Asia Pacific Journal of Advanced Education and Technology
Volume 2, Issue 4, December 2023 / P- ISSN 2815 – 245X / E – ISSN 2815 – 2468 / www.apjaet.com

Community-Based Drug Recovery Program Social Services in Disruptive Times: Experience of Person Who Use Drugs in Palawan, Philippines

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DOI:https://doi.org/10.54476/apjaet/38760

Abstract

The COVID-19 pandemic has presented significant challenges for individuals who use drugs (PWUDs) in accessing and completing community-based drug rehabilitation programs (CBDRPs) social services. This study investigates the experiences of PWUDs undergoing CBDRP in Palawan, Philippines, amidst the pandemic, focusing on changes in social service support mechanisms facilitating their recovery. Through stratified purposive sampling, 188 PWUDs participating in CBDRP across 11 municipalities in Palawan engaged in focus group discussions between July and December 2022. Participants shared insights on the effects of the pandemic, including social isolation, modifications in CBDRP service delivery, shifting focus of CBDRP officers, and changing family dynamics. Thematic analysis revealed four key themes: (1) PWUDs' experiences with CBDRP support mechanisms; (2) Challenges in completing CBDRP; (3) Leadership initiatives observed by PWUDs; and (4) Role of local groups and PWUDs' families in PWUDs' recovery during the pandemic. The study underscores the importance of equity, technology utilization, participatory approaches, and institutional capacity strengthening to mitigate the disproportionate impact of COVID-19 on vulnerable populations. Ensuring the availability and accessibility of social services and acknowledging the diverse needs of PWUDs during disruptive times can foster a resilient system capable of effectively managing disruptions like the COVID-19 pandemic.

Keywords: community-based drug program, social services, person who use drugs, COVID 19, public policy

Introduction

The reach of the effect of the COVID-19 pandemic has been so great that from an individual level to the level of the biggest and strongest institutions, escape has not been possible. The disruption of the pandemic created consequences beyond public health issues. It has significantly disrupted key social services' content, structure, and delivery (Chirico et al., 2022; Giebel et al., 2021; Gittings et al., 2021). The immediate depth of the effect of the pandemic has put a strain not only on social service policymakers and development organizations but also on people instrumental to the delivery of social services. In

addition, the focus of policymakers and development organizations has been shifted to the enhancement of the health system and curving the human-to-human transmission putting strain on economic development (Sarkodie & Owusu, 2021). It created a disproportion of attention in economic development and sustaining social services, particularly to vulnerable sectors such person who use drugs (PWUD) who like those needing critical health attention, likewise, need social services to continue in their recovery (Galarneau et al., 2021). This could be problematic since pro-poor social service delivery is argued to be a 'key entry point' to sustained social development in 'difficult environments and situations (Berry et al, 2004). Studies on the effects of COVID-19 and the consequent lockdowns on individuals in recovery from substance use disorder (SUD) illustrate how economic stress, increased vulnerability to domestic abuse and violence, reduced health services could lead to negative health-seeking behavior and new psychopathologies (Shircliff et el., 2022; Ji et al., 2022; Bragard et al., 2022). These are relevant to the resurgence or persistence of substance abuse disorder that community-based drug rehabilitation programs (CBDRP) aim to address.

The disruption brought about by the COVID-19 pandemic resulted in difficulties in accessing CBDRP social services. Several studies have confirmed such scenarios from the perspective of the service providers and that of the recipients of the social services (Conway et al., 2022; Aponte-Melendez et al., 2021; Kesten et al, 2021; Schofield et al., 2022). To ensure uninterrupted delivery of services during a pandemic, social service providers employed a multitude of strategies to continue services (Gujral et al., 2023; & Lin, C. et al., 2023).

In the Philippines, the delivery of social services for persons who use drugs (PWUDs) accessing community-based drug rehabilitation programs (CBDRP) uses issuances of the Department of Health (DOH), the Department of Interior and Local Government (DILG) and Dangerous Drugs Board (DDB) in the implementation and delivery of its social services (DOH, 2017; DILG, 2018; DDB, 2020). The local government of Palawan commenced implementing its CBDRP in 2016 through Executive Order No. 134A (Executive Order No 134A, 2016). The pre-pandemic design of the program was challenged during the pandemic with studies showing social services providers during COVID 19 pandemic operates in a different system due to the unprecedented crisis thus responding differently to adapt and thrive (McCoyd et al., 2023; Schmid & Bradley, 2022; Bastaits et al, 2022; & Muñoz-Moreno et al., 2020).

Given the reality of COVID-19 changing the system where policy engagements are more on the short-term, the goal of the study is to document the experiences of PWUDs during the COVID-19 pandemic. Specifically, the study using focus group discussion (i) determines the experiences of PWUDs on CBDRP social services support mechanisms as against "as planned"; (ii) determines the experiences of PWUDs on the challenges in completing CBDRP during pandemic; (iii) determines the extent where in-charged officers provided leadership initiatives in the delivery of social services; and (iv) determines the participation and possible roles of local groups and PWUDs' families in the recovery of PWUDs during disruptive time.

Objectives of the Study

This study aimed to 1) determine the experiences of PWUDs on CBDRP social services support mechanisms as against as planned; 2) examine the challenges in completing CBDRP during the COVID-19 pandemic; 3) provide leadership initiatives during the COVID-19 pandemic.

Methodology

The study used a qualitative method in gathering data following the phenomenological design and employed two different data-gathering techniques – (1) focus group discussion; and (2) literature review and data mining.

Using stratified purposive sampling technique, the population of CBDRP social service recipients in Palawan was determined based on location and after securing the list of CBDRP recipients per location from local government units, purposive sampling was applied where 188 PWUDs aged 18+ participated in the focus group discussions (FGD). Prior to the FGD, the study was explained, and consent was solicited. The interview guide for the FGD was developed with CBDRP social service providers at the provincial level and was pre-tested in one barangay. Based on the suggestions during pre-testing, guide questions were modified accordingly. FGD consisted of no more than 12 participants with at least two facilitators. The discussion lasted on average 45 minutes (ranging from 30-60).

Facilitators of the FGD wrote down the information provided by participants and analyzed using inductive thematic analysis (Baun & Clarke, 2006). Interview notes were read repeatedly and to identify the main content units, a feed-forward strategy was used. Data was reviewed by 3 independent researchers, and should there be disagreements, these were resolved through a consensus (Hickey & Kipping, 1996).

Results and Discussion

1. Background Characteristics

1.1. CBDRP Social Service Recipients: Person who uses drugs

There is a total of 188 PWUDs who participated in this study. The majority (70.59%) belong to the 20-44 age group while close to a quarter (29.41%) belong to the 45-64 age group. About a third (31%) of the respondents are in the food industry- agriculture or farming, fishing, and livestock. Of the total respondents, 19% indicated having multiple sources of income; however, 18% of the respondents did not indicate any sources of income. The responses on the sources of income are the food industry (31%), transportation (12%), wholesale and retail trade (11%), technical vocation (7%), and owning a dwelling for rent (7%). More than a third (36%) belong to an average-sized family with four to five household members, while 26% reside with a smaller household with one to three household members. About a quarter of the PWUDs (24%) belong to a large family with more than five members and 15% live alone or are single. The majority (91%) of the PWUD participants live in rural barangays, in a two-room house (41%), and living arrangements of either standalone house (44%), compound-style (38%), or shared house (15%). On access to the internet, 56% of PWUDs indicated having no access to the internet. On owning mobile phones, 68% indicated having 1 – 3 mobile phones, 26% have more than 3 mobile phones and 6% have no access to mobile phones.

2. Qualitative findings

Through thematic analysis, four overarching themes were identified in Table 1, it includes the following (1) experiences of PWUDs on CBDRP social services support mechanisms as against ”as

planned" (two subthemes); (2) challenges and issues experienced in completing CBDRP during COVID 19 pandemic (two subthemes); (3) leadership initiatives observed by PWUD during pandemic, and (4) role of local groups and PWUDs' family in the recovery of PWUDs during COVID 19 pandemic (two subthemes).

Table 1
Themes and subthemes from the interview

Themes	Subthemes
1. Experiences of PWUDs on CBDRP social services support mechanisms as against "as planned"	Shift from tradition to technology-driven method in relaying CBDRP related information
	Shift from face-to-face to hybrid mode of CBDRP social services
2. Challenges in completing CBDRP during pandemic	Support needed in completing CBDRP during COVID 19 pandemic
3. Leadership initiatives observed by PWUD during pandemic	Barangay officials seen as providing vital roles in the delivery of social services during disruptive times
4. Role of local groups and PWUDs' family in the recovery of PWUDs during COVID 19 pandemic	Increase trust in local groups as provider of psychosocial support
	Increase role of family members in the recovery process of PWUDs

2.1. Theme 1: Experiences of PWUDs on CBDRP social services support mechanisms as against "as planned"

In the 2019 annual reports of CBDRP Palawan, the program runs from 6 to 24 months with structured activities (psycho/social/spiritual support; motivational interviewing/counseling/life coaching; relapse prevention; family therapy, sports activities, medical and health-related activities, employment/livelihood support and community engagements) facilitated by members of anti-drug abuse council (ADAC) on a face-to-face basis at least 3 times a week (PGP, 2019). According to the CBDRP Operation Head of Palawan, during the pandemic, there were no specific issuances on the implementation of the CBDRP social services. Instead, ADACs adhere to the issuances of DOH and DILG relating to the management of COVID-19.

2.1.1. Shift from traditional to technology-driven mode of communication

According to the PWUDs, the mode of communication used in relaying CBDRP social services changed from traditional such as house-to-house visitation of ADACs, hand-delivered letters, and postal services, to the use of technology such as text messages, social media, and mobile calls. PWUDs added that although there is a shift in using technology as a mode of communication, the traditional mode is still used. Further, they indicated that the frequency of information relating to CBDRP has decreased significantly. Mostly, the text messages are COVID-19-related services such as financial assistance or food packs to be claimed in the barangay.

> *"Barangay officials send us messages through social media and text messages. They hardly visit us except when distributing food packages."* (R#105)

2.1.2. Shift from face-to-face to hybrid mode of CBDRP social services

The 2021 report of CBDRP Palawan indicated a shift in the mode of delivery from face-to-face to hybrid mode - limited face-to-face activities, online activities, phone calls, and modular (PGP, 2021).

Before the pandemic, PWUDs associated CBDRP with three types of activities – sports and wellness, community services, and different activities supported by the ADACs facilitated on-site and on a face-to-face basis. There is an overwhelming mention of positive experiences (enjoyed CBDRP, regained good health, becoming more sociable, and life becoming more comfortable) in comparison to negative experiences (negative effects on work and livelihood, reduced self-reliance, and limited mobility) on CBDRP as experienced before the pandemic.

During the pandemic, PWUDs reported three ways of accessing CBDRP activities – face-to-face, online, and modular, but still prefer face-to-face activities because ADACs have no online activities, no or poor internet connection, house near to venue of activity, have their transportation, and feels better when attending face-to-face activities. On the contrary, some PWUDs experience difficulty in physically attending the activities due to work or other schedule conflicts, difficulty accessing transportation, discrimination, and poor road, weather, and physical conditions.

Although PWUDs are aware of online activities, very few mentioned attending online activities due to having no devices like mobile phones/gadgets or computers; having no mobile load to connect to the internet, slow internet connection and they prefer face-to-face meetings. Some PWUDs are not aware of online activities. On the use of modules, PWUDs are ambivalent in their answer. They claim the modules sustained the CBDRP activities; however, they also claim they did not answer the modules seriously.

"I prefer face-to-face so we can comfortably talk and discuss problems" (R #81)

2.2. Theme 2: Challenges in completing CBDRP during COVID-19 pandemic

Before the pandemic, PWUDs identified physical infrastructure (facilities - health center and accommodation), financial support (financial assistance), social technology support (livelihood or employment programs, opportunity for community services/engagements), and enforcement (improved surveillance) as areas needing improvement. During a pandemic, PWUDs added access to CBDRP services (able to attend physical activities, no device/gadget for online activities, and poor internet connection/ no online communication/ not aware) and mental health (counseling and house visitation) as areas needing improvement (*Table 2*).

Table 2
Support to PWUDs to complete CBDRP

KIND OF SUPPORT (AREAS OF IMPROVEMENT)	PRE-PANDEMIC		DURING PANDEMIC	
	RESPONSES	FREQUENCY OF MENTION n=188	RESPONSES	FREQUENCY OF MENTION n=188
Physical infrastructure	Facilities (health center, accommodations)	84	Facilities (health center, accommodations)	45
	Lack of communication	26	Venue for activities/Computers	44
Fiscal support	Financial assistance	26	Increased/sustained "ayuda" or financial assistance, employment, capital	159
Social technology	Livelihood or employment programs	91	Face-to-face events for PWUDs	105
	Opportunity for community services	102	Maintain health protocols	102
	Sports and leisure activities	25	Form an organization for PWUDs	25
			Coastal clean-up	22
			Sustain/Continue CBDRP activities	24
Enforcement	Law enforcement and improved surveillance	48	Barangay visitation for counseling	110
Mental health support			Counseling/ House visitation	134
Access to activities			Able to attend physically/prefer face-to-face activities	122
			No device/gadget for online activities	35
			Poor internet connection/no online communication/ not aware	71

PWUDs expressed disappointment with CBDRP being stopped and delivered instead via online or modules. The desire to attend face-to-face CBDRP activities became more evident when they expressed support for social needs – having face-to-face events for PWUDs but maintaining health protocols, forming an organization for PWUDs, coastal clean-up, and sustaining/continuing CBDRP activities.

From the discussion, PWUDs expressed the need for mental health support activities particularly counseling due to worries about financial/employment needs, having limited social interaction, fear of their health and safety, and stresses from studies. It can also be noted that law enforcement is viewed by PWUDs during COVID-19 as a provider of mental health support.

> "*Asking me how I am. Regularly counseling or even just monitoring us will be helpful (R #127)"* and *"There are not many people to talk to since gathering is prohibited so I hope for house visitations." (R #29)*

2.3. Theme 3: Extent of in-charge officers providing leadership initiatives during COVID-19 pandemic

The leadership and the delivery of CBDR social services are tasked to the anti-drug abuse council at the different levels of the local government units – provincial, municipal, and barangay as per DILG memorandum Circular 2018-125 (DDB-DILG, 2018). During COVID-19, PWUDs identified government, civil society, and business sectors as those providing leadership initiatives with barangay officials mentioned as the most followed by uniformed personnel, community members/community care team, and rural health units.

The chairman of the Barangay. He provided help; did what was required of him, and many times did beyond his duty. He is a servant leader with a good heart." R#19).

2.4.Theme 4: Participation and role of local groups and PWUDS families in the delivery of CBDRP

In addition to the barangay identified by PWUDs providing leadership and social services during the pandemic, PWUDs identified local groups and their family as being vital in their recovery. PWUDs indicated lecturer, house visitation, counseling partner, participant, or donor/benefactor as some roles. PWUDs also mentioned support such as increased government financial assistance, communication and coordination, and recognition or honoraria; and a few answered livelihood or family support and providing infrastructure such as offices for the use of local groups.

This study explored the experiences of PWUDs undergoing CBDRP in Palawan during a disruptive time, i.e., during the COVID-19 pandemic. Overall, findings confirm (i) that during disruptive times, the content, structure, and delivery of social services designed in a pre-disruptive system face challenges and will require a spectrum of modifications to be accessible to target recipients (Schmid, 2022; Evans et al., 2023; Schofield et al., 2022; Russell et al., 2021); (ii) that during disruptive times, PWUDs require support mechanisms on mental health to augment planned CBDRP social services (Kelly et al. 2022; & Stack et. al., 2021); (iii) that PWUDs see the barangay officials/volunteers as their 1st line of the service provider on mental health (Kyoon-Achan & Write, 2020; and (iv) that local groups and families of PWUDs contribute to the implementation of CBDRP during the disruptive time (MacInnes et. al., 2022; Jewett et. al, 2021; Pitas, 2020).

During a pandemic, PWUDs indicated sustained CBDRP support delivered through modules, online, and limited face-to-face and yet highlighted more negative experiences - affecting work and livelihood, boredom, fear and uncertainties, reduced reliance, and receiving no services from CBDRP implementers, similarly observed in the study on PWUDs in the United States (Vahratian et al., 2020). Psychological distress affecting functional, social, and emotional aspects of a PWUD cannot be denied; hence PWUDs needs for such services become more evident (Kelly, 2022). The experiences of PWUDs suggest that policy change on the content, structure, and delivery of CBDRP social services was not sufficient to compensate for the psychological distress and that CBDRP social services access and retention particularly on psychological support are critical during disruptive times.

The change in the perspective on enforcement as surveillance to house visitation by the barangay officials and/or local groups strengthens the value placed by PWUDs in the barangays and local groups especially volunteers in providing support in their recovery. Studies indicated that quality of life is directly associated with the availability of support groups (Birkeland et al., 2021), and that family and social networks result in improved quality of life, improving substance use outcomes, thus supporting recovery (Muller et al, 2017).

The study also reveals the significant roles of informal carers and PWUD families as alternatives in sustaining CBDRP activities during disruptive times. Informal carers such as community volunteers, local groups, and family members of PWUDs, who provide support in the recovery of PWUDs before the COVID-19 pandemic, are seen to have a significant role in the recovery of PWUDs even during disruptive times. Meeting psychological needs has been identified by PWUDs as one of the barriers to completing CBDRP during disruptive times. To overcome this barrier, PWUDs identified family support and good family relationships as mechanisms to overcome challenges and issues faced during a pandemic. A similar claim was mentioned by PWUDs in the discussion on family dynamics wherein being open with family helps to overcome challenges and issues during disruptive times. Various studies have interpreted family support to be a positive factor in the recovery of PWUDs – in addition to life skills, family support significantly contributes to the recovery of mild-risk PWUDs (Sy & Hechanova, 2020); frequency of relapse among PWUDs decreases with improved social support from family, friends, and social groups (Atadokht et al., 2015).

In relation to connecting with local groups, a significant number of PWUDs mentioned community services and engagements as support mechanisms needing improvement in their CBDRP activities prior to the pandemic (Table 2). Findings also revealed that during a pandemic, PWUDs desire to form themselves into an organization. Studies on the value of peer support were highlighted in various studies - Hagaman, et al. (2023) claimed that peer recovery support specialists play an important role in the recovery of PWUDs; Eddie et al. (2019) mentioned that peer recovery support services open the possibility for reduced substance use, improved relationship with service providers and social support; and Magidson et al. (2022) provided promising indication on the use of peer model for reducing substance use stigma. This provides another perspective on providing CBDRP social services to PWUDs through their peers.

Conclusion

The study highlights the encumbrance of the COVID-19 pandemic on vulnerable populations such as PWUDs and the disruption it causes in the delivery of social services to recipients in recovery, revealing the importance of incorporating the equity principle, leveraging technology through digital transformation and engagement, tailored participatory approach in the provision of physical, social and psychological

support mechanisms and strengthened institutional capability at the lowest level of government to deliver a spectrum of mitigating mechanisms. Policies and measures should recognize not only the physical and social needs of the PWUDs but also the heightened psychological needs during disruptive times. The interruption in the delivery of social services to PWUDs in recovery during disruptive times draws attention to the inequitable and disproportionate impact on vulnerable populations, possibly reversing recovery progress; thus, the need for a high-quality and balanced policy of care and public health measures. Enabling the availability and accessibility of social services and recognizing the different needs of the PWUDs during disruptive times can lead to a more resilient system that can effectively withstand disruptions such as the COVID-19 pandemic.

Recommendations

The experiences of PWUDs during COVID-19 pandemic provided a perspective of the disruptions in such situations to the recovery progress of the PWUDs; and highlighted the value of a support system as key to the recovery process of PWUDs from substance abuse. Through multi-stakeholder work achieving sustained CBDRP social services delivery during disruptive times, it is recommended to strengthen the national and local enabling environment by promoting: (1) improved delivery of social services using different modalities; (2) policy/legislation reform and enforcement on mental health through the barangay; (3) improved economic incentives reducing triggers; and (4) intra-and inter-sector coordination for the delivery of CBDRP social services. These efforts aim to create an environment of sustained CBDRP social services delivery during disruptive times.

Acknowledgment

The author acknowledges the support of the local government units in Palawan and the Community Enhancement and Livelihood Program of the Provincial Government of Palawan.

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