- Availability of drug treatment services
- Financing drug treatment services
- Oversight of drug treatment services
- Irregularities in service provision
- Perception of drug treatment

In order to find quality primary research data in this area, the team of researchers contacted international associations of professionals involved in drug treatment. We chose NGOs that work with professionals involved in drug treatment and rehabilitation or advocating for the strengthening of these services. We selected the International Consortium of Universities for Drug Demand Reduction (ICUDDR) and the International Society of Substance Use Professionals (ISSUP), because of their global network of experts and their national chapters. In order to assure full anonymity, both organizations shared the link to our survey via their newsletters, reminding respondents that participation was entirely voluntary and no identifying information was collected. The full survey, including opening remarks, data & safety regulations, and a list of questions can be found in appendix VI.

The responses from the Perception and Oversight categories, particularly the questions regarding the use of criminal punishment and involvement of law enforcement were used to assign different

countries to the drug treatment typology; whether the system depended more on the criminal justice system, the ministry of health, or non-government actors. From there, the general pattern of responses within the different categories was analyzed, removing the results from question 13, "The lack of mechanisms to ensure transparency has an impact on the quality of drug treatment services", as we later decided that the wording was ambiguous and the responses could be structured from a normative point of view, in lieu of a reflection of the de facto conditions on the ground.

3.4 Limitations to research

- Corruption is difficult to define, as it comprises various practices[18] in both private and public sectors (Søreide 2014). Cultural perceptions also play a role in how societies understand corruption and differentiate it from accepted social practices (Rose-Ackerman and Palifka 2016). Bearing this in mind, this research focuses on the types of corruption that affect the healthcare sector and drug treatment systems. The categories were selected by reviewing secondary literature and summarized in section 2.2. of this paper.

- For the particular case of drug treatment systems, there is an additional problem in reporting corruption instances by stakeholders from the public and private sectors. Fear of repercussions in the form of a reduction of funding or the limitation of the services providers can offer to PWUDs, hampers the stakeholders' capacity and willingness to report corruption. Therefore, this research relies on secondary literature and data collected anonymously through an online survey in order to identify how corruption might be impacting drug treatment systems.

- At the patient level, although accounts of negative experiences from PWUDs that are in any kind of treatment would enrich our analysis, the paper does not include this type of anecdotal information for various reasons: 1) It is difficult to access such personal accounts from patients affected by corrupt practices because of fear of retaliation or further stigmatization, 2) all patient-centered research is very protected and accessing this types of data would require compliance with a number of data privacy regulations and the procurement of consent from patients themselves.

- Because of the lack of research on the topic of corruption in drug treatment systems, the paper includes a systematic review of works and concepts related to the nature of the different drug treatment systems and the potential correlation with corrupt practices. After identifying the vulnerabilities that different systems have, the paper includes recommendations to improve existing strategies that combat corruption in drug treatment systems. These recommendations will focus on the forms in which innovation in data collection mechanisms can help to bolster transparency and accountability in the provision of drug treatment. Given the limitations in the scope of the research and available data, the paper will not include specific evidence-based strategies.

- The authors are aware that the consequences of drug use are not homogenous between or within countries; patients at different socioeconomic levels, such as a doctor and a someone in halfway home, will not be perceived equally by society and most likely by the law. The scope of the paper will no include the heterogeneity analysis of the treatment of patients, and it would be a fruitful opportunity for future research.

[18] According to Soreide 2014, 2-3, corrupt practices include crony capitalism, embezzlement, extortion/extortive corruption, facilitation payments, kickback,m kleptocracy, lobbyism/campaign finance, patronage, queue corruption, regulatory capture, rent-seeking, state capture, systemic corruption, tender corruption. These are definitions used by international bodies such as the World Bank.

4 Key Findings

4.1 Assessment of drug legislation

4.1.1 General considerations

Although all countries have developed their own legislation on drugs, following or mentioning the provisions enshrined in the UN Conventions on Drugs, they present important differences in the way they describe the treatment as a strategic part of drug policy as well as its objectives. Among the countries reviewed for this paper[19], only a few had designed specific legislation on drug treatment as well as developed a national strategy or plan of action to keep track of the results (i.e., Chile, Germany, South Africa, and USA states included in the assessment). Those countries with defined national strategies undertook a self-assessment of their treatment options, which serve as good examples of best practices to improve the quality of drug treatment and improve transparency and compliance from both public and private stakeholders.

4.1.2 Framing of drug use and correlation to overseeing drug treatment

An important aspect encoded in drug legislation is the framing of drug use. Concerning this aspect, countries fall into one of the following categories: Criminalization[20], depenalisation[21], decriminalization[22], regulation[23], and legalization[24]. Although this does not mean that drug treatment is not available in the most punitive legislations (as in the case of Singapore and the Misuse of Drugs Act 5 of 1973), it provides an insight into the type of regulation that drug treatment has. Countries with full criminalization have their treatment providers are overseen or managed by an actor from the criminal justice system (CJS) (i.e., Nigeria's DDR[25] is part of the drug enforcement agency, and Singapore relies on the Commissioner of Prisons for surveillance of treatment centers).

Countries that fall into categories of depenalization and decriminalization have their treatment services managed either by a public health actor (i.e., Costa Rica's Instituto Costarricense sobre Drogas, that falls under the Ministry of Health), or health-oriented institutions with the supervision of an actor from the CJS (i.e., Chile's Servicio Nacional para la Prevención y Rehabilitación del Consumo de Drogas y Alcohol falls under the authority of the Ministry of Interior and Public Safety). Countries with drug legislations from these two categories rely on stakeholders from the healthcare sector to advise, continuously assess and manage their treatment alternatives. They also have national strategies that include mechanisms for self-assessment, which should facilitate closer control of the quality of their treatment options and reduce instances of corruption.

4.1.3 Treatment availability and financing

The drug legislation assessment showed important discrepancies in the way that treatment was financed in each country. Similarly to the previous section, there is a correlation between the nature of the financing of treatment, its availability, and the nature of their drug legislation. Countries that

[19] Botswana, Chile, Colombia, Costa Rica, Germany, Nigeria, The Philippines, Singapore, South Africa, USA-California, USA-Oregon, and USA-Puerto Rico.

[20] Drug use is considered a punishable criminal offense regardless of the type of drug or amount

[21] Drug use is considered a criminal offense that is not punishable but considered a minor crime or where drug treatment is advisable

[22] Drug use is considered a non-criminal offense that could be punishable with fines or other non-criminal sanctions

[23] Drug use is legal and regulated like to other substances such as alcohol or tobacco

[24] Free and unregulated market

[25] DDR stands from Drug Demand Reduction Unit

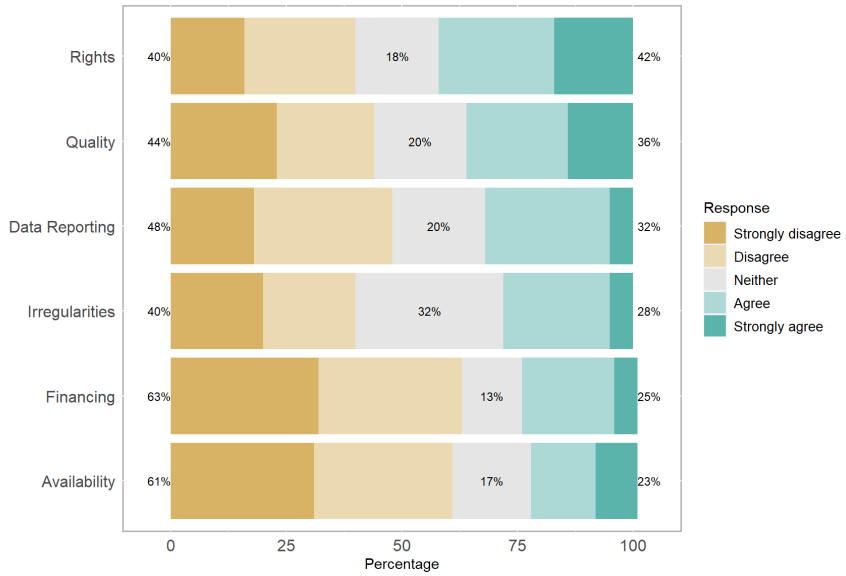
fall under depenalization or decriminalization cover the cost of treatment in alliance with healthcare insurers and it's partially or completely free (i.e., Chile, Germany), while more punitive legislations can not only charge the PWUDs for their treatment (aside from the fine they must pay as a sanction), but they can extend the payment obligation to their immediate family[26] (i.e., The Philippines).

4.2 Results from the survey

A global analysis of the survey responses indicated that the worst-performing indicators by far were those related to the financing and availability of drug treatment for patients, with 63% and 61% of the responses in the respective categories being negative or strongly negative, as seen in figure 1. This points to a worrying characteristic present in most systems surveyed, which is that most patients have great difficulty affording and accessing any sort of drug treatment at all, greatly limiting access to the help they need regardless of the qualities of the treatment itself.

When converting the responses to numerical values and carrying out the analysis within each category, as seen in table 1, we found that this pattern was replicated across categories, though the average public system had a score of 2.95 for financing compared to the private's 2.08 and the justice system's 2.47. Though the public system received a higher score in the financing questions, the questions in the category did not address the funding available to the systems, but the use of resources and the affordability to patients, as seen in Appendix VI.

Figure 1: Global response distribution by category



[26] According to the Comprehensive Dangerous Drugs Act of 2002 (Art. VIII, section 74) "The parent, spouse, guardian or any relative within the fourth degree of consanguinity of any person who is confined under the voluntary submission program or compulsory submission program shall be charged a certain percentage of the cost of his/her treatment and rehabilitation, the guidelines of which shall be formulated by the DSWD taking into consideration the economic status of the family of the person confined."

We also found that the private systems received a score of 2.5 for data reporting, compared to the public's 2.88 and the justice system's 3, presumably as a result of the outsourcing of drug treatment possibilities and the states corresponding lower priority to oversee the industry. It should be noted that the high data reported score from the criminal justice system is likely a result of higher funding received and the conditions on reporting imposed by international donors that might send aid to developing countries and does not necessarily reflect the reporting of treatment quality or patient improvement. The higher priority that justice systems have in terms of funding when compared to the public health system can also be seen in the availability score (2.5 vs. 2) (Reuter 2006; Babor et al. 2018). A radar graph that illustrates the relative scores of each system can be found in Appendix IX.

Table 1: Average category scores response by system type

Category	Criminal Justice System	Private	Public
Availability	2.5	2.5	2.0
Data Reporting	3.0	2.5	2.9
Financing	2.5	2.1	3.0
Irregularities	2.8	2.6	3.0
Quality	3.0	2.9	2.4
Rights	2.9	3.1	3.0

5 Empirical Analysis

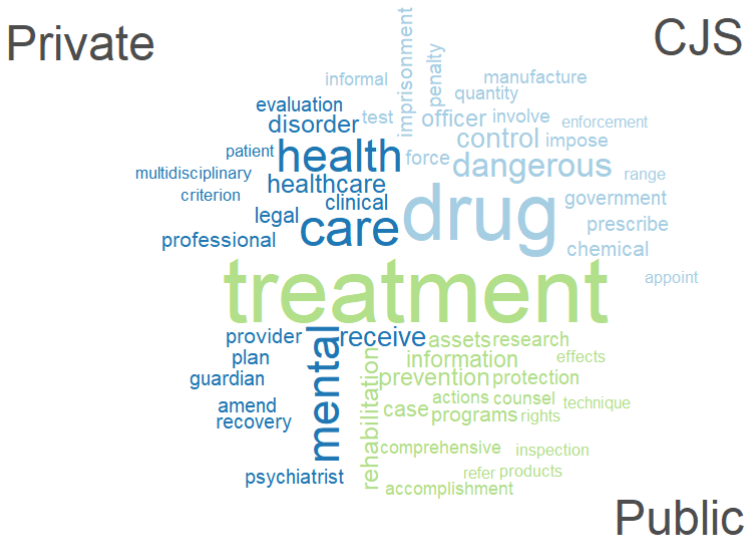
5.1 Drug legislation

The textual analysis of the drug legislations supported the findings of previous research and literature on the topic of drug treatment. Insofar the development of specific guidelines for treatment, few countries have established protocols that build from the existing WHO guidelines. Moreover, most countries lack a self-assessment mechanism that allows authorities to evaluate the performance of their drug treatment system against the set objectives.

As figure 2 shows, drug legislation defines and regulates treatment in different forms, and it is correlated to the type of authority in charge of overseeing treatment. A stark contrast is present in the comparison between the private sector and facilities operated by law enforcement actors. In this case, private rehabilitation service providers often emphasize aspects such as holistic (multidisciplinary) treatment and health care as elements of drug treatment. In contrast, services managed under the CJS see treatment as an alternative or complement to punishment, where rehabilitation is forced upon an ill or dangerous individual.

The different framing of drug treatment is an important indicator of the type of data that countries collect and use to measure the quality of treatment. Countries, where treatment of PWUDs is handled exclusively by public health or private healthcare providers, would often have a more developed set of criteria to measure the quality of services with a patient-centered approach.

Figure 2. Word cloud from textual analysis of drug legislations[27]



5.2 Online Survey

Section 4.2 noted that availability and financing were the worst-performing sections within the survey. While the scope of our investigation prevents us from recommending changes to the national budgets allocated for drug treatment systems, it is important to highlight the heterogeneity of implications from corruption across drug treatment system types. As we proposed in our framework, systems that operate within the state and are integrated into the CJS would be more prone to suffer from bribery, extortion, and other rights violations due to the power disparity between the officials and the patients. The limited capacity reflected in the survey responses would mean that patients and their families might resort to exchanging favors for access to treatment and the providers might feel more empowered to take advantage of their position. In contrast, low availability in countries where treatment is provided by private organizations might result in only those with the most resources being able to afford care. The results from the responses in the patient's rights and agency category support our hypothesis, the private/non-governmental system has a higher score (3.1) than the public (2.96) or criminal justice systems (2.92).

Considering that none of the responses in the survey included a high-income country that had a public system, the framework would also explain why the public systems on average had a lower quality score than the other two categories. The questions in the category covered the existence of guidelines and auditing to confirm whether the guidelines were being followed. While private systems are interested in offering a high-quality service to continue having customers, and the justice system will need to have guidelines to share reports with donors, poor countries with public systems may not have the resources to design quality guidelines and, as poor countries tend to be more corrupt, any initiative to install guidelines that would guarantee quality and reduce waste would likely be met with pushback (Fisman and Golden 2017). In this case, the recommendations would consist of investing in the creation of guidelines following the framework suggested by

[27] The word cloud shows relative frequency, taking into consideration the documents' lengths and how often the words appeared in the other types of systems.

international organizations, and periodical audits and evaluations to confirm that the guidelines are being followed.

As table 1 found, private systems had the lowest score for data reporting. This has several implications, one of them being that if policymakers do not have access to industry data, they are unable to make informed decisions on how to better safeguard patients' rights, or improve national drug treatment legislation as a whole. This can also result in patient brokerage and false invoicing, as is seen especially in sober homes in Florida (Plante 2018). Should treatment centers share more information regarding their treatment, they could not only increase transparency and reduce the ease of overbilling, but the data could also help inform lawmakers on the current state of drug treatment.

6 Conclusion

This paper has covered different areas in which increased transparency could lower the prevalence of corruption within drug treatment systems. The previous sections have highlighted the vulnerabilities that different drug treatment regimes might have. Bearing this in mind, this paper proposes three recommendations that could benefit all member states and their citizens; digitalization of processes, public-private partnerships, and Inter-agency communication.

Firstly, following the COVID-19 pandemic, many countries were forced to adapt administrative processes to the digital world. Quality and compliance guidelines could be integrated into semi-automated digital processes that are pre-determined by health regulation protocols, leaving fewer points where officials could exercise their discretion to influence treatment or procurement decisions, and deviations from the guidelines could be traced. The resulting streamlining of processes could also increase availability, lowering the opportunities to extort patients. The implementation of virtual assistance, even as points of first contact for potential incoming patients, could not only speed up the attention process but also could make patients more comfortable than an in-person consultation given their perceptions about the use of drugs.

Secondly, given the limited budget in most countries allocated to drug treatment, any solution has to be cost-efficient. This is why public-private partnerships that could share the cost burden among several actors could be particularly fruitful. Some international social media companies tend to already have their initiatives to curb addictive behavior; examples include Instagram's "Guides" feature that allows creators to work with mental health organizations to share well-being content with their followers and Facebook's Emotional Health Center that counts with region-specific resources addressing a variety of health topics (Watson 2022). Countries could benefit from these pre-existing initiatives with little effort, only needing to provide contact information for accredited treatment centers or support groups. States could also propose similar initiatives that either socialize patients' rights so they can know what to expect from their service provider or create anonymous whistleblower mechanisms.

Thirdly, our last recommendation addresses the issue of inter-agency communication. Given the multidisciplinary nature of drug treatment, it is paramount for actors to improve their channels of communication for three purposes: data collection, treatment of the patient, and sharing best practices. The UN Conventions on Drugs already emphasize the relevance of cross-border work between agencies, but this has developed mostly in cooperation among law enforcement agencies. There is a need to increase cooperation between public health actors to socialize best practices and

evidence-based treatment. This is an excellent opportunity for international organizations like UNODC or WHO, or regional organizations to foster closer dialogue among CJS, public health, and the private sector.

To enact these recommendations, all governments must take deliberate steps to improve their data reporting performance. The data recorded should also have several different categories, including not only medication used, and the allocation of resources, but also the effectiveness of the treatment as measured by the rehabilitation of patients and different treatment methods. The yearly collection and sharing of data would also allow for easy comparison between treatment providers, which would incentivize providers to improve their metrics to avoid reputational damage. Governments could either incentivize improvements in data collection by financing training courses for private institutions or take more direct action by setting industry-wide standards.

This research project began by asking the question: what makes drug treatment systems vulnerable to corruption and how can this be mitigated by innovation that promotes transparency? An initial assessment of drug legislation and results from our online survey show that the strong disparity in the framing of drug treatment in domestic legislation accounts for loopholes unique to the treatment for drug use and drug-related disorders, not present in treatment for other chronic illnesses. This area of study would benefit greatly from future research that further analyses the consequences of different treatment regimes in relation to transparency concerns, and how these outcomes can be affected by other situational factors.

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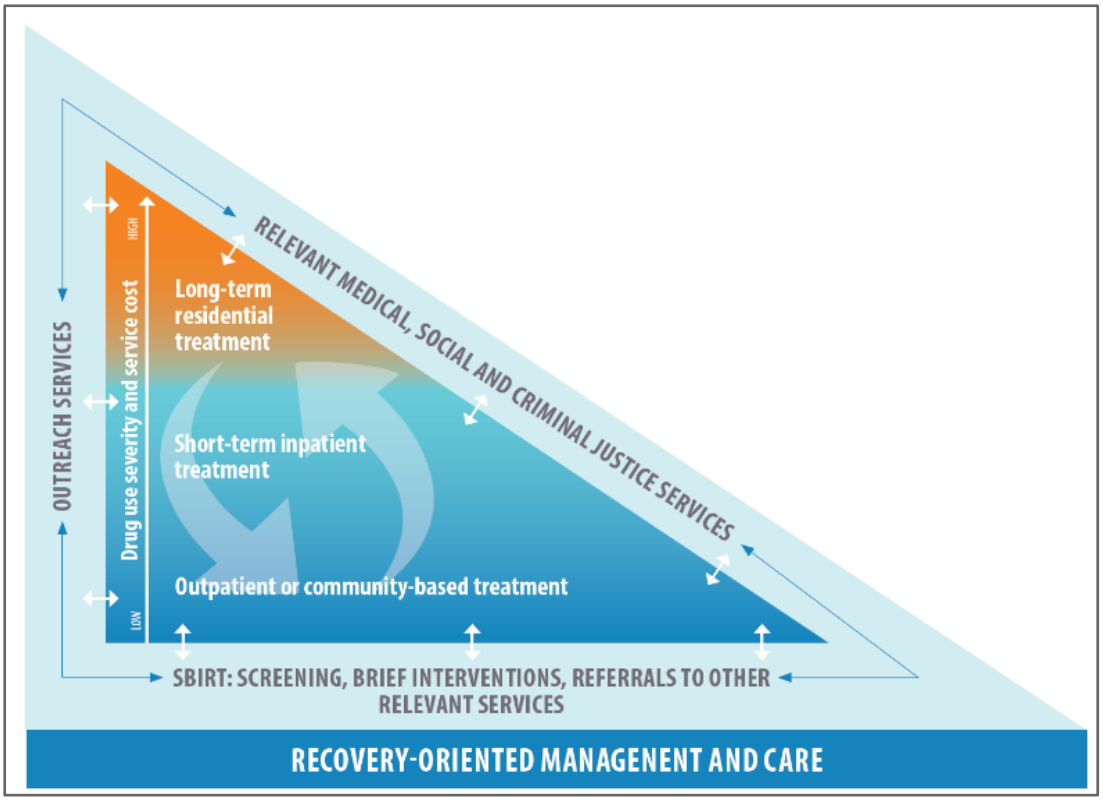
Appendix

I. Suggested interventions at different system levels

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

Source: (Campello 2021, 18)

II. Effective and integrated system model for the relevant services and modalities



Source: (WHO 2020).

III. Countries selected for assessment of drug legislation

Country	Region	Income Level
Botswana	Africa	Upper-middle income
Chile	South America	High-income
Colombia	South America	Upper-middle income
Costa Rica	Central and North America	Upper-middle income
Germany	Europe	High-income
Nigeria	Africa	Lower-middle income
Philippines	East Asia	Lower-middle income
Portugal	Europe	High-income
Singapore	East Asia	High-income
South Africa	Africa	Upper-middle income
Thailand	East Asia	Upper-middle income
Turkey	Europe	Upper-middle income
USA - California	Central and North America	High-income
USA - Oregon	Central and North America	High-income
USA - Pto. Rico	Central and North America	High-income

IV. Country distribution according to region and income

Region	Number of Countries
Africa	3
Central and North America[28]	4
East Asia	3
Europe	3
South America	2
Income Level	**Number of Countries**
Lower-middle income	2
Upper-middle income	6
High-income[28]	7

V. Aspects included in the assessment of drug legislation

Issue	Provision in Legislation	Aspects to evaluate
0. Official Source	National legislation on drugs - provisions on treatment	0.1. Does the country have drug legislation? 0.2. Does the country have a plan of action or evaluation of the drug strategy? 0.3. Does the evaluation contemplates/measures indicators related to drug treatment?
1. Definition of Drug use	1.1. Crime	1.1.1. Not considered a crime 1.1.2. Considered a crime 1.1.3. Difference according to drug type 1.1.5. Prior records aggravating penalty
	1.2. Illness	1.2.1. Is it considered akin to a mental illness? Is it framed as the fault of the individual? 1.2.2. Is it associated with societal, familial, or environmental causes (not the sole responsibility of PWUD)?
	1.3. Subject to punishment	1.3.1. Is the type of punishment done through criminal (incarceration, criminal record) or non-criminal sanctions (fines, social service, treatment)? 1.3.2. Are there clear guidelines for law enforcement to process PWUD? (i.e., how to process a suspect while guaranteeing their rights)

[28] California, Oregon, and Puerto Rico disaggregated and analyzed as individual states.

2. Point of entry to the treatment system	2.1. Voluntary/Spontaneous	2.1.1. Are there options for voluntary/spontaneous treatment? 2.1.2. Can Medical professionals suggest the remission of PWUDs to treatment? 2.1.3. Can law enforcement suggest the remission of PWUDs to treatment? 2.1.4. If there is a prior record of drug use, is still voluntary?
	2.2. Compulsory	2.2.1. Are medical professionals obligated to send PWUD to rehabilitation? 2.2.2. Are law enforcement obligated to send PWUD to rehabilitation, without involvement/notification to a medical professional?
3. Qualities of drug treatment system	3.1. Degree of availability	3.1.1. Does the legislation guarantee access to treatment for everyone? 3.1.2. Is there any person or group of people excluded from treatment services?
	3.2. Purpose of treatment	3.2.1. Is the language used in the legislation emphasizing the well-being of PWUD that go to treatment? 3.2.2. Is the language framing treatment a means of punishment? Does it mix it with criminal sanctions?
4. Financing of treatment	4.1. Payment and coverage	4.1.1. Does the legislation define the budget or source for financing treatments?
	4.2. Payment and coverage	4.1.1. Does the legislation define a budget or source for financing treatments for PWUDs?
5. Quality Assurance	5.1. Controlling entity	5.1.1. Is there a designed official body in charge of supervising treatment services for PWUDs? to what ministry does it belong?
	5.2. Criteria to certify treatment	5.2.1. Has the legislation established guidelines to collect data on drug treatment systems? 5.2.1. Data collection is quantitative (number of patients), qualitative (quality of services), or both? 5.2.3. Are there reports tracking trends in treatment and proposing improvements?
6. Language	6.1. Discourse on drug use	6.1.1. What is the overall depiction of drug use and the role of treatment as part of drug policy?
	6.2. Vagueness or gaps in law	6.2.1. Have any of issues 1-5 have been formulated in a vague manner, allowing for interpretation and potentially increasing instances of malpractice?

VI. Online survey

The purposes of this questionnaire survey are:

- Gather data on trends concerning practices in the provision of drug treatment services that might affect patients' rights and that could be associated with a lack of transparency and governance in drug treatments
- Find empirical evidence to complement existing research on mechanisms to strengthen transparency and accountability in drug treatment systems

The estimated time for completion is 15-20 minutes on average. Your feedback is an indispensable contribution to the success of this research.

1. **Selection of participants:**

In order to find quality primary research data in this area, we are reaching out to country experts that work in a variety of sectors (NGO's, Public Sector, Private Sector, Health Care Professionals, Academic Institutions, International Organisations, CSO's) to make use of their first-hand knowledge in their area of expertise.

2. **Privacy policy & storage:**

The data collected for the questionnaire survey are anonymous. The team will make use of LimeSurvey in order to collect the responses from participants. This is a survey tool that complies with the data safety regulations of the European Union and it's approved by the University of Vienna. The survey does not collect information that can lead to identifying individual participants, and all responses are anonymized.

Participants who are willing to partake in subsequent group interviews can contact our research team (contact information below). Data will not be shared with individuals outside of the research team (Alejandra Cervantes Nieto and Christian Castaño Bonilla). The research team will securely store the informant's personal information. Access to the stored information requires credentials and passwords only known to the university researchers. This personal information will be stored only for the duration of the project and will be discarded after the analysis and publication process end, by mid-2023 [29].

Individuals partaking in this survey can withdraw from the project at any given time. To do so, they only need to contact the researchers in the e-mails provided below. This means the respondent will be removed from the list of interview candidates and all related information will be deleted from our database immediately and permanently. In this case, these individuals will not be contacted anymore by the research team.

3. **Structure of the survey:**

The survey opens with two general questions to gather statistical information about the respondent's involvement with drug treatment systems. The following questions can be answered on a five-point Likert scale, with choices ranging from strongly disagree (1) to strongly agree (5).

[29] This stage of the project was subjected to the number of responses the team would receive in the online survey. If the number would be below 50, the focus groups would not take place and the analysis would concentrate on the legislation assessment and the responses provided in the online survey. This paragraph was included as it was part of the information provided to survey respondents before answering the questions.

The participants will read a statement and choose the answer within the provided scale. The questions were designed to gather first-hand data from country experts' experience while avoiding asking about sensitive topics. This was done in an effort to collect more honest responses. The survey wraps up with an open-end question to gather additional commentaries that the participant considers relevant to the research.

4. List of questions:

Dimension	Num.	Question
Participant Assessment	1	In which region is your country located? (open-ended)
	2	What category would best describe your current position? (more than one option allowed)
Data reporting: Regarding public availability of treatment data.	3	My country's drug treatment providers share up-to-date data on the number of people in treatment
	4	It is easy to find data on the number of people in treatment and rehabilitation for illicit narcotics in my country
Measures of quality in services provided: Indicators used to set up the standards for drug treatment services provided in your country, including measurements that go beyond the quantitative data on the number of people who use drugs (PWUDs) and are in treatment.	5	Drug treatment providers do a self-assessment to evaluate the quality of their services
	6	My country has drug treatment guidelines
	7	Providers of drug treatment in my country are audited at least once a year to assess their compliance with drug treatment guidelines
	8	Drug treatment availability is a priority in my country
	9	Drug treatment quality is a priority in my country
	10	Drug treatment providers employ personnel with the medical training necessary to treat PWUDs
	11	Drug treatment providers employ evidence-based services and practices to treat their patients
	12	Civil Society Organisations (CSO) work together with the government to improve the quality of drug treatment
	13	The lack of mechanisms to ensure transparency has an impact on the quality of drug treatment services
	14	The government regularly evaluates rehabilitation and drug treatment providers to ensure the quality of their services.
Patients' rights and agency: Regarding the rights of patients in all stages of their treatment, and their agency to make decisions during the	15	Patients' rights and well-being are prioritised at all treatment levels
	16	Patients in drug treatment have the means to report instances when they feel their rights are being undermined
	17	Patient reports of violations against their rights are regularly reviewed and

treatment process.		addressed
	18	Patients are free to decide when to begin treatment
	19	Patients are free to change treatment or withdraw completely if they choose to do so
	20	Patients are informed about their rights when undergoing treatment for the use of drugs or disorders associated with drug use
Availability of drug treatment services: Regarding the geographic availability of drug treatment services in accordance to the number of providers.	21	There are enough treatment options and drug treatment providers to meet the population demand
	22	Services for PWUD are available both in the main cities in my country and in rural areas
	23	PWUDs who seek to voluntarily undergo drug treatment have the right to choose the centre and type of treatment they want
	24	PWUDs who are mandated to undertake treatment have the possibility to go to the provider that best suits them according to their living conditions
Financing drug treatment services: Regarding the funding sources for drug treatment, including those allocated to treatment providers and the costs for the patients.	25	Drug treatment centres have enough resources to provide quality service
	26	Drug treatment services are covered by public healthcare
	27	Treatment is available to all patients regardless of their financial capacity
	28	Drug treatment services provided free of charge often require the patients' commitment to supporting a particular social, political, or religious cause
	29	Financial aid that is given to drug treatment services is used efficiently and appropriately
Oversight of drug treatment services: Regulation of the services provided in treatment either by government or private actors to assure compliance with the standards for drug treatment in the country.	30	Most of the drug treatment services provided in my country are operated by the government
	31	Most of the drug treatment services provided in my country are operated by private for-profit institutions
	32	Non-profit institutions are the main provider of drug treatment services in my country
	33	Government has strong control over the type of drug treatment services that the private sector or NGOs provide
	34	There is a strong involvement of law-enforcement actors in the monitoring of treatment centres in my country
	35	Drug treatment providers are best overseen by law enforcement
	36	State regulations require strict controls over the medicine distributed to patients

	37	Providers of drug treatment have a clear process of procurement of medicines and equipment used for purposes of rehabilitation
Irregularities in the provision of services: Mechanisms are in place in order to facilitate the tracking of instances where protocols to assure the quality of service were not followed, affecting the patient.	38	Professionals have the means to report instances of mismanagement of prescribed medication for OST anonymously, without fear of reprisal
	39	Professionals can speak about resource allocation issues for patient treatment (deviation of funds for activities not helping the patient recover)
	40	Patients have the means to report instances where they need to make unofficial payments to acquire necessary services in their treatment
	41	There is an ombudsman available to report practices that affect the provision of drug treatment
Perception of drug treatment: The way drug treatment is framed in society.	42	People who fail to rehabilitate from substance use are afraid of criminal sanctions
	43	In my country, criminal punishment is considered to be an important aspect of drug treatment
	44	Drug treatment is voluntary and with the main objective of improving the well-being of the patient
Final Question	45	Is there anything you would like to add concerning the mechanisms to guarantee the rights of patients that undergo drug treatment or the quality of treatment? (open-ended)

VII. Matrix of drug legislation assessment[30]

Issue	0. Official Source	1. Definition of Drug use		
Provision in Legislation	National legislation on drugs - provisions on treatment	1.1. Crime	1.2. Illness	1.3. Subject to punishment
Botswana	Drugs and Related Substances Act 18 of 1992	The crime is punished by both fines and imprisonment, with lesser sentences being doled out for cannabis use.	There is no mention of the consumption of drugs as an illness in the policy.	The punishment is mostly criminal, with a strong emphasis on imprisonment. Officers are allowed to search any place or person without a warrant as long as they have "reasonable grounds for believing that any person has committed an offense".
Chile	Reglamento De Centros De Tratamiento Y Rehabilitación De Personas Con Consumo Perjudicial O Dependencia A Alcohol Y/O Drogas, 2009 Ley 20000, 2005	Drug use is not criminalized	Substance abuse is framed as a mental illness that requires professional medical help. While the legislation does not identify social causes as possible reasons for substance abuse, at no moment does it suggest that the PWUD is at fault?	As the use is not criminalized, there is no punishment related to consumption.
Colombia	Ley 1616 De 2013 and Ley 1566 De 2012	Drug use is not criminalized	The consumption, abuse, and addiction to drugs are considered to be a question of public	As the use is not criminalized, there is no punishment related to consumption.

[30] Sources used for the legislation assessment: Botswana (Drugs and Related Substances Act 18 of 1992), Chile (Reglamento De Centros De Tratamiento Y Rehabilitación De Personas Con Consumo Perjudicial O Dependencia A Alcohol Y/O Drogas, 2009 and Ley 20000, 2005), Colombia (Ley 1616 De 2013 and Ley 1566 De 2012), Costa Rica (Reforma integral Ley sobre estupefacientes, sustancias psicotrópicas, drogas, 2001), Germany (Drug Commissioner of the Federal Government 2012; EMCDDA 2019; Federal Ministry of Justice of Germany 1981), Nigeria (Ediomo-Ubong, Obot, and Umoh 2017; Government of Nigeria 1935; Madubuike 2022), The Philippines (Government of the Philippines 1972; 2002; PDEA 2013), Singapore (The Law Revision Commission under the Authority of the Revised Edition of the Laws Act (Chapter 275) 2017), South Africa (Abuse of Dependence-Producing Substances and Rehabilitation Centres Act of 1971 and Prevention of and Treatment of Drug Dependency Act 70 0f 2008), USA-California (SB349 Ethical Treatment for Persons with Substance Use Disorder Act, SB-855 Health coverage mental health or substance use disorders, Health and Safety Code Section 11350-11356.5), USA Oregon (Drug Addiction Treatment and Recovery Act), and USA-Puerto Rico (Law 67 of 1993 and the Mental Health Act).

			health and the wellbeing of individuals, families, and communities.	Treatment plans will be designed to be the least restrictive as possible to a patient's freedom.
Costa Rica	Reforma integral Ley sobre estupefacientes, sustancias psicotrópicas, drogas, 2001	Drug use is not criminalized	Substance abuse is framed as a mental illness that requires professional medical help. The legislation gives a wide mandate to the state, charging it to ensure prompt identification, treatment, education, post-treatment, rehabilitation, and social re-adaptation of those affected.	As the use is not criminalized, there is no punishment related to consumption.
Germany	Federal Narcotics Act 1981 (Betäubungsmittelgesetz) National Strategy on Drug and Addiction Policy 2012	Use of drugs is not defined as a (criminal) offense. However, "unauthorized personal possession and purchase of drugs are criminal offenses punishable by up to 5 years in prison". There are other non-criminal sanctions for possession of small quantities p.4 EMCDDA Germany	Use of drugs is framed as addiction. "People suffering from addiction are afflicted with a disease and require extensive medical help and support. Addiction is a disease that can affect anyone. It is not a matter of personal failure, but often the result of personal circumstances or experience." p. 8 National Strategy The National Strategy on Drug and Addiction Policy includes the pillars of 1) prevention, 2) therapy, counseling, and aid in overcoming addiction, 3) harm-reduction measures, and 4) repression, by combating drug-related criminality.	"When a sentence is imposed, the principle of 'treatment instead of punishment' still allows — under certain circumstances — a postponement or remission of the punishment if the offender enters treatment." p.4 ECMDDA / Sec. 36. Narcotics Act
Nigeria	Dangerous Drugs Act 1935 Decree No. 49 of 1989 (Establishment of the National Drug Law Enforcement Agency) National Drug Control Master Plan 2021-2025	Drug use is considered an offense under the Dangerous Drugs Act	"There is no mention of treatment for drug use disorders. Furthermore, there is heavy reliance on criminal sanctions to curb drug offenses". (Ediomo, 2017, 52)	"Any police officer may arrest without warrant any person who has committed, or attempted to commit or is reasonably suspected by the police officer of having committed or attempted to commit an offense under this Act" 21. Drug Legislation

Philippines	Comprehensive Dangerous Drugs Act of 2002 [Republic Act No. 9165]	It is considered an offense, punishable with rehabilitation (art. 15). If the person possesses any amount of drugs, penalties go from 12 years to the death penalty, depending on the amounts (art. 10 and art. 11)	There is no mention of drug use as an illness, although the immediate course of action after a person tests positive for drugs is to commit them to treatment.	First-time offense: 6 months of rehabilitation in the government center. Second-time offense: 6 to 12 years in prison plus a fine between 50.00+2000.000 pesos.
Singapore	Misuse of drugs act (Act 5 of 1973). Revised in 2008	(Art. 8) it shall be an offense for a person to — (a) have in his possession a controlled drug; or (b) smoke, administer to himself(...) Art. 24 (no search warrant needed if there is suspicion of drug production, trade, or use)	Crime punishable with imprisonment and physical punishment (art. 33)	Maximum of 10 years or 20.000 or both (second schedule) possession of drug paraphernalia: 3 years offense outside of Singapore (between 2 and 10 years). 4.000 to 40.000 fine
South Africa	Abuse of Dependence-Producing Substances and Rehabilitation Centres Act of 1971 Prevention of and Treatment of Drug Dependency Act 70 0f 2008	The crime is punished by both fines and imprisonment.	The use of drugs is considered a crime, however, the state of being dependent is considered to be an illness.	All instances of use must be reported to a police officer so the patient is taken into custody.
USA - California	SB349 Ethical Treatment for Persons with Substance Use Disorder Act SB-855 Health coverage mental health or substance use disorders Health and Safety Code Section 11350-11356.5	The crime is punished by both fines and imprisonment.	The use of drugs is considered a crime, however, the state of being dependent is considered to be an illness.	Patients are taken to jail for processing and can face both prison and fines. The state does provide a bill of rights but for treatment, not the judicial system.

USA - Oregon	Drug Addiction Treatment and Recovery Act	Addiction is treated as a mental health issue and uses civil punishment such as a fine or a health assessment.	The consumption, abuse, and addiction to drugs are considered to be a question of public health and the well-being of individuals, families, and communities.	Patients can never be imprisoned, only subject to fines or voluntary health assessments.
USA - Pto. Rico	Law 67 of 1993 Mental Health Act	Use is not necessarily seen as a crime, indeed the legislation looks at use as a mental health issue, but the use of involuntary civil commitment could be seen as a punishment.	Use is seen as an addiction, and addiction is seen as a mental health issue.	Patients can and often are subject to involuntary civil commitment.

Issue	**2. Point of entry to the treatment system**	
Provision in Legislation	2.1. Voluntary/Spontaneous	2.2. Compulsory
Botswana	The relevant legislation does not mention rehabilitation at all. All rehabilitation centers are privately owned and operated.	The relevant legislation does not mention rehabilitation at all. All rehabilitation centers are privately owned and operated.
Chile	The service is offered both spontaneously as well as by referral, but in both circumstances, it must be completely voluntary. Patients in residential programs or outpatient services have the right to exit the program at any point.	No step in the rehabilitation process is compulsory.
Colombia	The service is offered both spontaneously as well as by referral, but in both circumstances, it must be completely voluntary. Patients in residential programs or outpatient services have the right to exit the program at any point.	
Costa Rica	The service can be voluntary, though should someone be caught using drugs in public, voluntary and free hospitalization or outpatient treatment will be promoted and facilitated with exclusively therapeutic and rehabilitation purposes in a public or private health center.	No step in the rehabilitation process is compulsory.

Germany	Early stage interventions: Doctors, general practitioners, and pediatricians, and family doctors, as initial contact for people seeking help. They can also detect early stages of addiction. Practitioners should provide counseling sessions to motivate patients to reduce use of harmful substances (alcohol and other legal and illicit drugs). p.13 NS. Workplace: Employers and company doctors promote health with the aid of self-help groups for addicts. (private-public partnership) Outpatient counseling centers: psychosocial care and psychotherapy	No step in the rehabilitation process is compulsory
Nigeria	Primary healthcare (PHC) facilities are the first and most common points for treatment, but in many cases, there is a limited capacity to offer these services. Stigmatization of drug use poses a barrier for people to access treatment. Goals of NS 2021-25: 1) substance use treatment should be integrated into primary healthcare facilities, 2) Treatment strategy developed and implemented by FMOH, NDLEA, NAFDAC, Nigeria Correctional Services and NACA, 1) Each geopolitical zone should have 2 community-level treatment centers, 2 NDLEA stand-alone centers 2 drug-treatment wards/unites outside the psychiatric wards in hospitals.	Treatment can be imposed in addition to criminal punishment (treatment, education, aftercare, rehabilitation of social reintegration). Minors can receive treatment as an alternative to conviction or criminal punishment.
Philippines	The law considers the option of voluntary submission of a drug dependent, but: it is considered voluntary if a person request treatment or if a family member, spouse, guardian, or relative makes the request (sec. 54). The request is done to the Narcotics Control Board and goes through court procedures, mandating rehabilitation at a center or a DOH-physician appointed by the board for at least 6 months. **Risks of having a criminal record if treatment fails.**	If tested positive for drugs (but no possession of drugs): Testing can happen at school, workplace, or under the suspicion of using drugs. First-time offense: 6 months of rehabilitation in the government center. Second-time offense: 6 to 12 years in prison plus a fine between 50.00+2000.000 pesos.

Singapore	There are privately-run centers approved by the MOH, such as National Addictions Management Service, The Cabin Singapore, or We Care community services. They deal with other types of addiction as well. A lot of voluntary treatment is offered abroad by countries like Thailand, where those with money go (less control from the government - avoiding punishment).	Testing might be ordered by the director at any point where there is suspicion of drug use. Positive results undergo treatment or rehabilitation or both at an approved institution for 6 months. It can be extended an additional 6 months if it is considered that further treatment is needed. After release, 2 years of supervision may follow.
South Africa	Admission can be voluntary, though PWUD can be referred to a public prosecutor by a social worker, community leader or person closely associated with the patient.	Once arrested, patients are not referred to medical professionals until charged.
USA - California	Admission is voluntary and spontaneous, there is no referral.	Patients have not referred
USA - Oregon	Admission is voluntary and spontaneous, there is no referral.	Patients are not referred
USA - Pto. Rico	Admission can be both voluntary or forced by court order.	The patients always appear before a judge before being transferred to an institution

Issue	**3. Qualities of drug treatment system**	
Provision in Legislation	3.1. Degree of availability	3.2. Purpose of treatment
Botswana	Rehabilitation centers are private and scarce.	
Chile	The only people not allowed are those who pose a threat to themselves or others, they must be referred to a mental institution. The rehabilitation centers are dedicated exclusively to PWUD.	There is no mention of criminal sanctions, as the relevant legislation frames this as a mental health issue that should be addressed by medical professionals.
Colombia	There is a large emphasis on accessibility, with attention or resources being available at any institution providing health services, and further resources being available at schools, workplaces, and community centers.	There is no mention of criminal sanctions, as the relevant legislation frames this as a mental health issue that should be addressed by medical professionals.
Costa Rica	The legislation leaves the treatment open to all.	There is no mention of criminal sanctions, as the relevant legislation frames this as a mental health issue that should be addressed by medical professionals.

Germany	Treatment is open to all PWUD for the early stages of addiction, rehabilitation, and post-rehabilitation (reintegration, help to find job, psychological support). For inmates, rehabilitation services are also available in prison p.21 ECMDDA.	
Nigeria	Although it should be integrated in Primary healthcare facilities and there should be rehabilitation centers managed by the DDR and the NDLEA, there is a lack of capacity. Work with NGOs (religious Christian-based centers - outpatient model), like the Goodworker centers. Majority of centers are run by religious groups. There is an overall lack of full rehabilitation centers. (Faldoun 2021) Numbers: 11 model drug treatment centers 2000 drug treatment practitioners and service providers certified	Reduce drug use and harms associated to drug use. deterrence mechanism to reduce drug-related offenses.
Philippines	At least 1 drug rehabilitation center in each province, depending on the availability of funds. (sec. 75) The parent, spouse, guardian, or any relative within the fourth degree of consanguinity of any person who is confined under the voluntary submission or compulsory submission programs shall be charged a certain percentage of the cost of his/her treatment and rehabilitation, the guidelines of which shall be formulated by the DSWD taking into consideration the economic status of the family of the person confined. (sec. 74))	Complete rehabilitation.
Singapore	The Minister may, from time to time, by notification in the Gazette, declare any institution or place to be an approved institution or a community rehabilitation center for the purpose of the treatment and rehabilitation of drug addicts and other persons under this Act, and may at any time in like manner revoke or amend any such notification. (sec. 35) under CJS: approved institutions, except those designated under paragraph (b), shall be under the Commissioner of Prisons (Sec. 36) (specifically, under the director of prisons).	Punishment and helping the individual to end addiction.
South Africa	The legislation requires only one public center in each province.	The treatment is meant to improve the patients' well-being, but is forced upon them as punishment.

USA - California	Treatment is open to all who can afford it.	The language emphasizes both the rights of the patient as well as the responsibility of the centers to offer evidence-based treatment.
USA - Oregon	Health assessment, treatment, and recovery services for drug addiction are available to all those who need and want access to those services.	The purpose is to reduce addiction, improve public health, and lower costs.
USA - Pto. Rico	Health assessment, treatment, and recovery services for drug addiction are available to all those who need and want access to those services.	The purpose is to reduce addiction and improve public health.

Issue	**4. Financing of treatment**	
Provision in Legislation	4.1. Payment and coverage	4.2. Payment and coverage
Botswana	Information not available	Information not available
Chile	No, but it is free.	It is fully financed.
Colombia	The National Narcotics Council, through the Fund for Rehabilitation, Social Investment, and the Fight against Organized Crime, will contribute to financing social investment through the Ministry of Health in programs for the care and treatment of chronic mental health illnesses.	The costs are overwhelmingly covered by health service providers for public clinics.
Costa Rica	Article 145 names 8 sources, including fines and confiscated assets from combating drug trafficking and money laundering.	The state finances de treatment.

Germany	The National Strategy states that funds must be provided by the responsible parties (Municipal and regional public funds EMCDDA 16) and additional funds will come from the federal government. Cost of Treatment: (detoxification or withdrawal), the costs are negotiated with the health insurance funds. Cost rehabilitation: (post-detox) are covered by German Federal Pension covers the costs post-detox (medical rehabilitation). Cost of integration: The office in charge of administering basic income support and the employment agencies are responsible for the integration of former addicts into some form of employment, Cost for additional services to PWUD: the debt counseling centers are responsible for any debt, and psychiatric specialists, psychologists, and psychological psychotherapists are to be contacted for the treatment of the psychological problems that often accompany addiction.	States finance treatment through different agencies (see 4.1).
Nigeria	Information not available	Information not available
Philippines	The parent, spouse, guardian, or any relative within the fourth degree of consanguinity of any person who is confined under the voluntary submission or compulsory submission programs shall be charged a certain percentage of the cost of his/her treatment and rehabilitation, the guidelines of which shall be formulated by the DSWD taking into consideration the economic status of the family of the person confined. (sec. 74)	
Singapore	Information not available	Information not available
South Africa	Funding will be procured by the Ministry of finance.	
USA - California	The costs must be borne by the patient, however, all health insurance policies in the state must provide coverage for medically necessary treatment of mental health and substance use disorders.	The insurers must cover and pay for "necessary" treatment.
USA - Oregon	The funding is mostly from the legislature and from the tax revenue collected by marijuana sales.	The service is state-funded.
USA - Pto. Rico	Department of Health and the Corrections Administration pays for the service.	The public service is prioritized for those of limited financial resources, with private options also being available.

Issue	5. Quality Assurance	
Provision in Legislation	5.1. Controlling entity	5.2. Criteria to certify treatment
Botswana	Information not available	Information not available
Chile	The controlling entity is El Servicio Nacional para la Prevención y Rehabilitación del Consumo de Drogas y Alcohol, under the authority of el Ministerio del Interior y Seguridad Pública	The individual centers are tasked with the collection of data on patients' treatment, progress, and exit. Additionally, there are explicit requirements on both physical facilities as well as the quantity and quality of center staff.
Colombia	The Ministry of Health and Social Protection and the National Superintendence of Health.	Protocols and guidelines are updated every five years to stay up to date. Citizens are encouraged to participate in the designs, and hold officials accountable. Statistics must be sent to the Observatorio Nacional de Salud and the Sistema de Salud Pública.
Costa Rica	El Instituto Costarricense sobre Drogas, del Ministerio de la Presidencia de Costa Rica, and el Ministerio de Salud.	The legislation delegates the protocols and requirements to other agencies, such as the Ministry of Health, and is very light on detail.
Germany	Responsibility falls on the 16 Länder and there are no uniform criteria for quality assurance.	Accreditation systems include the cooperation network Equity in Health and its database of good practice projects, the Green List Prevention, and the seal of approval of the statutory health insurers (Zentrale Prüfstelle Prävention) p.22 ECMDDA Both the pension insurance fund and addiction counseling centers are responsible for immediate follow-up treatment as prophylaxis against a relapse. (p.14 NS)

Nigeria	"Demand reduction activities such as prevention and treatment are not necessarily coextensive with law enforcement." There is a Drug Demand Reduction Unit as part of the Drug Law Enforcement Agency, but "in most commands of the agency, DDR Units reek of poor staffing and underfunding." Ediomo, 2017, 54 The DDR is responsible for the maintenance and operation of the agency's treatment and rehabilitation centers and works with NGOs and specialist treatment centers. Additional input from NDLEA, FMOH (Federal Ministry of Health), and NAFDAC (National Agency for Food and Drug Administration and Control).	National Minimum Standards for Drug Dependence Treatment and Standard Policy and Practice Guidelines for NDLEA. The majority of rehabilitation centers in Nigeria are run by religious groups and are widely accepted by the medical community. They meet a need the government is failing to address. However, although most operate under international standards of drug-use prevention, patients in these centers are usually expected to participate in some form of religious worship. (Faldoun 2021) Pilot of quality assurance tool for assessment of treatment facilities fostering a human-centered approach to treatment
Philippines	Centers managed and maintained by the Nal. Buro of Investigation (NBI), the PNP and the DOH. The DHO can promote, assist or support (if feasible) operations and maintenance of private centers through grants, donations, or subsidies from either government or private sources. DOH responsibilities (sec. 76): Oversee and monitor the integration, coordination, and supervision of all drug rehabilitation, intervention, after-care, and follow-up programs, projects, and activities as well as the establishment, operations, maintenance, and management of privately-owned drug treatment rehabilitation centers and drug testing networks and laboratories throughout the country in coordination with DSWD and other agencies	Information not available
Singapore	Under CJS: approved institutions, except those designated under paragraph (b), shall be under the Commissioner of Prisons (Sec. 36) (specifically, under the director of prisons).	
South Africa	The Department of Health.	The legislation delegates the protocols and requirements to other agencies, such as the Ministry of Health, and is very light on detail.
USA - California	State Department of Health Care Services	The legislation is light in detail in the criteria for a licensed health center.

USA - Oregon	Oregon Health Authority	The legislation names the specialists that each center must have, along with the services they must provide.
USA - Pto. Rico	Department of Health and the Corrections Administration	The legislation does refer to the types of healthcare professionals needed in the centers.

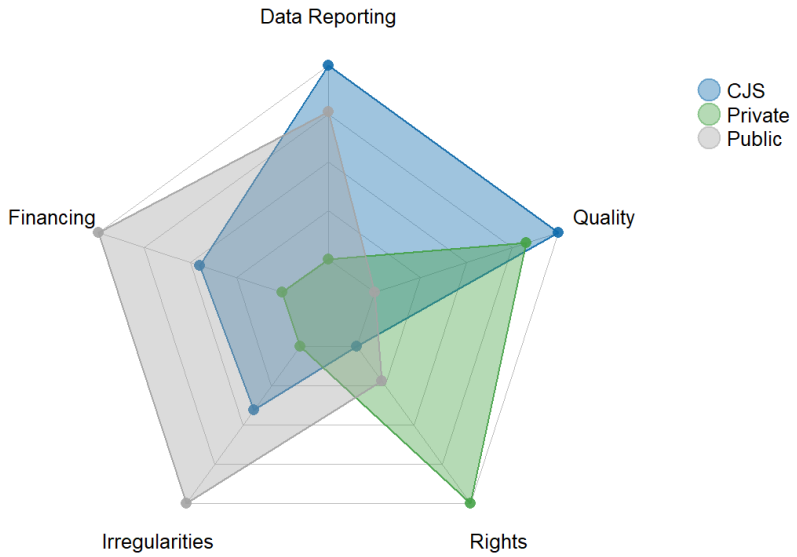
Issue	**6. Language**	
Provision in Legislation	6.1. Discourse on drug use	6.2. Vagueness or gaps in law
Botswana	Most of the language in the legislation criminalizes the use of drugs, often imparting the same punishment for the use and dealing of a controlled substance.	The vagueness with which they describe the situations in which officers can search places or persons without a warrant is very worrisome, as it could lead to planting evidence and extortion, a situation that can arise even in more developed nations.
Chile	With the use not being criminalized, the treatment is presented as the only solution to address the public health problem.	The pricing structure is not clearly laid out in the legislation, but the rights of the patients and their families are explicitly mentioned, increasing the levels of transparency and agency.
Colombia	With the use not being criminalized, the treatment is presented as the only solution to address the public health problem.	In terms of therapy, legislation stipulates the right to enough time and sessions to ensure dignified treatment to obtain results in terms of change, well-being, and quality of life, without going into more detail. Apart from this, the patients are guaranteed high levels of transparency in terms of their programs before beginning, including risks, benefits, alternatives, and efficacy levels.
Costa Rica	The language is overwhelmingly focused in terms of health, education, rehabilitation, and readaptation.	There is not much detail in the staff requirements for the centers, or the rights that the patients have to leave the program. This opacity leaves much uncertainty for the Ministry of Health to create protocols and regulations.
Germany	Whenever there is mention of the use of drugs it is associated with or equaled to addiction. There is no mention of the use of drugs as a choice (like alcohol or tobacco). People developing addiction disorders are not blamed for addiction, but several factors are considered catalysts for use	There is not much difference between first-time patients and recidivists. Vagueness between "Possession" and "use" Differences between states on what constitutes a "minimal" amount

	of drugs. Both treatment (services for PWUD) and prevention are at the cornerstones of drug policy.	
Nigeria	Information is not available	Information is not available
Philippines	Use is an offense. Treatment is both a necessary health strategy and a punishment	The possession with intention of distribution / personal use is not clear enough. If law enforcement is suspicious of an individual, they may surveil, ask for tests or search without a warrant.
Singapore	Use is an offense both in Singapore and outside if the citizen is caught using drugs. Treatment is both a necessary health strategy and a punishment **Patients are referred to as "inmates":** Every inmate shall be deemed to be in the legal custody of the approved institution or community rehabilitation center in which he is for the time being detained. (sec. 40).	The possession with intention of distribution / personal use is not clear enough. If law enforcement is suspicious of an individual, they may surveil, ask for tests or search without a warrant.
South Africa	Most of the language in the legislation criminalizes the use of drugs, often imparting the same punishment for the use and dealing of a controlled substance.	The Director-General has wide discretion to release involuntary patients. Those convicted of "interfering" with the responsibilities of police officers or the Director could face fines and imprisonment. The state also has the right to confiscate vehicles or property that was used for drug use.
USA - California	Use in itself is considered a criminal act, only dependence is viewed as an illness.	The court is allowed to grant probation that would lower or eliminate imprisonment, however, there is no detail on the conditions under which the court would grant this.
USA - Oregon	With the use not being criminalized, the treatment is presented as the only solution to address the public health problem.	There is no mention of socializing the patients' rights
USA - Pto. Rico	Drug use is seen as a mental health problem.	The law is very vague in terms of the professional qualifications of the evaluators that determine if the patient is addicted or if they need more treatment. The criteria for judges to send patients to centers against their will is also ambiguous.

VIII. Respondent distribution according to region and income

Region	Number of Countries
Africa	7
Central and North America	5
Asia	6
Europe	1
South America	3
Income Level	**Number of Countries**
Lower-middle income	9
Upper-middle income	9
High-income	4

IX. Relative categorical scores for each drug treatment regime type



CORRUPTION IN DRUG TREATMENT SYSTEMS

INNOVATION AGAINST CORRUPT PRACTICES

Policy Brief

Project developed in the frame of the Regional Academy of the United Nations 2022, in cooperation with the United Nations Office on Drugs and Crime

INTRODUCTION

What makes drug treatment systems vulnerable to corruption and how can this be mitigated by innovation that promotes transparency? Previous research on corruption in health systems has been fundamental for policymakers to identify the negative impact of this phenomenon on the healthcare sector overall[1]. Such research has highlighted the link between higher levels of good governance and transparency and lower instances of corruption in the provision of healthcare services[2].

CORRUPTION IN DRUG TREATMENT

Higher levels of corruption not only weaken the drug treatment systems but also result in less protection for PWUDs. It makes the system opaque, reducing accountability and the ability of governments and other actors (i.e., IOs, INGOs, and CSOs) to timely identify violations of the patient's rights. However, research on specific types of corruption in drug treatment services - a system with a unique constellation of stakeholders and patients different from the rest of the healthcare sector, remains very limited. This policy paper aims to provide some insights on this topic and to provide recommendations to improve transparency and compliance in drug treatment as a way to combat corruption.

OBJECTIVES

- Understand how corruption weakens different types of drug treatment systems.
- Identify the most common forms in which corruption affects the patients, with a special emphasis on the (lack of) safeguarding of their rights.
- Provide recommendations to design strategies that strengthen transparency in the provision of drug treatment services. Such strategies should focus on the quality of the service provided to improve top-down overseeing and to give patients more agency and channels to inform about corruption instances.

ANALYSIS AND OPTIONS

After our analysis, we found that the low availability that characterizes all types of drug treatment systems could result, especially in the public and criminal justice systems, in bribes, extortion, and other rights violations for patients. For this reason, these two systems could benefit from innovation that increases capacity at a relatively low cost- such as virtual consultations. This would also have the benefit of increasing the ease of access, especially for patients that might be reluctant to go to an in-person visit. These two systems, which had the lowest scores for patient rights and agency, could also benefit from the installation of an ombudsman office, anonymous whistleblower mechanisms, and other mechanisms for patient empowerment that would help the power asymmetry.

Most common words in drug legislation by category

Rank	CJS	Private	Public
1	drug	mental	treatment
2	dangerous	health	rehabilitation
3	officer	care	prevention
4	chemical	healthcare	information
5	control	disorder	assets
6	force	receive	case
7	prescribe	clinical	programs
8	quantity	provider	research
9	imprisonment	recovery	protection
10	manufacture	professional	accomplishment

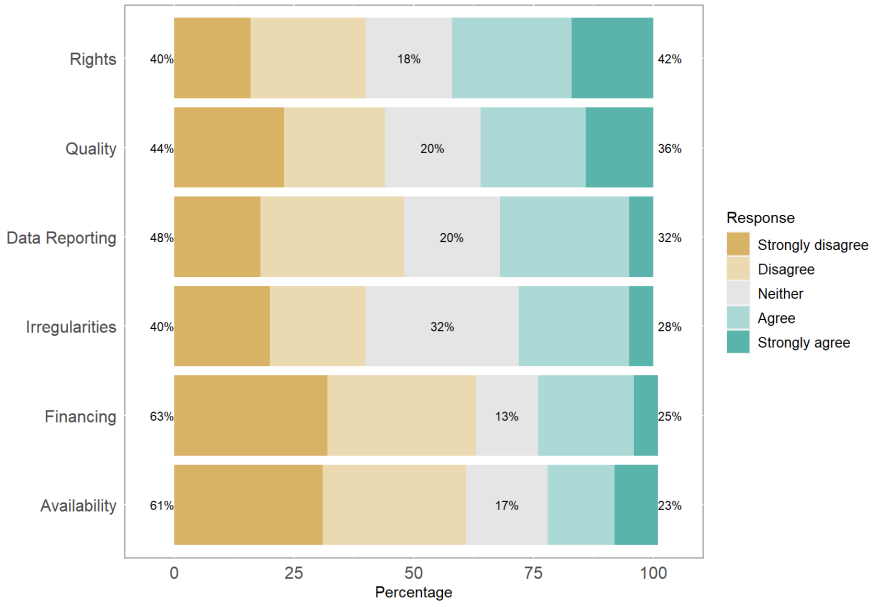
RAUN Regional Academy on the United Nations

UNODC United Nations Office on Drugs and Crime

This policy brief was produced as a part of the 2022 RAUN research project "Corruption in drug treatment systems, innovation against corrupt practices" for the UNODC. A full paper will be published at the RAUN website or can be requested directly from the authors.

Countries with a public system were the ones that had the lowest score for having guidelines and regular audits. Following the COVID-19 pandemic, many countries had to digitalize some of their healthcare services. Similarly, some processes in drug treatment could be digitalized, leaving fewer points where officials could influence decisions on procurement or treatment, and deviations from the guidelines could be traced.

Online survey on transparency in treatment services - responses distributed by category.



Private treatment systems were the ones with the lowest data reporting scores. The lack of data impacts policymakers' decision-making on better safeguarding patients' rights or improving national drug treatment legislation. This can also result in problems like patient brokerage and false invoicing, as reported, for example, in some sober homes in Florida[3]. Data sharing could increase transparency and reduce overbilling and help inform lawmakers about the current state of drug treatment. The data recorded should also have several different categories, including medication used, the allocation of resources, but also the effectiveness of the treatment as measured by the rehabilitation of patients and different treatment methods.

RECOMMENDATIONS

01

DIGITALIZATION OF PROCESSES

This mechanism would speed up the attention of patients, reduce bureaucratic hurdles and in some cases facilitate anonymity for a first-time consultation. It would also expand the communication channels between PWUDs and providers.

02

PUBLIC-PRIVATE PARTNERSHIPS

Alliances with private sector to boost communication with PWUDs. Companies behind social media networks would be ideal partners to socialize information on treatment, patients' rights, providers' duties, and whistleblower mechanisms, among others.

03

INTER-AGENCY COORDINATION

Cross-sectoral actors must improve their channels of communication. IOs are ideal partners to increase cooperation between public health and CJS actors to socialize evidence-based treatment and best practices against corruption.

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