Journal of Public Health and Development
Vol.19 No.3 September-December 2021

REVIEW ARTICLE

Treatment and rehabilitation for illicit drug users in the Philippines: a review of policy and service arrangement

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Received: 8 February 2021
Revised: 7 April 2021
Accepted: 14 April 2021
Available online: September 2021

ABSTRACT

Drug use disorders remain a social and political concern in the Philippines despite the promulgation of a policy on drug treatment and rehabilitation in 1972. This study reviewed and discussed the Philippine drug treatment and rehabilitation policy through the comparison of formal policy documents promulgated between 2002 and 2019 (n = 23) with dimensions on drug abuse treatment and rehabilitation identified by the United Nations Office on Drugs and Crime. The local policy can account for all principal and subsidiary domains of drug treatment and rehabilitation. The most well-articulated and explicated domains were (a) strategic definitions and principles, (b) legal and regulatory background and (c) development and implementation of an effective treatment strategy. Provisions regarding the rights and duties of treatment participants were few and general in scope. As a growing area of focus by practitioners and academics in the local and regional areas, the results of this analysis may serve as a starting point for a more thorough examination of the Philippine drug rehabilitation and treatment policy to inform policy review and revision.

Key words: substance abuse treatment centres, substance-related disorders/therapy, analysis, policy, Philippines

INTRODUCTION

Illicit drug use has been a social and public health concern worldwide, and the Philippines is no exception. Most experts recognise that drug use disorder is a chronic, relapsing medical condition that requires appropriate, evidence-based promotion, prevention, treatment and recovery strategies directed at the population and individual levels [1–3]. Treatment and rehabilitation remains a cornerstone intervention which aims to (a) reduce drug use, (b) promote health and well-being and (c) prevent risk arising from complications [3]. The establishment and implementation of treatment and rehabilitation services, therefore, should be a priority for jurisdictions that are confronted with a high prevalence of drug use disorders among their population.

In the Philippines, a lower-middle-income country (2018 GDP of USD 356.8 billion) in maritime Southeast Asia (2020 population: 109,947,900), approximately 2% of the population was documented to have used illicit drugs [4]. Methamphetamine has become the most commonly used drug and the increasing number of female users of methamphetamine in the Philippines has been alarming [5]. However, the current intensified campaign against illicit drugs by the government elected in 2016 has revealed that only a small proportion of persons who use drugs (PWUD) are able to avail of treatment services, with the rest either incarcerated or, worse, killed [6]. From 2014 to 2018 alone, official reports showed that only approximately 5,000 to 6,000 individuals were admitted annually to treatment centres [7–11].

Despite official recognition of treatment and rehabilitative services as a component of the country's drug policy since as early as 1972 [12, 13] and the government's investment in building additional rehabilitation facilities in recent years [14–16], the service provision does not seem to keep up with demand. Although previous literature has offered a broad critique or description of the drug treatment and rehabilitation policy in the Philippines [17–27], systematic and evaluative reviews that help outline a comprehensive picture of the current drug rehabilitation policy are scant. This study is intended to fill the knowledge gap to review and discuss the prevailing policy and program on drug treatment and rehabilitation in the Philippines. Relevant policy documents are retrieved, reviewed and discussed based on an internationally recognised guiding framework[i]. This framework has three domains: (a) strategic definitions and principles (i.e., principles underlying treatment approach, as well as the purpose and outcomes of the treatment system); (b) legal and regulatory background (i.e., legal provisions affecting treatment and rehabilitation); and (c) the development and implementation of an effective treatment strategy (i.e., operationalization of the strategy and policy on treatment and rehabilitation) [28].

METHODS

Data sources. Formal policy documents, such as statutes, executive orders, administrative issuances and jurisprudence, were retrieved from the websites of the Dangerous Drugs Board (DDB), Department of Health (DOH) and other government agencies mandated to oversee and/or implement rehabilitation for drug dependence in the Philippines for the period between 2002 and 2019 or between the time of enactment of the most recent legislation on dangerous drugs and the conduct of the search. Archival search was also performed at the office of the Dangerous Drugs Abuse Prevention and Treatment Program of the DOH. Citations

of other policy issuances within formal policy documents were also reviewed and retrieved. A senior official involved in the drug rehabilitation process (currently retired) assisted in vetting the completeness of the policy documents collected. Where multiple policies pertain to the same subject, the most recent iteration was selected for inclusion in the analysis. Issuances that were clarificatory or intended to disseminate another policy document were excluded.

Tools. To facilitate data extraction and analysis, a matrix was developed in Microsoft Excel, with the dimensions of drug abuse treatment and rehabilitation in the *rows*, the policy document in the *columns* and the specific provisions of the statute or regulation in the *cells* where the row and column intersect.

Analysis. The content of the policies was mapped by the lead author against three major dimensions of drug abuse treatment and rehabilitation identified by the UNODC [28]. The comparison serves as a guide in describing the current Philippine policy on drug rehabilitation and in identifying strengths and gaps of the continuum spanning treatment, rehabilitation and aftercare. As mentioned in the preceding section, the exact quotes of the salient provisions of statutes and regulations were matched to each dimension using a spreadsheet application. These were subsequently qualitatively summarised and synthesised by noting similarities and differences between the (a) UNODC dimensions and the policy provisions and (b) provisions of different statutes and regulations included in the analysis. The resulting analysis was subsequently reviewed and vetted by co-authors with experience and expertise in drug rehabilitation practice and policy. Where applicable, textual data were converted into matrices and diagrams to better summarise the policy content.

RESULTS

A total of 181 documents were retrieved for this review and analysis, most of which were excluded as these were duplicates, clarificatory for another issuance, administrative in nature (i.e., assignment of personnel to attend a meeting) or repealed by a recent issuance. As a result, 23 policy documents (see Table 1) were reviewed, and the following discussion is presented.

Table 1 Policy documents included in the review

Policy Document	Framework Component		
	Strategic definitions & principles	*Legal & regulatory background*	*Treatment strategy*
Statutes and Executive Orders			
(1) Republic Act No. 9165, Comprehensive Dangerous Drugs Act of 2002 (June 7, 2002)	♦	♦	♦
(2) Executive Order No. 4, Providing for the Establishment and Support of Drug Abuse Treatment and Rehabilitation Centers Throughout the Philippines (October 11, 2016)		♦	
(3) Executive Order No. 15, Creation of the Inter-agency Committee on Anti-Illegal Drugs (ICAD) and Anti-Illegal Drug Task Force to Suppress the Drug Problem in the Country (March 6, 2017)		♦	
(4) Executive Order No. 66, Institutionalizing the Philippine Anti-Illegal Drug Strategy (October 29, 2018)	♦		
Administrative issuances and regulations			
(5) Implementing Rules and Regulations of Republic Act No. 9165, Otherwise Known as the "Comprehensive Dangerous Drugs Act of 2002" (November 7, 2002)	♦	♦	♦
(6) DDB Board Regulation No. 1, series of 2006, Guidelines in the Implementation of the Aftercare Program for Recovering Drug Dependents (June 6, 2006)			♦

Policy Document	Framework Component		
	Strategic definitions & principles	*Legal & regulatory background*	*Treatment strategy*
(7) DDB Board Regulation No. 7, series of 2006, Institutionalizing the Dangerous Drugs Board Integrated Drug Abuse Information Network (DDB IDADIN) (December 6, 2006)			♦
(8) DDB Board Regulation No. 2, series of 2007, Rules Governing Voluntary Confinement for Treatment and Rehabilitation of Drug Dependents (June 6, 2007)			♦
(9) DDB Board Regulation No. 3, series of 2016, Guidelines on Handling Voluntary Surrender of Drug Personalities (August 3, 2016)			♦
(10) DDB Board Regulation No 4, series of 2016, Oplan Sagip: Guidelines on Voluntarily Surrender of Drug Users and Dependents and Monitoring Mechanism of Barangay Anti-Drug Abuse Campaigns (September 19, 2016)			♦
(11) PhilHealth Circular No. 2016-0030, Medical Detoxification Package (November 3, 2016)		♦	
(12) DOH Administrative Order No. 2017-0018, Guidelines for Community-Based Treatment and Support Services for Persons who Use Drugs in Primary Health Care Settings (August 29, 2017)		♦	
(13) DDB Board Resolution No. 2, series of 2018, Referral System in Accessing Health Care Services for Persons Who Use Drugs (January 24, 2018)			♦

Policy Document	Framework Component		
	Strategic definitions & principles	*Legal & regulatory background*	*Treatment strategy*
(14) DDB Board Resolution No. 4, series of 2018, Establishment and Operation of Pilot Community-Based Treatment Drug Abuse Recovery Facilities (Recovery Clinics and Homes) (January 24, 2018)		♦	♦
(15) DOH Department Memorandum No. 2019-0066, Dangerous Drugs Abuse Prevention and Treatment Program (DDAPTP) Strategic Roadmap 2017-2022 (January 21, 2019)	♦		
(16) DDB Board Regulation No. 1, series of 2019, Implementing Rules and Regulations Governing the Accreditation of Drug Rehabilitation Practitioners (February 7, 2019)		♦	
(17) DDB Board Regulation No. 2, series of 2019, Implementing Rules and Regulations Governing the Accreditation of Drug Abuse Treatment and Rehabilitation Centers (February 7, 2019)		♦	
(18) DOH Administrative Order No. 2019-0005, Guidelines for the Establishment of Pilot Recovery Clinics for Persons Who Use Drugs (May 15, 2019)		♦	
(19) DDB Board Regulation No. 7, Consolidated Revised Rules Governing Access to Treatment and Rehabilitation Programs and Services (October 29, 2019)			♦

Policy Document	Framework Component		
	Strategic definitions & principles	*Legal & regulatory background*	*Treatment strategy*
Jurisprudence			
(20) Supreme Court En Banc Resolution G.R. No. 226679, Estipona vs. Hon. Frank E. Lobrigo (August 15, 2017) declaring unconstitutional Section 23 of Republic Act No. 9165, which provides that "Any person charged under any provision of this Act regardless of the imposable penalty shall not be allowed to avail of the provision on plea-bargaining"		♦	
Guidelines and manuals			
(21) DOH-UNODC Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in the Philippines (2015)		♦	
(22) DOH Manual of Operations for the Accreditation of Drug Abuse Treatment and Rehabilitation Centers (2018)		♦	
(23) Philippine Anti-Illegal Drug Strategy (2018)	♦		

Strategic definitions and principles

A strategic plan is the fundamental step for drug treatment and rehabilitation. It requires a clear conceptualisation and definition of treatment, a well-recognised treatment strategy development and a treatment framework articulating treatment approaches, goals, objectives, outputs and achievement indicators [28]. In the Philippines, a two-pronged strategy that focuses on drug demand and supply reduction was emphasised in the Philippine Anti-Illegal Drug Strategy, consistent with the provisions of the governing statute on dangerous drugs:

...The government shall pursue an intensive and unrelenting campaign against the trafficking and use of dangerous drugs and other similar substances through an integrated system of planning, implementation and enforcement of anti-drug abuse policies, programs, and projects. The government shall however aim to achieve a balance in the national drug control program so that people with legitimate medical needs are not prevented from being treated with adequate amounts of appropriate medications, which include the use of dangerous drugs. It is further declared the policy of the State to provide effective mechanisms or measures to re-integrate into society individuals who have fallen victims to drug abuse or dangerous drug dependence through sustainable programs of treatment and rehabilitation. (Section 1, Republic Act [RA] No. 9165).

These objectives are achieved through the delivery of a combination of services aimed at addressing the physical, psychological, vocational, social and spiritual needs of a PWUD. The provision of treatment and rehabilitation services was transferred from law enforcement agencies to the DOH in 2002 when RA 9165 superseded the previous Dangerous Drugs Act (i.e., RA 6425). This transfer of responsibility is in line with the key principle that 'drug use disorders should be considered primarily as health problems rather than criminal behaviors' [29].

Legal and regulatory background

A well-defined strategic plan shall be backed up by relevant legislation and regulations that involve the designation of a lead department that is assigned with overall responsibility, commitment of professional standards and conduct, stipulations of the rights and duties of treatment participants, service standards and accreditation, service quality control, regulation of pharmacotherapy, preparation for fiscal issues, a measure for coercive treatment and preparation for treatment in the criminal justice system [28].

Firstly, with respect to the designation of responsibility, the Philippine DOH is the lead agency in implementing treatment and rehabilitation programs for PWUD. Specifically, and in relation to treatment and rehabilitation, the DOH is tasked to (a) monitor treatment and rehabilitation initiatives as well as the operation of rehabilitation facilities; (b) develop policies, guidelines and standards for the establishment and operation, of treatment and rehabilitation facilities and (c) undertake accreditation of treatment and rehabilitation facilities in the public and private sectors. In this capacity, the DOH liaises with the Department of Social Welfare and Development, which is tasked with training social workers in centres, and the Department of Interior and Local Government for implementation of policies and programs in devolved provincial, city, municipal and barangay (village) governments. Policies developed in relation to the DOH's functions under RA 9165 are issued through the DDB as a policymaking body, whereas policy implementation is overseen by the Inter-Agency Committee on Anti-Illegal Drugs (ICAD) through the Philippine Drug Enforcement Agency as an implementing agency.

Secondly, in terms of professional

standards and treatment and rehabilitation delivery, the Philippine regulations recognise a broad range of individuals and professionals who are involved in drug treatment and rehabilitation. They are collectively referred to as rehabilitation practitioners and constitute physicians, nurses, psychologists and social workers, among others [30]. Given the lack of formal training institutions on addiction science in the Philippines, professionals working with PWUD are required to undergo a process of individual accreditation through registration with the DOH once every five years. Those who are not psychiatrists or have not undergone an addiction medicine program are required to take a training course on the management of drug dependents prior to accreditation[31, 32]. This credentialing process is necessary not only as a means of quality assurance but also to establish the credibility of a physician who administers the Drug Dependency Examination (DDE) as part of the statutory requirement when determining whether a person is drug dependent and the level of its severity. Notably, the current policy does not outline nor provide any guidance on professional conduct, although it notes that registration and licensing with the Professional Regulation Commission, which has its own professional code of conduct, is a requirement for accreditation. Furthermore, psychiatrists and addiction medicine specialists are expected to be certified by their respective speciality organisations, which also promulgate their own codes of practice for their members.

Thirdly, regarding treatment participants' rights and duties, prior to the enactment of RA No. 10173 or the Data Privacy Act of 2012, the maintenance of confidentiality of records pertaining to treatment and rehabilitation has been upheld by the Philippines' drug rehabilitation policy, which imposes fines and imprisonment as penalties for violation of the provision on confidentiality of records. Beyond the right to privacy, the accreditation standards for treatment and rehabilitation centres provide a two-page list of patient rights, which encompass (a) maintenance of personal dignity of the patient during the period of treatment and rehabilitation; (b) respect for culture and beliefs of the patient and their family; (c) solicitation of informed consent for procedures done in the facility and (d) respect for personal space, physical privacy and time with family members (during visits and telephone calls). Individuals submitting to rehabilitation are to be referred to as 'clients' (for those availing of non-residential treatment) or 'patients' (for those admitted in residential facilities). The policy does not explicitly describe the monitoring mechanism to ensure that these rights are upheld. In addition, two duties of treatment participants are explicitly mentioned in the documents reviewed in this study. Firstly, treatment participants are expected to comply with the regulations of the centre where they are undergoing treatment. Secondly, they are required to complete the prescribed treatment duration. Disciplinary measures, which are to be 'humane', 'safe' and not violent or life-threatening, may be imposed by the facility on errant patients. In the worst case, failure to comply with these duties may mean withdrawal of exemption from criminal liability granted to those who voluntarily submit to rehabilitation.

Fourthly, service standards and accreditation are documented. For instance, institutions or agencies that provide treatment and rehabilitation services are required to undergo accreditation by the DOH once every three years. The standards assessed during the accreditation process pertain to (a) service capability (i.e., residential, outpatient or residential with

outpatient services), (b) staffing with trained and accredited physicians and other rehabilitation practitioners, (c) equipment/instruments to deliver services, (d) physical structure and utilities (i.e., non-residential facilities are supposed to have a floor area of at least 60 square meters, whereas residential facilities are required at least 420 square meters of space), (e) manual of operations of the facility, (f) quality improvement activities of the centre, (g) staff protection policy against violence perpetrated by a patient or employee and (h) information management equipment and system. Facilities not complying with these standards face penalties of fines, license revocation and prohibition from operation for one year.

Fifthly, a number of fiscal issues have been mentioned in the reviewed policy documents. For example, funding to support the establishment, maintenance and operations of government treatment centres is derived mainly from allocations from national government revenues, fees and fines charged as part of the provisions of RA No. 9165 and part of the national government share from the operations of the Philippine Amusement and Gaming Corporation. Health facilities may also claim PHP 10,000 for medical detoxification for eligible members of the Philippine Health Insurance Corporation, the country's social health insurance scheme. Owing to the devolved structure of governance, provincial, city and municipal governments are also mandated to allocate part of their local budget for treatment and rehabilitation services. Private-sector donations or official development assistance, when available, can also be tapped for this purpose. Treatment under the voluntary confinement scheme even in government facilities is not free. Co-funding or cost-sharing from the family of the PWUD is expected, the amount of which is determined on the basis of the local context and a social worker's assessment of the family's economic situation (i.e., services are free for indigent patients). Private treatment centres are allowed to charge for their services to cover operating costs.

Sixthly, two pathways to treatment and rehabilitation are offered in the Philippines. PWUD, or individuals who avail of plea-bargaining, may submit themselves to voluntary rehabilitation (directly or by surrendering to law enforcement authorities), resulting in exemption from criminal liability under the Dangerous Drugs Act provided they meet other criteria defined by law. This exemption is one motivator for entering treatment. Alternatively, individuals may undergo treatment through a court mandate when (a) they escape and do not return for voluntary rehabilitation, (b) they refuse to undergo voluntary rehabilitation despite being a drug dependent and (c) a person undergoing trial is found to be drug dependent, in which case the trial is suspended until after completion of treatment and rehabilitation.

Developing and implementing an effective treatment strategy

Following a strategic plan, standards and regulations, implementation is the next policy concern that encompasses partnerships, the involvement of service users and community, policy commitment, mechanisms for assessment and planning, research evidence, step-by-step approaches, coordination, building on community-based responses, ensuring service availability and accessibility and performance monitoring [28]. Among these principles and instructions, drug treatment process and monitoring are crucial.

	ENTRY	→	ASSESSMENT	→	TREATMENT	→	EXIT
PROCESS	(a) Voluntary rehabilitation (b) Referral after voluntary surrender (c) Compulsory rehabilitation		Risk of drug abuse and dependence ↓ If high-risk: Severity of substance use disorder		Risk- and severity-appropriate interventions (see Table 2) ↓ If with severe dependence: Temporary release and aftercare for at most 18 months		Discharge from treatment Community support and reintegration program
ACTORS	Local anti-drug abuse council Law enforcement agencies Courts		Local health centre Dangerous Drugs Board		Treatment centre Local health centre (if with comorbidities) Speciality health facilities (if with comorbidities) Social services Dangerous Drugs Board Courts		Social services Courts Law enforcement agencies Courts Local anti-drug abuse council

Figure 1. Schematic diagram showing the simplified treatment and rehabilitation process

First, the improved policy mechanisms on treatment and rehabilitation occur in stages and triage PWUD on the basis of the level of risk for drug abuse and dependence, as well as the severity of the substance-use disorder. Figure 1 shows a simplified schematic of the process. In general, PWUD enter the treatment and rehabilitation process through three streams: (a) they voluntarily submit themselves for rehabilitation in a facility; (b) they are referred for treatment and rehabilitation after voluntarily surrendering to law enforcers or community officials or (c) they are mandated to undergo treatment and rehabilitation by a court order. Regardless of the source, all individuals are initially screened to determine their risk for drug abuse and dependence using the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) tool. Risk for co-occurring mental disorder is also screened using the Self-Report Questionnaire (SRQ). For those determined

to be high risk for substance use and mental disorder undergo an additional test, the DDE will be administered to determine a diagnosis for substance use disorder and a recommendation for the suggested treatment modality. This step is followed by the provision of treatment interventions, which, as shown in Table 2, can occur in four different treatment settings and using four different modalities depending on a combination of these two characteristics. PWUD with severe substance abuse disorder are further required to undergo an aftercare program during the period of their provisional release from treatment. All PWUD are then directed to a reintegration program. Persons with co-occurring mental disorders are, after screening, referred to speciality centres for further assessment and management. Likewise, PWUDs with co-occurring medical disorders are also co-managed or referred to the appropriate medical speciality. Exit from the program is determined by completion of the program in terms of duration and interventions and the PWUD's status at the end of such a period (i.e., rehabilitated or not). Once deemed rehabilitated by the attending physician or case manager, persons admitted under the voluntary rehabilitation scheme are discharged into the community, whereas those who were committed to rehabilitation by virtue of a court order are either released on parole or are returned to the prison system whilst awaiting trial for any pending case filed in court.

Last but not the least, monitoring of individuals who are undergoing or have completed treatment and rehabilitation is within the purview of the facility that provided the intervention. Officials and the anti-drug abuse councils at the provincial, city and municipal levels are expected to monitor persons who surrendered under the anti-drug program of the locality as well as those who have been given community-based interventions. These data points are reported quarterly and captured in the centralised database, the Integrated Drug Abuse Data Information Network, which is maintained by the DDB. Part of the data representing the consolidated profile of persons seen in facilities is published by the DDB on its website on an annual basis (https://www.ddb.gov.ph/research-statistics/statistics). The task of monitoring accredited rehabilitation practitioners and facilities is vested with the Health Facilities and Services Regulatory Bureau of the DOH. This power includes the conduct of unannounced monitoring visits to accredited facilities, unrestricted entry to the centre and access to records, reports, patients and employees of the institution.

Table 2. Summary of the current treatment and rehabilitation interventions in the Philippines

Risk-level for drug abuse and dependence	Low	Moderate	High		
Severity of substance-use disorder			Mild	Moderate	Severe
Setting	Community, home, school	Community-based treatment		Non-residential centre	Residential centre
Treatment interventions	General interventions, e.g., Brief intervention, Individual and Family Programs, Health and Psychoeducation, Psycho/ Socio/ Spiritual Support	Case management with individual treatment plan Psychoeducation/ advocacy Counselling/ coaching Education/ employment support Relapse management Recovery skills Life skills		Detoxification	
				Structured out-patient modalities Faith-based structured interventions Individual or group counselling Behavioural modification programs Social support activities Attendance to support group meetings	Therapeutic community model, Minnesota model, or other evidence-based programs
Duration	To be determined by attending physician or case manager				At least six months of treatment followed by at most 18 months of aftercare

DISCUSSION

This study describes and discusses the policy on drug treatment and rehabilitation in the Philippines. A content analysis of the 23 policy documents showed that the local policy accounts for the majority of tasks articulated in the three domains of drug treatment and rehabilitation by the UNODC in 2003.

Moreover, the analysis of this review has implications for policy and research.

First, the current policy appears to have been influenced by the broader turn in drug control policy that emphasises rehabilitation and recovery [33]. Although the prior drug policy enacted in 1972 contained provisions on drug treatment and rehabilitation [13], the 2002 statute was the first to enunciate a reintegration-focused national policy, which in turn set the tone for other formal policy documents promulgated by government agencies. The new focus can also be gleaned from the transfer of authority over drug treatment and rehabilitation from law enforcement agencies to a public health agency. Nonetheless, duality seems to be present when the broader drug policy of the Philippines (dubbed a 'war on drugs') is considered because a predominance of criminal justice approaches remains, especially in recent years [19–21, 23, 25, 27, 34]. A policy based on prohibition has been shown by empirical evidence to further exacerbate the drug problem, which is why the current recommendation is to adopt an evidence-based public health approach to drug policy, emphasising harm reduction and recovery [35]. Furthermore, the exemption from criminal liability offered to PWUD only applies to first-time offenders who are subjected to mandatory treatment and rehabilitation. A statutory penalty of imprisonment and fine is imposed on repeat offenders, which prior research has shown to constitute a significant proportion of clients of treatment and rehabilitation centres in the country [36]. Thus, conflict occurs between a restorative justice approach which decriminalises drug use and a retributive justice approach which maintains the criminal nature of drug use. This apparent dichotomy warrants not only further investigation by scholars but also a review by policymakers because the implications for the design and implementation of a drug rehabilitation program are quite substantive.

Secondly, on the basis of the number of provisions and level of detail written in the examined policies, the most well-articulated and explicated dimensions appear to be (a) service standards and accreditation, (b) professional standards and (c) treatment process and monitoring. In other words, broad policy directives enunciated in the statute on dangerous drugs with respect to these three domains are given further clarity and made more operational in regulations and guidelines promulgated by government agencies. By contrast, written aspects of the provisions with regards to the rights and duties of treatment participants are relatively general in scope. The rights of PWUD undergoing treatment must be articulated and clarified especially in light of empirical evidence from other countries showing that instances of human rights abuses occurred in treatment facilities [37, 38]. In the document entitled *International Standards for the Treatment of Drug Abuse Disorders*[ii], the treatment participants' rights are specified and assured with standards [29] which can be regarded as a reference for future policy amendment in the Philippines. Adopting a more culturally appropriate and cost-effective approach and humanist stance to the treatment environment may also be needed[39,40]. Individual institutions providing drug and rehabilitation services might have developed their own statements on the rights of individuals undergoing treatment, an area that deserves examination and documentation by researchers. Prior local research, for example, was able to document that treatment and rehabilitation centres were found highly compliant in observing patient's rights, pointing to a generally rights-respecting and behaviour-change-oriented stance adopted by Filipino treatment service providers [41].

Thirdly, the authority of the DOH, DDB and ICAD may overlap with respect

to overseeing the drug treatment and rehabilitation system. The delineation of the policymaking and coordinative functions of these three agencies is not well-defined. For example, two separate policies were issued on community-based rehabilitation in two separate years, but these two were still cited by the concerned agencies in the recent regulations analysed for this study. A central tenet in management and organisational theory holds that a single locus should be the source of all authority from which directions must emanate to ensure stability [42]. This idea was echoed by the UNODC [28]. To this end, then, researchers may find value in analysing the authority, power and relationships among these three organisations, the results of which can be used by policymakers when revisiting the provisions vested in these three agencies with their respective functions.

Fourthly, implementation of the policy occurs at the level of provinces, cities, municipalities and barangays, which have been granted a certain degree of autonomy through devolution for purposes of promoting responsiveness and self-reliance[43]. Decentralisation as a policy is documented to have had mixed effects on health and social services in the country[44-46] Conspicuously, these administrative units, by and large, seem 'directed' by the centrally promulgated policies and regulations to provide treatment and rehabilitation services. At the same time, these administrative units are enjoined to contribute their fair share in the fiscal aspect of the program. One critique that arises from the foregoing consideration is that local governments appear to have a very minimal and token role in treatment and rehabilitation, whereas they can play a more vital and critical role as social actors/agencies in designing and implementing interventions towards building drug-resistant and drug-resilient communities [47]. Further, local government units are in a better position to create contextually-appropriate drug treatment and rehabilitation programs that take into account the geographic, political, and socioeconomic realities of their catchment areas. Given the decentralised mode of governance adopted by the Philippines, two avenues of inquiry arise in relation to this scenario: (1) What is the role and contribution of local government units in defining the drug treatment and rehabilitation policy of the Philippines? (2) How do institutions navigate the central–local divide when implementing the drug treatment and rehabilitation policy?

Fifthly, resource support to policy implementation requires further attention. A finding from the lead author's previous research showed that PWUD or their families pay out-of-pocket for medicines for tuberculosis if these are not available in the facility[48]. Although the cost-sharing scheme mandated by law has been observed to be effective because it is implemented in a socialised manner, the lack of adequate and sustainable funding from the national government to support the operation of treatment and rehabilitation centres for the whole duration of treatment may present as a financial barrier to care [49]. Furthermore, the social health insurance coverage is also limited to detoxification, which, as depicted in Table 2, is only one of the interventions required by PWUD. A lack of sufficient funds will render the holistic recovery of the PWUD unattainable and the whole treatment and rehabilitation program a losing venture[7–11]. In light of the Philippines' thrust to attain universal health coverage [50], this provision of the regulation may need to be revisited. To assist in this policy review, determining first the cost of treatment, including those directly related to service provision and nonmedical care

costs,[51] from the perspective of the institution and the family may be a more prudent approach, especially because drug use disorders are chronic conditions requiring long periods of repeated treatment.

Lastly, the credentialing and accreditation process for rehabilitation practitioners warrant scrutiny considering the prevailing professional practice regulations in the country. This consideration is specifically with respect to the provision of counselling and psychotherapy services that are statutorily vested in licensed psychiatrists and psychologists alone, naturally prohibiting other professionals from rendering the same. However, the lack of licensed psychologists who can fill the vacant posts in treatment and rehabilitation centres is widely acknowledged[36,39]. Such a deficiency can be explained by two reasons: (a) a clinical psychology license in the Philippines requires possession of a graduate degree in the field and (b) most licensed psychologists prefer working in the business industry and elsewhere as human resource development personnel rather than in the drug treatment and rehabilitation facilities due to better pay and better opportunities for career development.

In conclusion, the Philippine drug treatment and rehabilitation policy, although comprehensive in scope, may not have articulated sufficient provisions to satisfy recommended attributes of elements of such policy. The policy needs to be revisited and evaluated. Further research should also be carried out to inform the policymaking process.

Notwithstanding the potential contributions of this review, a few limitations of the analysis undertaken for this paper should be noted. Firstly, although policies encompass a broad class of pronouncements and directives by individuals or institutions in authority[52], this study was focused solely on an analysis of written documents that formalised these policies for two reasons. (1) Written policies are more concrete, enduring and stable than other forms of policy. (2) From a pragmatic perspective, formal policies are also more 'overt', explicit and do not require interpretation on the part of the reader. This decision, however, may have resulted in what may be considered as a rather 'thin' description of the policy content for some domains. Moreover, the reliance on formal policies may result in the exclusion of policies that are manifested in, for example, the budgetary allocation for treatment and rehabilitation services by different government instrumentalities or the actual practice of those in charge of overseeing or providing the service. Therefore, future research may consider a broader set of sources of policy. Such an approach can include soliciting the viewpoints of policymakers and service providers to capture the informal aspects of the drug treatment and rehabilitation policy, analysing the pronouncements made by senior executives and decision-makers involved in rehabilitation or examining government budgetary allocation to the different components of drug treatment and rehabilitation.

Policy analysis may focus on context, content, process, key players and stakeholders and impact [52]. The development of drug policies has been shown to be influenced by considerations apart from scientific evidence, with policymakers oftentimes succumbing to pressure from different interest groups [53]. The focus of this study was limited to one dimension as the initial intent in carrying out the analysis was exploratory, that is, the study can be considered an initial attempt to determine the contours of the topic, which have not been analysed previously. The next logical step, then, is to undertake an expanded and in-depth analysis of the Philippine drug treatment and rehabilitation policy from several (or all) of the other

dimensions mentioned above. A comparison between the national policy with other countries and jurisdictions (e.g., member states of the Association of Southeast Asian Nations) may also be instructive to benchmark the Philippines' performance. Examining how the Philippine drug rehabilitation policy has evolved using a historical lens might also be instructive.

These limitations notwithstanding, this study still fills a knowledge gap. To the authors' knowledge, no study that analysed the Philippines' drug rehabilitation and treatment policy has yet been published. As a growing area of focus by practitioners and academics in the local and regional area, results of our analysis may serve as a starting point for a more thorough examination of the Philippine drug rehabilitation and treatment policy, in turn, serving as a prelude to policy review and revision. Furthermore, this study contributes to the growing literature that analyses the drug treatment policies of different countries [54–61], which may pave the way for a systematised synthesis and cross-country comparative policy analysis.

ACKNOWLEDGEMENTS

Ms Danika Joy D. Bardelosa assisted in the preliminary collation of policy documents. Dr Ivanhoe C. Escartin reviewed the initial list of policy documents collected for this review.

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