IN SEARCH OF AN INTER-SECTORAL COLLABORATIVE MODEL FOR DRUG REHABILITATION IN THE PHILIPPINES: A CASE COMPARISON STUDY

CARL ABELARDO T. ANTONIO

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In search of an inter-sectoral collaborative model for drug rehabilitation in the Philippines: a case comparison study

Carl Abelardo T. Antonio

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CERTIFICATE OF ORIGINALITY

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Carl Abelardo T. ANTONIO (Name of student)

ABSTRACT

Significance, knowledge gaps, and aims of this research: Drug dependence is a major public health and social concern in the Philippines, where approximately 2% of the population are estimated to be current drug users. A national policy was instituted that aims to control drug supply while at the same time providing services to reintegrate people who use drugs (PWUD) into society, the latter through provision of treatment and rehabilitation services. Collaboration is a key strategy to enable organizations involved in drug rehabilitation to address the complex medical, mental, social, and legal problems confronting PWUD. One important challenge in, however, is the fragmentation of service provision across different agencies, resulting in a weak continuum of care. The aim of this research is to describe and review the current process and framework of interagency collaboration in drug rehabilitation in the Philippines using a multiple case study design to propose a feasible model of collaboration.

Methods: This is a qualitative research design with multiple sources across three studies. Study One utilizing a scoping review approach (54 papers from 5,632 unique records) to synthesize and categorize the key components (i.e. the nature, goal, structure and composition, activities, and outcomes) of inter sectoral collaboration for drug rehabilitation. Study Two conducted focus group discussions (seven focus groups with 27 participants) with drug rehabilitation personnel coming from social work, law enforcement and rehabilitation settings. It uncovered the attitude of different sectors towards collaboration, the actual practice of collaboration, and some facilitators and barriers to collaboration, including the impact of COVID-19 on interagency collaboration. Study Three conducted semi-structured individual interviews (28 informants) with staff members working in drug treatment and rehabilitation centres, court personnel, law enforcement agent, and former drug users for

capturing direct experience and perception of intersectoral collaboration.

Key findings, innovation, and originality: Using thematic analysis, four themes emerged in the focus group study, namely “partnership” (theme 1), “participation” (theme 2), “push and pull” (theme 3), and “pandemic” (theme 4) that represented the agencies’ perception about inter sectoral collaboration for drug rehabilitation. Individual interviews generated more in-depth and subjective understanding of the study topic, and five themes emerged, including: perspective (theme 1), purpose (theme 2), properties (theme 3), push and pull (theme 4), politics and pandemic (theme 5). Connecting the themes and research objectives, three key findings were identified. First, partnerships were formed for three reasons: resource scarcity (i.e., an agency cannot provide a service needed by PWUD, but another organization is able to do so), legitimacy (i.e., public recognition for localities that are able rehabilitate identified PWUDs), and compliance to government/executive mandate. Second, in terms of professional perspective, law enforcement and legal fields tended to ascribe to prohibition, whereas those from health, social work, and education services favored rehabilitation. Last, there was variation in terms of participating agencies' collaborative arrangement structure.

Implications and conclusion: In summary, this is one of the first qualitative study exploring and narrating the intersectoral collaboration for drug rehabilitation during the COVID-19 pandemic period in Philippines. This research addresses a research gap in the topic of collaboration in drug rehabilitation, which is predominantly North American in orientation and derived from short-term project demonstration grants, by offering a real-world perspective on collaboration from the Philippine context. This study will also serve as input to the development of guidelines in the operationalization of collaboration in the local setting as well as in other jurisdictions with similar conditions.

PUBLICATIONS ARISING FROM THE THESIS

Journal articles

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Antonio, C. A. T., & Li, C. M. J. (2023). Definition and conceptualization of collaboration in drug rehabilitation: Systematic synthesis and comparison using a scoping review approach. *Acta Medica Philippina*, *57*(5), 16–27. https://doi.org/10.47895/amp.vi0.3040

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Book chapters

Antonio, C. A. T., & Li, C. M. J. (2023b). Drugs and crime: Reflections on the Philippines' war on drugs. In *Current Problems of the Penal Law and Criminology. Aktuelle Probleme des Strafrechts und der Kriminologie* (Ser. No. 9, pp. 85–98). essay, Prokuratura Krajowa.

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Maraming salamat po!

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1. Introduction

The Philippines is an archipelagic nation of more than 7,000 islands located in maritime Southeast Asia. Based on the most recent census of population conducted in 2020, the country's population of 109,035,343 is relatively young (median age: 25.3 years) with a slight male predominance (sex ratio: 103 males for every 100 females), literate (literacy rate: 97.0%), and predominantly Roman Catholic (78.8%) (Mapa, 2021, 2022, 2023a, 2023b). Geographically, Filipinos are distributed over three major island groups (Luzon in the north, Visayas in the middle, and Mindanao in the south), 17 administrative regions, 81 provinces, 1,488 municipalities and 146 cities, and over 42,000 barangays (villages). The Philippines is a lower-middle income country, with a gross domestic product in 2024 reported at 471.522 billion US dollars (IMF, 2024). Wealth distribution is uneven, with about a tenth (10.9%) of the population being considered poor (i.e., below the annual per capita poverty threshold of PHP 13,873 [or about USD 250]) (Mapa, 2024).

Historically, drug use and drug dependence have been considered as a public health and social concern since the 18th century, but this has become more pronounced with the election of a new government in 2016, which has identified the problems of illicit drugs, poverty, and corruption as central issues that need to be addressed if the Philippines is to realize its vision of providing more citizens with improved quality of life by 2040 (National Economic and Development Authority, 2017). It is in this context that this research on interagency collaboration in drug rehabilitation will take place.

This Chapter situates the research project within the broader issue of drug use and dependence in the Philippines. It first briefly presents the problem of illicit drugs in the country and compares this with the situation in other areas in the region. The next section expands on a description on the nature, magnitude, and consequence of the problem of drug

abuse and dependence. The policy response by government is then briefly explained, with emphasis on drug rehabilitation. Lastly, the gaps in, and implications for, knowledge, policy and practice being addressed by this research are discussed.

1.1. Drug abuse and dependence in the Philippines

1.1.1. The problem of illicit drugs

Illicit drugs were supposed to have first been introduced in the Philippines in the mid-17th century, although it was only two centuries later that addiction of locals with opium was mentioned in the historical records leading the Spanish governor general in the Philippines to issue in 1814 a decree punishing individuals involved in the trade and use of this substance (Zarco, 1995). Marijuana (*Cannabis sativa*) was introduced in the country in 1955 and, along with synthetic drugs, has gained popularity among the population during the post-war period (Zarco, 1995).

Today, crystalline methamphetamine hydrochloride (also known as *shabu* in the vernacular) is the predominant drug of concern in the country, as this substance accounts for a significant proportion of drug-related seizures in 2021, followed by marijuana and ecstasy (methylenedioxy-methamphetamine or MDMA) (Philippine Drug Enforcement Agency, 2021). In its most recent published report, the Philippine Drug Enforcement Agency (PDEA), the lead implementor of the country's drug control policy, reported that they seized a total of 2,300 kilograms of methamphetamine, 6,200 kilograms of marijuana, 1.2 kilograms of cocaine, and over 75,000 tablets of ecstasy (Philippine Drug Enforcement Agency, 2021). Of note, the volume of illicit substances seized by law enforcement agencies has increased over the past years. This situation may be partly explained by the intensified supply reduction initiatives, especially in terms of implementing anti-illegal drug operations in the country.

Further efforts are required, however, for the supply of cocaine and ecstasy, both of which are smuggled into the country from other embarkation points.

Using the reported volume of drugs seized by government authorities as indicator of the magnitude of the problem on illicit drugs, the Philippines can be said to be in the middle when compared with other countries in East and Southeast Asia (UNODC, 2023).

Both domestic and imported sources of drugs have been identified by law enforcers (Philippine Drug Enforcement Agency, 2021). Methamphetamine is either produced locally by clandestine laboratories mainly operating in the National Capital Region as well as Central Luzon (although clandestine laboratories have been dismantled in other regions as well), or smuggled by international syndicates who are taking advantage of the country's long coastline. The latter is also the preferred route for entry of cocaine. Marijuana, meanwhile, is cultivated in the upland areas of northern Luzon and the mountainous areas of Mindanao. With respect to drug trafficking, the identified sources for methamphetamine brought to the Philippines are countries in the Mekong region (Cambodia, Lao PDR, and Viet Nam), while ecstasy comes mainly from Europe (The Netherlands, Germany, Belgium, and France) (UNODC, 2020). On the other hand, the Philippines was reported as the embarkation point for some of the methamphetamine seized in Taiwan and Japan (UNODC, 2020).

1.1.1. Magnitude and nature of drug use

Information on the extent of the drug abuse problem has been tracked by the Dangerous Drugs Board, the highest policy-making body on drug-related matters in the country, through five waves of national surveys (Dangerous Drugs Board [DDB], 2005; DDB, 2008; DDB, 2012; DDB,2019a; DDB & Resources, Environment, and Economics Center for Studies, Inc.,

[REECS], 2016) commissioned by the agency since the promulgation of the Republic Act No. 9165, or the "Comprehensive Dangerous Drugs Act of 2002". Among other data, the surveys quantified the prevalence of *lifetime drug use* (i.e., proportion of respondents who have used drugs at least once in their lifetime) and *current drug use* (i.e., proportion of respondents who continue to use drugs, regardless of frequency, within the year prior to the survey). Survey results are summarized in Table 1-1.

Table 1-1. Trend in current and lifetime drug use, Philippines, 2005 to 2019

	Survey Year				
	2005	**2008**	**2012**	**2015**	**2019**
a. Survey sample size	12,000	12,714	10,752	5,000	9,341
b. No. of respondents who reported to have ever used drugs at the time of the survey	2,755	1,334	456	306	541
c. Prevalence: lifetime users	**22.96%**	**10.57%**	**4.24%**	**6.12%**	**5.79%**
d. No. of respondents who were using drugs within the 12 months prior to the survey	1,673	322	195	113	192
e. Prevalence: current users	**13.04%**	**2.53%**	**1.81%**	**2.26%**	**2.05%**

Sources: Dangerous Drugs Board (2005, 2008, 2012, 2019a); Dangerous Drugs Board and Resources and Resources (2016)

Extrapolating the prevalence from the most recent population data (2019), it can be said that among Filipinos 10 years or older, approximately 4.7 million have ever used drugs, while around 1.7 million are current users. Notably, the prevalence of both lifetime and current drug use among Filipinos has declined by 75% and 84%, respectively, from 2005 to 2019, although there is a notable upward trend in prevalence from 2012 to 2015 (44% increase in lifetime users, and 25% increase in current users). The general decline in drug use in the Philippines has been attributed to the intensified implementation of supply reduction strategies by law enforcement agencies, as well as the expansion of drug testing for certain population segments (i.e., mandatory testing for applicants of driver's license, firearms holders, military, and civil servants; random testing among students) (DDB, 2008; DDB, 2012). Comparison of time trend, however, is complicated by differences in the sampling

population and design used across the different survey waves (i.e., the 2008 survey focused on persons aged 10 to 44 years, while succeeding surveys captured older age groups; the 2012 survey was capped at 5,000 respondents due to funding constraints, and the grouping of sampling areas was limited to five clusters instead of including all the administrative regions as was done in the preceding surveys).

Meanwhile, in the same year, the number of persons arrested and imprisoned for drug-related offenses was substantially lower than the estimated prevalence indicated above. Law enforcers, principally the Philippine Drug Enforcement Agency and the Philippine National Police, reported a total of 62,082 persons arrested for various violations of the statute on dangerous drugs, which represent only about 3% of the estimated prevalent cases of drug users (Philippine Drug Enforcement Agency, 2019).

1.1.2. Profile of drug users

Current drug users are typically male adults who have completed at vocational education and belong to lower socioeconomic groups (Dangerous Drugs Board, 2019a). Specifically, about nine in 10 current drug users belong to the 18 to 59 age group (Table 2). Males outnumber females by a ratio of 7:1. Only about one-third of current users are estimated to have never been married. In terms of educational attainment, at least half have completed high school education, while one in four were able to complete college-level education. Thus, it is not unexpected that about two-thirds are working, either as employees, business owners, or self-employed.

Table 1-2. Demographic characteristics of current drug users, Philippines, 2019 (n = 191)

Demographic characteristics	Number	Percentage
Age group		
10 to 17	1	1%
18 to 59	178	93%
60 and older	12	6%
Sex		
Male	179	94%
Female	13	7%
Sex ratio	*13:1*	
Educational attainment		
Elementary	44	23%
High school	81	42%
College	45	24%
Vocational	15	8%
Not specified	6	3%
Socioeconomic class (based on DSWD classification)		
Class C	7	4%
Class D	29	15%
Class E	153	80%
Not specified	2	1%

Source: Dangerous Drugs Board (2019a)

Five administrative regions that accounted for a large proportion of drug users were Region III in Central Luzon; the National Capital Region; Region 4A in Southern Luzon; and Visayas regions (consisting of Region VI Western Visayas; Region VII Central Visayas) in central Philippines. Notably, in the major metropolitan centers of the country can be found in two of these regions: i.e., all cities under the National Capital Region, otherwise known as Metro Manila, and Cebu City, the center of commerce and trade in the Visayas.

The two most popular drug types used in the Philippines are methamphetamine hydrochloride, locally known as *shabu*, and cannabis or *marijuana* (DDB, 2005; DDB, 2008; Dangerous Drugs Board, 2019a; DDB & REECS, 2016). Peer pressure, as well as curiosity,

or the desire to experience effects of drugs, both account for about 80% of reasons cited for first-time drug use (DDB & REECS, Dangerous Drugs Board, 2019a; 2016).

1.1.3. Cost and consequence of drug use

In addition to the effects of drug use on physical health, there are also documented consequences to the family and the Philippine society.

First, the cost of drug consumption amounts to a sizeable proportion of the family's income, which leads to financial difficulties for some. The estimated annual consumption of drugs cost individual users the amount of PHP 55.8 billion pesos (or approximately USD 1 billion), a number which is equivalent to 0.34% of the country's gross domestic product in 2015 of USD 292.8 billion (DDB & REECS, 2016). Given that the average annual income of families in the Philippines in 2015 was PHP 267,000 (about 5,300 US dollars), expenditures on drugs could be said to account for about 10% of a family's total income, or almost equal to what is spent on house rental (12.2% of total household expenditure), and higher than the allocation for utilities (7.9%), transportation (6.2%), education (3.8%), and healthcare (3.7%) (PSA, 2017). About 10% of families reported facing financial problems in relation to drug use by a household member (DDB & REECS, 2016).

Second, drug use was reported to have resulted to strained relations among members in about a third of families (DDB & REECS, 2016). This includes causing grief or depression to other family members (11%), as well as separation within the family (12%). Furthermore, among persons who stopped using drugs in the Philippines, about half indicated that drug use did nothing good in their lives, and 6.65% were jailed because of their drug use (DDB, 2008). Children in families with a drug user were also exposed to drugs at an early age, and were

oftentimes involved as runners or watchers; in some cases, children also initiated drug use because of this early exposure (Porio & Crisol, 2004).

In terms of the burden of disease, drug use disorders accounted for 167 per 100,000 disability-adjusted life years (Uncertainty Interval [UI]: 121.99–220.33), or the years of healthy life lost, among the Philippine population (Institute for Health Metrics and Evaluation, 2015). This is equivalent to 0.53% (UI: 0.40%–0.69%) of the total disability-adjusted life years estimated for Filipinos in 2017. The burden of disease has markedly decreased by 21% from the earliest estimate of 210.99 per 100,000 disability-adjusted life years (UI: 161.04–265.16) in 1990. This burden may be higher if other related conditions are taken into consideration. For instance, about 4% of persons diagnosed with HIV in the Philippines are injecting drug users (Gangcuangco, 2019). The prevalence of syphilis, a sexually transmitted infection, was estimated to be about 2.5% among persons who inject drugs, a magnitude higher than that for other most-at-risk populations like freelance sex workers (2%) or men who have sex with men (1.5%) (World Health Organization [WHO]2015). Further, persons who use drugs admitted in rehabilitation centers were found to have a burden of tuberculosis twice to six times higher compared to the general population (Antonio et al., 2020).

Finally, as incarceration is one of the penalties for violation of current drug use regulations, the cost to the state may be significant. The annual cost for imprisonment per inmate was estimated to be around USD 1,500, and this amount was expected to increase because of the government's intensified anti-drug campaign (Macarayan et al., 2016). Meanwhile, in 2019, the allocation to support the operation of government-owned drug rehabilitation centers amounted PHP 1.2 billion (USD 23 million), which represented around 1.2% of the approved budget for the Department of Health for that year (Congress of the Philippines, 2017).

The figures mentioned in this section should be considered as indicative, rather than definitive, measures of the extent of the problem of drug use and abuse in the Philippines. The intensified national campaign on anti-illegal drugs initiated by the government elected in 2016 seems to point to the possibility that the magnitude of the problem may be higher than previously thought (Mutiarin et al., 2019; Simbulan et al., 2019). For example, around 1.2 million drug users surrendered to authorities within the first few months of the launch of the president's "war on drugs" (Mutiarin et al., 2019), and the number has considerably grown since (PDEA, 2016; PDEA, 2018a; PDEA, 2018b).

1.2.The Philippine policy on dangerous drugs

The national policy on dangerous drugs is embodied in Republic Act No. 9165 promulgated in 2002 (Congress of the Philippines, 2002). This statute is an amendment to the then three-decade old legislation, Republic Act No. 6425 or "The Dangerous Drugs Act of 1972" (Congress of the Philippines, 1972). The policy uses a two-pronged approach that highlights the need, on the one hand, to control trafficking and use of drugs, while also recognizing, on the other, that persons who use drugs (PWUD) require treatment and rehabilitation so that they can reintegrated into society. The DDB, composed of 12 member agencies from the health, social, and law enforcement sectors among others, is the principal government body that develops and monitors regulations and strategies that operationalize the provisions of Republic Act No. 9165. Implementation of the policy is guided by the national roadmap outlining the country's anti-illegal drug strategy adopted in 2018 (DDB, 2018), and overseen by the Interagency Committee on Anti-illegal Drugs (President of the Philippines, 2017).

A balanced approach aimed at supply reduction and demand reduction is achieved through enforcement of mandates by four government agency clusters. Supply reduction involves

taking away drugs from the market through anti-illegal drug operations spearheaded by law enforcement agencies (enforcement cluster), as well as the prosecution of cases involving violations of Republic Act No. 9165 (justice cluster). Initiatives under these two clusters include the seizure of illicit drugs, controlled precursors and essential chemicals, and laboratory equipment; dismantling of drug dens and clandestine laboratories; identification and persuasion of suspected drug users in the community to submit to drug rehabilitation; and the arrest and prosecution of persons involved the trafficking and sale of drugs. Demand reduction, on the other hand, consists of the provision of promotive and preventive (advocacy cluster), and rehabilitative and reintegration services (rehabilitative and reintegration cluster). Activities under demand reduction include conduct of educational programs, seminars and services in schools, workplaces, and the community; and the provision of treatment and rehabilitation services for those diagnosed with drug use disorders.

While the policy as written on paper seems to point to a state that strives to address concerns on the trafficking and sale of drugs, on the one hand, while recognizing the provision of treatment and rehabilitation programs for PWUD with legitimate medical needs, on the other, implementation indicate otherwise, especially since the installation of a new government following the 2016 national elections. Specifically, this pertains to what has been noted by several scholars as a preponderance of violence in the president's "war on drugs", which has resulted to the deaths of suspected drug personalities, often in the course of surrender or arrest, or what has been termed "extra-judicial killings" (Cornelio & Medina, 2019; Gallagher et al., 2019; Jensen & Hapal, 2018; Johnson & Fernquest, 2018; Mutiarin et al., 2019; Reyes, 2016; Simangan, 2018). Official government reports show that about 5,000 individuals have been killed in drug-related operations within the first 12 months of the current government, while non-government estimates place the figures at between 7,000 and 16,000; either source present numbers which are much higher than the number of persons judicially executed from

1993 to 2006, as well as the extra-judicial killings in the 1970s (Johnson & Fernquest, 2018). This situation prompted a group of scholars convening during the annual conference of the Global Health Program of the Association of Pacific Rim Universities in Manila in 2017 to issue a statement calling on the government to reframe the drug problem in the Philippines from one of criminality to a complex issue that requires a holistic and rights-based approach (Simbulan et al., 2019). Among others, these scholars noted that interventions to prevent and control drug abuse should incorporate strategies that address "health, psycho-social, socio-economic and rights-related" dimensions, and that government should tackle the root cause of the problem of illicit drugs, i.e., "social inequality and injustice, lack of economic and social opportunities, and powerlessness among the Filipino people" (Simbulan et al., 2019).

1.3.Overview of drug rehabilitation in the Philippines

As mentioned in the preceding section, the provision of treatment and rehabilitation services formed a cornerstone of the Philippine policy to address the drug problem since the first statute on dangerous drugs was enacted in 1972. Since 2002, the supervision of drug treatment and rehabilitation efforts was transferred from the National Bureau of Investigation (an attached agency of the Department of Justice) to the DOH. Drug rehabilitation is guided by the provisions of Republic Act No. 9165, a 2019 DDB regulation on the "Consolidated Revised Rules Governing Access to Treatment and Rehabilitation Programs and Services", and the DOH's 2018 "Manual of Operations for the Accreditation of Drug Abuse Treatment and Rehabilitation Centers".

From 1972 to the present, treatment and rehabilitation has been either voluntary (i.e., PWUD or his guardian submits the person for rehabilitation) or compulsory (i.e., PWUD sent by courts to treatment). The former is generally reserved for persons who are charged with

violation of the provisions on the possession and use of dangerous drugs, while the latter happens in instances when a person is being prosecuted for a crime (which may or may not be related to drugs) and is suspected or found to be a PWUD.

Treatment and rehabilitation services for both voluntary and compulsory treatment are provided through public or private facilities accredited by the DOH. These offer a range of medical, behavioral, and social interventions intended to address a PWUD's problems offered in either a residential (i.e., PWUD is admitted in a treatment facility for the duration of rehabilitation; this is mandated for those with severe drug dependence) or non-residential setting (i.e., PWUD are treated on an out-patient basis; this is available for those with milder forms of drug dependence). Services required by PWUD but not offered by a provider should result to referral to another agency that can provide such service.

Duration of treatment for those with severe forms of drug dependence is statutorily mandated to be a minimum of six months' duration followed by 18 months of aftercare, while the length of treatment for those with milder forms of drug dependence will depend on the assessment of the attending physician. At the end of the treatment process, persons who submitted to voluntary rehabilitation are reintegrated into the community, while those under compulsory treatment are remanded to the courts for continuation of the legal proceedings against them.

The challenges confronting drug rehabilitation in the Philippines pertain to the quantity and quality of available services (DDB, 2018). In the preceding section, it was mentioned that only about 1% of the estimated drug users were admitted to a treatment facility pointing to an issue of access, and which the government is addressing through establishment of additional facilities across the country. More importantly, however, an assessment by the DDB in 2018 has shown that the treatment modalities offered in facilities are currently fragmented, and

there is weak continuum of care and service delivery from assessment and intake through to social reintegration (DDB, 2018). In part, this may be partly due to the lack of guidance on how to operationalize such referral process to realize the desired state of having holistic and comprehensive care, especially considering that services required by PWUD are offered by different agencies or institutions. In a study on tuberculosis prevention and control in government treatment and rehabilitation centers in the Philippines, for example, it was found that none of the six facilities included in the research consistently established referral and coordination mechanisms with the tuberculosis control program of the local health department with jurisdiction over the facility for concerns on diagnosis, drug supply, and continuity of care (Guevarra et al., 2020).

1.4.Significance of the study

In recognition of the often complex medical (Cherubin & Sapira, 1993), mental (Flynn & Brown, 2008; Morisano et al., 2014), social (Daley, 2013), and legal (Chandler et al., 2009) problems that PWUD confront, prevailing regulations in the Philippines mandate that organizations providing drug treatment and rehabilitation services work closely with agencies in the social and legal services, as well as local government units and civil society organizations, as PWUD enter and undergo the rehabilitation process, and are later on transitioned to aftercare and reintegration (DDB, 2018; DDB, 2019b). In other words, these organizations must work together or collaborate to deliver the services needed by a PWUD, a core principle of the international standards for drug treatment and rehabilitation (UNODC, 2017). Collaboration is expected to enable organizations to capitalize on synergy, specifically by allowing them to merge existing resources and strengths to address common concerns (Lasker et al., 2001).

The current scholarship on interagency collaboration has attempted to define and measure collaboration by institutions providing services for PWUD (Clark et al., 2017; Delany et al., 2003; Drabble, 2011; Fletcher et al., 2009; Goodman, 2015; He, 2015, 2017; Hoffman et al., 2004; Iachini et al., 2015; Rush, 2014; Smith & Mogro-Wilson, 2007, 2008; Welsh et al., 2016; Wenzel et al., 2004). Despite underlying similarities by which collaboration has been defined in the literature, there is still a notable difference in terms of terminology (i.e., *collaboration*, *integration*, *cooperation*), as well as the precise definition for these terms. For example, some sources view "collaboration" as a lower form of "integration", while others use these terms (together with "partnership" and "networking", among others) interchangeably. Further, studies on collaboration have been limited to a measurement and description of a combination of two to three aspects of collaboration at any one time, despite the identification of at least five dimensions by which collaboration can be conceptualized: (i.e., in terms of level of intensity, activities, development over time, focus, and type). This proposed research, then, is envisioned to be able to contribute to the conceptual domain, specifically by investigating how agencies involved in drug rehabilitation in the Philippines understand and define collaboration, and whether the five dimensions of collaboration can be observed in this context.

Over 50 empirical papers were published on the topic of collaboration in context of drug rehabilitation from 1990 to 2019 (Abdel-Salam et al., 2017; Amaro et al., 2004; Anastas et al., 2019; Appel et al., 2017; Barreira et al., 2000; Bennett & Lawson, 1994; Best et al., 2010; Bonham et al., 1990; Bouis et al., 2007; Bray & Rogers, 1995; Brindis et al., 1997; Clark et al., 2017; Clodfelter et al., 2010; Coll et al., 2010; Crome et al., 2000; D'Aunno et al., 2017; Darfler et al., 2019; Drabble, 2011; Drabble & Poole, 2011; Drainoni et al., 2014; Formica et al., 2018; Glenn & Moore, 2008; Green et al., 2008; Guerrero et al., 2016; Gurewich et al., 2014; He, 2015, 2017; Heckman et al., 2004; Huebner et al., 2015; Hunter et al., 2005;

Iachini et al., 2015; Kikkert et al., 2018; Lee et al., 2006; Ma et al., 2016; Masson et al., 2013; McCarthy et al., 1992; Mittal & Suzuki, 2017; Morgenstern et al., 2009; Pelissier & Cadigan, 2004; Proeschold-Bell et al., 2010; Proeschold-Bell et al., 2016; Rosenheck et al., 2003; Ryland & Lucas, 1996; Samet et al., 2003; Schlenger et al., 1992; Smith & Mogro-Wilson, 2007; Van Hasselt et al., 2005; Veysey et al., 2004; Watkins et al., 2017; Welsh et al., 2016; Wenzel et al., 2004; Whiters et al., 2010; Wood & Austin, 2009; Zaller et al., 2007). These sources offer a wealth of information on the structure and outcomes of different collaborative initiatives, and point to factors at the contextual, organizational, and individual levels that may affect the success of collaboration.

Notably, however, these are limited by their focus on partnerships between two institutions formed as part of a research or project demonstration grant, which fails to capture the complexity of collaborative arrangements that arise in real-world practice. Furthermore, it is notable that most (i.e., nine in 10) empirical papers on collaboration were done mainly in the United States, the social and policy context – in both general and drug use aspects – of which differs from most other jurisdictions. From this perspective, then, the Philippine situation presents a unique opportunity to contribute to the body of knowledge on collaboration, this time in the setting of a lower-middle income economy in the southeast Asian region, operating on a devolved form of governance (Congress of the Philippines, 1991), and with a national drug rehabilitation policy that operates on both voluntary and compulsory treatment paradigms (Congress of the Philippines, 2002).

With reference to the current Philippine policy, there is an apparent mismatch between the demand and availability of treatment and rehabilitation services in the country. Figure 1-1 shows the trend in the reported number of persons admitted in treatment and rehabilitation facilities in the Philippines from 2002 (the date when reporting became mandatory following

promulgation of Republic Act No. 9165) to 2023 (the latest reporting year with data available). Over this 21-year period, an average of about 4,400 persons were admitted in the different reporting facilities, with peak admission occurring in 2003 (Dangerous Drugs Board, 2023). From 2012, it can be noted that the number of persons admitted is exhibiting a generally upward trend, such that admissions in 2018 is almost double that reported in 2012. There was also a concurrent increase in the number of rehabilitation facilities, from 30 in 2012 to 75 in 2023. Understandably, a dip in the number of admissions occurred during the pandemic period. Despite the increasing trend in persons admitted for rehabilitation, however, it is notable that the number of persons provided treatment and rehabilitation services represents less than 1% of the estimated number of prevalent cases in the country, indicating that a larger number of PWUD are not able to avail of the services. This may perhaps be attributed to the low number of available rehabilitation facilities, not to mention the possibility that some of those who are supposed to undergo treatment and rehabilitation may have been instead subjected to extra-judicial killing.

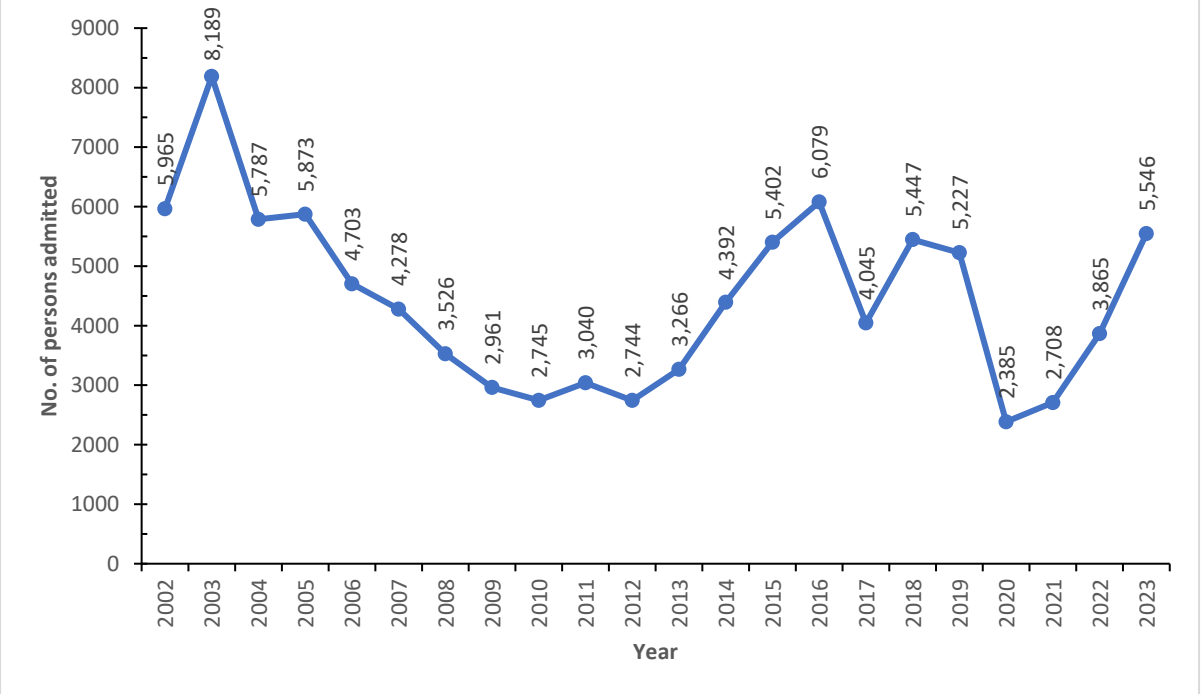

Figure 1-1. Trend in reported number of admissions of drug rehabilitation facilities, Philippines, 2002 to 2023

Source: Dangerous Drugs Board (2023)

There is also little guidance available from existing Philippine regulations on how to operationalize collaboration at the point of implementation. This is in contrast to the availability of issuances directed at national government agencies spelling out the terms of coordination and collaboration at this level (President of the Philippines, 2017).[*] It can be surmised that, following the logic of Lipsky's street-level bureaucracy (Lipsky, 1971), a substantive amount of discretion is exercised by managers and front-line staff rehabilitation, public health, social and law enforcement agencies in interpreting the mandate to work together, which may translate to wide variations in practice and outcomes. A previous research on the management of tuberculosis in rehabilitation centers, for instance, has shown that there is wide variation in how this is practiced owing to the lack of regulation or guidance in this regard (Guevarra et al., 2020). Understanding how collaboration is currently practiced at the implementation level in the Philippines, then, can serve as a starting point for the development of more concrete guidance and measures for partnerships at the frontline to truly attain the goal of improving the health and well-being of a PWUD.

1.5.Chapter summary

Drug dependence is a major public health and social concern in the Philippines, a lower-middle income country in Southeast Asia. Crystalline methamphetamine hydrochloride

[*] In 2022, or around the time of the completion of data collection for this research, the Philippines elected a new president, Ferdinand "Bongbong" Marcos, Jr. His administration views the drug problem as a mental health concern that requires a whole-of-government approach to its resolution. This is in stark contrast to the policy position of the previous administration under Rodrigo Roa Duterte, who emphasized prohibition and legal measures against drug users.

References:

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(locally called *shabu*) and marijuana are the predominant drugs of concern in the country, while seizure of cocaine and ecstasy have been noted to be on an uptrend in recent years. Domestic and imported sources of drugs have been identified by law enforcement agencies, while the Philippines has also been noted to be an embarkation point for some methamphetamine seized in other East Asian countries.

Around 2% of the population are current drug users, which is equivalent to approximately 1.8 million Filipinos aged 10 years and older. Most drug users are adult males who have completed college and are working. Drug use has been attributed to peer pressure, as well as the physical effects of the drug on stamina and appetite. The consequences of drug use, on the other hand, include medical problems (i.e., increased risk for infectious diseases), family concerns (i.e., reduced household finances, strained family relations), and social costs (i.e., cost for treatment and rehabilitation borne by government).

As a response, the Philippines instituted a national policy that aims to control drug supply while at the same time providing services to reintegrate drug users into society. The latter is through provision of treatment and rehabilitation services under the ambit of the Department of Health. The desired balanced response, however, appears to be skewed towards supply reduction efforts to the detriment of the health and social needs of drug dependents, especially when viewed in the light of the extra-judicial killings of drug personalities and the low coverage for treatment and rehabilitation services (i.e., around 1% of estimated users). With respect to treatment and rehabilitation, one important challenge is the fragmentation of service provision across different agencies, resulting to a weak continuum of care.

This research on inter-agency collaboration is, thus, being proposed in this context. It will address a gap in knowledge in the current scholarship on this topic, which is predominantly North American in orientation and derived from short-term project demonstration grants, by

offering a real-world perspective on collaboration from the Philippine context. This study will also serve as input to the development of guidelines in the operationalization of collaboration in the local setting.

2. Literature Review

2.1. Perspectives of rehabilitation

Rehabilitation refers to the process of addressing dependency to psychoactive substances such as illicit drugs, with the intent of reducing or preventing further use of such substance, and minimizing the health, social, and/or legal consequences that arise from such behavior (WHO & UNODC, 2020). Previous literature identified four main government responses to address the drug-use problem, namely prohibition, harm reduction, medicalization, and legalization (Abadinsky, 2014). There are particular philosophical and assumptions of drug-use problem behind each response. A rehabilitation programme may have one or more components of the aforementioned responses.

Prohibition, stemming from the 1961 UN Single Convention on Narcotic Drugs, refers to the approach whereby the manufacture, trade, possession, or use of drugs outside of scientific and medical purposes is tightly regulated and, in many cases, deemed illegal and subject to penalties such as imprisonment and payment of fine. Prohibition has been the most dominant model adopted by countries in addressing the drug problem for most of the 20th century (Taylor, Buchanan, & Ayres, 2016), and stems from the view that drug use and criminality in society are tightly intertwined (e.g., Pierce et al, 2017; Rafaiee, Olyaee, & Sargolzaiee, 2013). In fact, prior research has shown that drug users, compared to non-users, are thrice more likely to commit legal offenses (Bennet et al, 2008). The exact mechanism for the drugs-crime linkage has yet to be fully explicated but is postulated to arise either from the need to fund drug use, commitment of crime while under the influence of drugs, or the close association of drug trafficking with other criminal activities (Deitch, Koutsenok, & Ruiz, 2020). Regardless of mechanism, both national and global drug prohibition has been found to be useful by most countries as it has become a tool with which to further strengthen, or

justify, police and military power; a cause to which recent or long-standing social ills can be attributed; and a force to unite different political ideologies (Levine, 2003). The exact penalties within a prohibition regime vary. For example, in the United States, simple possession will result to imprisonment for at most three years, and fine of at least USD 1,000 (21 U.S. Code § 844), while capital punishment is imposed by Singapore for drug trafficking (Misuse of Drugs Act). The utility of prohibition, however, has come under question on issue of effectiveness (i.e., it has not substantially addressed the drug supply and use issue) as well as cost (i.e., the financial and economic cost of enforcement at the national and local levels) (Miron & Zwiebel, 1995), leading to the rise of the alternative perspectives discussed in the succeeding paragraphs.

Harm reduction is a broad term referring to interventions that aim to reduce the negative consequences of certain behaviors and has been applied in HIV prevention and alcohol poisoning prevention programs (Logan, & Marlatt, 2010). Harm reduction, however, was originally developed in the 1960s for substance abuse programs drawing on a public health approach and recognizes that the behavior cannot be stopped instantaneously. Incremental changes in behavior from the current level of drug use towards abstinence, coupled with interventions to prevent negative consequences of drug use at the individual and social levels, as well as non-judgmental service provision, are at the core of harm reduction strategy (Bartlett et al, 2013; Logan, & Marlatt, 2010; Tsui, 2000). More formally, harm reduction programs have the following features: safety (i.e., creation of a space for the prevention of physical and psychological harm), education (i.e., raising client awareness on how to reduce harm in various situations), supplies (i.e., access to supplies related to the program), partnership (i.e., between the client and the provider, as well as between community organizations), and policy (i.e., presence of evidence-based, cost-effective policies that support harm reduction) (Kerber, Donnelly, & dela Cruz, 2000). Examples of harm reduction

programs include needle exchange programs (i.e., for the reduction of risk from blood-borne infections) and methadone maintenance programs (i.e., for prevention of deaths from opioid poisoning or overdose) (Cheung, 2000). The effectiveness of harm reduction approaches in reducing both drug use and the harms associated with such behavior has been reported in several countries, mainly in Europe (Cheung, 2000; Logan, & Marlatt, 2010), but has been challenging in some Asian countries due to the prevalence of punitive policies and issues with program implementation (Stone, 2015).

Medicalization refers to the phenomenon whereby biological explanations – whether at the genetic or biochemical levels – are offered for behavioral problems (Wyatt, 2009). This has given rise to the brain disease model of addiction, which posits that there is an underlying neurobiological basis for the formation of drug dependence. Specifically, this model states that drug addiction, along with other compulsive behaviors, results to a disruption of a biological process in the brain, which in turn manifests as changes in the emotional balance and decision-making behaviors of persons who use drugs (Volkow, Koob, & McLellan, 2016). Briefly, intake of a drug results to an increase in dopamine levels in the brain, which in turn triggers the reward mechanism to produce feelings of dysphoria. Repeated drug use is a response to the need to experience the same feeling evoked by the high dopamine levels produced by the drugs. The pairing of the stimuli with drug use leads to a reduction of the effect of other healthful rewards in the environment. Persons who use drugs experience dysphoria and distress during withdrawal, resulting to further use of the drug. The disruption of the brain pathways is also used to explain the chronic, relapsing nature of drug addiction. The brain disease model serves as the basis for the use of pharmacotherapy in the drug rehabilitation process, specifically either for detoxification or for therapy. Detoxification refers to the safe discontinuation of a substance of dependence to minimize withdrawal symptoms and is typically completed from 28 days (in the residential setting) up to 12 weeks

(in the community setting) (Diaper, Law, & Melichar, 2014). Meanwhile, therapy, or maintenance treatment, is about longer-term use of the medication with the intention of achieving abstinence. Currently approved pharmacotherapy is for opioid use disorder, specifically methadone (long-acting full μ opioid receptor agonist), buprenorphine (partial μ and κ opioid receptor agonist), and naltrexone (opioid receptor antagonist) (Klein, 2016). In addition, α-2 adrenoceptor agonists (e.g., lofexidine) is also used during detoxification to manage the release of noradrenaline (i.e., opioids inhibit noradrenaline release, and its discontinuation may lead to a noradrenergic detoxification 'storm') (Diaper, Law, & Melichar, 2014). For purposes of detoxification, buprenorphine and methadone appear to be more effective than α-2 adrenoceptor agonists based on a meta-analysis of 23 randomized controlled trials (Meader, 2010). Meanwhile, methadone appears superior to buprenorphine for maintenance therapy as reflected in a Cochrane meta-analysis of 31 studies (Mattick et al, 2014). There is presently no approved pharmacotherapy for stimulants (i.e., cocaine) and cannabis use disorders (Diaper, Law, & Melichar, 2014; Swinford-Jackson et al, 2021).

At the opposite end of prohibition is *legalization*, a view that upholds the idea that drug possession and use is not a criminal offense (Vicknasingam et al, 2018), but should be treated as being similar to other substance use behaviors such as alcohol intake and smoking. Simply put, legalization is the repeal of current policies on drug prohibition, and rests on two principal arguments (Ostrowski, 1990). First is that individuals have the right to self-determination, which includes the right to ingest substances that may affect mood and behavior; and second, is that the cost of implementing prohibition strategies far outweigh the possible benefits, especially when the emergence of black markets for drug trafficking is taken into consideration (Ostrowski, 1990). Several states in the US have adopted varying policies liberalizing use of marijuana either for medical or recreational purposes (Pacula, & Smart, 2017), although the health and social impact of such policies have been mixed (French

et al, 2022; Svrakic et al, 2012).

2.2. Perspectives and theories of interagency collaboration

As mentioned in the preceding section, drug dependents have multiple needs during the period of treatment and rehabilitation. Thus, several agencies and organizations are typically involved in the rehabilitation process, which results to some form of interorganizational partnerships. Two streams of theories have been advanced to explain either the *rationale* or *process* for interagency collaboration. The theories relating to the rationale for collaboration are resource dependence theory, institutional theory, rational choice theory (He, 2017), and mutual dependency theory (Smith & Mogro-Wilson, 2008), while those relating to the process of collaboration are diffusion of innovation theory (Martinez-Brawley, 1995), and the stages of change construct from the transtheoretical model (Prochaska, 2000; Simpson, 2002). In this section, the two theories on interagency collaboration that underlie the analysis for this thesis, namely resource dependence theory and institutional theory, are presented.

The most predominant theory used to explain why organizations collaborate is *resource dependence or exchange*, which stemmed from the work in the 1960s and 1970s by Jeff Pfeffer and Gerry Salancik that aimed to provide an alternative perspective to economic theories that explain interorganizational relationships (Davis & Cobb, 2010). This theory posits that organizations are open systems that are not fully autonomous but operate within a network of interdependencies with other organizations. That is, organizations depend on other organizations for important resources, and this dependence is reciprocal in nature. Meanwhile, there is scarce resource availability due to interorganizational competition for resources. The complexity of the environment in which the organization operates, coupled with rapid changes in the milieu, prompt organizations to reduce the level of uncertainty in

the resource environment through formation of new forms of interdependencies. Organizations are, thus, compelled to work with other partners which are able to augment such resource constraint – whether in the form of human, material, financial, or even political resource – thereby attaining cost reduction, efficiency, and cost-effectiveness for the larger partnership.

Two important aspects are considered by organizations when forming interorganizational arrangements within the resource dependence paradigm (Drees & Heugens, 2013). First is *organizational autonomy* (i.e., "freedom to make its own decisions about the use and allocation of its internal resources without reference or regard to the demands or expectations of potential linkage partners"), and second is *organizational legitimacy* (i.e., "a generalized perception or assumption that the actions of an entity are desirable, proper, or appropriate within some socially constructed system of norms, values, beliefs, and definitions"). In short, interorganizational arrangements help organizations re-establish their autonomy by stabilizing the resource supply and flow, while also enhancing their legitimacy through the formation of visible ties with other organizations that are perceived by external stakeholders to be legitimate. Organizations that intend to improve their autonomy must establish linkages that are flexible and less invasive, while those seeking to improve legitimacy must create visible, more formal partnerships.

Additionally, organizations must attain some level of awareness and consensus (Van De Ven, 1976). *Awareness* refers to the knowledge of possible agencies from which needed resources are available, which may arise from either a general information on the goals, mandates, and profile of other agencies, or a manager/staff's personal connections with a counterpart in another agency (i.e., boundary spanners). *Consensus*, on the other hand, pertains to the extent to which the partner organizations agree on their common goals, and the services and

resources that will be shared or exchanged.

Several tactics are available to managers when employing resource dependence theory, each of which have varying effect on organizational autonomy (Davis & Cobb, 2010). These are, from the least constraining to the most restrictive, identification of new suppliers/partners (especially if dependence is with a sole source); formation of associations or groups; establishment of alliances or coordination of activities; co-optation of other organizations through membership in governing boards; and incorporation of another organization through mergers/integration. As will be evident in the next section, these tactics, with the exception of the first on identification of new suppliers, mirror the different degrees of collaboration as identified by Konrad (1996).

The application of the resource dependence model, particularly in the social services sector such as the drug rehabilitation field, will lead to two patterns of behavior (Aldrich, 1976). First, the justification for the organization's claim to the need for supply will be tied to the fulfilment of program requirements, leading to the employment of highly visible outcomes (e.g., number of clients served). Second, the reduction of uncertainty will be achieved through standardization of transactions with other organizations (e.g., routinization of procedures).

While resource dependence was primarily applied to business enterprise and industry (Hillman, Withers, & Collins, 2009; Davis & Cobb, 2010; Drees & Heugens, 2013), empirical work exists that utilized the theory in the analysis of collaboration between non-profit organizations (Guo & Acar, 2005); child welfare and drug treatment service providers (He, 2015, 2017; Smith & Mogro-Wilson, 2008); and probation/parole agencies and community treatment providers (Welsh et al., 2016).

The preceding paragraphs highlighted the primarily internal orientation of resource

dependence theory, which is in contrast to the external orientation of *institutional theory*. While papers on institutional theory can be traced back to as early as the 1950s, current understanding and empirical work related to this theory emanated from the 1977 seminal paper of John W. Meyer and Brian Rowan (David, Tolbert, & Boghossian, 2019). An institution, as understood in the theory, refers to one of two things: it can either be a rule-like quality of an organized pattern of action, or an embedding in formal structures (Zucker, 1987). Elements of an organization are subjected to institutionalization whereby such element is considered a legitimate part of the organization not out of technical, economic, or efficiency concerns, but in consideration of the symbolic properties that relate to such process (Meyer & Rowan, 1977). That is, the organizational elements or structures are invested with cultural meaning, which in turn are associated with values that an organization wishes to be identified with. Extending the argument further, Meyer and Rowan (1977) state that the external environment in which the organization is embedded is also an institution in itself, and that organizations tend to imitate these environmental elements. The resulting homogenization of organizations within that environment, a process referred to as isomorphism, is deemed an important determinant of organizational survival. In essence, organizations enter into partnerships with other organizations to attain a certain level of isomorphism with the institutional environment.

There are three mechanisms by which isomorphism is achieved: coercive, mimetic, and normative (DiMaggio & Powell, 1983). Coercive isomorphism results from pressures, which are either exerted by other organizations or the cultural expectations of the society in which the organization is embedded. Such pressures can be formal and direct (e.g., compliance to government mandates, statutes and regulations; imposition of standard operating procedures by private organizations), or informal and indirect (e.g., creation of hierarchical organization to be able to transact with other formal organizations). Coercive isomorphism results to a

mandated contingency for the formation of interorganizational relationships (i.e., organizations form partnerships out of necessity) (Oliver, 1990). Mimetic processes arise from uncertainty and ambiguity in the environment, in which case organizations model themselves after other organizations. This modelling stems from the need to demonstrate legitimacy by showing relevant stakeholders that an organization is able to offer similar services, or behaves in the same manner, as another organization in the same field, usually one deemed more legitimate or successful. Lastly, normative pressures refer to the expectations that stem from the professionalization of the workforce, who in turn lobby for the adoption of particular policies and practices that define working conditions and legitimize autonomy of such workers.

Thus, interagency collaboration may be the product of government mandates or regulatory directives, such as when cooperation with other agencies is part of statutory provisions (e.g., formation of working groups), or when such partnership becomes a requirement for funding of programs (i.e., funding is provided to the joint program, and not channelled to individual agencies or organization). Alternatively, collaboration can be explained by extrinsic pressure (e.g., there is public demand for agencies to work together), or conformance to norms (i.e., there are other organizations in the same field or discipline that are working together).

Institutional theory has been applied to various setting and industries such as schools, law offices, and businesses (Zucker, 1987; David, Tolbert, & Boghossian, 2019). Application of the theory specifically on organizational partnerships focused on non-profit organizations and (Guo & Acar, 2005); and child welfare and drug treatment service providers (Smith & Mogro-Wilson, 2008).

While resource dependence theory and institutional theory have different assumptions and key concepts, it has been suggested that these theories need not be mutually exclusive but that

both can simultaneously be used to explain why organizations decide to collaborate (Hillman, Withers, & Collins, 2009). In short, organizations can choose to work together because of the desire to address internal resource scarcity, as well as conform to external norms.

Table 2-1. Comparison of resource dependence and institutional theories

	Resource dependence theory	Institutional theory
Orientation	Internal	External
Main proposition	Organizations operate within a network of interdependencies with other organizations for important resources	Organizations tend to imitate the external environmental elements in which it is operating
Purpose of forming partnership	Augment a resource constraint within the organization to attain cost reduction, efficiency, and cost-effectiveness for the larger partnership	Organizations enter into partnerships to attain a certain level of similarity (i.e., isomorphism) with the institutional environment
Considerations	**Organizational autonomy**: Extent of freedom to make decisions about use and allocation of resources (i.e., organizations stabilize their resource supply and flow) **Organizational legitimacy**: Perception that actions of an organization are within socially accepted norms (i.e., stakeholder view that formation of partnerships is legitimate or desirable)	**Coercion**: mandated contingency for the formation of interorganizational relationships (e.g., compliance to government mandate) **Mimesis**: organizations model themselves after other similar organizations (i.e., benchmarking or modelling) **Normative pressure**: Expectations from professionalization of the workforce or the working environment (i.e., professional expectations)

2.3. Models of interagency collaboration

Differences in the rationale for collaboration, specifically the value placed by organizations on the extent of autonomy, legitimacy, and isomorphism attained through partnership with other organizations, can give rise to different forms or models of collaborative arrangements, which can be described in terms of *degrees* (level of intensity and formality), *elements* (constitutive structure and activities), *stages* (development of partnership over time), *levels* (focus of the collaborative), and *type* (collaboration in policy or practice).

First, collaboration is viewed as a continuum of strategies that differ in terms of the intensity of activities jointly undertaken as well as the formality of the governance arrangement between participating units, which is referred to as *degrees of collaboration*. There are a few

iterations in the published literature that differ in the number of points in the continuum (Ahgren & Axelsson, 2005; Addiction and Mental Health Collaborative Project Steering Committee, 2015; Claiborne & Lawson, 2005; Rush, 2014), but all of which appear to be derived from the original framework proposed by Konrad (1996). The hierarchical services integration framework presents a continuum of five points, which are briefly described below:

a. Information sharing and communication: Relationships between agencies are not formally structured. Agency representatives may share general information about programs, services, and clients. Communications may be less frequent or ad hoc. Activities may include sharing informational brochures, educational presentations, newsletters, or joint staff meetings.

b. Co-operation and coordination: Cross-agency activities are somewhat more structured. Agencies may work together to change procedures or structures to help make programs more successful. Activities may include reciprocal client referrals and follow-up processes, verbal agreements to hold joint staff meetings, mutual agreements to provide priority responses, or joint lobbying for legislative change or funding requests.

c. Collaboration: Although temporary or brief collaboration can operate informally, ongoing collaborations are usually more structured. Autonomous agencies and programs work together with a common goal, product, or outcome. Examples include partnerships with written agreements, goals, formalized operational procedures, and possibly joint funding, staff cross training, or shared information systems.

d. Consolidation: Consolidated systems may be those under an umbrella organization or those with some centralized functions (e.g., program or financial administration). Line

authority for programs or services is contained within different divisions or agencies. Cross-program collaboration, coordination, cooperation, and information sharing are more frequent and often more structured activities. An example might be a government agency with responsibility for different human service programs.

e. Integration: A fully integrated system has a single authority that is comprehensive in scope, operates collectively, addresses client needs in an individualized fashion, and is multi-purpose and cross-cutting. Categorical lines are transparent with fully blended activities and pooled funding. The client perceives service delivery as "seamless," with little or no organizational barriers to access. Management and operational decisions are the responsibility of a single entity.

Second, initiatives have also been described in terms of the *elements* or components of such collaboration, which encompass the structure and activities shared by participating organizations. There are a total of 51 elements identified in the literature (Bolland & Wilson, 1994; Centers for Disease Control and Prevention, 2009; Claiborne & Lawson, 2005; Fletcher et al., 2009; He, 2015; Konrad, 1996; Reilly, 2001; Wenzel et al., 2004), all of which can be categorized into three broad groups of activities:

a. Service delivery: Activities that pertain to direct provision of services to the target client (e.g., case management, joint assessment and planning of client service goals, case referrals)

b. Administration: Activities that relate to the management of the partnership (e.g., governance system, management team, communication pathways, conflict resolution processes, resource sharing, information management)

c. Planning: Activities that refer to planning for the partnership (e.g., agreements, goal

identification, budgeting, policy formulation)

Third, partnerships evolve over time, and this process has been termed *stages of collaboration*. The life cycle of partnerships follows a three-part process (Fletcher et al., 2009; Iachini et al., 2015; Reilly, 2001; Tseng, Liu, & Wang, 2011; Welsh et al., 2016):

a. Formation: The initial stage during which potential partner organizations are identified, preliminary inception meetings are held, and the decision to collaborate is formed (and formalized, if needed). Conceptualization of how the collaborative will be structured, and the terms and rules of engagement are also discussed at this stage.

b. Implementation: Activities planned during the formation stage are put into action, and services to clients are delivered. Formal or informal discussions also take place between organizations to manage the partnership.

c. Maintenance: This stage includes monitoring of on-going activities, continuous planning for future activities and engagements, and resource mobilization to sustain the collaborative.

While the first three models mentioned above are the predominant ones cited in the literature, two additional models have been described as well.

The fourth model is referred to as the *levels of collaboration*, which extended the previously described elements (Addiction and Mental Health Collaborative Project Steering Committee, 2015; Fletcher et al., 2009; Messeri et al., 2003; Rush, 2014). More commonly, collaboration between organizations take place at the *service level*, which pertains to improving service provision at the provider-client interface. That is, partnerships that only involve service delivery elements can be conceived as being at the service level of collaboration, which is what was predominant in the US in the 1970s (Fletcher et al., 2009). Meanwhile, partnerships

that are focused on more macro issues such as improvement in the administration of the organization, and policy formulation and implementation are at the *system level* of collaboration.

The fifth model, *type of collaboration*, distinguishes between partnerships that exist in formal documents only (or *symbolic* type), and those that are implemented, with or without the benefit of a partnership agreement document (or *substantive* type) (He, 2015).

2.4. Conceptual framework

Before presenting this study's conceptual framework, which is a diagram of the relationship between concepts being investigated (Hart, 2018), it is worthwhile to provide a recapitulation of what was mentioned in the preceding paragraphs.

First, the approach to drug rehabilitation undertaken by an organization or state is informed by different understandings of the underlying reason for the development of drug dependence. Hence, some approaches involve incarceration, while some use pharmacotherapy. Still other services employ behavioral approaches. Given the complexity of issues that co-occur with drug dependence, clients are typically provided a combination of these services. Since no one organization involved in handling of drug dependents has the technical and administrative capacity to offer these different modalities, some form of collaborative arrangement is entered into by these agencies.

Second, the rationale for collaboration has been formally explained using two main theories. A resource dependence perspective argues that organizations operate in a complex and uncertain environment where resource is scarce. Hence, to secure resources and enhance organizational autonomy, while maintaining legitimacy, organizations form partnerships (or interdependencies) with other related organizations. Meanwhile, institutional theory posits

that the formation of collaboratives is driven by the need to be isomorphic with the institutional environment. That is, partnerships are formed either as mandated by the state through policies, statutes, or regulations; from the need to conform with the practice of other organizations in the same field of practice; or pressure from the public or stakeholders. These two theories, it has been suggested, are not mutually exclusive, but can coexist, such that organizations enter into partnerships to address both internal and external needs.

Third, different collaborative arrangements can arise from the partnership between two organizations, which differ in terms of formality, structure, engagement, and activities. Specifically, these have been described in the literature as *degrees* (level of intensity and formality), *elements* (constitutive structure and activities), *stages* (development of partnership over time), *levels* (focus of the collaborative), and *type* (collaboration in policy or practice) of collaboration.

The figure below presents the study's conceptual framework, and is described in the succeeding paragraphs.

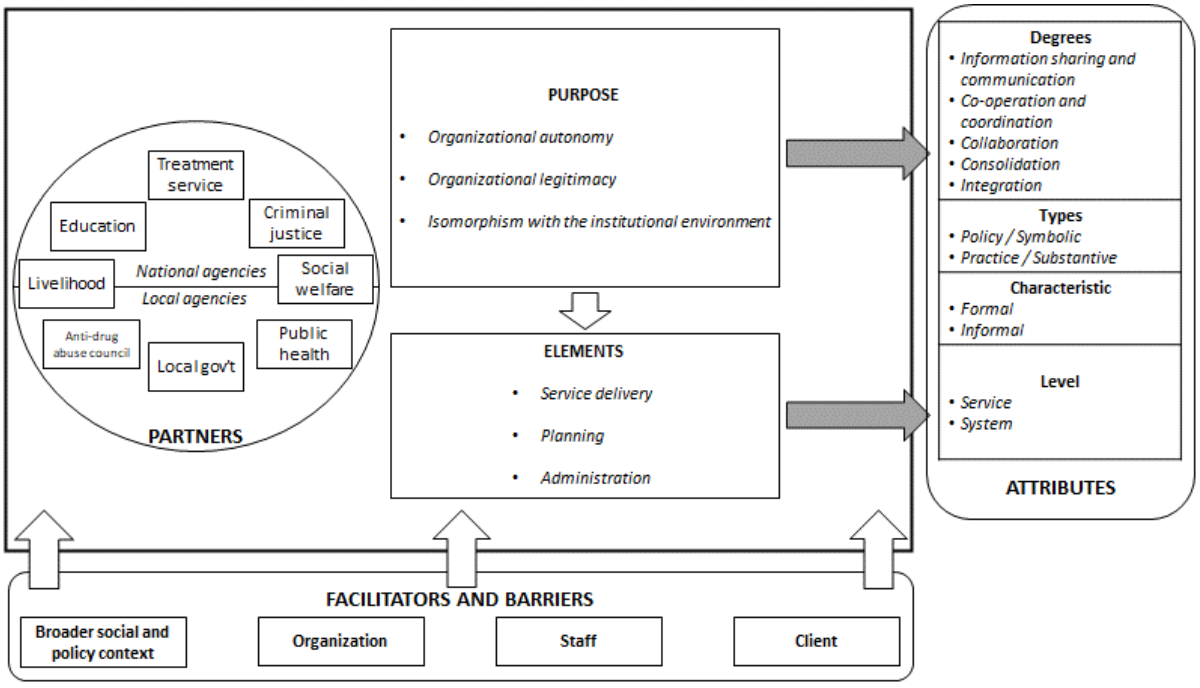

Figure 2-1. Conceptual framework of the study

Collaboration in the context of drug treatment and rehabilitation is undertaken to address the complex medical, psychological, social, and legal problems of PWUD. Drug Abuse Treatment and Rehabilitation Centers (DATRCs) in the Philippines are able to offer some, but not all, of the services required by PWUD across these four areas. Hence, the partners or the stakeholders in the collaborative process will be examined in terms of the relationships of organizations that offer related services such as health, education, livelihood, social welfare, and legal services. Of note, a distinction will be made between organizations operating at the national and local government levels, as some of the agencies are under the ambit of the governor (in case of provinces), or mayor (in case of cities or municipalities) by virtue of Republic Act no. 9165, or the Local Government Code of 1991.

The purpose for collaboration can either be to enhance organizational autonomy, organizational legitimacy, or isomorphism with the institutional environment, which can influence the degree, type, and characteristic of collaboration. For example, organizations that wish to maintain autonomy will enter into less intense forms of collaboration, such as information sharing or cooperation, while those that are willing to sacrifice part of their autonomy in exchange for more resources may opt for consolidation or even integration. Likewise, organizations that are concerned with legitimacy will opt for more visible, symbolic, and formal collaborative attributes.

Purpose is also closely related to the decision on what elements of collaboration to pursue. Mandates from the state may specify the types of activities undertaken by partner agencies, which can involve some or all of the categories of service delivery, administration, and planning. Meanwhile, organizations that wish to maintain autonomy, may limit their involvement to service delivery, as joint planning and administration may be deemed as encroaching on the powers of the organization. The elements, in turn, will specify the level of

collaboration. That is, partnerships that only involve service delivery are at the service level of collaboration, while those that involve planning and administration are at the system level of collaboration.

The extent to which partnerships are able to attain their stated goal is driven or hindered by influences at four levels: contextual (i.e., broader environment external to the initiative), organizational (i.e., internal to the organization or unit involved in the initiative), staff (i.e., knowledge, skills, and attitude of organizational personnel involved in collaboration), and client (i.e., characteristics of the target client of the partner organizations).

2.5. Knowledge gaps to be filled

Collaboration is a key strategy to enable organizations involved in drug treatment and rehabilitation to address the complex medical, mental, social, and legal problems confronting PWUD. Despite the existence of over 50 empirical papers describing collaboration in this field, as well as the presence of a Philippine policy enjoining collaborative action to address the problem of drug dependence, the following gaps in the literature were noted: (a) differences in the definition and conceptualization of collaboration across studies; (b) predominance of published papers done in the United States, which has a distinct and different social and policy context from other jurisdictions; and (c) lack of guidance/policy on the operationalization of collaboration in the Philippine context as well as in other territories with a similar arrangements for drug treatment and rehabilitation.

3. Methodology

3.1. Research questions and objectives

Although the previous literature has provided solid foundation of the study topic, some crucial questions remained answered. Specifically, this study is intended to address the following questions:

RQ1. Why do drug treatment and rehabilitation centers collaborate with other agencies that cater to PWUD?

RQ2. What are the similarities and difference of philosophical base/attitude toward drug treatment across collaborative parties?

RQ3. How is collaboration practiced by agencies involved in providing services to PWUD who are undergoing drug treatment and rehabilitation?

RQ4. How well are the target outcomes of collaborative practices attained by participating agencies?

RQ5. What challenges to collaboration are experienced by the participating agencies?

RQ6. How has the COVID-19 pandemic affected different aspects of interagency collaboration.

The objective of this research is to describe the practice of interagency collaboration in the context of drug treatment and rehabilitation in the Philippines. Specifically, it will:

SO1. critically review the rationale for, understanding of, and attitude towards collaboration among agencies involved in drug treatment and rehabilitation;

SO2. critically review the structure and composition of, and activities in, collaborative arrangements in terms of: (1) degrees, or level of intensity and formality; (2) levels, or the focus of the collaborative; (3) type, or a distinction between collaboration on in policy and practice; and (4) stages, or the development of partnership over time;

SO3. identify and discuss the goals and outcomes within such collaborative arrangements;

SO4. determine the benefits and costs of collaboration;

SO5. describe the facilitators and barriers to interagency collaboration at the context, organizational, staff, and client levels; and

SO6. discuss the impact of the COVID-19 pandemic on different aspects of interagency collaboration.

3.2. Study focus and setting

This study took place in two localities with licensed DATRCs owned and operated by the DOH. One site was a large (i.e., ≥300 beds) DATRC in an urban setting, while the other site was a smaller (i.e., ≤100 beds) DATRC in a rural setting. The study sites specifically are City of Ilagan, Isabela (urban) and Municipality of Pilar, Bataan (rural).

Clustering of study sites was informed by findings in the literature of contextual, organizational, staff, and client-level facilitators and barriers to collaboration. An urban and rural division represent variation in terms of local socioeconomic situation, which was identified as an important contextual that influences collaborative initiatives (Abdel-Salam et al., 2017; Amaro et al., 2004; Anastas et al., 2019; Barreira et al., 2000; Bouis et al., 2007;

Bray & Rogers, 1995; Clark et al., 2017; D'Aunno et al., 2017; Darfler et al., 2019; Drabble, 2011; Drabble & Poole, 2011; Formica et al., 2018; Glenn & Moore, 2008; Green et al., 2008; Guerrero et al., 2016; Gurewich et al., 2014; He, 2015; Heckman et al., 2004; Hunter et al., 2005; Iachini et al., 2015; Lee et al., 2006; Ma et al., 2016; McCarthy et al., 1992; Smith & Mogro-Wilson, 2007; Veysey et al., 2004; Welsh et al., 2016; Wenzel et al., 2004; Whiters et al., 2010). The local context can also be used as a proxy measure for client-level factors, especially the socioeconomic status of clients, that are also known to facilitate or hinder collaborative processes (Amaro et al., 2004; Anastas et al., 2019; Bray & Rogers, 1995; Darfler et al., 2019; Glenn & Moore, 2008; Gurewich et al., 2014; He, 2017; Heckman et al., 2004; Lee et al., 2006; Pelissier & Cadigan, 2004; Whiters et al., 2010). Meanwhile, the number of beds allocated per facility can be used as a proxy for the organizational- and staff-level determinants of collaboration (Anastas et al., 2019; Appel et al., 2017; Barreira et al., 2000; Bouis et al., 2007; Bray & Rogers, 1995; Clark et al., 2017; D'Aunno et al., 2017; Drabble, 2011; Drabble & Poole, 2011; Drainoni et al., 2014; Formica et al., 2018; Green et al., 2008; Guerrero et al., 2016; Gurewich et al., 2014; He, 2015, 2017; Heckman et al., 2004; Huebner et al., 2015; Iachini et al., 2015; McCarthy et al., 1992; Mittal & Suzuki, 2017; Rosenheck et al., 2003; Smith & Mogro-Wilson, 2007; Veysey et al., 2004), as this may indicate the level of organizational complexity of the DATRC's set-up, as well as resource availability (i.e., larger facilities will have more resources and a better developed organizational set-up compared to smaller facilities).

3.3. Study design

The research objectives were addressed using a multiple case study design (Byrne, 2009; Creswell & Poth, 2018).

Case study research is a qualitative research design that investigates the a real-life and contemporary bounded system, called a case, and reports an in-depth description of the case using data gathered from multiple sources of information (Creswell & Poth, 2018). For purposes of the current research, the case, which is defined as bounded systems that will be studied in context (Harrison et al., 2017), was taken to mean the collaboration or partnership between the selected DATRC and agencies in the public health, social welfare, and criminal justice fields. The geographic and spatial boundaries were the immediate locality in which the DATRC is located, whereas the examination and analysis of the case of interest (i.e., interagency collaboration in the context of drug treatment and rehabilitation) was limited to the period following promulgation of the most recent regulation on the drug treatment and rehabilitation process (i.e., 2019). As mentioned in the preceding section, cases were selected based on differences in contextual factors that have been shown to drive the collaborative process and outcomes, i.e., selection of cases will follow the diverse method (Seawright & Gerring, 2008). This will allow for representation of the "full variation in the population" (not in the statistical sense of representation, that is). Use of multiple cases will yield a more robust and compelling evidence and allow for better comparison, contrasted to a single case study approach, of the similarities and differences across cases in terms of the dimensions, attributes, outcomes, and facilitators and barriers to collaboration in the context of drug treatment and rehabilitation (Yin, 2017).

A case study design was chosen for this research as it fulfils the three conditions espoused by Yin (2017): (i) type of research questions asked; (ii) researcher control over events or phenomenon; and (iii) focus on contemporary or historical events. Specifically, a case study design is suitable for research that asks "how" and "why" questions (i.e., explanatory in nature); examines a contemporary (i.e., recent past and present) event within its context; and does not require researcher control over, or manipulation of, the phenomenon. These three

conditions are met by this proposed research as detailed in the preceding paragraphs. Furthermore, a case study design is appropriate for purposes of this research as it will allows the researcher to "generate an in-depth understanding of a program… to inform policy development" (Schwandt & Gates, 2018), which is one of the desired outcomes of this project.

The strengths of a case study design were leveraged to help address the study objectives. Among these are its being grounded in contemporary, real-world situations, and use of multiple data sources to generate in-depth descriptions of cases (Krusenvik, 2016). This results to an analysis that is able to capture the complexity of phenomenon, while at the same time rooting this in the context in which the case was studied. Further, the drive for in-depth case descriptions may allow for identification of information that were not anticipated during the conceptualization phase of a study.

On the other hand, the principal criticism against case study research is the validity and transferability of its findings, especially if the bounding of a case results to a phenomenon that is too narrow and specific or unique (Crowe et al., 2011). To address this concern, this study selected cases guided by a particular conceptual framework, and was subject results to respondent validation (discussed in the succeeding paragraphs). A second pitfall of a case study design is the possibility of collecting large volume of data that may not be relevant to the research questions, or may not be of high value (Crowe et al., 2011). While flexibility during data collection was observed such that any relevant but unanticipated information was still captured, the whole process was not be carried out randomly but was guided by the questions of interest to this study.

Consistent with case study methodology, data were collected from multiple sources to generate case descriptions (Yin, 2017). Specifically, the following sources of evidence were

examined: (i) documentation, (ii) focus group discussion, and (iii) semi-structured interviews. A review of documentation pertaining to collaboration provided preliminary information on the nature, goal, structure and composition, activities, and outcomes of collaborative initiatives between DATRCs and the agencies in the public health, social welfare, and criminal justice fields, and can help define the outlines and boundaries of inter-sectoral collaboration in the study sites. Focus group allowed for further exploration of the views and perspectives of different professionals on the actual practice of collaboration activities between DATRCs and the agencies in the public health, social welfare, and criminal justice fields. In addition to providing information on different aspects or facets of collaboration, data from these two methods were used in the generation of the interview guide and identification and selection of respondents for the last component of the study, which was intended to generate additional insights on the case not captured in the earlier two phases. Temporally, collection and retrieval of documentation took place first, followed by focus group discussion (August to September 2021). Interviews were conducted last (November to December 2021) following preliminary analysis of data from review of documentation and focus group data. The relationship between these three methods is depicted in Figure 3-1, while the sampling, study population, and specific procedures for each of these methods are discussed in the succeeding sections.

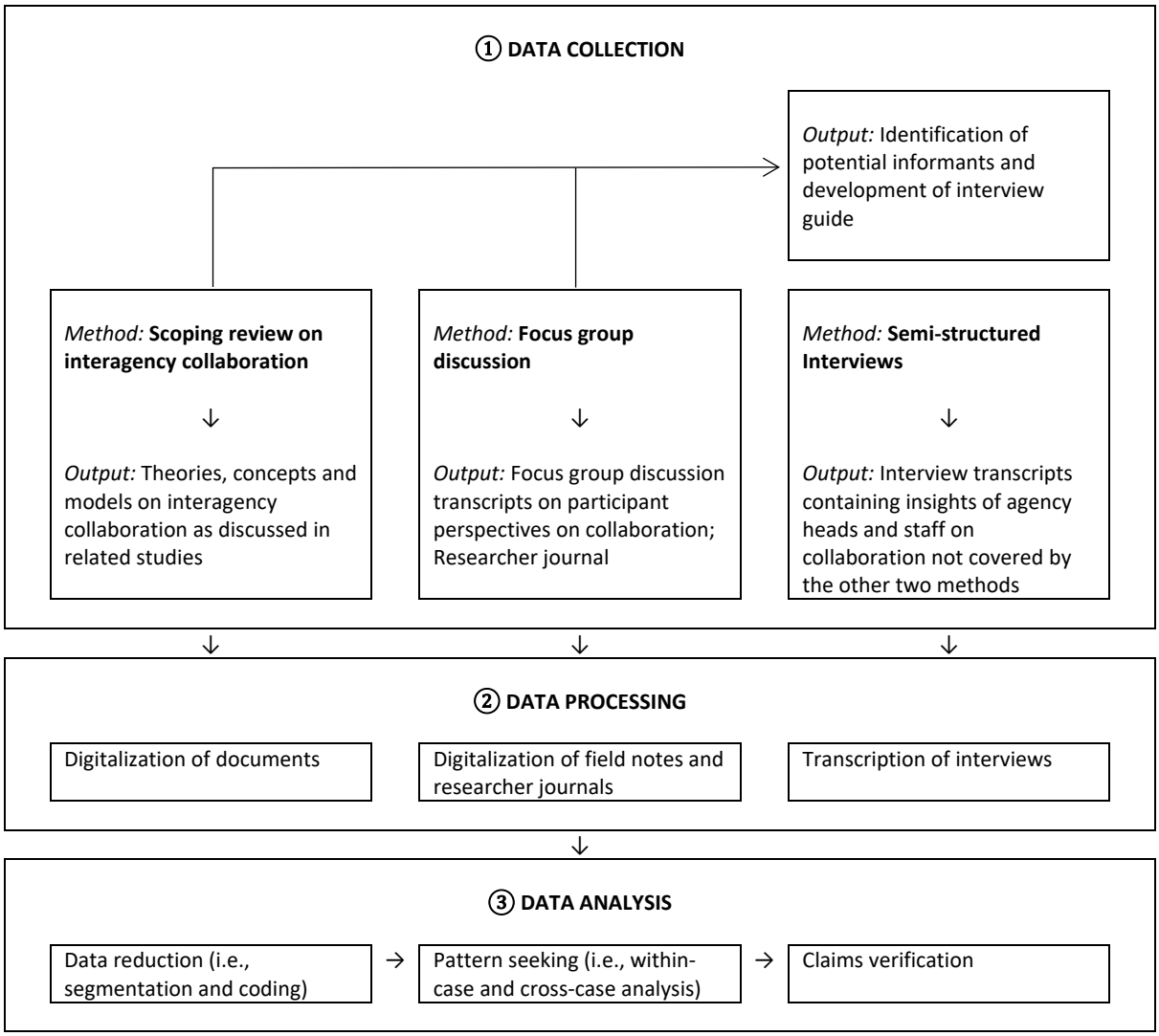

Figure 3-1. Methodological framework for the study

3.4. Scoping review

This first component of the study addressed the research questions and specific objectives pertaining to the rationale (RQ1, SO1); structure, composition and activities (RQ3, SO2); and goals and outcomes of the collaborative arrangements (RQ4, SO3).

A scoping review following the method of Peters et al. (2017) was used to answer the research objective. First, a preliminary search in MEDLINE (via EBSCOhost) was

undertaken to generate a list of possible keywords and synonyms for “collaboration” and “drug rehabilitation”, the key ideas of interest in the review. Perusal of the resulting 29 papers from a total of 181 records retrieved from the preliminary search resulted to the inclusion of eight terms. The expanded search strategy, thus, included “collaborate/collaboration/collaboratives”, “partnership”, “cooperation”, “coordination”, “linking/linkage”, and “coalition” for the *concept*, and “drug rehabilitation”, “substance-related disorders rehabilitation”, “drug treatment”, “addiction treatment”, and “substance abuse treatment” for the *population*. Terms for *context* were not included in the search as the review was interested in retrieving information for all settings or countries in which collaboration was reported.

The following eligibility criteria for articles were specified prior to commencing the search:

- Discusses the *population* and *concept* of interest
- Peer-reviewed, scholarly empirical paper (i.e., stipulated or identifiable method from which results presented in the paper were derived). Editorials, commentaries, letters to the editor, extended essays, conference reports and the like were to be excluded.
- Published in English as it is the primary language of the review author.

Expanded search was carried out in four major databases for medical and social sciences using index terms and key words combined for maximum sensitivity: MEDLINE (via EBSCOhost), CINAHL Complete (via EBSCOhost), Embase, and PsychINFO (via ProQuest). Inclusive search period was from database inception to November 2019. The search strategy used for this project is presented in Table 1.

Automated and manual deduplication of search results was done using EndNote (X9.2,

Clarivate Analytics, 2019). Screening of title and abstract for relevance by two independent assessors (the author and a PhD student from another institution) and disagreements were settled by consensus. Full text of eligible records was retrieved from the electronic collection/subscription of the libraries of The Hong Kong Polytechnic University (n = 234), The Chinese University of Hong Kong (n = 17), Brown University (n = 10), and University of the Philippines (n = 10). Full-text screening done by the author and confirmed by two independent assessors (two PhD students from another institution), with disagreements were settled by consensus. References list of full-text papers was reviewed to identify additional papers for inclusion in the review.

Charting of data from the included sources of evidence were undertaken by the author using NVivo (12 Pro for Windows, QSR International, 2018) (O'Neill et al., 2018; QSR International, 2016). Specifically, this involved the development of a coding structure based on a preliminary reading of the first 10 papers to capture key data points of interest to address the aim of the review (see Appendix for definition of these codes):

a. Basic information on the paper

    - ✓ Author
    - ✓ Year of publication
    - ✓ Country of origin
    - ✓ Aim/purpose of the paper
    - ✓ Design/methodology

b. Information on the collaborative initiative

- ✓ Name/title of initiative
- ✓ Purpose/goal of initiative
- ✓ Geographic scope (i.e., international, national, sub-national)
- ✓ Participating groups (i.e., types of professionals, agencies, organizations, or sectors)
- ✓ Nature of initiative (i.e., research, short-term project, program)
- ✓ Type of partnership (i.e., information and communication, cooperation and coordination, collaboration, consolidation, integration
- ✓ Outcome (if reported)
- ✓ Moderators, if reported (i.e., facilitators and barriers to collaboration), categorized into (a) contextual, (b) organizational, (c) individual staff, and (d) client dimensions

Papers were imported from EndNote into NVivo in Portable Document Format. Passages (i.e., sentences or paragraphs) from each article that were deemed relevant to the data extraction points were coded to the appropriate node. “Framework Matrices” and “Matrix Coding Query” functions of were used to analyze the extracted data. Results were summarized as the level of intensity, or the number of articles, corresponding to each of the items above.

This scoping review was prepared in compliance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for scoping reviews (PRISMA-ScR) (Tricco et al., 2018).

3.5. Focus group discussion

This second component of the study addressed the research questions and specific objectives pertaining to the attitude of agencies towards collaboration (RQ2, SO1); the actual practice of collaboration (RQ3, SO2); and some facilitators and barriers to collaboration (RQ5, SO5), including the impact of COVID-19 on interagency collaboration (RQ6, SQ6).

A focus group discussion is a planned series of discussions with participants chosen because of common traits linked with the topic intended to draw opinions about how these participants relate to a specific issue or topic (Krueger & Casey, 2015). In this approach, the group, rather than the individual, is the source of data, and valuable information and insight is gained from the interaction of the members of the group (i.e., participants assembled in the same venue are not simply asked to answer the same set of questions individually) (Acocella, 2011). Focus groups have been previously utilized in drug addiction research (Neale et al, 2005). Specifically, focus groups were used by scholars to identify causes of drug use (e.g., Mburu et al, 2020; Nakhaee & Jadidi, 2009; Voon et al, 2008); explore understanding on consequences of drug use behavior (e.g., Lee et al, 2006); and understand components of primary prevention (e.g., Tahlil & Aiyub, 2012), treatment and rehabilitation (Faberman et al, 2018), and relapse prevention strategies (e.g., Davis & O'Neill, 2005; Islam et al, 2012).

A focus group was noted to be useful for orienting the researcher in a new field; obtaining insight on different research populations or study sites; developing data collection instruments for other study components; and even confirming or validating data collected through other methods (Flick, 2014). In addition, focus groups were viewed as being more efficient and less expensive compared to other data collection techniques since the researcher and respondents are all present at the same time and place (Nyumba et al, 2018). However,

because of the group interaction inherent in a focus group approach, participants may portray themselves, through their answers, as being more rational and thoughtful, or as possessing deep knowledge or experience about a topic (Krueger & Casey, 2015). The facilitated and guided nature of the discussion also relies on the skill of the moderator (Leung & Savithiri, 2009). Furthermore, focus groups are generally not recommended when group members are not comfortable with each other (e.g., stakeholders with diametrically opposing views on a topic) or when the topic is sensitive (e.g., stigmatizing or taboo topics) (Krueger & Casey, 2015; Nyumba et al, 2018).

Considering the local pandemic situation, the focus group was conducted synchronously online, with the researcher acting as moderator. Similar to other data collection methods, virtual or online focus groups have also been conducted, usually through the use of a chat/messaging application or conferencing software or platform (Flick, 2014). Because of the absence of face-to-face interaction, virtual focus groups have proved useful for research on sensitive topics or issues where participants may wish to remain anonymous (Woodyatt et al, 2016); among study populations who are hard to include because of accessibility constraints (Tates et al, 2009); and even during the current pandemic situation when group meetings are discouraged by public health protocols (Dos Santos Marques et al, 2020). The platform where the discussion is conducted, however, may prove to be a challenge since participants will naturally be limited to those who have Internet connectivity; the quality of interaction and discussion will depend to a large extent on the stability of Internet connection and the level of technological literacy of the participants; and the moderator may be deprived of non-verbal cues (e.g., facial expression) that may provide context to participant responses if the quality of video image is poor (Dos Santos Marques et al, 2020; Flick, 2014; Rezabek, 2000).

A focus group is appropriate to address the objectives listed above, as well as a preliminary approach to data collection within the overall methodological framework of the study, since it was noted to be particularly useful in the exploration of thoughts and views on, among others, organizational concerns and issues (Krueger & Casey, 2015). More specifically, a group discussion will also a) allow for elicitation not only of individual ideas, but also opinions that more closely resemble communication in everyday life; and b) provide opportunity for validation of individual views, especially those that may not be congruent with social or group perspectives (Flick, 2014). In addition, this study component will provide preliminary data that will be used in the development of the interview guide for the semi-structured interviews.

Four related considerations in forming participant groups are participant selection or sampling, group composition, group size, and number of groups.

First, since the intent of focus groups is to generate insights on a specific group of individuals with knowledge or experience on a topic or issue, purposeful sampling is the preferred approach (Krueger & Casey, 2015). Purposeful sampling is a participant selection technique commonly used in qualitative research, the aim of which is to identify and select individuals or groups who, by knowledge or experience, can generate rich information on a particular phenomenon of interest given resource constraints in the research (Palinkas et al, 2015).

Second, given that data collection will take place in the context of a group discussion, it is important that the groups constituted are homogenous in nature (Rabiee, 2004). Homogeneity refers to the minimization of variation in characteristics of the members of the sub-group, which is preferred as it facilitates data collection and simplifies analysis since the focus is on a particular sub-group, allows participants to engage in discussion, and reduces participant discomfort from dealing opposing or conflicting views (Krueger & Casey, 2015; Palinkas et

al, 2015; Rabiee, 2004). However, a little heterogeneity may be useful in obtaining a wide range of perspectives on a topic, which may not be achievable if all members of the group share similar characteristics and views (Acocella, 2011). Further, to capture the possible effect of different settings on interagency collaboration, newly formed groups will be involved in the discussion instead of relying on pre-formed groups (i.e., individuals belonging to the same workplace).

The third consideration is the size of a focus group, which is primarily determined by the purpose of the focus group, which is to elicit group interaction. Thus, the general rule of thumb is to have anywhere between five to eight participants per group, and not more than 10, as large groups may be difficult to manage and will give limited opportunity to participants to share their views (Carlsen & Glenton, 2011; Krueger & Casey, 2015).

The number of groups to form is the last consideration in the formation of focus groups. There are three reasons why more than one group should be formed: (a) generates greater breadth and depth of information compared to having a single group; (b) aids in comparing patterns and themes within and across groups; and (c) important in determining whether saturation has been reached (i.e., no new information emerges regarding an idea or topic) (Carlsen & Glenton, 2011; Krueger & Casey, 2015). The generally accepted rule of thumb is to plan for between two to five focus groups within each category (Carlsen & Glenton, 2011; Krueger & Casey, 2015; Leung & Savithiri, 2009).

Given the foregoing considerations, this research involved four participant groups who are considered homogenous because they belong to the same agency (i.e., drug treatment and rehabilitation, public health, social welfare, criminal justice). Diversity within each group was ensured by recruiting members who have different genders, working experience, and context/workplace location. Each group was targeted to be composed of six participants, and

at least two groups were formed within each participant category. Thus, a total of 48 participants were invited in eight focus group sessions (Table 3-1).

Table 3-1. Distribution of focus group participants by agency type, by session

No.	Participant Group	No. of participants		
		Group 1	**Group 2**	**Total for category**
1	Drug treatment and rehabilitation (i.e., physicians and/or rehabilitation professionals in accredited treatment and rehabilitation centers)	**6**	**6**	**12**
2	Public health (i.e., municipal health officers and/or public health nurses in areas where drug treatment and rehabilitation centers are located)	**6**	**6**	**12**
3	Social welfare (i.e., social worker in the municipal/city/provincial social welfare office within the catchment area of a drug treatment and rehabilitation center)	**6**	**6**	**12**
4	Criminal justice (i.e., police officers, court sheriff, drug enforcement agency personnel involved in the transfer of clients to and from a drug treatment and rehabilitation center)	**6**	**6**	**12**
	TOTAL	**24**	**24**	**48**

Recruitment of potential participants were made through referral by the heads of Drugs Abuse Treatment and Rehabilitation Centers where the proponent has previously conducted research in 2017-2018. This approach ensured that rapport is already established among a part of the target focus group participants, and that the invitation to potential participants from other agencies will be supported by the endorsement of the head of the treatment and rehabilitation center. Once the participants have been identified, they were contacted directly to invite them to the focus group session. To ensure that enough participants will attend the session, a 20% over recruitment was implemented (Onwuegbuzie et al, 2009).

Each focus group session, which were expected to last between 60 to 90 minutes, were recorded for later transcription and analysis, and followed the format outlined in Table 3-2.

Table 3-2. Process flow for focus group discussion

1. A follow-up email will be provided to the participants one week and one day before the scheduled focus group session. They will also be provided with an advanced copy of the informed consent form for their perusal.

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2. At the start of the session, the moderator will begin by thanking the participants for joining the session. Once this has been accomplished, the purpose of, and procedures for, the focus group will be explained (i.e., the session will be recorded for later analysis; only one person, to be recognized by the moderator, should speak at a time; there are no right or wrong ideas or opinions in the discussion) (Flick, 2014).

↓

3. The discussion proper will commence, which will cover the five categories of questions identified by Krueger and Casey (2015) (Table 3-3). As noted by Flick (2014), the discussion will be conducted informally to create an environment where participants will be willing to share their ideas.

↓

4. At the end of the session, the moderator will provide a short summary of the main discussion points; ask the participants if they have any additional ideas that they would like to share but were not discussed during the session; and thank the participants for their contribution to the research to conclude the session.

↓

5. Documentation of observations in field notes.

Table 3-3. Questions for the focus group discussion

Question Category (Krueger & Casey, 2015)	Specific Question/s
Introductory question	What is the first thing that comes to mind when you hear the word "collaboration"?
Transition question	Would you remember the last instance when you engaged in collaboration?
Key questions	• In your experience, to what extent, or how frequent, do you collaborate with the other agencies involved in drug treatment and rehabilitation? • Can you describe what activities you do when you say you are "collaborating" with the other agencies involved in drug treatment and rehabilitation? • In your opinion, what helped facilitate this collaboration? • Do you think there are aspects that are making collaboration challenging? • How has the COVID-19 pandemic affected your collaborations activities?
Ending question	(After the moderator has provided a short summary of the main discussion points): Are there any additional ideas that you would like to share before we end the session?

In addition to the recording of the discussion, the researcher/moderator also prepared observational notes during the discussion, and a summary note written immediately after the discussion (Rabiee, 2004). This included, among others, points where participants agreed or disagreed with certain ideas discussed during the session.

Two broad participant types may pose a challenge to meaningfully collecting data from focus groups, making appropriate group management an essential moderation skill (Krueger and Casey, 2015). On the one hand, experts and rambling participants may dominate the discussion, precluding contribution by other group members. To manage this kind of

participant, the moderator, at the outset, mentioned that the idea of all group members is important. The moderator was also on the lookout for moments when dominant participants pause in their contribution and used this as an opportunity to request others to speak (i.e., by using such words as “Thank you for that idea. Are there others who want to comment on the question?” or “That’s one point of view. Let’s hear what others have to say.”). On the other hand, some participants were too shy or reluctant to contribute to the discussion. In this case, the moderator first observes who among the participants have not yet shared ideas to a particular question. They were then requested and encouraged to share their thoughts (i.e., “I don’t want to leave you out of this conversation. What do you think?”).

3.6. Semi-structured interviews

This third component of the study addressed the research questions and specific objectives pertaining to the goals and outcomes (RQ4, SO3); benefits and costs (RQ4, SQ4); and facilitators and barriers to collaboration (RQ5, SO5). It was also used to supplement data for the other research questions and specific objectives derived from the first two components (i.e., review of documentation, focus group discussion).

Expert interview technique, a specific form of semi-structured interviews, was used given the nature of the topic, the type of persons who will best be able to provide the information being sought, and the focus on eliciting “explicit, tacit, professional or occupational knowledge” (Littig, 2008).

At least 16 informants from four agencies involved in the drug treatment and rehabilitation process (i.e., DATRC, public health, social welfare, criminal justice) across the two study sites were invited to participate in interviews for the project (Table 3-4), all of whom were chosen through theoretical sampling (Palinkas et al., 2015). In addition to stratification by

agency, informants were further stratified by position level as previous research (Smith & Mogro-Wilson, 2007; Wenzel et al., 2004) has shown that the perspectives of these two types of personnel with respect to aspects of collaboration differ in terms of level of detail. Saturation is a criterion used as basis to stop sampling, and refers to a state where no new data can be found for each category or theme (Creswell & Poth, 2018; Flick, 2014).

Table 3-4. List of informants to be recruited, by type of agency and position

Agency	Position		Total per agency per round
	Managerial	Front-line	
Treatment center	2	2	4
Public health	2	2	4
Social service	2	2	4
Criminal justice	2	2	4
Total per category per round	8	8	
Minimum number of rounds of interviews			**2**
Total number of interviews			**32**

The procedure for conducting the interviews, adapted from Flick (2014), is outlined in Table 3-5.

Table 3-5. Process flow for conduct of semi-structured interviews

1. Preparation and finalization of interview guide (see indicative questions in Table 3-6)

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2. Official communication with head of agency indicating nature of research, identifying informants proposed by the researcher (see Table 3-4), and requesting for nomination of one to two alternate informants

↓

3. Invitation/recruitment of identified informant
If informant declines, step (3) will be repeated with alternate informants until one of them agrees to participate OR the list is exhausted

↓

4. Administration of informed consent
If informant declines, step (3) will be repeated with alternate informants until one of them agrees to participate OR the list is exhausted

↓

5. Selection of date, time and venue of interview (*may coincide with administration of informed consent*)

↓

6. Interview proper (*to include request for permission to audiotape the interview, introduction to the purpose of the interview, and conclusion*)

Interviews were expected to take about one hour at most and were collected on a single instance per informant.

The indicative questions for the interviews are shown in Table 3-6. These were mainly derived from the literature outlining the elements of collaboration, while the rest were developed after consideration of the different components of the conceptual framework presenter earlier. As presented in Figure 3-1, the interview guide was finalized after data from documentation review and focus group discussion have been completed.

Table 3-6. Indicative interview questions

Rationale for collaboration
- Can you tell me about your organization's partnership, linkage or referral system with any (a) public health agency, (b) social welfare agency, and (c) criminal justice agency?
- Why was the partnership formed?
- How long has this partnership/collaboration been in place?

Planning
- What are the goals of the partnership?
- Are there any formal planning activities done for the partnership? How frequently are these conducted?

Structure, composition, and administration
- Who leads or initiates contacts or activities within the partnership? Are there assigned focal persons or linkage agents from each agency?
- How is the collaborative engagement managed?
- How are decisions that concern the partnership arrived at?
- Is there any form of resource sharing (e.g., budget, staff) between the partner agencies? How are these shared resources managed?
- What are the mechanisms for communication between agencies?
- Have any conflicts between the involved agencies arisen in the context of collaboration? How were these resolved?

Service delivery
- Can you tell me about how your organizations manage common clients/patients? For example, are there joint assessment and planning activities?
- Is there a referral mechanism for common clients/patients of the two agencies? How is this done?
- Has there been any common training participated in by staff from the partner organizations? How have these trainings affected the partnership or the provision of services?
- Are there opportunities to hold joint meetings of staff from the partner agencies?

Outcomes
- In what ways has the partnership (positively or negatively) affected the participating agencies? The staff? The clients?
- What factors (at the contextual, organizational, staff, and client levels) do you think has helped the partnership attain these results?
- What factors (at the contextual, organizational, staff, and client levels) do you think has prevented the partnership from attaining any of its goals?
- What factors (at the contextual, organizational, staff, and client levels) do you think has helped sustain the partnership?
- What factors (at the contextual, organizational, staff, and client levels) do you think has challenged the partnership?

Interview data was analyzed using thematic analysis following the framework by Braun &

Clark (2006), which was selected because it offers a more robust framework for handling qualitative data that can be applied across research traditions (Braun, & Clarke, 2014). The steps of analysis were: (a) familiarization with the data; (b) generation of initial codes; (c) search for themes; (d) review of themes; (e) defining and naming themes; and (f) production of the report. Data analysis was carried out using NVivo (release 1.6.1; QSR International, 2020). Briefly, digitalized copies of translated transcripts were uploaded into NVivo. These were read and re-read to ensure familiarization with the data. Codes were developed initially from the conceptual and theoretical framework of the study. New codes that emerged from the data during full coding added as these were encountered during coding. To standardize the application of codes, a code book was generated. The generated codes were analyzed to identify patterns, which were labelled as themes and sub-themes. Themes were then reviewed at two levels: first for coherence with respect to the coded data extracts, and second for coherence or alignment with the analytic framework of the study. A label was then assigned to each theme to capture its "essence."

3.7. Ensuring quality of data

One challenge confronting qualitative research is with respect to the quality, validity and reliability of findings, more so for this study that aims to integrate findings from multiple sources. While there are multiple perspectives with respect to the validation of qualitative research (Creswell & Poth, 2018), this section shall employ the terminology and criteria on "trustworthiness" and validation offered by Lincoln and Guba (1985).

Credibility refers to confidence in the results as presented. This will be ensured in this study through the researcher's prolonged engagement in the field (i.e., multiple visits per site over a period of seven months), triangulation (i.e., by data source and by method, as mentioned in

the preceding section), member checking (i.e., feedback from informants on data and preliminary findings), and peer debriefing (i.e., through consultations and discussions with the Chief Supervisor and Co-supervisor throughout the study).

Transferability pertains to the extent to which findings can be applied in other contexts. This will be ensured through the generation of thick descriptions (Geertz, 1973 [2008]) for the cases such that there is sufficient detail in terms of the various components and attributes of collaboration, as well as the context in which each case was studied.

Dependability is about the consistency of findings, and that these could be repeated or reproduced. This will be facilitated through the development of this detailed study protocol that outlines the procedures to be done at various points of the research. Details of the data collection and analysis will also be captured through the researcher's journal, as well as the analytic memos to be written in NVivo. In the final report, an audit trail will be presented by means of examples showing the data sources (e.g., interview transcripts), and how these were analyzed to arrive at the study findings. Finally, the study results will be subjected to an external audit/peer review by a panel of examiners.

Lastly, confirmability refers to the degree to which the study findings are rooted in the data. In addition to triangulation, the establishment of an audit trail, and external audit/peer review described above, reflexivity will be practiced through maintenance of a research journal and the preparation of analytic memos in NVivo. The researcher's preconceptions, beliefs and assumptions on the topic will also be reported in manuscripts and other publications.

3.8. Ethical considerations

This research was conducted in compliance with relevant statues and regulations promulgated

by duly constituted authorities in relation to the conduct of research involving human participants. The study protocol was submitted for review by the Human Subjects Ethics Sub-committee of The Hong Kong Polytechnic University (HSEARS20210616001).

Privacy and confidentiality. Information obtained in the course of the research will be kept confidential. While persons who submitted to interviews may be easily identified through playback of their audio recording, no names will be collected from them, nor will they be identified by name or institution in the final study report. Likewise, no names will be recorded in the field notes or researcher journal. Audio recordings of interviews and their corresponding electronic transcriptions will be kept in a secure medium, with access restricted to the researcher only to safeguard the confidentiality of information.

While confidentiality and anonymity of information shared by focus group participants with the researcher are bound by ethical rules of conduct, the same cannot be said of other participants. That is, the researcher does not have control over what participants may do with the information that they were able to hear from the discussion. Relatedly, and specific to online or virtual focus groups, it is possible that participants are joining the communication platform from a space where confidentiality of the discussion may be compromised (e.g., joining the focus group in the office or home setting where other individuals may be able to hear the inputs of other participants) (Daniels et al, 2019). To address this issue, the following strategies will be adopted (Sim & Waterfield, 2019):

- Access to the conferencing platform to be used for the focus group will be restricted to invited participants by through assignment of a meeting password (Lobe et al., 2020).
- Participants will be encouraged to join the online discussion from a private space in their home or office (i.e., marking the space with a “do not

disturb" sign), and to use headphones/earphones to limit broadcast of the discussion.

- Before the start of the focus group discussion, the moderator will remind participants that, while the discussion is public in nature, anonymity and confidentiality of data shared within the focus group should be maintained. Further, participants should be mindful of issues that they feel might be unsuitable for sharing in a public setting.

- After the focus group discussion, and after the ending question has been addressed, the moderator will once again remind participants on confidentiality and anonymity of data.

Informed consent process. The informed consent forms will be sent by the researcher to the potential participants of the focus group and individual interviews through their official email (this will be requested from the head of agency during the nomination process) email at least one week in advance of the scheduled session to allow ample time for perusal of this contents. Participants will be requested to return a scanned copy of the signature page for recording purposes. Alternatively, they may reply to the email indicating their consent to participate (Lobe et al., 2020). Should the potential interviewee not give consent, the next person on the short list provided by the head of office/agency chief will be contacted by the researcher.

Vulnerability. This research does not directly involve vulnerable populations as participants. No form of situational vulnerability is foreseen.

Recruitment. The head of office/agency will be requested to provide a short list of the names,

offices and contact information of suitable personnel for the focus groups and interviews, in addition to the ones initially identified by the researcher. They will be contacted directly through email or phone call by the researcher to seek their involvement in the research as interviewees. Should they indicate interest, informed consent shall be administered as stated above, and the interview shall commence thereafter. It is also possible to hold the interview at a later time, if this will be so requested by the potential interviewee.

Risks. Economic harm to interviewees should they not consent to be interviewed, or if they provide information that may be seen as a slight to the image of their organization, is a possibility, but this will be mitigated through a) non-disclosure to the head of office/agency of the final person in the short lists who was interviewed; b) non-identification of interviewees in the results of the study; and c) safeguarding of all recordings of the interview. There is a possibility that the institution may be placed at risk in the course of the interview where information on activities not in consonance with established standards or guidelines may be uncovered in the course of the research. This will be mitigated through non-identification of facilities in the published version of the study.

There may be some form of psychological risk to participation especially in the discussion of participants' work during the COVID-19 pandemic. While the chance of this harm from happening is low since the focus of the discussion is on collaboration, it is still possible that feelings of guilt and/or fear may arise when participants describe their experience of working during the COVID-19 pandemic. During the data collection proper, the researcher will be alert and sensitive to signs of discomfort, distress, or oversharing among participants, and will attempt to steer the discussion in another direction.

Benefits. There will be no direct benefits to the individual or institutional participants in this research. However, they may be able to obtain indirect benefits later in the future through

improved policies and strategies on improving interagency collaboration for drug treatment and rehabilitation.

Incentives or compensation. No incentives or compensation will be provided to individual or institutional participants in this project.

Community considerations. Findings of this study will redound to managers and implementers drug treatment and rehabilitation programs.

4. Results: Scoping review

4.1. Selection of sources of evidence

A total of 5,329 unique records were retrieved from a comprehensive search of four databases, of which 5,358 were excluded after title and abstract screening due to irrelevance to the eligibility criteria (Figure 4-1). The full text of the remaining 271 records were retrieved and assessed and 217 were found to be ineligible after matching with the exclusion and inclusion criteria (153 papers did not focus on a collaborative initiative as defined for this review; 13 papers had the wrong population; 50 were not empirical papers; and the full-text for one record was not located even after exhaustive search across four libraries). Thus, 54 (Abdel-Salam et al., 2017; Amaro et al., 2004; Anastas et al., 2019; Appel et al., 2017; Barreira et al., 2000; Bennett & Lawson, 1994; Best et al., 2010; Bonham et al., 1990; Bouis et al., 2007; Bray & Rogers, 1995; Brindis et al., 1997; Clark et al., 2017; Clodfelter et al., 2010; Coll et al., 2010; Crome et al., 2000; D'Aunno et al., 2017; Darfler et al., 2019; Drabble, 2011; Drabble & Poole, 2011; Drainoni et al., 2014; Formica et al., 2018; Glenn & Moore, 2008; Green et al., 2008; Guerrero et al., 2016; Gurewich et al., 2014; He, 2015, 2017; Heckman et al., 2004; Huebner et al., 2015; Hunter et al., 2005; Iachini et al., 2015; Kikkert et al., 2018; Lee et al., 2006; Ma et al., 2016; Masson et al., 2013; McCarthy et al., 1992; Mittal & Suzuki, 2017; Morgenstern et al., 2009; Pelissier & Cadigan, 2004; Proeschold-Bell et al., 2010; Proeschold-Bell et al., 2016; Rosenheck et al., 2003; Ryland & Lucas, 1996; Samet et al., 2003; Schlenger et al., 1992; Smith & Mogro-Wilson, 2007; Van Hasselt et al., 2005; Veysey et al., 2004; Watkins et al., 2017; Welsh et al., 2016; Wenzel et al., 2004; Whiters et al., 2010; Wood & Austin, 2009; Zaller et al., 2007) articles were included in the scoping review.

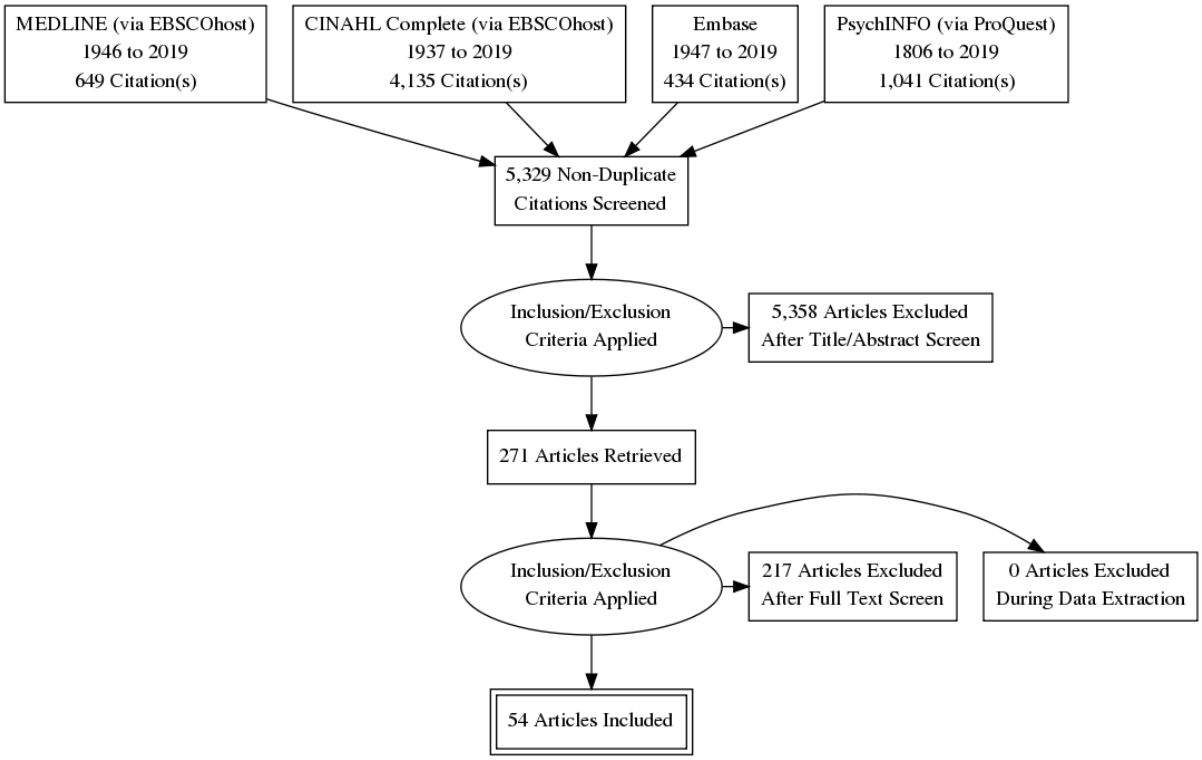

Figure 4-1. Study flow diagram

4.2. Characteristics of sources of evidence

The earliest record included in the analysis was published in 1990 (Bonham et al., 1990) while two papers were published in 2019 (Anastas et al., 2019; Darfler et al., 2019). Around one fourth (n = 28) of papers included in the analysis were published between the periods 2006 and 2010 (Best et al., 2010; Bouis et al., 2007; Clodfelter et al., 2010; Coll et al., 2010; Glenn & Moore, 2008; Green et al., 2008; Lee et al., 2006; Morgenstern et al., 2009; Proeschold-Bell et al., 2010; Smith & Mogro-Wilson, 2007; Whiters et al., 2010; Wood & Austin, 2009; Zaller et al., 2007) and 2016 to 2020 (Abdel-Salam et al., 2017; Anastas et al., 2019; Appel et al., 2017; Clark et al., 2017; D'Aunno et al., 2017; Darfler et al., 2019; Formica et al., 2018; Guerrero et al., 2016; He, 2017; Kikkert et al., 2018; Ma et al., 2016; Mittal & Suzuki, 2017; Proeschold-Bell et al., 2016; Watkins et al., 2017; Welsh et al., 2016). The current decade accounted for two out of five (n = 23) papers analyzed for this review.

Nine out of 10 papers (n = 49) reported on a collaborative project or program located in North America, specifically the United States (Abdel-Salam et al., 2017; Amaro et al., 2004; Anastas et al., 2019; Appel et al., 2017; Barreira et al., 2000; Bennett & Lawson, 1994; Bonham et al., 1990; Bouis et al., 2007; Bray & Rogers, 1995; Brindis et al., 1997; Clark et al., 2017; Clodfelter et al., 2010; Coll et al., 2010; D'Aunno et al., 2017; Darfler et al., 2019; Drabble, 2011; Drainoni et al., 2014; Formica et al., 2018; Glenn & Moore, 2008; Green et al., 2008; Guerrero et al., 2016; Gurewich et al., 2014; He, 2015, 2017; Heckman et al., 2004; Huebner et al., 2015; Iachini et al., 2015; Lee et al., 2006; Masson et al., 2013; McCarthy et al., 1992; Mittal & Suzuki, 2017; Morgenstern et al., 2009; Pelissier & Cadigan, 2004; Proeschold-Bell et al., 2010; Proeschold-Bell et al., 2016; Rosenheck et al., 2003; Ryland & Lucas, 1996; Samet et al., 2003; Schlenger et al., 1992; Smith & Mogro-Wilson, 2007; Van Hasselt et al., 2005; Veysey et al., 2004; Watkins et al., 2017; Welsh et al., 2016; Wenzel et al., 2004; Whiters et al., 2010; Wood & Austin, 2009; Zaller et al., 2007) and Canada (Drabble & Poole, 2011). The rest of the records were from Europe (Best et al., 2010; Crome et al., 2000; Hunter et al., 2005; Kikkert et al., 2018)and China (Ma et al., 2016).

In terms of aim or purpose, more than half (n = 29) of the papers were descriptive in nature (i.e., presents the organization/structure, function/process, products/outcomes, and facilitators/barriers of a collaborative arrangement) (Abdel-Salam et al., 2017; Amaro et al., 2004; Anastas et al., 2019; Appel et al., 2017; Barreira et al., 2000; Bonham et al., 1990; Bouis et al., 2007; Bray & Rogers, 1995; Clark et al., 2017; Clodfelter et al., 2010; Crome et al., 2000; Drabble, 2011; Drabble & Poole, 2011; Formica et al., 2018; Green et al., 2008; Gurewich et al., 2014; Heckman et al., 2004; Huebner et al., 2015; Iachini et al., 2015; Ma et al., 2016; McCarthy et al., 1992; Mittal & Suzuki, 2017; Ryland & Lucas, 1996; Van Hasselt et al., 2005; Veysey et al., 2004; Wenzel et al., 2004; Whiters et al., 2010; Wood & Austin, 2009; Zaller et al., 2007), while around a third (n = 17) were explanatory (i.e., test of

hypothesis or the efficacy/effectiveness of interventions) (Best et al., 2010; Coll et al., 2010; D'Aunno et al., 2017; He, 2015, 2017; Kikkert et al., 2018; Lee et al., 2006; Masson et al., 2013; Morgenstern et al., 2009; Pelissier & Cadigan, 2004; Proeschold-Bell et al., 2010; Proeschold-Bell et al., 2016; Rosenheck et al., 2003; Samet et al., 2003; Smith & Mogro-Wilson, 2007; Watkins et al., 2017; Welsh et al., 2016). A few papers were had evaluative (i.e., assessment of a particular intervention or practice in real-life situations in the social world) (Brindis et al., 1997; Darfler et al., 2019; Drainoni et al., 2014; Hunter et al., 2005; Schlenger et al., 1992) or exploratory (i.e., generation of initial insights into the nature of an issue) aims (Bennett & Lawson, 1994; Glenn & Moore, 2008; Guerrero et al., 2016).

Quantitative, specifically survey research (n = 9) (Bennett & Lawson, 1994; D'Aunno et al., 2017; Formica et al., 2018; Glenn & Moore, 2008; He, 2015, 2017; Lee et al., 2006; Rosenheck et al., 2003; Smith & Mogro-Wilson, 2007) and quasi-experiments with pre- and post- designs (n = 8) (Abdel-Salam et al., 2017; Best et al., 2010; Bouis et al., 2007; Bray & Rogers, 1995; Coll et al., 2010; Proeschold-Bell et al., 2010; Proeschold-Bell et al., 2016; Zaller et al., 2007), and mixed method approaches, i.e., case study (n = 18) (Amaro et al., 2004; Appel et al., 2017; Barreira et al., 2000; Bonham et al., 1990; Clodfelter et al., 2010; Crome et al., 2000; Drabble, 2011; Drabble & Poole, 2011; Gurewich et al., 2014; Heckman et al., 2004; Huebner et al., 2015; Hunter et al., 2005; McCarthy et al., 1992; Ryland & Lucas, 1996; Van Hasselt et al., 2005; Veysey et al., 2004; Whiters et al., 2010; Wood & Austin, 2009) or program/project evaluation (n = 6) (Anastas et al., 2019; Brindis et al., 1997; Darfler et al., 2019; Drainoni et al., 2014; Guerrero et al., 2016; Schlenger et al., 1992), both accounted for about 90% of the methods utilized by the paper authors. Notably, a few of the collaborative initiatives were tested using a randomized trial design (Kikkert et al., 2018; Masson et al., 2013; Morgenstern et al., 2009; Samet et al., 2003; Watkins et al., 2017; Welsh et al., 2016).

The characteristics of included articles are summarized in Table 4-1.

Table 4-1. Characteristics of articles included in the scoping review (N = 54).

Characteristic	No.	%	Source
Year of publication			
1990 or earlier	1	2%	Bonham et al. (1990)
1991 to 1995	4	7%	Bennett and Lawson (1994); Bray and Rogers (1995); McCarthy et al. (1992); Schlenger et al. (1992)
1996 to 2000	4	7%	Barreira et al. (2000); Brindis et al. (1997); Crome et al. (2000); Ryland and Lucas (1996)
2001 to 2005	9	17%	Amaro et al. (2004); Heckman et al. (2004); Hunter et al. (2005); Pelissier and Cadigan (2004); Rosenheck et al. (2003); Samet et al. (2003); Van Hasselt et al. (2005); Veysey et al. (2004); Wenzel et al. (2004)
2006 to 2010	13	24%	Best et al. (2010); Bouis et al. (2007); Clodfelter et al. (2010); Coll et al. (2010); Glenn and Moore (2008); Green et al. (2008); Lee et al. (2006); Morgenstern et al. (2009); Proeschold-Bell et al. (2010); Smith and Mogro-Wilson (2007); Whiters et al. (2010); Wood and Austin (2009); Zaller et al. (2007)
2011 to 2015	8	15%	Drabble (2011); Drabble and Poole (2011); Drainoni et al. (2014); Gurewich et al. (2014); He (2015); Huebner et al. (2015); Iachini et al. (2015); Masson et al. (2013)
2016 to 2020	15	28%	Abdel-Salam et al. (2017); Anastas et al. (2019); Appel et al. (2017); Clark et al. (2017); D'Aunno et al. (2017); Darfler et al. (2019); Formica et al. (2018); Guerrero et al. (2016); He (2017); Kikkert et al. (2018); Ma et al. (2016); Mittal and Suzuki (2017); Proeschold-Bell et al. (2016); Watkins et al. (2017); Welsh et al. (2016)
Country of origin			
United States of America	48	89%	Abdel-Salam et al. (2017); Amaro et al. (2004); Anastas et al. (2019); Appel et al. (2017); Barreira et al. (2000); Bennett and Lawson (1994); Bonham et al. (1990); Bouis et al. (2007); Bray and Rogers (1995); Brindis et al. (1997); Clark et al. (2017); Clodfelter et al. (2010); Coll et al. (2010); D'Aunno et al. (2017); Darfler et al. (2019); Drabble (2011); Drainoni et al. (2014); Formica et al. (2018); Glenn and Moore (2008); Green et al. (2008); Guerrero et al. (2016); Gurewich et al. (2014); He (2015, 2017); Heckman et al. (2004); Huebner et al. (2015); Iachini et al. (2015); Lee et al. (2006); Masson et al. (2013); McCarthy et al. (1992); Mittal and Suzuki (2017); Morgenstern et al. (2009); Pelissier and Cadigan (2004); Proeschold-Bell et al. (2010); Proeschold-Bell et al. (2016); Rosenheck et al. (2003); Ryland and Lucas (1996); Samet et al. (2003); Schlenger et al. (1992); Smith and Mogro-Wilson (2007); Van Hasselt et al. (2005); Veysey et al. (2004); Watkins et al. (2017); Welsh et al. (2016); Wenzel et al. (2004); Whiters et al. (2010); Wood and Austin (2009); Zaller et al. (2007)
United Kingdom	3	6%	Best et al. (2010); Crome et al. (2000); Hunter et al. (2005)
Canada	1	2%	Drabble and Poole (2011)
China	1	2%	Ma et al. (2016)

Characteristic	No.	%	Source
The Netherlands	1	2%	Kikkert et al. (2018)
Aim/purpose of the paper			
Exploratory	3	6%	Bennett and Lawson (1994); Glenn and Moore (2008); Guerrero et al. (2016)
Descriptive	29	54%	Abdel-Salam et al. (2017); Amaro et al. (2004); Anastas et al. (2019); Appel et al. (2017); Barreira et al. (2000); Bonham et al. (1990); Bouis et al. (2007); Bray and Rogers (1995); Clark et al. (2017); Clodfelter et al. (2010); Crome et al. (2000); Drabble (2011); Drabble and Poole (2011); Formica et al. (2018); Green et al. (2008); Gurewich et al. (2014); Heckman et al. (2004); Huebner et al. (2015); Iachini et al. (2015); Ma et al. (2016); McCarthy et al. (1992); Mittal and Suzuki (2017); Ryland and Lucas (1996); Van Hasselt et al. (2005); Veysey et al. (2004); Wenzel et al. (2004); Whiters et al. (2010); Wood and Austin (2009); Zaller et al. (2007)
Explanatory	17	31%	Best et al. (2010); Coll et al. (2010); D'Aunno et al. (2017); He (2015, 2017); Kikkert et al. (2018); Lee et al. (2006); Masson et al. (2013); Morgenstern et al. (2009); Pelissier and Cadigan (2004); Proeschold-Bell et al. (2010); Proeschold-Bell et al. (2016); Rosenheck et al. (2003); Samet et al. (2003); Smith and Mogro-Wilson (2007); Watkins et al. (2017); Welsh et al. (2016)
Evaluative	5	9%	Brindis et al. (1997); Darfler et al. (2019); Drainoni et al. (2014); Hunter et al. (2005); Schlenger et al. (1992)
Method used			
Quantitative	25	46%	
Case series	*1*	*2%*	Mittal and Suzuki (2017)
Cohort	*1*	*2%*	Pelissier and Cadigan (2004)
Survey	*9*	*17%*	Bennett and Lawson (1994); D'Aunno et al. (2017); Formica et al. (2018); Glenn and Moore (2008); He (2015, 2017); Lee et al. (2006); Rosenheck et al. (2003); Smith and Mogro-Wilson (2007)
Quasi-experiment	*8*	*15%*	Abdel-Salam et al. (2017); Best et al. (2010); Bouis et al. (2007); Bray and Rogers (1995); Coll et al. (2010); Proeschold-Bell et al. (2010); Proeschold-Bell et al. (2016); Zaller et al. (2007)
Controlled trial	*6*	*11%*	Kikkert et al. (2018); Masson et al. (2013); Morgenstern et al. (2009); Samet et al. (2003); Watkins et al. (2017); Welsh et al. (2016)
Qualitative	5	9%	Clark et al. (2017); Green et al. (2008); Iachini et al. (2015); Ma et al. (2016); Wenzel et al. (2004)
Mixed-/ Multi-method	24	44%	
Case study	*18*	*33%*	Amaro et al. (2004); Appel et al. (2017); Barreira et al. (2000); Bonham et al. (1990); Clodfelter et al. (2010); Crome et al. (2000); Drabble (2011); Drabble and Poole (2011); Gurewich et al. (2014); Heckman et al. (2004); Huebner et al. (2015); Hunter et al. (2005); McCarthy et al. (1992); Ryland and Lucas (1996); Van Hasselt et al. (2005); Veysey et al. (2004); Whiters et al. (2010); Wood and Austin (2009)
Evaluation	*6*	*11%*	Anastas et al. (2019); Brindis et al. (1997); Darfler et al. (2019); Drainoni et al. (2014); Guerrero et al. (2016); Schlenger et al. (1992)

4.3. Features of collaborative initiatives

Nearly half (n = 24) of the collaborative initiatives discussed in the included articles were existing programs, or were permanent or on-going services of a group or organization (Bennett & Lawson, 1994; Clark et al., 2017; Clodfelter et al., 2010; D'Aunno et al., 2017; Drabble, 2011; Drabble & Poole, 2011; Formica et al., 2018; Glenn & Moore, 2008; Green et al., 2008; Guerrero et al., 2016; Gurewich et al., 2014; He, 2015, 2017; Huebner et al., 2015; Hunter et al., 2005; Iachini et al., 2015; Lee et al., 2006; Ma et al., 2016; Mittal & Suzuki, 2017; Pelissier & Cadigan, 2004; Ryland & Lucas, 1996; Smith & Mogro-Wilson, 2007; Van Hasselt et al., 2005; Wenzel et al., 2004). Most of the initiatives, however, were projects that were developed either as part of project demonstration grants (n = 20) (Amaro et al., 2004; Anastas et al., 2019; Appel et al., 2017; Barreira et al., 2000; Best et al., 2010; Bonham et al., 1990; Bray & Rogers, 1995; Brindis et al., 1997; Coll et al., 2010; Crome et al., 2000; Darfler et al., 2019; Drainoni et al., 2014; Heckman et al., 2004; McCarthy et al., 1992; Rosenheck et al., 2003; Schlenger et al., 1992; Veysey et al., 2004; Whiters et al., 2010; Wood & Austin, 2009; Zaller et al., 2007)or as part of a research project (n = 10) (Abdel-Salam et al., 2017; Bouis et al., 2007; Kikkert et al., 2018; Masson et al., 2013; Morgenstern et al., 2009; Proeschold-Bell et al., 2010; Proeschold-Bell et al., 2016; Samet et al., 2003; Watkins et al., 2017; Welsh et al., 2016).

Four categories or clusters of project or program goals were identified from the included articles: increase client access to a particular service (n = 24) (Anastas et al., 2019; Appel et al., 2017; Barreira et al., 2000; Clark et al., 2017; Darfler et al., 2019; Drainoni et al., 2014; Formica et al., 2018; Glenn & Moore, 2008; Guerrero et al., 2016; Gurewich et al., 2014; He, 2017; Hunter et al., 2005; Mittal & Suzuki, 2017; Proeschold-Bell et al., 2010; Proeschold-Bell et al., 2016; Rosenheck et al., 2003; Samet et al., 2003; Schlenger et al., 1992; Van

Hasselt et al., 2005; Watkins et al., 2017; Welsh et al., 2016; Wenzel et al., 2004; Whiters et al., 2010; Wood & Austin, 2009); improve coordination of services being offered by two or more groups (n = 6) (Abdel-Salam et al., 2017; Bennett & Lawson, 1994; Best et al., 2010; Bray & Rogers, 1995; Coll et al., 2010; McCarthy et al., 1992); enhance the provision of an existing service through the effort of two or more groups (n = 4) (Clodfelter et al., 2010; Iachini et al., 2015; Kikkert et al., 2018; Masson et al., 2013); and develop a service offered under a collaborative arrangement (n = 2) (Amaro et al., 2004; Bouis et al., 2007). Meanwhile, 14 projects had dual goals: increase service access and improve coordination (Bonham et al., 1990; He, 2015; Lee et al., 2006; Ma et al., 2016; Morgenstern et al., 2009; Pelissier & Cadigan, 2004; Zaller et al., 2007); develop a service and increase service access (Crome et al., 2000; Heckman et al., 2004; Ryland & Lucas, 1996; Veysey et al., 2004); improve both service provision and coordination (Green et al., 2008; Huebner et al., 2015); develop a collaborative service and improve coordination among participating groups (Brindis et al., 1997). Specific goal was not stated nor could be inferred for the four remaining papers (D'Aunno et al., 2017; Drabble, 2011; Drabble & Poole, 2011; Smith & Mogro-Wilson, 2007), which could be attributed to the fact that authors undertook analysis for multiple collaborative arrangements.

Only six of the papers were able to examine collaboration at a national scale, four of which utilized existing nationally-representative survey data (D'Aunno et al., 2017; He, 2015, 2017; Lee et al., 2006), while the other two used data from a project information system established to track recipients of services under a collaborative program (Pelissier & Cadigan, 2004) and a national evaluation of recipients of a grant for demonstration projects (Schlenger et al., 1992). Almost all of the papers analyzed for this scoping review were focused on initiatives implemented at an institutional, county or state level.

4.4. Collaborative arrangements

In terms of participating groups, about two-thirds of the articles presented partnership between two groups, one of which is involved in providing addition treatment services for PWUD. Their partner organizations come from the public health and primary care fields (n = 19) (Anastas et al., 2019; Appel et al., 2017; Bouis et al., 2007; Bray & Rogers, 1995; Clark et al., 2017; D'Aunno et al., 2017; Darfler et al., 2019; Drainoni et al., 2014; Guerrero et al., 2016; Gurewich et al., 2014; Masson et al., 2013; McCarthy et al., 1992; Proeschold-Bell et al., 2010; Proeschold-Bell et al., 2016; Ryland & Lucas, 1996; Samet et al., 2003; Schlenger et al., 1992; Watkins et al., 2017; Wood & Austin, 2009); social services, including those providing child welfare and catering to victims of domestic violence (n = 9) (Bennett & Lawson, 1994; Bonham et al., 1990; Drabble & Poole, 2011; Glenn & Moore, 2008; He, 2015, 2017; Huebner et al., 2015; Iachini et al., 2015; Smith & Mogro-Wilson, 2007); criminal justice system, specifically the courts, police and correctional facilities (n = 8) (Abdel-Salam et al., 2017; Best et al., 2010; Formica et al., 2018; Hunter et al., 2005; Pelissier & Cadigan, 2004; Van Hasselt et al., 2005; Welsh et al., 2016; Wenzel et al., 2004); and mental and psychiatric service providers (n = 4) (Barreira et al., 2000; Clodfelter et al., 2010; Kikkert et al., 2018; Rosenheck et al., 2003). Two partnerships were unique in that one was between a government and private addiction treatment service providers (Crome et al., 2000), while another was between an addiction treatment service and a faith-based group (Whiters et al., 2010). More complex collaborative arrangements were reported in 12 papers in which more than two groups were reported to be working together to serve the needs of a PWUD (Table 4-2).

Table 4-2. Collaborative arrangements with more than two participating groups (n = 12)

No. of papers	Participating groups					Source
	Addiction treatment	Mental health	Social services	Criminal justice	Public health	
4	✓	✓	✓			Heckman et al. (2004); Morgenstern et al. (2009); Veysey et al. (2004); Zaller et al. (2007)
3	✓		✓	✓		Coll et al. (2010); Drabble (2011); Green et al. (2008)
2	✓	✓			✓	Lee et al. (2006); Mittal and Suzuki (2017)
1	✓	✓	✓		✓	Amaro et al. (2004)
1	✓		✓		✓	Brindis et al. (1997)
1	✓			✓	✓	Ma et al. (2016)

The target client of the collaborative programs and projects analyzed for this review were mainly PWUD who had a co-occurring medical, mental and/or social problem (Table 4-3). Only seven papers described initiatives that were focused on individuals without any co-occurring disorder (Bray & Rogers, 1995; Crome et al., 2000; Darfler et al., 2019; Glenn & Moore, 2008; Gurewich et al., 2014; Ma et al., 2016; Watkins et al., 2017), while one paper was focused on pregnant women who had substance use disorder (Brindis et al., 1997).

Table 4-3. Problems co-occurring with drug dependence among clients of collaborative arrangements (n = 46)

No. of papers	Co-occurring problem			Source
	Medical	Mental	Social	
21			✓	Abdel-Salam et al. (2017); Bennett and Lawson (1994); Best et al. (2010); Bonham et al. (1990); Coll et al. (2010); Drabble (2011); Drabble and Poole (2011); Formica et al. (2018); Green et al. (2008); He (2015, 2017); Heckman et al. (2004); Huebner et al. (2015); Hunter et al. (2005); Iachini et al. (2015); Morgenstern et al. (2009); Pelissier and Cadigan (2004); Smith and Mogro-Wilson (2007); Van Hasselt et al. (2005); Welsh et al. (2016); Wenzel et al. (2004)
12	✓			Appel et al. (2017); Clark et al. (2017); D'Aunno et al. (2017); Drainoni et al. (2014); Guerrero et al. (2016); Masson et al. (2013); McCarthy et al. (1992); Proeschold-Bell et al. (2010); Proeschold-Bell et al. (2016); Samet et al. (2003); Schlenger et al. (1992); Wood and Austin (2009)
5		✓		Anastas et al. (2019); Barreira et al. (2000); Clodfelter et al. (2010); Kikkert et al. (2018); Ryland and Lucas (1996)
5	✓	✓		Bouis et al. (2007); Lee et al. (2006); Mittal and Suzuki (2017); Whiters et al. (2010); Zaller et al. (2007)
3		✓	✓	Amaro et al. (2004); Rosenheck et al. (2003); Veysey et al. (2004)

4.5. Level of partnership

Classification of the level of partnership of the reported initiatives following the typology by Konrad (1996) showed that there were three predominant modes that were used or demonstrated. At the lower end of the spectrum are programs or projects that had some structure in terms of their partnership and utilized, among others, client referral and follow-up and joint staff meetings, in which case they were at the stage of cooperation and coordination (n = 18) (Bennett & Lawson, 1994; Best et al., 2010; Bonham et al., 1990; Bray & Rogers, 1995; Brindis et al., 1997; Coll et al., 2010; D'Aunno et al., 2017; Darfler et al., 2019; Guerrero et al., 2016; Gurewich et al., 2014; Hunter et al., 2005; Lee et al., 2006; Masson et al., 2013; McCarthy et al., 1992; Morgenstern et al., 2009; Pelissier & Cadigan, 2004; Samet et al., 2003; Wenzel et al., 2004). More structured efforts where partner groups enter into formal agreements, define common goals, establish an organizational structure, and engage in cross-training of staff, or at the level of collaboration, were reported in 22 papers (Abdel-Salam et al., 2017; Amaro et al., 2004; Appel et al., 2017; Clark et al., 2017; Crome et al.,

2000; Drabble, 2011; Drabble & Poole, 2011; Formica et al., 2018; Glenn & Moore, 2008; Green et al., 2008; He, 2015, 2017; Heckman et al., 2004; Huebner et al., 2015; Iachini et al., 2015; Ma et al., 2016; Ryland & Lucas, 1996; Smith & Mogro-Wilson, 2007; Van Hasselt et al., 2005; Welsh et al., 2016; Whiters et al., 2010; Wood & Austin, 2009). About one-fourth of papers reported on the highest level of integration in which a single entity manages and delivers an array of "seamless" services (Anastas et al., 2019; Barreira et al., 2000; Bouis et al., 2007; Clodfelter et al., 2010; Drainoni et al., 2014; Kikkert et al., 2018; Mittal & Suzuki, 2017; Proeschold-Bell et al., 2010; Proeschold-Bell et al., 2016; Rosenheck et al., 2003; Schlenger et al., 1992; Veysey et al., 2004; Watkins et al., 2017; Zaller et al., 2007). Notably, none of the included articles utilized strategies at the information and communication or consolidation levels.

4.6. Outcomes of collaboration

Half of papers measured and reported outcomes of the collaborative arrangements using quantitative or qualitative measures. The most commonly reported result of a collaborative was an increase of utilization of services by target clients (n = 10) (Darfler et al., 2019; Huebner et al., 2015; Masson et al., 2013; McCarthy et al., 1992; Mittal & Suzuki, 2017; Pelissier & Cadigan, 2004; Samet et al., 2003; Schlenger et al., 1992; Whiters et al., 2010; Zaller et al., 2007), followed by enhanced quality of service provision (n = 7) (Appel et al., 2017; Bouis et al., 2007; Bray & Rogers, 1995; Brindis et al., 1997; Coll et al., 2010; Crome et al., 2000; Drainoni et al., 2014); and reduced use of drugs by target clients (n = 4) (Kikkert et al., 2018; Proeschold-Bell et al., 2010; Proeschold-Bell et al., 2016; Watkins et al., 2017). One paper each reported an outcome of improved partnership between the participating groups (Abdel-Salam et al., 2017), and reduced reoffending by target client (Best et al., 2010). Four projects/programs reported attainment of two outcomes: improved partnership

among participating groups and enhanced quality of service provision (Clodfelter et al., 2010; Green et al., 2008); increased service utilization and reduced drug use among target clients (Morgenstern et al., 2009); and reduced reoffending and drug use of target clients (Van Hasselt et al., 2005).

4.7. Facilitators and barriers

Facilitators and barriers to collaboration were identified in 36 (or 67%) of the papers (Abdel-Salam et al., 2017; Amaro et al., 2004; Anastas et al., 2019; Appel et al., 2017; Barreira et al., 2000; Bennett & Lawson, 1994; Bouis et al., 2007; Bray & Rogers, 1995; Clark et al., 2017; D'Aunno et al., 2017; Darfler et al., 2019; Drabble, 2011; Drabble & Poole, 2011; Drainoni et al., 2014; Formica et al., 2018; Glenn & Moore, 2008; Green et al., 2008; Guerrero et al., 2016; Gurewich et al., 2014; He, 2015, 2017; Heckman et al., 2004; Huebner et al., 2015; Hunter et al., 2005; Iachini et al., 2015; Lee et al., 2006; Ma et al., 2016; McCarthy et al., 1992; Mittal & Suzuki, 2017; Pelissier & Cadigan, 2004; Rosenheck et al., 2003; Smith & Mogro-Wilson, 2007; Veysey et al., 2004; Welsh et al., 2016; Wenzel et al., 2004; Whiters et al., 2010). While papers may specify both, authors more frequently reported barriers overall, and at the contextual and organizational levels among the four domains identified for this analysis (Figure 5-1).

Positive factors at the contextual level (i.e., broader environment external to the initiative) include those relating to the availability of policies that promote collaboration, availability of resources to support the initiative, and the geographic proximity of collaborating parties (Anastas et al., 2019; Barreira et al., 2000; Bray & Rogers, 1995; Clark et al., 2017; D'Aunno et al., 2017; Drabble, 2011; Drabble & Poole, 2011; Guerrero et al., 2016; Gurewich et al., 2014; He, 2015; Smith & Mogro-Wilson, 2007; Veysey et al., 2004), while barriers are with

respect to the socioeconomic situation of the locality/ies in which collaboration will be implemented, policy restrictions and constraints, and differences in disciplinal orientations (Abdel-Salam et al., 2017; Amaro et al., 2004; Anastas et al., 2019; Bouis et al., 2007; Bray & Rogers, 1995; Clark et al., 2017; D'Aunno et al., 2017; Darfler et al., 2019; Drabble, 2011; Drabble & Poole, 2011; Formica et al., 2018; Glenn & Moore, 2008; Green et al., 2008; Gurewich et al., 2014; He, 2015; Heckman et al., 2004; Hunter et al., 2005; Iachini et al., 2015; Lee et al., 2006; Ma et al., 2016; McCarthy et al., 1992; Welsh et al., 2016; Wenzel et al., 2004; Whiters et al., 2010).

The three most common drivers identified from issues internal to the organization or unit involved in the initiative are knowledge transfer and cross-training of staff, the availability of communication and problem-solving mechanisms, and alignment of the institution's purpose and values with the goal of the collaborative (Anastas et al., 2019; Appel et al., 2017; Barreira et al., 2000; Bouis et al., 2007; Bray & Rogers, 1995; Clark et al., 2017; D'Aunno et al., 2017; Drabble, 2011; Drabble & Poole, 2011; Drainoni et al., 2014; Formica et al., 2018; Green et al., 2008; Guerrero et al., 2016; Gurewich et al., 2014; He, 2015, 2017; Heckman et al., 2004; Huebner et al., 2015; Iachini et al., 2015; McCarthy et al., 1992; Mittal & Suzuki, 2017; Rosenheck et al., 2003; Smith & Mogro-Wilson, 2007; Veysey et al., 2004). Absence of information and communication technology, resource constraints, and mistrust among partners, on the other hand, were cited as organizational barriers to collaboration (Abdel-Salam et al., 2017; Amaro et al., 2004; Anastas et al., 2019; Bennett & Lawson, 1994; Bouis et al., 2007; Clark et al., 2017; D'Aunno et al., 2017; Darfler et al., 2019; Drabble, 2011; Drabble & Poole, 2011; Formica et al., 2018; Glenn & Moore, 2008; Green et al., 2008; Guerrero et al., 2016; Gurewich et al., 2014; Heckman et al., 2004; Hunter et al., 2005; Iachini et al., 2015; Lee et al., 2006; Ma et al., 2016; Welsh et al., 2016; Wenzel et al., 2004).

Partnerships are helped by the presence of staff involved in implementing the initiatives who have the right knowledge, skills, and attitude that complements the collaborative (Abdel-Salam et al., 2017; Anastas et al., 2019; Appel et al., 2017; Bray & Rogers, 1995; Drainoni et al., 2014; Formica et al., 2018; Green et al., 2008; Guerrero et al., 2016; Iachini et al., 2015; Smith & Mogro-Wilson, 2007). In addition to the absence of the positive attributes just mentioned, a staff-level barrier is the actual or perceived high demand on staff to implement the activities under the collaborative arrangement (Amaro et al., 2004; Anastas et al., 2019; Bennett & Lawson, 1994; Bouis et al., 2007; Darfler et al., 2019; Drabble, 2011; Drabble & Poole, 2011; Green et al., 2008; Guerrero et al., 2016; Hunter et al., 2005; Iachini et al., 2015; Lee et al., 2006; Ma et al., 2016; McCarthy et al., 1992; Welsh et al., 2016).

Only client's readiness to participate, and level of engagement, in the activities of partnership arrangements was identified as a facilitator at this level(Heckman et al., 2004; Pelissier & Cadigan, 2004). However, this can be negatively affected by socioeconomic status, ability to meet basic needs, and ability to pay for services offered by partner organizations (Amaro et al., 2004; Anastas et al., 2019; Bray & Rogers, 1995; Darfler et al., 2019; Glenn & Moore, 2008; Gurewich et al., 2014; He, 2017; Heckman et al., 2004; Lee et al., 2006; Pelissier & Cadigan, 2004; Whiters et al., 2010).

Table 4-4 lists the facilitators and barriers to collaboration identified in this scoping review.

Table 4-4. Facilitators and barriers to collaboration

		Facilitator		Barrier
Contextual		▪ Policies supporting collaboration (i.e., laws, regulations, incentives) ▪ Availability of funding and other resources ▪ Proximity of collaborating providers or organizations ▪ Pressure from stakeholders to collaborate ▪ History of prior collaboration ▪ Commitment from partners		▪ Policies on (and competition for) financing and reimbursement for shared services ▪ Local situation: Rural setting, geographic distance, low income, poor transportation, lack of community resources ▪ Differences in professional and theoretical frameworks of disciplines ▪ Legal and policy constraints (e.g. confidentiality, innovative services) ▪ Mismatch between service developed and client needs or cultural practices ▪ Limited time to implement collaborative arrangement (i.e., funded project)
Organizational		▪ Conduct of cross-training ▪ Mechanism for communication, linkage and problem-solving ▪ Alignment of organizational (and professional) purpose and values with collaborative arrangement ▪ Stakeholder engagement ▪ Skilled staff in sufficient numbers ▪ Ability of partners to enter into flexible arrangements ▪ Leadership buy-in and oversight ▪ Presence of boundary-spanners ▪ Clear delineation of boundaries and expectations		▪ Access to information technology, especially for tracking of clients ▪ Lack of common time for activities (e.g., trainings, meetings) ▪ Staff turnover and burnout ▪ Scarcity of institutional resources (i.e., staff, funds) ▪ Differences in institutional mandates and orientation to practice ▪ Competition among partner institutions ▪ Mistrust among partner institutions ▪ Reliance on volunteer members or paid project staff
Staff		▪ Staff commitment and motivation ▪ Regular communication ▪ Positive attitude towards collaboration (e.g., readiness)		▪ Apprehension among managers and staff ▪ High demands on staff to deliver services ▪ Staff not possessing the right skills and disposition ▪ Cultural competence
Client		▪ Client readiness and engagement		▪ Socioeconomic status and ability to meet basic needs ▪ Clients not wanting services ▪ Ability to pay for services, including insurance status

4.8. Summary of evidence

This review was performed to describe the current empirical research on collaboration in the context of drug treatment and rehabilitation. Search, retrieval, and review of records from four databases yielded a total of 5,329 unique citations, of which 54 met the inclusion and exclusion criteria and were included in the analysis. Papers were, in most cases, published in the current decade (i.e. 2011 to 2020), and primarily described, or tested the impact of, a collaborative activity in the United States using data derived from a case study or survey research. These initiatives were research or demonstration projects implemented at the state

or country level meant to increase access to services by PWUD with a concurrent medical or social problem. As such, treatment services were often partnered with public health/primary care or social service organizations and delivered through a partnership instituted at the level of collaboration or cooperation. Where outcomes of initiatives were reported, these were commonly about increase in service utilization by target client or enhancement of service provision by participating groups. Facilitators and barriers to collaboration were reported by around two-thirds of papers, and these were primarily those pertaining to the contextual or organizational dimensions.

The preponderance of papers from the United States may be explained by the nature of the initiatives being reported. That is, these were mainly projects funded by an external organization, which usually stipulate a published manuscript as part of the contractual arrangement for the grant. Two pairs of papers included in this review – McCarthy et al. (1992) and Schlenger et al. (1992) and Heckman et al. (2004) and Veysey et al. (2004) — were even published in the same journal issue sponsored by the project. This is not to say, however, that the initiatives reported in the reviewed papers are the only collaborative arrangements in existence. Results of state or national surveys conducted by Bennett and Lawson (1994), Rosenheck et al. (2003), and Formica et al. (2018), and the secondary analysis of national datasets by He (2015) and D'Aunno et al. (2017), seem to indicate that there are more unreported or undocumented formal and informal collaborative arrangements between treatment services and other agencies or organizations being implemented across the United States.

The other implication of the nature of reported initiatives as projects is that these have created what can be considered as “artificial” partnerships that was dependent on the availability of funding to support activities, and short-term engagements that may not have allowed for

sufficient planning or goal attainment (especially if it is not maintained after termination of the grant). These, in turn, have been identified as barriers to collaboration (Abdel-Salam et al., 2017; Amaro et al., 2004; Hunter et al., 2005; Welsh et al., 2016).

It is also notable that despite the complexity of the intersecting medical, social, economic and legal needs of PWUD, only one in five papers reported on collaborative arrangements involving more than two sectors, organizations, or services (Amaro et al., 2004; Brindis et al., 1997; Coll et al., 2010; Drabble, 2011; Green et al., 2008; Heckman et al., 2004; Lee et al., 2006; Ma et al., 2016; Mittal & Suzuki, 2017; Morgenstern et al., 2009; Veysey et al., 2004; Zaller et al., 2007). It is, of course, possible, when this situation is viewed from the fact that most of the papers published pertain to projects, that the delimitation to two partner services was driven by the goal of the grant as well as funding constraints.

Finally, it was interesting that most authors appeared to apply the terms “cooperation”, “coordination”, “collaboration”, and “integration” rather loosely when describing their initiatives such that some were interchanged or even misapplied. As such, part of work that went into the analysis for this review was in classifying the type of collaborative arrangement being reported in papers, with the author relying on the description of the program or project and matching it with the characteristics of the different levels of collaboration.

There are two possible sources of bias that may affect the quality of results reported I this review (Tse & Yu, 2013). Pragmatic considerations resulted to exclusion of non-English language publication, grey literature, and unpublished sources, which may have introduced selection bias in this review. This may be partly off-set, however, by the design of the search strategy to attain maximum sensitivity (i.e., be as inclusive of papers as much as possible during the first-level search) across four databases such that only 1% of the records retrieved were found to be relevant to the research question. Information bias in the form of

misclassification of studies across the data points of interest is also a possibility given that only a single reviewer undertook data extraction. To mitigate this possibility, papers included for analysis were read in full at least twice prior to data extraction and coding. Data in NVivo was also reviewed once all papers have been coded but prior to undertaking analysis.

The currently available published empirical papers on collaboration in drug rehabilitation describes this phenomenon in the form of projects implemented in a single country. This presents an opportunity for research on on-going collaborative programs in other settings and jurisdictions.

5. Results: Focus group discussion

As mentioned previously, the second component of the study-focus group discussion is intended to address the research questions focusing on the attitude of agencies towards collaboration, the actual practice of collaboration, and some facilitators and barriers to collaboration, including the impact of COVID-19 on interagency collaboration.

Specifically, focus group participants were invited to offer their views towards the following aspects:

- In your experience, to what extent, or how frequent, do you collaborate with the other agencies involved in drug treatment and rehabilitation?
- Can you describe what activities you do when you say you are “collaborating” with the other agencies involved in drug treatment and rehabilitation?
- In your opinion, what helped facilitate this collaboration?
- Do you think there are aspects that are making collaboration challenging?
- How has the COVID-19 pandemic affected your collaborations activities?

5.1. Characteristics of the participants

Four related considerations informed the formation of participant groups, namely participant selection or sampling, group composition, group size, and number of groups. Given these foregoing considerations, this research involved four participant groups who are considered homogenous because they belong to the same agency (i.e., drug treatment and rehabilitation, public health, social welfare, criminal justice). Diversity within each group was ensured by

recruiting members who have different genders, working experience, and context/workplace location. Each group was targeted to be composed of six participants, and at least two groups were formed within each participant category (i.e., one each for the rural and urban sites). Thus, a total of 48 participants were invited in eight focus group sessions.

A total of seven focus group discussions with 27 participants (2 to 8 participants each) were conducted synchronously online, with the researcher acting as moderator. The sessions lasted between 60 to 90 minutes. The focus group discussion with the rural public health group did not push through despite repeated attempts at rescheduling the activity since the invitees were involved in conducting vaccination for COVID-19 at that time, which was in the initial phase of roll-out.

As shown in Table 5-1, participants had a mean age of 41 years old (range: 22 to 59 years old), with more female (59%) than male participants. Around two-thirds (67%) of participants had post-graduate degrees, and about three-fourths (74%) were occupying non-managerial or staff positions. Participants had about eight years of service at the time of the interview, with 10 participants having more than 10 years of service. Notably, two participants nominated by the head of agency were new to the job, having less than one year of experience in the institution. In terms of agency representation, participants from the rehabilitation centers and law enforcement groups had the most, with 10 each, which may reflect the greater involvement of social work and public health workers in the provision of services related to the pandemic situation at the time the focus groups were conducted.

Table 5-1. Profile of focus group participants

No.	Grp	Code	Age	Sex	Agency	Location	Educational level	Position classification	Yrs. of service
1	1	P1	41	F	Rehabilitation	Rural	Post-graduate	Non-managerial	4
2		P2	56	F	Rehabilitation	Rural	Post-graduate	Managerial	6
3	2	CC	49	F	Rehabilitation	Urban	Post-graduate	Managerial	4
4		FO	54	M	Rehabilitation	Urban	Post-graduate	Managerial	3
5		MA	59	F	Rehabilitation	Urban	Post-graduate	Non-managerial	4
6		FR	50	M	Rehabilitation	Urban	Post-graduate	Non-managerial	3
7		JF	51	F	Rehabilitation	Urban	Post-graduate	Non-managerial	3
8		EP	46	M	Rehabilitation	Urban	Post-graduate	Non-managerial	5
9		CM	22	F	Rehabilitation	Urban	Post-graduate	Non-managerial	<1
10		JC	35	M	Rehabilitation	Urban	Post-graduate	Non-managerial	5
11	3	KP	38	F	Public health	Urban	Bachelor's	Non-managerial	9
12		RC	28	M	Public health	Urban	Post-graduate	Non-managerial	<1
13	4	JC	32	F	Social work	Rural	Bachelor's	Managerial	7
14		LS	47	F	Social work	Rural	Bachelor's	Non-managerial	15
15	5	01_FQ	47	M	Law enforcement	Urban	Post-graduate	Managerial	22
16		01_PP	40	F	Law enforcement	Urban	Post-graduate	Non-managerial	15
17		02_GA	42	M	Law enforcement	Urban	Post-graduate	Managerial	15
18		02_A	38	M	Law enforcement	Urban	Bachelor's	Non-managerial	6
19		03_LA	32	F	Law enforcement	Urban	Bachelor's	Non-managerial	11
20		03_MA	39	F	Law enforcement	Urban	Post-graduate	Non-managerial	11
21	6	EB	52	F	Social work	Urban	Post-graduate	Managerial	12
22		JB	26	F	Social work	Urban	Bachelor's	Non-managerial	6
23		MA	30	F	Social work	Urban	Post-graduate	Non-managerial	5
24	7	EB	40	M	Law enforcement	Rural	Bachelor's	Non-managerial	16
25		CM	32	M	Law enforcement	Rural	Bachelor's	Non-managerial	10
26		KE	42	F	Law enforcement	Rural	Bachelor's	Non-managerial	14
27		CR	33	M	Law enforcement	Rural	Post-graduate	Non-managerial	8

5.2. Results of the focus group discussions

Using the thematic analysis method, four themes emerged from the data collected from the seven focus group meetings, namely:

1. partners, which describes who are involved in the partnership arrangements
2. participation, which highlights the two broad areas of work when agencies form partnerships with other agencies
3. push and pull, which identifies the facilitating and hindering factors to working with other agencies; and
4. pandemic, which explains the effect of the COVID-19 pandemic on

partnership between agencies

These themes align with the aims of this study component, which are to describe the rationale for, activities and structure of collaborative arrangements (themes 1 and 2), the facilitators and barriers to interagency collaboration (theme 3), and the impact of the COVID-19 pandemic on aspects of interagency collaboration (theme 4).

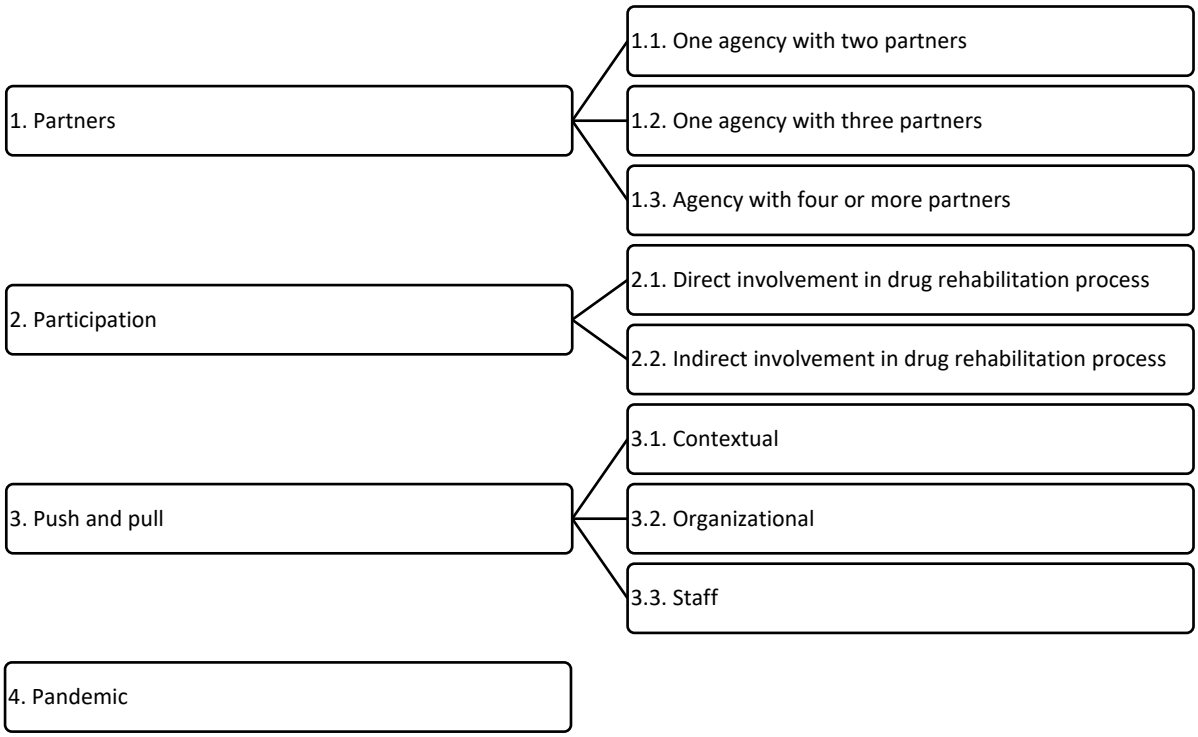

Figure 5-1. Themes from the focus group discussions

In presenting the supporting data extracts for each theme and sub-theme, the relevant quote is provided a code corresponding to the focus group number, participant number, and the sex of the speaker.

5.2.1. Theme 1: Partners

This theme addresses the research objective related to the structure and composition of collaborative arrangements, specifically exploring the agencies with which the groups have existing partnerships in the process of handling clients with drug problems.

Among the seven groups that participated in the focus group discussions, two mentioned having two partners only, two indicated having three partners, while the remaining three groups had four or more partners. It is interesting to note that only the law enforcement agencies in both the rural and urban areas had similarities in terms of their identified partners.

Sub-theme 1.1. Two partners

Two group mentioned having two partners only, namely the social work group from the rural area, and the public health group from the urban area.

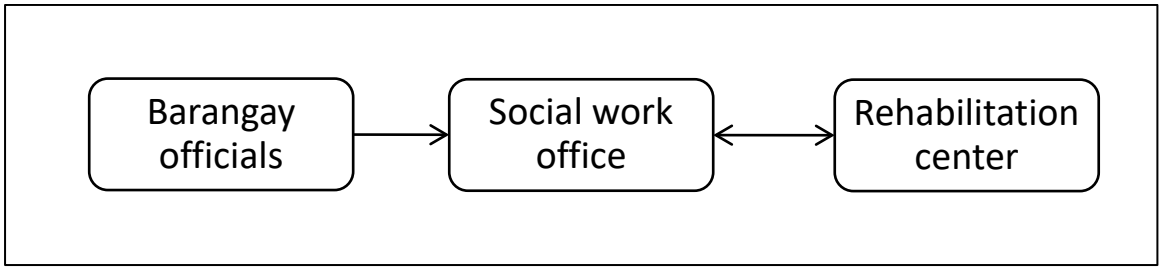

Figure 5-2a. Schematic diagram showing partnership of the rural social work office with two agencies

As depicted in Figure 5-2a, the social work office of the rural area has a unidirectional partnership with the barangay (village) officials, who refer residents who are suspected as being drug users for assessment, but only in cases where minors are involved:

> 4-14-F: *"Sometimes, there would be minors who would be identified as potential cases in the community. The barangay would then require our office's involvement… [The history of drug problem] usually comes up throughout the*

> *process especially during the interview and the counseling. Only then do we usually learn about a minor being a problem for their family or is having drug problems."*

Partnership of the rural social work office with the drug rehabilitation center can be characterized as bidirectional since the social work agency refers cases involving drug problems to the rehabilitation center for assessment and management:

> 4-14-F: *"When it comes to drug treatment and rehabilitation, we normally handle cases involving adult clients where we refer them to rehabilitation facilities. By this year, we have handled quite a significant number of adult cases."*

In addition, the rehabilitation center refers clients to the social work office for preparation of a social case study to assess the financial capability of the client or client's family in paying for the cost of drug rehabilitation:

> 4-13-F: *"We in the local government unit also assess the family of the admitted individual to determine which economic bracket they are classified under. We do this even when there is also some assessment in the [rehabilitation center]. This is to somehow lessen the financial burden of the family… The family will come to us and will inform us that one of their family members is admitted in the rehabilitation center… That is when we will assess their financial capability."*

Clients who have also completed residential rehabilitation are referred back to the social work office for provision of aftercare services after discharge:

> 4-13-F: *"Once a patient gets officially released, they undergo monitoring as well as aftercare in order to ensure the rehabilitation works. There is a set of activities given to the patient and this is monitored in order to make sure that these requirements are met… We are in-charge of the aftercare since we are the referring party."*

Meanwhile, as depicted in Figure 5-2b, the urban public health agency also has two partners, namely the local anti-drug abuse council, and the drug treatment and rehabilitation center.

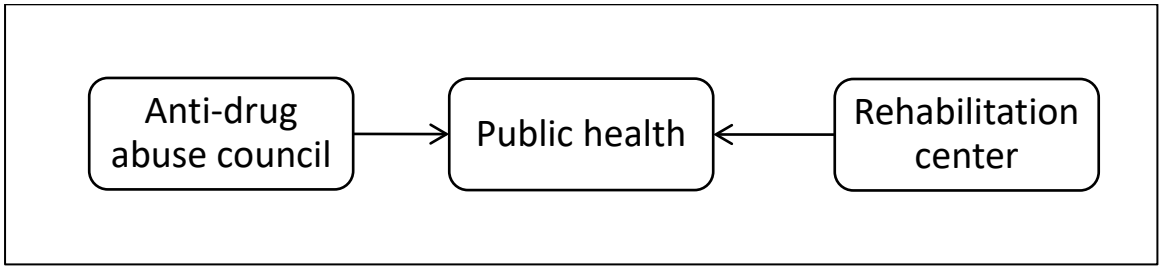

Figure 5-2b. Schematic diagram showing partnership of the urban public health agency with two agencies

The anti-drug abuse council refers drug personalities to the public health agency for medical clearance prior to delisting from the list of drug personalities in the area:

> 3-11-F: *"[S]ome clients have already visited us here … asking for medical … certificate so that they can be cleared from the list of, uhm, tokhang, for the operation tokhang."*

This was corroborated by the attending physician in the area:

> 3-12-M: *"I was able to assess the patients. … The first one is the … one diagnosed with … schizophrenia… They're asking for a medical certificate that is updated… The second one … they are asking for certification that the patient is … unable to stand."*

The rehabilitation center, on the other hand, refers back clients to the public health group when these individuals are about to be discharged from the rehabilitation center:

> 3-11-F: *"They [the rehabilitation center] sent a letter of invitation… This is for the release of the drug surrenderees. It's like a graduation of sorts... So we can serve as witnesses in the ceremony that will be held."*

Sub-theme 1.2. Three partners

Both law enforcement groups, i.e., in the urban and rural areas, mentioned having three partners, namely other law enforcement agencies, the barangay officials, and the rehabilitation center (Figure 5-3).

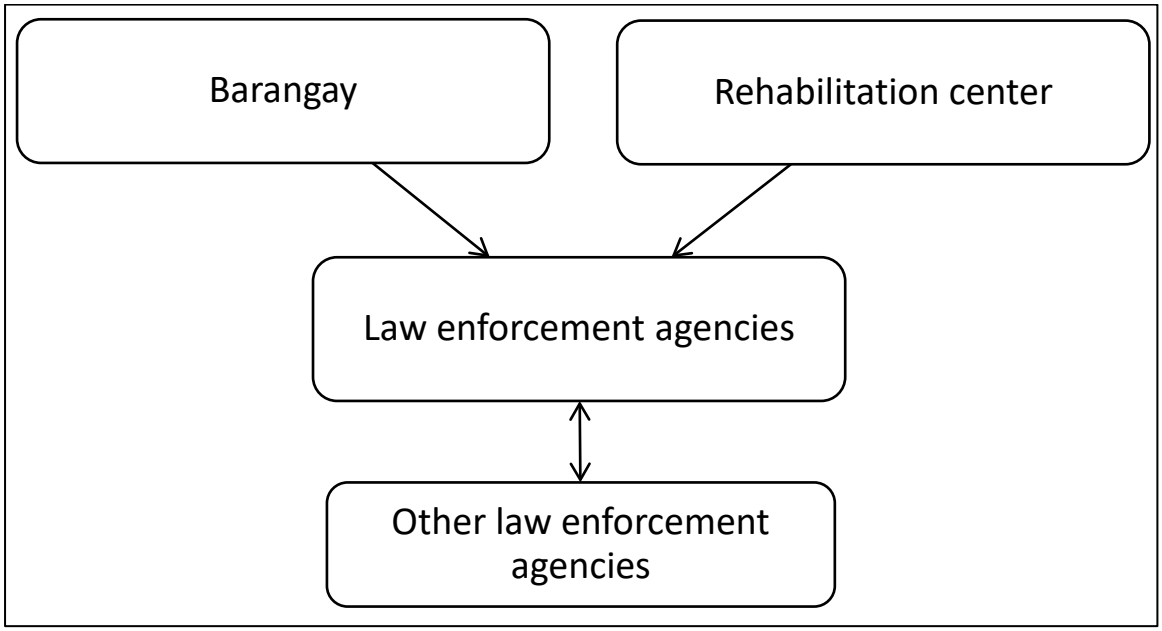

Figure 5-3. Schematic diagram showing partnership of law enforcement agencies

The barangay provides law enforcement agencies with the list of drug personalities in their jurisdiction, as well as in submitting a follow-up report whether such individuals have already completed rehabilitation:

> 5-17-M: *"The first phase is identification of the drug personalities within the barangay. The list of identified personalities or personal list comes from … the barangay."*

> 5-15-M: *"[T]he information … starts from the … barangay since they are the source of information which we utilize."*

> 7-24-M: *"Part of our rehabilitation work involves the barangay. When we conduct drug-clearing operations, surrenderees usually submit themselves first to the barangay. The barangay would first evaluate them and bioprofile them before forwarding them to us.?*

> 5-17-M: *"They [the barangay] will just report to us … if a certain drug personality has been discharged. That's part of the monitoring process of the Barangay Drug Clearing Program… They will just send us a certificate of completion. This will serve as an attachment as per the requirements of our barangay drug clearing operations. This is for the barangay where the personality came from. This is one of the requirements they submit as proof that a certain personality has already completed his/her rehab."*

Meanwhile, the law enforcement agencies transfer arrested drug personalities to the rehabilitation center upon orders of the court:

> 5-19-F: *"If the court releases an order directing us to transfer them to the drug rehabilitation center, then we transfer them… The court decides who among the PDLs will be transferred to the rehabilitation center."*

> 7-26-F: *"Sometimes, Drug Dependency Exams (DDEs) will be ordered and the court would order for their transfer to the treatment and rehabilitation center… The court would sometimes specify how many months they have to undergo rehabilitation at the TRC."*

There is also work between and among law enforcement agencies during the time that a drug personality is identified, placed under surveillance (drug enforcement agency and police), apprehended (police), and committed to jail (jail management agency) while undergoing trial in court:

Identification of drug personalities – 5-16-F: *"The [barangay] identifies those on the watchlist that they submit to PNP. And then the barangay drug watchlist will be submitted to PDEA."*

Apprehension and commitment of drug personalities – 7-24-M *"For us in the PNP, when we apprehend a drug personality, and after inquest proceedings, we bring them to BJMP for commitment… After thorough investigation, it is the court that gives us the commitment order. Upon receiving a commitment order, the PNP turns over the accused to BJMP's custody."*

Sub-theme 1.3. Four or more partners

The three remaining groups indicated having four or more partners in the drug treatment and rehabilitation process.

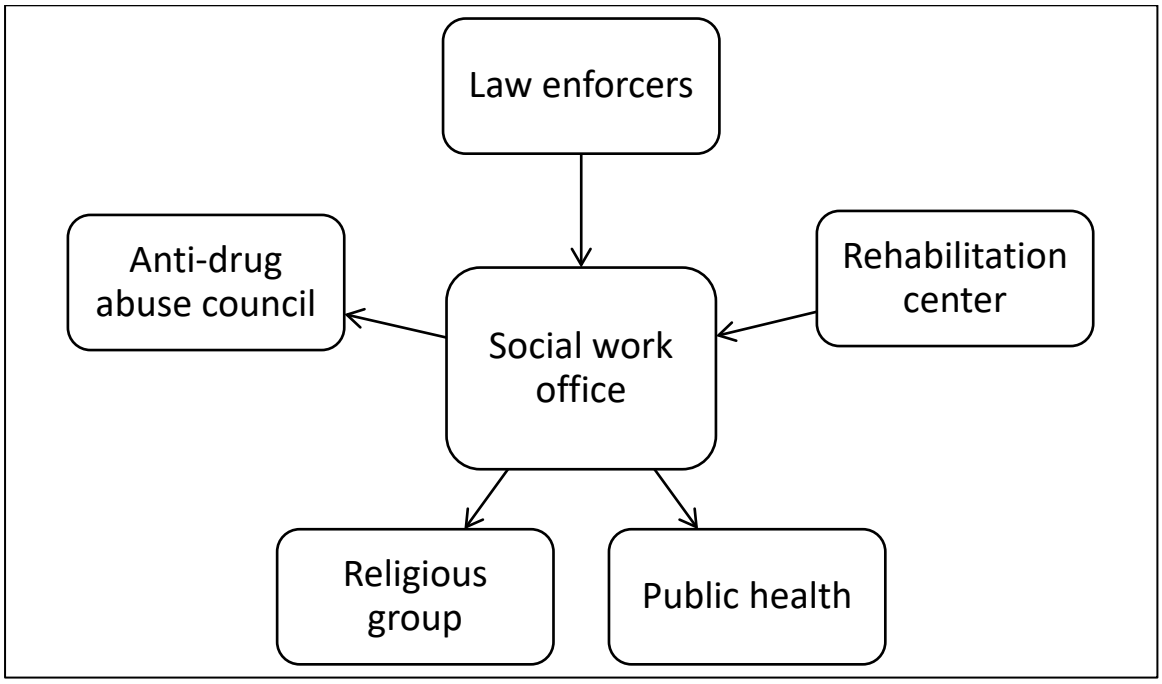

Figure 5-4a. Schematic diagram showing partnership of the urban social work office

The social work office receives referrals from the courts, through the jail management office,

for provision of psychosocial services to identified drug personalities (Figure 5-4a):

> 6-21-F: *"If there's already a court order, it's either BJMP or provincial jail, … so they will bring the body of the client to the office with the court order. Yes and then the letter of turnover as well from the BJMP or the provincial jail."*

> 6-23-F: *"I collaborate with personnel from either BJMP or the provincial jail who will turn over the client to us, bringing with them the court order saying that the person has to undergo the program we have in our office."*

When minors are involved in drug cases, the social work office also partners with law enforcement agencies during the period of arraignment and trial:

> 6-22-F: *"The agencies we collaborate with would be PAO, PNP, the prosecutor's office, especially … with the drug cases that when they seize drugs on the child in conflict with the law, they immediately send them for inquest… [W]e also assist them going to the prosecution office to file the child's case. And then from the prosecution office, the PAO is called to present the case filed on the child to both the children and their family. And then, after that…, we also assist the child to the court and the court suggests where the child will be transferred."*

The social work office also receives referrals from the rehabilitation center for provision of aftercare services to individuals who have already completed the required residential rehabilitation program:

> 6-21-F: *"There are also those who come from [the] treatment and rehabilitation center. Referrals from them as well to conduct aftercare programs … for the clients they have there. They are turned over to us after their treatment there."*

Meanwhile, in the provision of psychosocial interventions for cases referred to them by other agencies, the social work office has ties with other agencies that can provide additional

lectures:

> 6-23-F: *"And then, other than that, we have with us in the psychosocial sessions conducted, we invite speakers from City Health Office and I also invite [minister's association] for spiritual rehabilitation."*

The social work office also submits reports to the local anti-drug abuse council on the services that were rendered by the agency:

> 6-23-F: *"The only ones we encounter from the CADAC office would be regarding the reports we need to submit to the DILG because we also need to report how many clients we have catered for a certain period."*

Figure 5-4b shows the partnerships between the urban rehabilitation center.

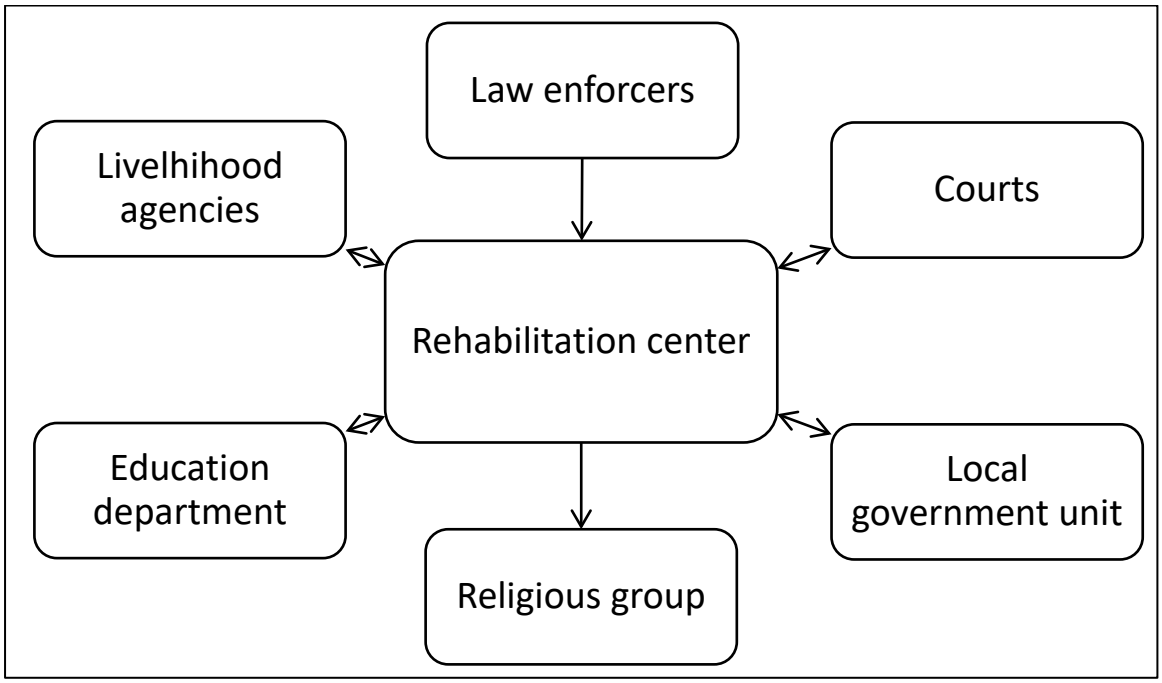

Figure 5-4b. Schematic diagram showing partnership of the urban rehabilitation center

The main partnership with law enforcers is in the transfer of clients to the rehabilitation center upon orders of the court:

> 2-6-M: *"When it comes to PNP, or the BJMP, they bring the patients for DDE. They also bring to our facility some of the patients for admission."*

However, one participant mentioned that they also sought the assistance of law enforcers when one of their residents absconded from the facility:

> 2-6-M: *"The most recent collaboration we … with PNP [was] when they arrested one of our patients. So it was PNP who helped us arrest that person."*

Clients admitted for rehabilitation are those who have court orders for admission. Such individuals are transferred from the jurisdiction of law enforcers to the rehabilitation center:

> 2-6-M: *"All our admitted patients need to have a court order to be admitted in our facility. That's why we need to have a collaboration with the judiciary."*

In addition, the rehabilitation center provides periodic updates to the courts on the progress of clients referred, including instances when individuals have to be brought out of the facility for emergency treatment in another institution:

> 2-6-M: *"Even the progress reports … are all submitted to the court to have progress… There is a progress report so that they know what is happening to the patients that they admitted in our facility."*

> 2-7-F: *"[H]ere in our facility, we actually write to the court the things we did to the patient. But since this is an emergency case, we first bring the patient to the hospital and we will just follow up on the court order."*

The partnership with the local government unit, meanwhile, is with respect to the provision of financial assistance to constituents admitted to the rehabilitation center for treatment:

> 2-4-M: *"The bulk of our collaborative work is with the local government units because all the support needed by our patients are provided by the local governments, especially for the financial support of our indigent clients. We need to talk with the local government unit where our patient came from. For financial*

support to sustain them in the program, especially those in the residential program."

Partnership with the local government also takes place after discharge, when clients are to be reintegrated into the community, as some of them, for instance, may require assistance with livelihood and employment:

Monitoring of clients after discharge – 2-9-F: *"[W]e strictly reinforce active and continuous coordination with LGUs down to barangay levels for the monitoring of clients."*

Livelihood assistance – 2-4-M: *"[I]t includes the livelihood programs when they are discharged. We're also requesting that from them… In terms of the livelihood interventions, we just agree on it upon discharge of the client. It's already their responsibility to provide assistance to the client once they are discharged in order to sustain the client's recovery."*

Three of the partnerships formed are with respect to the provision of additional services to clients during the period of rehabilitation. One such partnership is with the education department for the provision of learning intervention to residents:

2-7-F: *"So we have a collaboration with the Department of Education. Let's say for example, at present, we have seven adolescents who are enrolled in our program, right? So the OT Section made an arrangement with the DepEd so that they can continue their studies through an online or modular approach. The same goes with those in the alternative learning schooling. We are also collaborating with them. So far, that's how we collaborate with DepEd."*

There are also partnerships with three agencies that are involved in assisting residents develop skills that will help them have a source of livelihood after discharge from the facility:

2-4-M: *"In terms of skills development, … it would be the agencies like DA, TESDA … and DTI."*

There is also existing partnership with religious groups for the provision of spiritual support services to admitted clients:

2-4-M: *"One important group is the religious sector for building up spirituality among our clients. We also collaborate with the different sects to provide spiritual development among our clients."*

Lastly, the rural rehabilitation center has partnerships with four agencies (two hospitals were counted singly), three of which are directly involved in the drug rehabilitation process, while the fourth one pertains to advocacy activities being conducted by the institution (Figure 5-4c).

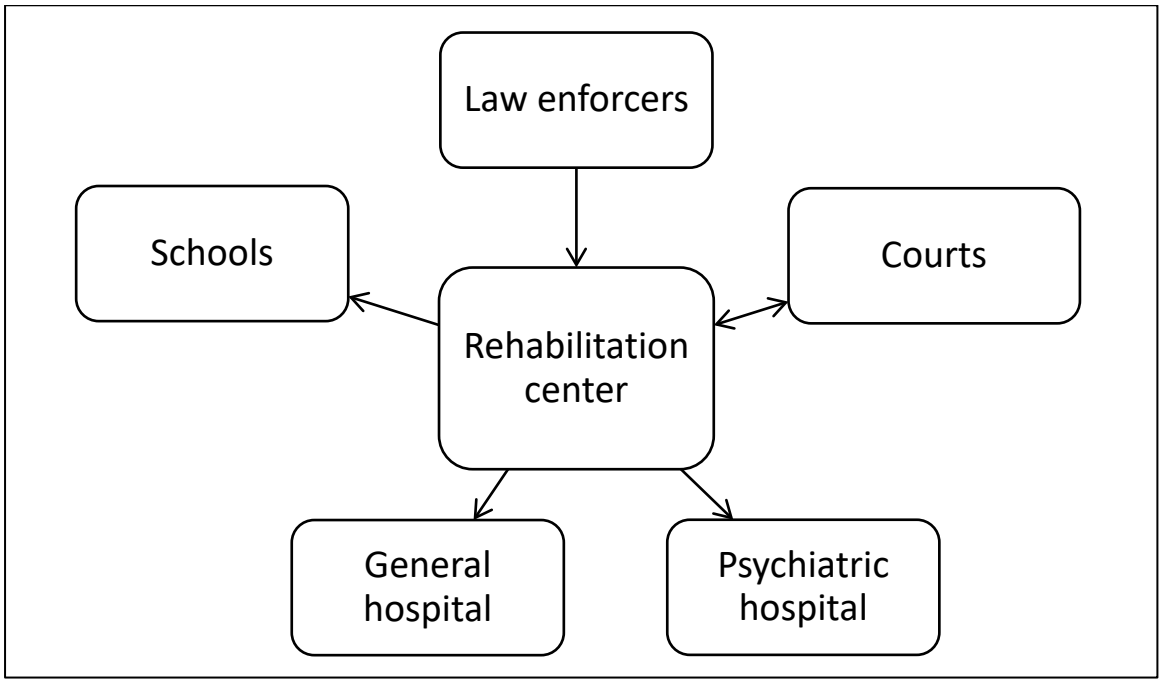

Figure 5-4c. Schematic diagram showing partnership of the rural rehabilitation center

First, similar to the urban rehabilitation center, admissions to the rural rehabilitation center are through a court order. Law enforcers bring the clients to the center, either for assessment of drug dependency or for admission:

> 1-2-F: *"[Client is] usually accompanied by a police then with a court order so that [we're] informed to what should be done, if he should get drug dependency [evaluation] or he will already be admitted."*

The institution also has a partnership with two hospitals for provision of services that are not available in the rehabilitation center. One such partnership is with the psychiatric hospital for referral and management of individuals with psychiatric illnesses:

> 1-1-F: *"[W]e used to collaborate with [psychiatric hospital] before, when we did not have a psychiatrist… Then we had a psychiatrist until last year. So now we do not have a psychiatrist again… It's the only mental institution here in our area. We had a MOA with the hospital… for management [of cases]. So, the psychiatrist visits here. Actually, their Director herself is the one going here, um, at least once a month to check on the psych patients who are here with us."*

A similar arrangement was entered into with a general hospital in the area for provision of laboratory services not available in the facility:

> 1-2-F: *"[W]hen we started … we did not have laboratories and all so we would be sending out the … lab tests to the [general hospital]. [W]hat we are just sending out [now] are those not available to us."*

While not directly related to drug rehabilitation, the participants also mentioned that they have partnership with various schools where they are invited as resource persons for advocacy and prevention activities for students:

> 1-2-F: *"[I]t's for the advocacy of the rehab… We have activities and we think … the students and the youth would benefit from it, we rewrite letters to them [the schools]. And then on the other hand, if they need us to have the seminars, and all the forums, they write us letters and then, just like that… [W]e have … competent*

doctors who conduct lectures regarding drug addiction, its ill effects and all. So, they are the ones who are giving lectures to the students."

5.2.2. Theme 2. Participation

This theme is focused on the rationale and activities of collaborative arrangements. Agencies working together may do so to either directly provide services to individuals undergoing rehabilitation, which includes the provision of clinical, psychosocial, spiritual, educational, financial services, or to participate in the process indirectly through referral or monitoring of clients before or after the rehabilitation proper.

Among the seven groups, the public health, social work, and rehabilitation groups (5/7) indicated having activities with direct involvement in drug treatment and rehabilitation, while law enforcement groups (2/7) had indirect involvement in the process.

Sub-theme 1. Direct involvement

Clinical services constitute one of the services provided under this sub-theme. For instance, the rural rehabilitation center has a partnership with a psychiatric facility for management of individuals with co-occurring disorders:

1-1-F: *"We had a MOA with the hospital… It's the only mental institution … here in our area… [T]he psychiatrist visits here … at least once a month to check on the psych patients who are here with us… probably around 20 [patients]… Those [medicines] … available in the [psychiatric hospital] were also being given by them. We are giving list there, then they give us. Some that they could give for free were being given. There are some that we purchase."*

The institution also has a partnership with a general hospital for laboratory services needed by residents that are not available in-house:

> 1-2-F: *"[W]hat we are just sending out are those not available to us... [I]t depends to what is needed to be done but usually just the specimen like blood or what, whichever specimen will be sent there. Those that need to be taken out are not often, like ultrasound, wherein the patient has to be there personally."*

Meanwhile, clients who have completed rehabilitation may also be required to secure medical clearance prior to delisting, hence the involvement of the public health office in the urban area:

> 3-11-F: *"Actually ... there has still been no direct ... meeting with the head of the CADAC but some clients have already visited us here ... asking for medical certificate so that they can be cleared from the list of, uhm, tokhang, for the operation tokhang."*

Related to clinical services is the provision of health education to drug dependents undergoing rehabilitation:

> 6-23-F: *"And then usually, I'll request [the health office] for health-related topics that they could discuss. They would say smoking cession or drinking, on drug use, and the like."*

Financial assistance to clients undergoing rehabilitation, specifically to cover the cost of the treatment program, is also one of the reasons why agencies participate in collaborative arrangements:

> 2-4-M: *"[T]he assistance extended to us by the LGU contributes to our income in order to sustain our indigent patients who cannot be supported by their respective LGUs… as [t]here are LGUs who really do not give support… So the assistance given by the supportive LGUS becomes our source of funds to support the clients*

> *who do not get support from their LGUs… [T]he minimum amount we charge the LGU for the indigents is at least 10,000 [pesos] per month … depending on the patient's classification. [This will cover] food, accommodation, lighting, water…"*

In addition, some partnerships were formed to provide educational and skills development activities to clients undergoing rehabilitation:

> 2-4-M: *"For our adult residents, the OT section also coordinates with DepEd for them to conduct distance education or face-to-face for the Alternative Learning System. So they also are given certificates of completion… Other than those agencies mentioned, we also have a collaboration with the Department of Agriculture, the Department of Labor, and the Department of Trade and Industry for the provision of skills development to our residents. At the same time, opportunities for employment."*

Spiritual services were also requested by rehabilitation provider from external partners:

> 2-4-M: *"One important group is the religious sector for building up spirituality among our clients. We also collaborate with the different sects to provide spiritual development among our clients… We are able to tap… the Catholic Church, Born Again… [and] Seventh Day Adventist"*

> 6-23-F: *"[R]egarding the spiritual rehabilitation, we invite the speaker from [local minister's association]. They don't have a separate program"*

Individuals who have completed the required residential rehabilitation program and were deemed rehabilitated were transferred to the social work office of their locality for provision of aftercare services:

> 2-6-M: *"We [rehabilitation center] also collaborate with … social workers … for … aftercare."*

> 6-21-F: *"And then… there are also those who come from [treatment and rehabilitation center]. Referrals from them as well … to conduct aftercare programs … for the clients they have there. They are turned over to us after their treatment there."*

> 4-14-F: *"Once a patient gets officially released, they undergo monitoring as well as aftercare in order to ensure the rehabilitation works. There is a set of activities given to the patient and this is monitored in order to make sure that these requirements are met… We are in-charge of the aftercare since we are the referring party. Other agencies also coordinate with the [social welfare department] for this matter. They are aware that our office is the one capable of accomplishing this task."*

Sub-theme 2. Indirect involvement

Other agencies may participate indirectly in the rehabilitation process, such as when law enforcers identify and refer voluntary surrenderers to the treatment and rehabilitation center:

> 5-17-M: *"We have this thing such as voluntary rehab. For example, a relative comes to us telling, "here's my child, he's addicted to illegal drugs," then we assist the family for a referral to the rehabilitation center… Those referred to us by their parents. We assist them on the requirements needed for admission to the rehab center."*

Most often, however, it is the court that directs individuals apprehended by law enforcement authorities to undergo treatment and rehabilitation. Hence, the involvement of law enforcement agencies such as the drug enforcement agency, police, and jail management office can be considered as indirect to the rehabilitation process itself:

5-17-M: *"The first phase is identification of the drug personalities within the barangay. From there, the next phase refers to the treatment of these identified users and pushers. In the case of users, the intervention is more on rehabilitation."*

7-24-M: *"[A] suspect gets apprehended, and we file a case to the court, the court directs us to commit that suspect to BJMP while the individual's hearing is ongoing. Once a judgement has been finalized by the court, this is where plea bargain comes in. The court may decide to subject the suspect to rehabilitation and direct the colonel to bring the individual to the rehabilitation center."*

7-27-M: *"Regarding drug-related PDLs that are committed to us, it is the PNP who we first collaborate with starting with the individuals who are committed to us. If they [PDLs] ever make a plea bargain, we also work with the courts. Sometimes, Drug Dependency Exams (DDEs) will be ordered and the court would order for their transfer to the Treatment and Rehabilitation Center."*

5-19-F: *"The court decides who among the PDLs will be transferred to the rehabilitation center. So the court orders detention of charged personalities in BJMP and then they decide who goes to which facility… Then while waiting for the decision of the court, they remain here in the facility of BJMP."*

Another form of indirect involvement is for the rural social work office, which prepares social case studies for clients admitted to the rehabilitation center, either upon the request of the court, or to attest to the financial status of the family as it relates to the cost of treatment and rehabilitation:

4-13-F: *"The family will come to us and will inform us that one of their family members is admitted in the rehabilitation center... That is when we will assess their financial capability. Also, recently there have been cases of voluntary commitment*

> *where the individual appears before the court. The court would then ask us to prepare a case study report detailing that the client is truly being admitted voluntarily to the rehabilitation institution."*

Lastly, the barangay can be considered as the beginning and end of the process since they are the ones tasked with identifying drug personalities in their communities (who are eventually sent to rehabilitation), as well as in monitoring those who have completed rehabilitation and have been reintegrated in their areas:

> 5-17-M: *"The first phase is identification of the drug personalities within the barangay. The list of identified personalities or personal list comes from BADACs or the Barangay Anti-Drug Abuse Councils."*

> 2-8-M: *"[W]e also collaborate, coordinate with the barangays. With the barangay officials for the endorsement of our aftercare clients when they have finished, when they are done with their aftercare. Even the inpatients, when they finish their inpatient rehabilitation, we usually coordinate with the barangay officials for monitoring purposes. Our social welfare officers here, they regularly coordinate with the barangay officials for the… to monitor compliance of our clients."*

> 5-17-M: *"They will just report to us if a certain drug personality has been discharged. That's part of the monitoring process of the Barangay Drug Clearing Program… They will just send us a certificate of completion. This will serve as an attachment as per the requirements of our barangay drug clearing operations. This is for the barangay where the personality came from. This is one of the requirements they submit as proof that a certain personality has already completed his/her rehab."*

5.2.3. Theme 3. Push and pull

The initiation and maintenance of partnerships can be affected by a variety of facilitating and hindering factors. Identification of these is important in the design of policies and programs requiring interagency collaboration, such that facilitating factors can be leveraged, while minimizing the effect of hindering factors.

Table 5-2 below summarizes the identified push and pull factors, and these are briefly discussed in the succeeding paragraphs.

Table 5-2. Push and pull factors to interagency collaboration

	Push	Pull
Contextual	• Change in local leadership • Discomfort with law enforcers	• Presence of incentive system
Organizational	• Communications challenges • Remote location • Duplication of work	• Common goal • Open lines of communication • Specified roles and responsibilities
Staff	• Different perspectives • Lack of staff • Workload of staff	

Sub-theme 3.1. Contextual factors

Collaboration was facilitated through an incentive system, whereby a locality's drug status is considered in the conferment of the Seal of Good Local Governance. This incentive system was developed during the term of President Rodrigo Duterte following his election in 2016. Thus, local government units are driven to work with other agencies to ensure that drug personalities in their areas are identified and given appropriate intervention, including treatment and rehabilitation:

> 5-17-M: *"The declaration of drug-cleared municipalities is a big boost on Pres. Duterte's campaign against drugs. It has a huge bearing on LGUs and is equivalent to a high score in terms of the auditing done by DILG. Hence, when I*

> *presented the program to LGUs and discussed to them the steps needed to be taken in order to have their municipalities declared as drug-cleared, they were very supportive."*

> 5-15-M: *"Based on experience, I'm happy to say that there were no LGUs who did not cooperate in this campaign against illegal drugs. In fact the campaign against illegal drugs is included as one of the parameters for an LGU or city government to receive the Seal of Good Local Governance. I'm referring to the SGLG award. This matter on drugs is one of the considerations."*

Because the local government unit has an important role to play in supporting individual during rehabilitation and reintegration, the frequent changes in the position of provincial governors, and city/municipal mayors, which happens every three years, was deemed an important barrier since the incoming elective official may have a different priority from the previous one, especially as it relates to the matter of drugs:

> 2-4-M: *"In terms of the challenges, especially with the local government units, it's the frequent change of leadership because of their very short term. Mayors have a three-year term. When the mayor gets replaced by someone who doesn't prioritize the anti-drug campaign, then the support that they would give would not be that much."*

The image of law enforcers can also influence the collaborative process. For instance, one participant mentioned that they did not include police officers anymore in their psychosocial program for drug dependents since the participants expressed fear that the presence of police officers was intended to profile them:

> 6-23-F: *"Yes, that was our first session so uhm, while we were brainstorming in the office about the possible topics we could include. We thought maybe it was a good idea to invite the police and have them explain to the clients everything about the*

> *law, what usually happens. And then during that time, during the session, the PNP obviously wore the uniform during the session and somebody else was taking pictures for documentation. But after the PNP left, the clients were asking "Why do they need to take pictures of us? Why do they have to be here?" It seemed from what I captured from their conversation was that there was a slight fear- When it comes to the PNP- Maybe it's because of the Tokhang operations."*

Sub-theme 3.2. Organizational factors

At the organizational level, having a common goal with partner agencies was considered by one participant as a contributor to the positive outcomes of the rehabilitation center's partnership with schools in the conduct of advocacy and preventive activities:

> 1-2-F: *"[W]e have the same goal, trying to educate the young people of what is happening around and what effect illegal drugs may do to them. So, I guess we have the same idea that is we wanted to, as much as possible, save these kids from even trying to use it."*

Such goal should be supported by a delineation of the mandates, roles and responsibilities of the parties. Such roles and responsibilities can be defined by the mandate of the agency:

> 6-22-F: *"[S]ince all of those agencies, it seems that what we're doing is mandated so everybody does their part… [S]ince everyone knows their part, our collaborations are more streamlined. It doesn't have a lot of issues."*

> 6-21-F: *"[W]e didn't have that much problem with … coordinating with the agencies because of that mandate and that is President Duterte's pet project which is why everybody works towards solving this problem, about the drugs."*

> 6-23-F: *"What helped in my case was even without the existence of a MOA, it was like everyone was willing to help. And they do know that yes, they are also part of the session. I've never encountered anyone who asked why they were included in the sessions. So everyone was willing."*

In other instances, the roles and responsibilities are defined through an agreement instrument such as a memorandum of agreement:

> 1-1-F: *"It's specified there in the MOA [with the psychiatric hospital], you know, like the minimum of, you know, one month of visitation, the meds, it's specified there, eh."*

> 2-4-M: *"[T]he positive aspect of having a MOA, as long as the mayor who signed the MOA remains, we are really able to implement the clauses we have agreed upon on that MOA."*

Having open lines of communication with other agencies was also deemed necessary as it facilitated the work, especially when referrals need to be made:

> 1-1-F: *"Open communication, that is because it's easier to, you know, eh, to have contact, for instance, there's a need for an urgent referral, we can easily call the [psychiatric hospital]."*

> 7-27-M: *"Before we do a transfer, we already coordinate with the TRC for the schedule so that they will not be caught off guard with sudden transfers. We already have established good relationship with them so that even through text or call, we can schedule transfers or any other concerns with them. Any concerns raised are also addressed."*

Social workers also found being able to utilize various communication medium as a facilitator in their work with families (e.g., preparation of social case studies, follow-up):

> 4-14-F: *"Regarding what helps collaboration with other agencies, social media, facebook messenger, telephone realy helps us. This saves us time by accessing the families instead of traveling to their location."*

Access to communications technology, however, was a barrier mentioned by participants, especially when dealing with agencies located far from their post:

> 5-15-M: *"Based on personal experience, Sir, there is a relative delay in the submission of reports among those barangays located at a distance as compared to those located near our office. I'm referring to places where roads are not well-developed yet. They have to cross rivers without a bridge. Hence, in very remote areas where communication signal is a problem, they have a delay in achieving their status as drug-cleared or drug-free barangay. It's the distance of their barangay. In addition, our way of communication is affected. If we cannot contact them directly, we rely on couriers. We rely on letters."*

> 2-9-F: *"[I]t's difficult to get in touch with them, especially for those in areas with poor signal."*

The contact information of other agencies, or their assigned focal persons, is also not frequently available:

> 2-8-M: *"Sir, when I said that we were having difficulty, it's because there were no available mobile numbers, so it's difficult to reach them, it's difficult to contact the MSWDO. But as for the endorsement of our residents, it's not difficult. It's just the difficulty in contacting them because we cannot locate their mobile number. But there is no problem with regards to the help that they're extending to us in the endorsement process for the discharge of our clients from our facility."*

There may also be some overlaps in the services being provided by different agencies, which hints at challenges in coordinating the particulars of activities:

> 6-23-F: *"For me the challenge was probably with the [health office], they conduct their own lectures on the participants which is probably why we sometimes receive comments that the topics are repetitive since they have taken them up during [their] sessions. Or sometimes with the [minister's association], "That's Pastor, the one we saw before. That was also what he discussed when we were still inside." There are those instances"*

Sub-theme 3.3. Staff level

The work of staff was generally reported to be positive when it comes to collaboration since the agency, overall, supports such interagency work.

One challenge reported by participants is the lack of qualified staff who can provide a service being requested by another agency, which delays fulfilment of requests lodged by other offices:

> 2-9-F: *"One is having limited manpower in the LGUs. They have a limited number of social workers so when we request for an assessment report, they are able to submit it but there's a slight delay due to the limited manpower."*

> 4-13-F: *"For us, one challenge is that there is only one social worker. It takes around two to three days to accomplish a report since part of conducting a case study report to assess a family's financial capability is visiting the place of residence and conduct interviews with the family. When you are the only social worker, you are practically an all-around worker."*

Relatedly, there were agencies where staff had to deal with significant workload from non-drug rehabilitation work, as in the case of courts, which are also handling other cases aside from violations of drug-related offenses:

> 2-7-F: *"One of the concerns raised by the caseload manager is upon discharge, there is a delay in the court orders. So there are cases which take about a month yet there's still no response from the court."*

> 2-6-M: *"Usually, we already know the problem with the judiciary, they are swamped with cases. So our courts have many backlogs… So the cases are lined up in court due to its large number. So that's number one, that's actually the number one reason. That's the number one reason. There's always a line that's why the orders are usually released late. Not late but there is a delay. There really is a delay, which we have expected already because we know that they are swamped with cases in our courts."*

Likewise, social workers may also be implementing other programs and providing other services mandated to their office:

> 4-14-F: *"The workload may be overwhelming at times. Even though there are three social workers in our office, it still depends on the population of the municipality and the number of programs being implemented. It still becomes a problem when a request comes and the three of us are preoccupied with other tasks. We usually could not attend to requests by other facilities regarding clients immediately. Sometimes these agencies would need to follow-up on their requests since we sometimes could not meet deadlines they set. This is also the problem with other municipalities since our offices have heavy workloads"*

Lastly, one participant shared an instance where several agencies had different perspectives on how to deal with drug dependents. At that time, the drug program was just being rolled-out, and the operational guidelines have yet to be issued and refined. However, the participant added that in the end, the various agencies were able to reach an agreement:

1-2-F: *"Actually, the only difficulty there is if there's a meeting, I guess, ahh, since- since, ahh, you came from different fields, there's from LGUs, there's from private sector, there's government, you know, from PNP, sometimes, there will be a clash of ideas, but ahh, in the end, there's common … decision."*

5.2.4. Theme 4. Pandemic

This pandemic situation affected a broad segment of the population, including the operation of various agencies involved in drug treatment and rehabilitation. During the discussion, the participants from the different highlighted the negative impact of the pandemic to their work with other agencies.

Firs, the imposition of lockdowns and institutional protocols to restrict the movement of persons and prevent the spread of the virus resulted to additional steps that had to be taken when drug personalities are transferred from the community to jails, and from jails to rehabilitation centers, a situation which held true for both the urban and rural sites:

5-15-M *"When we bring them to jail, there are certain requirements that we need to comply with first. We must have them undergo antigen testing first. If it turns out positive, it would be the cause of delay since he/she will undergo some procedures like the quarantine period."*

5-19-F: *"Before the pandemic, there's no need for a drug personality to undergo swab testing prior to their transfer to rehab. It's a requirement now. They should undergo a swab test and of course, they must have a negative result."*

1-2-F: *"Actually … very minimal now are being allowed by us for the drug dependency and even for our admission. We have to be very careful because … our*

> *residents, we wouldn't want them to be contaminated with the… virus so what happens here before is, before they come for a DDE they have to undergo tele-triage. And then after the tele-triage, we also have to have this health certificate from their … barangay… their health center for them to be able to come in. Then when they check here, we have a separate … triage to check … before they are attended by … our staff … and our doctors.*

> 2-7-F: *"Because of the pandemic, our assessment on our patients also became limited, especially for our clients who are to be admitted to our facility. Through the help of … our nurse…, he collaborates with the BJMP or with the parents of the client if voluntary. He makes sure that they are compliant with the requirements prior to admission. Our role is to review these requirements that they submit. If there's any problem, then we'll relay to [nurse] what needs to be done for the clearance. That's how we do it. But we have somehow adjusted with the online set-up. We communicate directly with the patients upon DDE through online set-up. So more or less, we are getting used to that set-up. Also, the additional lab tests they do outside help us in fully assessing the patients prior to their entry to our program.*

This restriction was imposed because the jail and rehabilitation center were both congregate and residential settings, where the virus can easily spread:

> 2-6-M: *"Even with our social services, with our aftercare OPD, we try to limit the exposure of our staff. Because if our staff gets exposed outside, there's the possibility that they would bring it here in the facility. We don't want to be like the other TRCs, prisons, and jails where there was a spread of COVID in their facility. So that's another reason why we limit our activities within our residential area."*

Thus, even the provision by other agencies of services to clients undergoing rehabilitation

was limited:

> 1-1-F: *"[The psychiatrist] could not come here, much more now that … the cases usually in [their area] is high… Most, most of the confirmed cases are from there… [T]here's no longer follow-up for the other, like, unlike before that it's monthly… [Consultations are done] as needed only.*

> 2-8-M: *"The one that was really affected by COVID-19 is the way we conduct their spiritual enhancement activities in collaboration with the Roman Catholic Church. The Catholic priest cannot hold a mass here due to COVID-19 restrictions… The mass is conducted here in our facility but due to the restrictions, the priest cannot go here now."*

> 6-23-F: *"This had a negative effect on the psychosocial sessions we conduct because a large gathering of people is not allowed and our clients come from the barangays which usually have a lot of cases that are active. And at the same time, I also have clients who were uhm, outside of [the city] before the lockdown. So they cannot return. So, while I want to conduct a session for them, we cannot do so because face-to-face is still not allowed because we're limited right now."*

Even the process of preparation of social case studies done by social workers was also affected:

> 4-14-F: *"The way we conduct case studies was affected. In the past, we could do it face-to-face. Now, we just ask them to fill-up some forms. This increased the processing time since back then, before the pandemic, we would just ask the families regarding deficiencies directly. What we do now is usually just ask for the contact number of the client family in case we have questions, or we need to notify them about deficiencies. We also contact through messenger since some have claimed it is where they are most active."*

Participants recognized that moving to online mode of communication was one way of addressing the challenge imposed by the pandemic

> 6-23-F: *"Collaboration with other agencies, when it's proving difficult to meet face-to-face, we now have an option to do it virtually or over the phone. Because sometimes when you visit an office, of course you'd have to undergo the whole protocol. You have to check the temperature and the disinfection but for example, coincidentally somebody there tested positive, it will be immediately canceled. So at least nowadays, even with the pandemic, we have another option with technology."*

However, adoption of such technology proved challenging as well. On the part of the clients, for example, not everyone may have access to technology:

> 6-23-F: *"While we want to do an online session, not all clients are capable of or know how to join the online platforms."*

Meanwhile, since the pandemic happened after the start of the fiscal year, agencies had limited elbow room in realigning some of their operational budget towards adoption of technologies:

> 2-4-M: *"From the perspective of the top management, in my point of view, it's difficult to work our way around during the pandemic because our available resources are affected. The fund which is supposed to be solely for our program management is split into COVID prevention as well. It's a big challenge to us because we know for a fact that in government, our resources are very limited. That's the biggest challenge to us, how to manage our resources. Second, we need to live with our means but as I've said, we have very limited resources. Even if we want to cope with the challenges of COVID, even if we want to transition everything that can be done online, our limited resources deter us from having good Internet connectivity. Like now, maybe you noticed, almost all of us get*

> *disconnected from time to time because it's a challenge to us. Our Internet connectivity is a challenge because we cannot afford to buy with our budget gadgets that would improve our connectivity or even to get us connected with [internet service provider] since we're in a remote place. Hence, the biggest challenges to us are our resources and at the same time, our connectivity to the outside world."*

Even the available technology proved challenging to use, as connectivity was not always up to speed:

> 4-14-F: *"When it comes to collaboration with other agencies, we are now conducting case conferences virtually - through Google Meet, Zoom, or calls. Last time, I was in a video call with parents, client, and the agency. Sometimes there are distractions and connections are unstable. It might consume more time than usual due to these setbacks where we need colleagues to repeat what we missed every time we get disconnected."*

> 5-15-M: *"On the part of those already inside the facility, we cannot have a face-to-face meeting with them even if we want to. So our option is to meet them virtually. However, the issue there lies on the Internet connectivity. Similar to our experience now, our audio is breaking up from time to time."*

At the start of the pandemic, communication of the new mode of interaction between agencies was not clearly cascaded:

> 1-1-F: *"For the court, because like now, MECQ, there is no face-to-face hearing, there's online hearing. So sometimes the, you know, it's really unclear, couldn't actually enter online hearings. Then also sometimes we were not sent a link so the hearing is over before we learned that there's a hearing."*

6. Results: Individual Interviews

This chapter presents the findings from the third study component, which was derived from 28 individual interviews covering the responses to the following questions:

- Why do drug treatment and rehabilitation centers collaborate with other agencies that cater to PWUD?
- What are the similarities and difference of philosophical base/attitude toward drug treatment across collaborative parties?
- How is collaboration practiced by agencies involved in providing services to PWUD who are undergoing drug treatment and rehabilitation?
- How well are the target outcomes of collaborative practices attained by participating agencies?
- What challenges to collaboration are experienced by the participating agencies?
- How has the COVID-19 pandemic affected different aspects of interagency collaboration?

Interview data was analyzed using thematic analysis following the framework by Braun & Clark (2006). Identification of themes and sub-themes from the data extracts are shown in Table 6-1.

Table 6-1. Identification of themes from data extracts

Theme	Sub-theme	Code	Translation	Transcription
2. Purpose	2.3. Resource scarcity	Educational service	[The teacher] comes … every Sunday morning, three hours every Sunday. So we, at the beginning, we had like, there were a lot of residents who didn't finish high school and there were also some who didn't finish grade 6 but we treated them as high school students, at the high school level. And then there were probably 35 residents to begin with and so the first ALS [alternative learning system] lasted for 10 months… [T]hen 17 out of the 35 residents were qualified to take the national accreditation and equivalency examination. So if they pass it, they're considered high school graduates at that time.	**<Files\\INT09_20211202_Urban_Rehab2>** Ah, bale po every Sunday po siya nagpupunta. 'Yon ang, ang kasulatan, Sunday morning po, three hours every Sunday. So we uhm, at the beginning nagkaroon po ng ano like, andami nila na mga hindi nakatapos ng high school na residents tapos mayroon din 'yong hindi nakatapos ng grade 6 pero tinreat nalang siya as high school ah, ah, ah parang ah, ah high school na student no, high school level. And then mga thirty, thirty, 35 yata po silang residents to begin with and so ano, this lasted po for 10 months 'yong first ALS nila 'yong ano po 'yong mga ano sa, ano sa Dep-, sa DepEd and then na-qualify po 17 out of the 35 na residents to take the national accreditation and equivalency examination. So bale kung napasa nila 'yon, ano ah, high school graduate na sila...
4. Push and pull	4.1. Pull: Contextual level	Cross-tab between *Availability of resources* and *Valence: Positive*	We have a separate budget in the [c]ity… In the past 3 years, the city of Ilagan has allocated 3.5 million pesos for its anti-drug activities.	**<Files\\INT06_20211125_Urban_CADAC>** Mayroon pong separate budget ang … siyudad … for the past three years ay nag-aallocate po ng 3.5 million para sa anti-drug, uhh, activities po.
5. Politics and pandemic	-	Cross-tab between *Pandemic situation* and *Valence: Negative*	One issue that emerged then was there was a COVID outbreak in the DOH rehab center. One of their doctors died. And they said that the virus was very virulent. Almost 50% of their personnel were infected. That led to problems with the accused that were supposed to undergo rehab.	**<Files\\INT12_20211203_Urban_Court>** Ah meron lang isang naging issue then the DOH rehab was also, ano ah parang nagkaron sila ng ano, what do you call this, there was an outbreak ng COVID sa loob. May namatay na isang doktor sa loob. And very strong daw yung virus na halos fifty percent of their ano of their personnel were also ano afflicted. Kaya nagkaproblema yung mga dadalhing irerehab.

6.2. Characteristics of the participants

At least 16 informants from four agencies involved in the drug treatment and rehabilitation process (i.e., treatment and rehabilitation center, public health, social welfare, criminal justice) across the two study sites were invited to participate in interviews for the project, all of whom were chosen through theoretical sampling (Palinkas et al., 2015). Additionally, 10 representatives from agencies mentioned during the FGD as important participants in the drug rehabilitation process (e.g., courts, anti-drug abuse councils, religious groups) were also invited to provide new information for the study. The perspective of eight clients who underwent drug rehabilitation as it relates to interagency collaboration were also sought. In addition to stratification by agency, participants were also stratified according to the following variables, which were reported in the literature as important influences on the informant's perception and experience of interagency collaboration: (a) profession or professional orientation (Bray and Rogers, 1995; Green et al., 2008); (b) educational level, as a proxy for knowledge (Anastas et al., 2019; Guerrero et al., 2016; Iachini et al.); (c) duration of service, as a proxy for experience in working with other agencies (Anastas et al., 2019; Iachini et al.); and (d) position level (Smith & Mogro-Wilson, 2007; Wenzel et al., 2004).

A total of 28 participants consented to be interviewed across the two sites, representing different organizations involved in the drug treatment and rehabilitation process (see table below). In addition to the four groups originally identified before the start of the study (i.e., rehabilitation center, social work, health, law enforcement), interviewees were also invited from the court (1), education (2), anti-drug abuse council (4), and religious groups (1) as these organizations were identified in the course of the preceding focus group discussion as being involved in the drug

treatment and rehabilitation process. Likewise, five former clients of drug rehabilitation centers participated in the interview to provide their perspective on their experience of interagency collaboration during their treatment and aftercare.

Participants' age ranged from 23 to 64, with a mean of 42.5 years old. There were slightly more males (57%) than females (43%). Half of the interviewees had post-graduate degrees (i.e., professional doctorate, master's degrees). Those who belonged to agencies equally represented staff and managerial positions, and had a broad range of experience, with five being relatively new (i.e., less than five years of working experience in the field), and six having served for at least 20 years.

Table 6-2. Profile of Interviewees

No.	Code	Age	Sex	Location	Education	Agency	Position	Years of service
1	FO	54	M	Urban	Post-graduate	Rehabilitation center	Managerial	3
2	MA	30	F	Urban	Post-graduate	Social work	Staff	5
3	GA	42	M	Urban	Post-graduate	Law enforcement	Managerial	15
4	JA	59	F	Urban	Post-graduate	Rehabilitation center	Staff	4
5	VS	48	M	Urban	Bachelor's	Religious group	Managerial	26
6	AN	31	M	Urban	High school	Client	Client	–
7	MC	37	M	Urban	Post-graduate	Public health	Staff	8
8	MD	35	F	Urban	Bachelor's	Social work	Managerial	8
9	DR	40	M	Urban	Bachelor's	Anti-drug abuse council	Managerial	14
10	BC	44	M	Urban	Bachelor's	Client	Client	–
11	EB	39	F	Rural	Post-graduate	Rehabilitation center	Managerial	12
12	RG	30	M	Rural	Bachelor's	Rehabilitation center	Staff	8
13	AB	52	M	Urban	Post-graduate	Court	Managerial	9
14	LJ	46	F	Urban	Bachelor's	Department of Education	Staff	20
15	GG	42	M	Rural	Post-graduate	Law enforcement	Managerial	7
16	ME	63	F	Rural	Post-graduate	Public health	Managerial	30
17	MV	32	F	Urban	Bachelor's	Public health	Staff	8
18	AT	49	M	Urban	Post-graduate	Anti-drug abuse council	Managerial	11
19	ER	23	M	Rural	High school	Client	Client	–
20	PN	29	M	Rural	High school	Client	Client	–
21	RC	55	M	Rural	Post-graduate	Department of Education	Staff	6
22	MG	35	F	Urban	High school	Client	Client	–
23	AM	35	M	Rural	Post-graduate	Anti-drug abuse council	Managerial	7
24	PD	27	F	Rural	Bachelor's	Anti-drug abuse council	Staff	3
24	ED	54	M	Rural	Post-graduate	Law enforcement	Managerial	30
26	MT	64	F	Rural	Post-graduate	Social work	Managerial	34
27	LB	37	F	Rural	Post-graduate	Public heath	Managerial	1
28	OM	58	F	Rural	Bachelor's	Social work	Managerial	35

6.3. Themes of the study

Five themes were identified in the course of thematic analysis of the data, namely: (a) philosophical base, (b) purpose of collaboration, (c) properties of collaboration, (d) push and pull factors, and (e) politics and pandemic. These themes represent the agencies involved in the collaboration, the reasons and for their partnership, the attributes of the collaborative, and the factors that influence how and why collaboration took place, and are aligned with the research questions that this study component aims to address (Table 6-3).

Table 6-3. Correspondence between the research questions and themes

Research question	Theme
What are the similarities and difference of philosophical base/attitude toward drug treatment across collaborative parties?	Theme 1: Perspective
Why do drug treatment and rehabilitation centers collaborate with other agencies that cater to PWUD?	Theme 2: Purpose
How is collaboration practiced by agencies involved in providing services to PWUD who are undergoing drug treatment and rehabilitation?	Theme 3: Properties
How well are the target outcomes of collaborative practices attained by participating agencies?	Theme 3: Properties
What challenges to collaboration are experienced by the participating agencies?	Theme 4: Push and Pull Theme 5: Politics and Pandemic
How has the COVID-19 pandemic affected different aspects of interagency collaboration?	Theme 5: Politics and Pandemic

The diagram below (Figure 6-1) shows the themes and sub-themes, while the succeeding paragraphs provide a discussion of each.

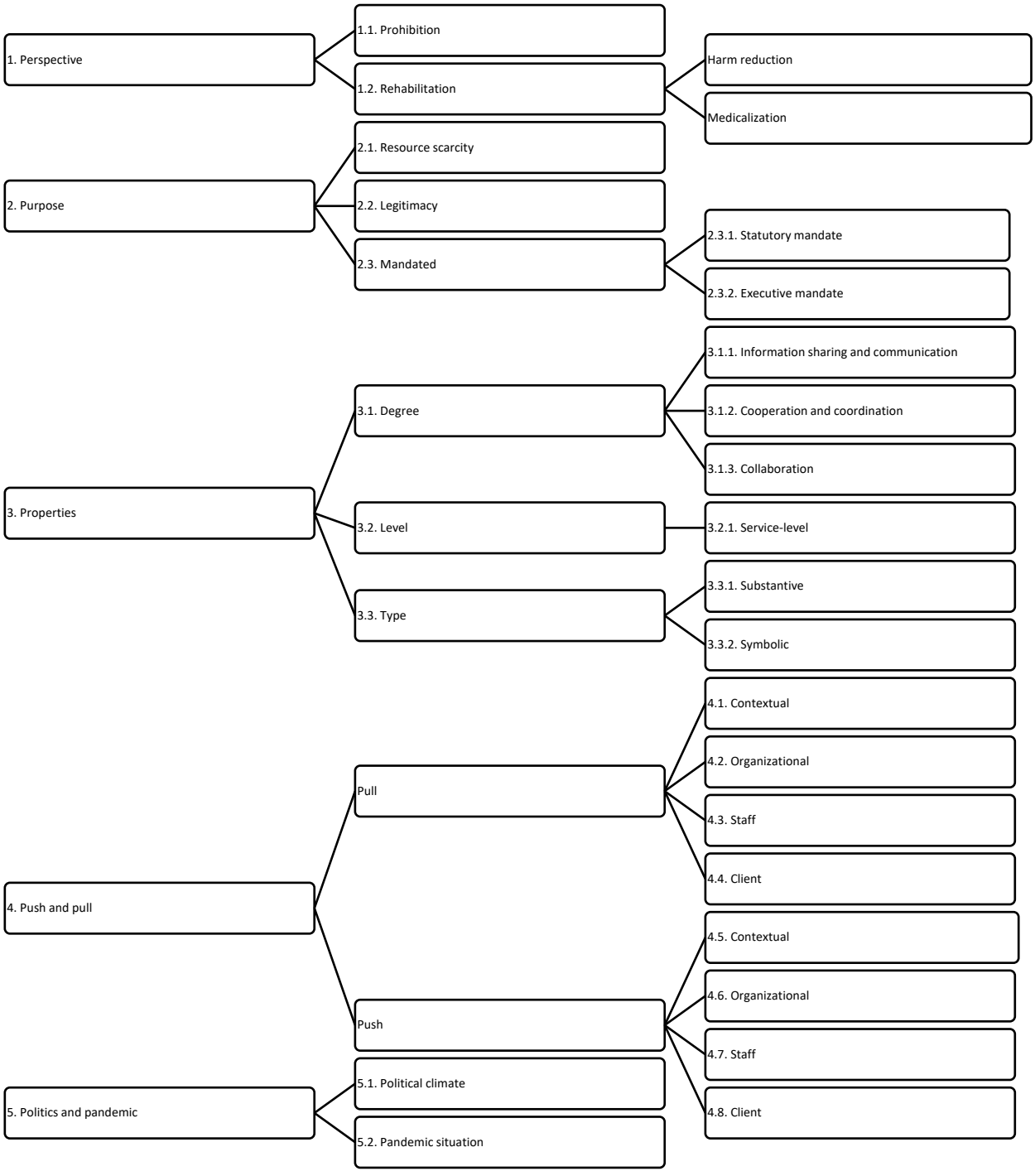

Figure 6-1. Hierarchy of themes and sub-themes identified from interviews

6.3.1. Theme 1: Perspective

This theme, which addresses the question on similarities and difference of philosophical base/attitude toward drug treatment across collaborative parties, represents the perspective or view of the agencies in addressing the problem of drug use and dependence. Such perspective influences not only the activities they implement, but also the extent to which working with other agencies is facilitated (i.e., if they share the same or opposite perspective). In the literature, the main categories of perspectives are prohibition, harm reduction, medicalization, and legalization (Abadinsky, 2014). Prohibition, which regulates the use of drugs and imposes penalties for manufacture, trade, possession, or use, is mainly the position taken by policymakers and law enforcers (Taylor, Buchanan, & Ayres, 2016). In contrast, harm reduction refers to interventions that aim to reduce the negative consequences of drug taking behavior and advocates for incremental changes in behavior from the current level of drug use towards abstinence (Logan, & Marlatt, 2010). This is a public health approach to addressing the drug problem, which is used by social workers and by some health professionals such as nurses. The third perspective, medicalization, involves the use of pharmacotherapy in the drug rehabilitation process to either control withdrawal symptoms through detoxification, or to achieve abstinence through treatment (Diaper, Law, & Melichar, 2014). Medicalization is mainly driven by health professionals. Lastly, legalization is the repeal of policies on prohibition, or the removal of criminal penalties associated with drug use behavior (Svrakic et al, 2021). This liberal position, although still debated in different countries and jurisdictions, has gained support from policymakers and some health professionals.

In this study, two broad categories of perspectives were mentioned by participants, namely *prohibition* and *rehabilitation*, with the latter incorporating elements of both harm reduction and

medicalization. Specifically, participants in the law enforcement and legal fields (4/28, 14%) mentioned ideas related to prohibition as an overarching approach, while participants from drug rehabilitation centers, social work, health, education, and religious group (15/28, 54%) tended to speak about rehabilitative approaches. There were no differences between the urban and rural sites in terms of information relating to this theme.

Table 6-4. Distribution of participants (agency) by perspective

Location	Agency	Prohibition	Rehabilitation
Urban	Rehabilitation center (2)		x
	Social work (2)		x
	Public health (2)		x
	Education (1)		x
	Religious group (1)		x
	Law enforcement (1)	x	
	Court (1)	x	
Rural	Rehabilitation center (2)		x
	Social work (2)		x
	Public health (2)		x
	Education (1)		x
	Law enforcement (2)	x	

Sub-theme 1.1. Prohibition

As mentioned in the preceding paragraph, prohibition refers to the institution of policies and practices that proscribe the use of illicit substances by way of regulation (i.e., imposition of penalties for trafficking, possession or use of drugs), or promotion of abstinence (Taylor, Buchanan, & Ayres, 2016). Informants were consistent in their description of the activities

related to identification and subsequent apprehension of drug personalities in the community as a way of implementing the provisions of Republic Act No. 9165.

The process of identifying drug personalities begins at the barangay (village) level, at which point a distinction is made between drug users who are sent to rehabilitation and drug pushers who must undergo reformation. Drug personalities thus identified are initially approached by barangay officials and law enforcers in an operation referred as Tokhang, in which these individuals are encouraged to submit themselves voluntarily to available government programs, or face arrest:

> *When we identify a drug pusher or user, within 30 days, we need to subject them to Tokhang. They must surrender or get arrested… If an individual is merely identified as a drug user, then we give him a chance to rehabilitate, to surrender… But if he's a drug pusher, then we admit him to Balay Silangan, a [reformation] center established by PDEA that is exclusive for drug pushers.* (ED, 54, male, rural, law enforcement)

The option for what was termed as reformation for drug pushers, however, is a recent development. Prior to the institution of the plea bargaining arrangement for drug pushing was approved by the Supreme Court in 2017 in the case of *Estipona vs. Hon. Frank E. Lobrigo* (Resolution G.R. No. 226679), violation of the regulation meant that individuals caught peddling drugs were immediately sent to prison, regardless if they were also drug users. As explained by one informant, obtaining an acquittal for a drug-related charge is quite difficult since there is usually solid evidence from a buy-bust operation led by law enforcement agencies:

> *There is no bail for Section 5. You automatically face jail time. After the buy-bust, they immediately undergo inquest procedures… So once the accused undergoes arraignment, that is the time when he/she will go here in the court coming from either the provincial*

> *jail or the BJMP, depending on their circumstances… [t]heir stay there also helped with their reformation. They have all the time to think things over.*
>
> *I tell them. "If you want to be acquitted of your charges, that will be impossible. The police are present. If you look around the courtroom, they are there. You had a transaction with those people. Now if I were to acquit you, for example, we push through with this trial. If I were to see that the evidence is weak or there is reasonable doubt, I will acquit you. But it will not be easy", I tell them.* (AB, 52, male, urban, court)

In addition, imprisonment without rehabilitation was reserved for those who were previously rehabilitated but were found to use drugs again, as provided for in Republic Act No. 9165:

> *Then I say [to the police], "If this person gets out of prison, … if he does it again, [d]on't ever bother bringing him to court because he will just give us a headache. We already gave them a chance and everything and they chose not to change. They are a cancer to society… Don't make our jobs harder." Especially when dealing with repeat offenders.* (AB, 52, male, urban, court)

This was corroborated by another interviewee from the law enforcement field who said that "*they're really just addicted to [drugs]*":

> **Interviewer:** *In such cases that you catch them for the second time, are they treated differently? Will they still need to go through the rehabilitation program?*
>
> **Interviewee:** *They are now arrested since they were already given a second chance. Yet, they still didn't want to change. They still resort to drug pushing. They are subjected to inquest proceedings by the fiscal. A case is filed against them in court.* (ED, 59, male, rural, law enforcement)

There was no drug rehabilitation program inside jails or prisons, where life was described to be difficult and, for some, a "living hell" (AB, 52, male, urban, court):

> *There was no rehab program during our time… [W]hen I was still inside the jail, we didn't practice that* (PN, 29, male, rural, client)

> *You'd get bullied. It's hard to sleep since you're sleeping on the cement floor. Your things will get stolen too. You'd be left with nothing... It's really hard...* (MG, 35, female, urban, client)

Sub-theme 1.2. Rehabilitation

In contrast to prohibition, individuals who surrendered, or were arrested for drug use, for the first time underwent rehabilitation, which can either take place in a residential facility, out-patient clinic, or community-based program, depending on the severity of the drug dependence identified as part of the initial evaluation by a physician, as provided for in DDB Board Regulation No. 7, series of 2019. This was also the process followed for those caught pushing/selling drugs but who availed of plea-bargaining to a lesser offense.

The process begins with a request for administration of a drug dependency examination on the individual by a trained physician, which will identify the severity of drug use disorder. Depending on the availability of programs in the locality, individuals with mild drug use disorder are directed to community-based programs, while those with moderate severity are sent to non-residential centers. Only individuals with severe drug use disorder are admitted in residential facilities.

> *I will now direct the accused to the DOH Drug Abuse and Rehabilitation Center … for the conduct of the drug dependency exam. [An] accused … categorized as severe … is recommended [to] undergo inpatient rehab. That's the recommendation when the DDE result is severe. Almost all of the results are severe. Some are moderate. That means that the DOH recommendation for them is outpatient rehab. They are not required to be admitted into the facility, but they are required to attend their rehab. They will go home then they will go to the rehab center to report for their outpatient rehab. If their result is mild, they will not undergo the rehab by the DOH, but they will undergo community-based rehab.* (AB, 52, male, urban, court)

In the rehabilitation center, persons who use drugs undergo a program that addresses different aspects or issues related to their drug use, which mirrors the harm reduction principle of providing interventions to prevent negative consequences of drug use at the individual and social levels (Bartlett et al, 2013; Logan, & Marlatt, 2010; Tsui, 2000). As emphasized by one respondent, the treatment provided to residents is holistic:

> *[W]e handle the cases of residents or patients. We call our patients "residents" since we consider the rehab center as a home... [W]e report all the domains of their life, like legal—all the aspects—legal, family, social, spiritual, everything… Here in our rehab center, we apply the holistic approach which means whole, so all aspects.* (RG, 30, male, rural, rehabilitation center)

Likewise, rehabilitation was a component of the intervention for those who were identified as being both a drug pusher and a drug user, even if they underwent the reformation program previously. As mentioned in the preceding paragraph, an individual brought to court is usually ordered to have a drug dependency examination to determine if they are drug users requiring rehabilitation:

> *Since they're both—a drug user and pusher, … we should treat their drug use first.* (GG, 42, male, rural, law enforcement)

This was corroborated by the experience of a client who first underwent rehabilitation for three months since he was identified as a drug user, before undergoing the 30-day reformation program:

> *I enrolled in the rehabilitation program after being released from prison… The first program I enrolled in was the CBRP program. The community-based rehabilitation program first… That was in 2020. Then after I graduated from CBRP, I was categorized in the drug clearing operations of PDEA as a pusher, so I really needed to enroll in Balay Silangan… I understand that there is really a need to undergo the program in Balay Silangan if you were categorized as a pusher by PDEA.* (BC, 44, male, urban, client)

Related to the concept of rehabilitation is the understanding of relapse in terms of drug use even among those who previously underwent treatment, and that relapse prevention is part of the process:

> *[I]t's very important to have a plan once they get out. If they don't have a plan in place, they are more prone to relapses. That's why we need a plan, we need to execute it once the resident is released so that his life will have a direction.* (RG, 30, male, rural, rehabilitation center)

Notably, this perspective is not widely shared, especially among law enforcers, which, as will be shown in the subsequent themes, affects the willingness of other agencies to work with them in handling drug cases:

> *Actually, all of them, or most of them, do not share the same views. Others would think "these people have already been given treatment and rehabilitation, why did they come back? Because it's not effective." Okay, that's their mentality, but me—although I'm not from the health sector, I have formal training and I learned that. I learned that … relapse is part of recovery and we can't avoid having relapse, that's why there is relapse prevention. So, that's the problem of law enforcers like me … is that they get mad, "You never learn. You've already been reprimanded but you keep doing it." It's because they don't understand that it's not easy to undergo treatment and rehabilitation. Every time I lecture, when I give preventive education programs in schools and in the community, I tell them, the drug users, once they stop using drugs, they feel a lot of pain. It's as if they had their arm cut up without anesthesia. So, as much as they can tolerate it, they would. But if it comes to a point that they can't anymore, the only thing—the only solution for the pain is to take drugs again. That's when relapse comes in. And what's even more painful, a lot of law enforcers don't understand that. So, maybe there's a need to have a better understanding, for law enforcers like me, when it comes to treatment and rehabilitation, not just law enforcement.* (GG, 42, male, rural, law enforcement)

6.3.2. Theme 2: Purpose

This second theme addresses the question on why agencies collaborate with others in the course of rehabilitation of persons who use drugs. Organizations had different reasons or purpose for entering into partnership arrangements with other agencies as reflected in the sub-themes under this category. An understanding of the motivation for engaging with other agencies can provide information on the appropriate mechanisms that can be used or tapped when developing a policy or program requiring interagency collaboration.

As mentioned in the literature, there are three distinct reasons why organizations work with other agencies. First, organizations typically deal with *resource scarcity* and so they choose to enter into partnerships to control uncertainty and attain a degree of autonomy from other organizations on which they are dependent upon for resources (i.e., by laying down the extent and boundaries of resource sharing). Second, organizations wish to generate a sense of *legitimacy*, or the sense that the actions they are taking, in this case partnership with other organizations, is appropriate and proper when viewed in the context of other similarly situated organizations. Third and last, organizations may enter into partnerships as a result of isomorphism, specifically through a coercive or *mandated* mechanism, if this is the situation in the environmental context in which such organizations are embedded. Of note, the first two are related to the resource dependence or exchange theory while the last is a concept from institutional theory.

These three purpose or reasons for collaboration have been observed in the data and is reflected in the sub-themes. The rehabilitation provider enters into partnership with agencies in the health, education, social work, and religious fields because of *resource scarcity*. That is, clients in the rehabilitation center require medical, psychiatric, educational, and other services that the facility cannot provide on its own because of lack of expertise or staff. Hence, formal or informal agreements and arrangements are made with external service providers that have the capability and resources to fill the service gap, and this was mentioned by 17/28 (61%) of participants, including two law enforcers with noted the financial contribution of local government units to the rehabilitation process.

Meanwhile, *legitimacy* was indicated as a reason for collaboration by participants from the law enforcement agencies and anti-drug abuse councils (7/28, 25%), specifically referring to the public recognition and incentive system created in 2018 that linked rehabilitation of drug

personalities, and subsequently declaration of a drug-free locality, to an award for good governance by virtue of DILG Memorandum Circular No. 2018-01. Local government units and law enforcers worked with rehabilitation centers to ensure completion of rehabilitation programs so that identified drug personalities can be delisted from their database, and a certification of a drug-free locality can be issued.

Lastly, organizations participated in the rehabilitation process because of a *mandate*, either arising from a law or regulation such as Republic Act No. 9165 and related issuances (i.e., statutorily mandated), which was mentioned by 10/28 (36%) participants who belonged to the law enforcement, rehabilitation, and anti-drug abuse council agencies, or from orders or instructions of the President, provincial governor, and/or city/municipal mayor (i.e., executive mandate), which were mentioned by informants from law enforcement agencies and anti-drug abuse councils (7/28, 25%). The handling of drug personalities from the point of identification at the community level through to provision of rehabilitation services and subsequent reintegration in the community is mandated by Republic Act No. 9165 and related issuances (i.e., *statutorily mandated*), which also defines the role of different agencies in this process. In this sense, and as will be mentioned in the succeeding paragraphs, this process results to transfer of drug using individuals from the community through the legal system, then the rehabilitation facility, before being returned back to the community once they have been deemed rehabilitated. While the statute has been in place about two decades previously, participants pointed out that participation of different agencies, particularly those that are supposed to bring in persons who use drugs to the rehabilitation center, has suddenly increased following the directive of President Rodrigo R. Duterte following his election in 2016, and the cascading of such directive by provincial governors and city/municipal mayors, which points to the effect of *executive mandate*.

Table 6-5. Distribution of participants (agency) by purpose

Location	Agency	Resource scarcity	Legitimacy	Mandated	
				Statutory	Executive
Urban	Rehabilitation center (2)	x		1	
	Social work (2)	x			
	Public health (2)	X			
	Education (1)	X			
	Religious group (1)	X			
	Law enforcement (1)	X	X	X	X
	Court (1)			X	
	Anti-drug abuse council (2)		X	X	X
Rural	Rehabilitation center (2)	X		1	
	Social work (2)	X			
	Public health (2)	X			
	Education (1)	X			
	Law enforcement (2)	PDEA	X	X	X
	Anti-drug abuse council (2)		X	X	X

Sub-theme 2.1. Resource scarcity

Resource scarcity was identified as a reason for entering into partnership agreements with other agencies, especially for services that are not available with the rehabilitation service provider. Typically, this will involve educational, livelihood and financial support services for persons undergoing rehabilitation to assist them during the period of their reintegration into the community.

The provision of learning interventions was identified as one important service during rehabilitation to enable individuals to seek better opportunities once they are discharged from the program, especially for those who have not completed basic education as this was perceived to

be a barrier for a drug dependent to seek employment opportunities requiring presentation of a certificate attesting to the educational level of the individual:

> *"[s]ome of them are illiterate. Others were only able to receive high school education. Accused individuals who are college graduates or those with master's degree are rare, doc. Those who were only able to receive elementary education are considered illiterate. Or those who received high school education. You almost never encounter a college graduate."* (AB, 52, male, urban, court)

Rehabilitation centers, by design, do not have any staff who are educators or teachers. Hence, partnership with the education department is undertaken to bridge this service gap through provision of an alternative learning system, which is true for both the urban and rural sites:

> *"[The teacher] comes … every Sunday morning, three hours every Sunday. So we, at the beginning, we had like, there were a lot of residents who didn't finish high school and there were also some who didn't finish grade 6 but we treated them as high school students, at the high school level. And then there were probably 35 residents to begin with and so the first ALS [alternative learning system] lasted for 10 months… [T]hen 17 out of the 35 residents were qualified to take the national accreditation and equivalency examination. So if they pass it, they're considered high school graduates at that time."* (JA, 59, female, urban, rehabilitation center)

> *"And there's also DepEd… [I]t's either the teacher or the school. Since their student is for treatment, they requested to collaborate with us regarding his/her education. Neither the studies nor the treatment should be sacrificed. These should be done simultaneously. So we arranged the schedule such that none would be sacrificed. Both are equally important."* (EB, 39, female, rural, rehabilitation center)

Another area where partnership is established because of resource scarcity is in the provision of opportunities for employability for individuals undergoing rehabilitation. The logic of this approach is that persons who use drugs, particularly those who are both drug users and drug pushers are unemployed and would use drugs as a means of livelihood:

> *"They are unemployed, they have a lot of problems, and they tend to spend a lot of time with their friends."* (ED, 54, male, rural, law enforcement)

> *"Part of the program is to give them skills training or livelihood assistance once they graduate. So that they will not be tempted to push drugs again. This business is lucrative. Without proper intervention or livelihood, they will just keep on pushing drugs like they used to."* (GA, 42, male, urban, law enforcement)

Support can come from the local government unit in the form of financial assistance to be used as a start-up capital for a business, direct employment with the local government unit or partner institutions, or skills training with a program accredited by the Technical Education and Skills Development Authority, the government agency mandated to supervise and accredit programs on skills training:

> *"Usually what we give them is the financial assistance, which is worth 5,000 that will be their start-up. And then, not only that, sir, we also refer them to the SWAD Office… for livelihood assistance also. And then, we refer those who need permanent jobs to the Office of the Mayor to give them work…"* (MD, female, urban, social work)

> *"In case that we can't really bring them in for employment, we offer them a special program wherein we refer them to TESDA. That is in partnership also with our LGU. Those*

> *are the manpower training programs of our local government unit that include automotive, driving and the like."* (MD, female, urban, social work)

There was also one instance where the rural-based rehabilitation facility entered into a partnership with a psychiatric hospital for the provision of clinical services and medications to individuals diagnosed with co-occurring disorders (i.e., individuals with both a psychiatric and drug dependence problem):

> *"For example, if I have a resident that needs psychological evaluation. The rehab center doesn't really have a registered psychologist. We do have a MOA with a partner agency... We refer the psych evaluation of our residents there."* (RG, 30, male, rural, rehabilitation center)

> *"So, we were providing medicines for their clients with mental health conditions as well as providing one of our staff, one of our doctors, used to go there, once a month, to do psychiatric follow-up… because during that time they had no psychiatrist."* (ME, 63, female, rural, health)

In addition, rehabilitation centers also partner with local government units to defray the cost of drug rehabilitation through a graduated cost-sharing scheme. That is, part of the expense for drug rehabilitation is shouldered by the facility, while the remainder is charged against the city or municipality from in which the client is residing:

> *"Since in rehabilitation centers like ours, inpatients are classified according to their social status just like in hospitals. This is the basis of their term of payment for the rehabilitation. Some are 100% paying, others 25%, 50% or 75% while there may also be 100% free… For example, the patient is indigent, if the LGU does not shoulder 100% of the overall cost*

> *of the patient, let's say they only provide for 50% of the cost, we will shoulder the remaining 50%."* (FO, 54 male, urban, rehabilitation center)

Local government units also provided financial assistance to cover transportation costs for clients who need to commute to the rehabilitation facility:

> *The convicted accused absconded because he/she did not have enough fare money to go to the rehab center. The problem was financial in nature. He did not have enough money to commute to the rehab center. It's actually pretty far… Sometimes, they don't have money for the fare. I tell them, "You can ask for assistance from your LGU. You can ask them for financial help. They have a budget for that"… They don't have money. The court cannot give them fare money. It's up to the LGU to deal with them.* (AB, 52, male, urban, court)

However, as noted by the informants, these arrangements will depend on whether the local government unit can provide such financial assistance during the period of rehabilitation.

Sub-theme 2.2. Legitimacy

While the partnership between agencies during the period of rehabilitation can be explained by resource scarcity, the participation of agencies that bring it clients to drug rehabilitation centers (i.e., law enforcers, local government units) can be explained by the need for *legitimacy*.

Specifically, this refers to the performance of agencies in addressing the drug-problem, which was tied to a recognition system whereby localities that have functional programs and are declared drug-free or drug-cleared are given incentives by the national government as provided under DILG Memorandum Circular No. 2018-01. Such declaration requires that identified drug personalities in the locality have already been provided an intervention, including rehabilitation

for drug users:

> *"[W]hen we say drug-cleared, that's true, all the drug personalities in the barangay, municipality if at the municipal level, and […] provincial level, have been given intervention."* (GG, 42, male, rural, law enforcement)

> *"[The barangay] has already made three books for this drug clearing because we identify everyone, then we give them a certificate. And for those who are not here [in the barangay], we have to locate them to confirm that they are really not here, then we will give them a certificate too. For those who died, we need the death certificate, and we attach it. What is difficult is that we have to notarize them individually. That is why we actually allocated a budget for this, so that we can achieve the drug clear status which can also serve as my legacy as the barangay chairman."* (AT, 49, male, barangay official)

Hence, there is an impetus for officials and law enforcers not only to identify drug personalities in their areas, but to also bring them to the rehabilitation facility so that a certification of rehabilitation can be issued once the individual has been discharged.

Such incentive system was not only limited to an award, but was also made a public activity, allowing agencies, particularly local government units, to compare performance with one another. As explained by one informant:

> *"At the start, around 2017 or 2018, those who got perfect scores throughout the whole Philippines, called gold awardees, were given cash incentives by the national government and DILG, and a plaque of recognition. Maybe if you have the time in the coming days, you can look it up on our social media, "anti-drug abuse council awarding". Pre-pandemic, mayors would go to Manila Hotel around December to personally be awarded a seal, I think it's a golden or glass seal or plaque, to recognize their effort for the drug*

> *campaign… [I]f there is a show-cause order, they are asked to explain why their scores are low, why their LGU is non-performing in relation to the anti-drug campaign, especially because it is the flagship program of the present administration. If they aren't able to explain it well, they can be charged with neglect of duty… [M]ayors compare notes. "What award did you get?" "We didn't get one." So it rubs off on each other… When it comes to the implementation, they all want to gain recognition since it confirms their performance."* (AM, 35, male, rural, anti-drug abuse council)

As such, local chief executives mobilize their local offices and agencies and resources to support this goal:

> *"The mayor is really focused in achieving his target of a drug-free [city], so all the other agencies involved are very cooperative towards meeting this target."* (MV, 32, female, urban, public health)

> *"Our target, challenge is to be the first city to be declared, I mean in the [region], to be the first city to be declared as drug-cleared city. Because if you do not have a goal, we are not eyeing something, we lack inspiration, we lack drive. Because that is not just for oneself. But that is something that can give us a feeling of a reward."* (VS, 48, male, urban religious group)

And since the recognition can be revoked if drug activity in a locality increases, governors and mayors need to continue monitoring the local situation, including bringing newly identified dug users to rehabilitation centers:

> *"Because if, for example, a certain town in [province] is not drug-cleared, the whole province is affected. We can no longer declare the province as drug-cleared as a whole if*

> *there are one or two towns that do not prioritize the anti-drug campaign of the government."* (GG, 42, male, rural, law enforcement)

> *"…[T]here is a process that is being followed, there are parameters set by PDEA... They have a list. They pass that down to the PNP in each town and city, and they ask them to verify if [the people on the list] are really drug personalities. Because that list still isn't confirmed. The information comes from tips, and there is a certain period, I'm not sure if it's 30 days, wherein they have to verify [the information] so that the person may be put into rehab or arrested. If they don't handle that immediately and the LGU has no sense of urgency, the province would not be drug-cleared. So it's not like if someone gets arrested today, tomorrow the whole province is no longer drug-cleared… [I]t's like there's a buffer. If ever a drug personality is caught, there needs to be an urgent intervention so you would have the chance to sustain the drug-cleared status of the province."* (AM, 35, male, rural, anti-drug abuse council)

Sub-theme 2.3. Mandated

Formation of partnerships can also be the result of mandates, either by operation of laws and regulations, or arising from instructions of executive officers such as the President, provincial governor, and/or city/municipal mayor.

Statutory mandate. Partnership arrangements happen by operation of Republic Act No. 9165 and regulations (i.e., DDB Board Regulation No. 7, series of 2019, DILG Memorandum Circular No. 2018-125) that mandate the role of different agencies from the time a person is identified as a drug personality through to aftercare, as shown in the diagram on the next page (Figure 6-2).

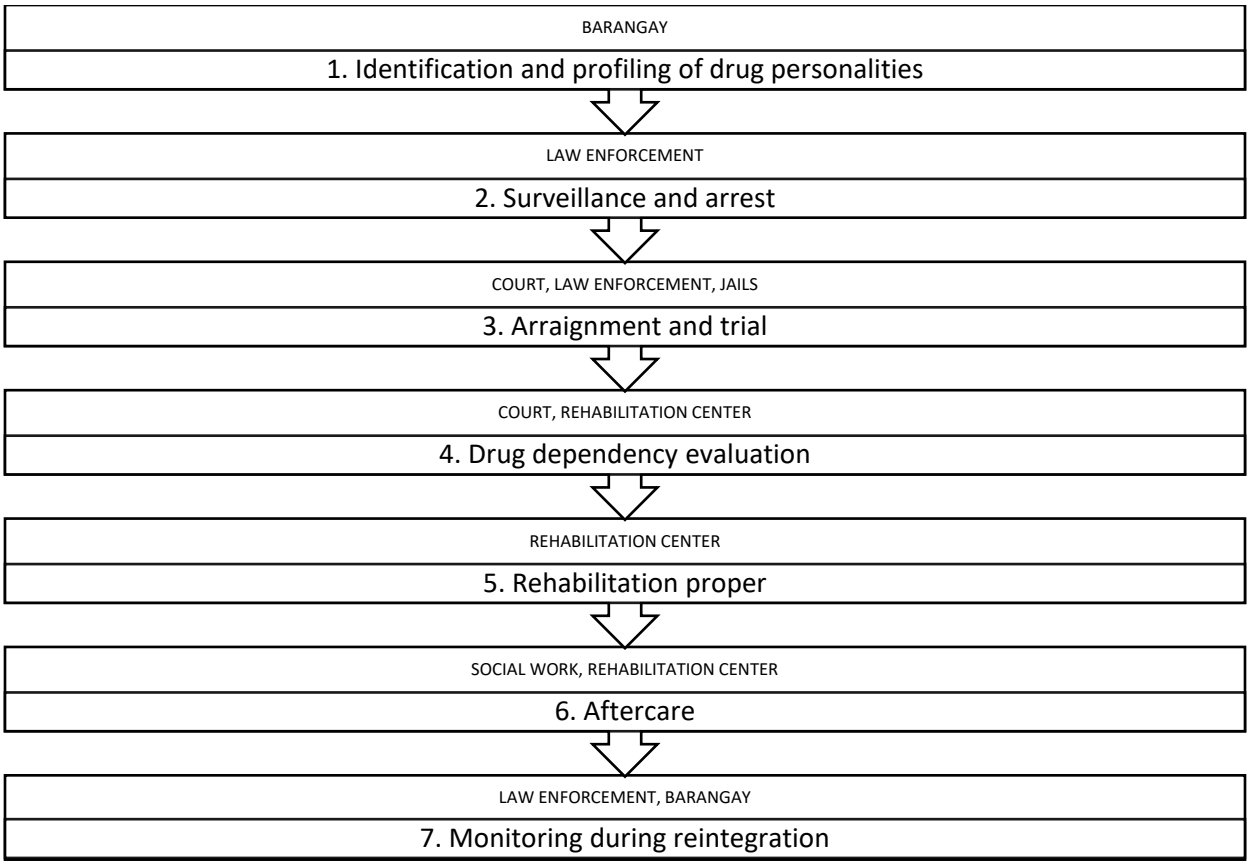

Figure 6-2. Schematic diagram of the process for identification and reintegration of drug personalities as mandated by current statutes and regulations. The numbered items indicate the procedures/steps, and the agencies involved in such step are identified immediately above.

Briefly, barangay officials, or elected individuals in the Philippine's smallest administrative sub-division, are tasked with the identification and profiling of drug personalities in their area:

> *"First of all, in identifying drug personalities in the barangay. Because one of their responsibilities is to figure out who these drug personalities are in the barangay."* (GG, 42, male, rural, law enforcement)

Barangay officials are mandated to work closely with law enforcement agencies to whom they submit the list of identified drug personalities for cross-checking and verification, and

subsequent surveillance:

> *"Barangays submit to us [police] their BADAC lists which include all the persons who are for surveillance."* (ED, 54, male, rural, law enforcement)

Once individuals under surveillance either surrender or are apprehended, they are brought before the court for arraignment for violation of Republic Act No. 9165. During the pendency of the case, the accused stays in prison:

> *"[O]nce a case is filed before the court and raffled to a particular branch... The process moves quickly because we are now dealing with a detention prisoner. Automatically, the wheels of justice should move for the accused. So immediately, once we receive the folder of the case, the accused is already a detention prisoner. There is no bail for Section 5. You automatically face jail time. After the buy-bust, they immediately undergo inquest procedures. So the accused stays in jail for a few days or months… Once the accused undergoes arraignment, that is the time when he/she will go here in the court coming from either the provincial jail or the BJMP, depending on their circumstances."* (AB, 52, male, urban, court)

The judge orders for the conduct of a drug dependency evaluation on the accused to establish if the person has a substance use disorder and to determine the required intervention for the individual. The evaluation is done by a trained physician working in a rehabilitation center:

> *"So what will happen on the supposed arraignment and pre-trial day is that I will now direct the accused to the DOH drug abuse and rehabilitation center … for the conduct of the drug dependency exam."* (AB, 52, male, urban, court)

Once the presence of substance use disorder is established, the court orders for the rehabilitation of the individual. Since drug rehabilitation entails costs even in public facilities, individuals

without any means of paying for the services are supposed to be supported by the government of their place of residence in defraying some or all of the cost of rehabilitation:

> *"So, the level of rehabilitation needed is based on severity. If the level is severe, the patient undergoes the inpatient program. If moderate, the patient is enrolled in the outpatient program. Whereas if the patient is a mild case, they are allowed in the community-based program."* (FO, 54, male, urban, rehabilitation center)

> *"[T]here are laws and pertinent DILG memorandum circulars saying that it's really the LGU which should be in charge of allocating funds for treatment and rehabilitation.* (GG, 42, male, rural, law enforcement)

Following completion of the rehabilitation period, and once an individual has been deemed rehabilitated by the attending physician or case manager, aftercare commences. While this is the mandated role of the social work department, in some instances, the rehabilitation center may also take on this role if the social work department is not capable of providing such services:

> *"The Dangerous Drug Board leads the development of the aftercare program which is supposed to be at the local level with the guidance of the Department of Social Welfare and Development."* (FO, 54, male, urban, rehabilitation center)

> *"Because under RA 9165, a resident who underwent rehab needs to undergo another 18 months of aftercare program. So even if they are outside, we still have continuous monitoring."* (RG, 30, male, rural, rehabilitation center)

An individual who is reintegrated into the community is monitored by both law enforcers and barangay officials, who will note in the watchlist that the drug personality has already undergone and completed rehabilitation:

> *"[In the Barangay Drug Clearing Program, the barangay submits the list of the drug personalities and shows the intervention programs they went through in order to be cleared.* (GG, 42, male, rural, law enforcement)

Executive mandate. Aside from statutes and regulations, some participants also indicated that partnership was boosted by executive mandate, either at the national (i.e., President) or the local (i.e., provincial governor, city/municipal mayor) levels.

A few informants mentioned that the involvement of different agencies was based on directives, or "*instructions*", from President Duterte who assumed office in 2016:

> At the level of the barangay, the smallest administrative unit of governance in the country: *"Actually, the role of the barangay [is stated] in the instruction of President Rodrigo Duterte regarding the drug [program]."* (AT, 49, male, urban, barangay)

> On the establishment of reformation centers: *"[E]very municipality has an established Bahay Pagbabago. We are sure that the … president gave instructions."* (MT, 64, female, rural, social work)

The president's directive resulted to an increase in activity of the interagency work done, for example, at the level of the barangay:

> *"The Drug War started during the start of Duterte's term in 2016… Even the barangays, their BADACs became active. Before, it's like they didn't care. Now, they have become active… They were already existing even before. They were created by the DILG however, they weren't active. That's why there's such a thing called revitalization of BADACs… They were really re-established during Pres. Duterte's term. There were already BADACs and MADACs even before as established by the DILG. However, they were non-functioning. I'm not sure but it seems like barangays were afraid of going against drugs.*

> *It's because even the higher ups were not that serious. Now that the president is resolved [in dealing with the drug problem], there's a massive change."* (ED, 54, male, rural, law enforcement)

> *"Actually even before the administration of President Duterte, many administrations ago, anti-drug abuse councils already existed, but ever since our president, President Duterte, was elected into office, the anti-drug abuse councils were strengthened. They realized that, before, meetings were conducted and members were present, but being organized is different from being functional."* (AM, 35, male, rural, anti-drug abuse council)

At the local government unit level, the involvement of the local chief executive especially in the mobilization of local agencies and resources is crucial as pointed out by one informant:

> *"So the—the mobilization, the [agency] wouldn't move … if there are no orders from the mayor, if there are no orders from the governor. And they won't make programs or start any initiatives without the approval of the mayor or governor."* (GG, 42, male, rural, law enforcement)

Even engagement of barangay officials is facilitated with support from the local chief executive:

> *"We have actually tried worked with them [barangay officials]. Even with the pandemic, it's easy working with them because our mayor's political will is quite strong and she is always ready to assist and is hands-on. So it's easy for the mayor to call her barangay captains and ask them for help when it comes to this."* (LB, 37, female, rural, public health)

6.3.3. Theme 3: Properties

This theme addresses the question on how collaboration practiced by agencies involved in providing services to persons who use drugs, as well as the outcomes of such partnerships.

Table 6-6. Distribution of participants (agency) by properties

Location	Agency	Degree	Level	Type
Urban	Rehabilitation center (2)	Collaboration	Service	Practice
	Social work (2)	Collaboration	Service	Practice
	Public health (2)	Cooperation	Service	Practice
	Education (1)	Collaboration	Service	Practice
	Religious group (1)	Collaboration	Service	Practice
	Law enforcement (1)	Information sharing	Service	Practice
	Court (1)	Coordination	Service	Practice
	Anti-drug abuse council (2)	Information sharing	System (attempt)	Policy
Rural	Rehabilitation center (2)	Collaboration	Service	Practice
	Social work (2)	Cooperation	Service	Practice
	Public health (2)	Collaboration	Service	Practice
	Education (1)	Collaboration	Service	Practice
	Law enforcement (2)	Information sharing	Service	Practice
	Anti-drug abuse council (2)	Information sharing	System (attempt)	Policy

The partnership between agencies can be characterized in terms of *degree* (i.e., level of intensity and formality), *levels* (focus of the collaborative), and *type* (collaboration in policy or practice). While participants did not directly described their partnerships in these terms, the categorization of partnerships based on these three systems can be inferred from a description of activities undertaken by agencies.

Of the five degrees of collaboration identified in the literature, three were noted from the data, namely information sharing and communication, cooperation and coordination, and collaboration, which are generally more informal forms of partnership (i.e. in contrast to consolidation and integration) that do not necessitate the establishment of a common authority to direct and implement the interventions and activities of the partnership. Among the informants, 7/28 (25%) described activities that were on information sharing and communication, particularly those coming from the anti-drug abuse councils and law enforcement agencies; 5/28 (18%) described activities on cooperation and coordination; while the rest (11/28, 39%) engaged in collaborative activities.

In terms of focus, the partnership arrangements in the study sites were operating at the service-level as reported by 19/28 participants (68%), which is to say that they are dedicated to improving service provision at the provider-client interface. Similarly, 68% of participants described their agencies as having a substantive type of partnership, which means that there is actual implementation of activities, although one informant raised an important counter-position in this regard.

Sub-theme 3.1. Degree

There were five degrees of collaboration identified in the literature, namely (a) information sharing and communication, (b) cooperation and coordination, (c) collaboration, (d) consolidation, and (e) integration (Konrad, 1996). Of these, only the first three were noted from the data, that is to say, there are no arrangements where all the services required for a drug dependent were placed under the authority of a single entity or agency, which is required for consolidation and integration.

Information sharing and communication is a partnership arrangement in which agencies come together to share general information about their programs or clients, usually through educational presentations or joint meetings. In the study sites, this sharing of information took the form of a report on the agency accomplishments through a body such as the local anti-drug abuse council.

The anti-drug abuse council meeting takes place quarterly, in which agencies provide updates on their activities related to addressing the drug problem. However, given the scope of the meeting, as well as the fact that it is held in conjunction with the peace and order council meeting, the anti-drug abuse council meeting is not merely focused on drug rehabilitation, but also discusses law enforcement issues:

> *"The council holds a meeting and talks about the status updates regarding the peace and order and anti-illegal drugs [campaign]. They would also talk about the actions that the council can take to maintain or strengthen the campaign against illegal drugs, keeping the peace and order and insurgency-free status of the province… He [the governor] wanted them to report their accomplishments quarterly alongside a target which they set during the first quarter. This was done so we can compare their accomplishment from the baseline data. He asked for a three-year target. Moving forward, that's what we have been doing in the council, what the reporters from member agencies do in every council meeting. The head of the drug treatment and rehabilitation here… usually presents and the PDEA presents as well. That includes their campaigns and activities against illegal drugs. The PDEA would also give an update on their drug clearing. If anyone has been sent for CBRP, like that, because as of now, the province of Bataan is drug-cleared. Those are the updates they give, what interventions they're doing to maintain the drug-cleared status of the province... [Head of rehabilitation center], on the other hand, would report about their interventions, the community-based drug treatment programs for the persons who use*

> *drugs. That's it. Those are their programs, the assistance they provide, their interventions, and the like. How many graduated from their center, how many enrollees they have, the statistics."* (PD, 27, female, rural, anti-drug abuse council)

However, not all agencies are able to report during the meeting, and so their report is usually just incorporated in the written minutes or accomplishments:

> *"[T]he CADAC meeting is always held together with the peace and order council meeting and most of the time, the conversation is focused on BPOC, the one for peace and order. And when it comes to CADAC, it's more on the drug-clearing, how many barangays are drug-cleared. By the time we try inserting that, we no longer have time… [B]ased on the agenda, everything's included there, it's all part of the plan, but when it comes to the actual, there's a lot of us reporting that we never finish. So there was one time… [w]e already prepared the report but we couldn't present it to the members."* (MA, 30, female, urban, social work)

Another mode of information sharing is through sharing of client or programmatic data between agencies. However, as emphasized by one information, data was just aggregated into a report, but there was no opportunity to discuss what the data meant for the drug rehabilitation program:

> *"Back in 2018, the focal person hadn't been established yet. So at that time, we, I, because our office is the secretariat, I had to visit every office and ask for reports. So during that time, I went to the [police], asked them for their report, and then after some time, [police] went to me asking for our data on drug surrenderers because they needed that to accomplish a report. But that's it, we never really got to sit down and talk about it."* (MA, 30, female, urban, social work)

Cooperation and coordination pertain to more structured but less formal type of partnership arrangements between agencies. The hallmark of cooperation and coordination is the institution

of joint activities (e.g., client referral and follow-up) to change procedures to make the program more successful.

In the study sites, cooperation was exemplified by the partnership between the social work office in the urban area with several agencies so that they can manage individuals referred to them for provision of rehabilitation services. Activities involved handling of client referrals from the court and jail, as well as linking clients with, for example, the health agency:

> *"Because like with BJMP, that's where the clients initially come from. RTC, on the other hand, instructs them to bring the clients to us. So that's how it started, that BJMP is responsible for bringing the client to me. And before, when we were looking for a program to run, that's when we discovered that the RHU, other than being invited as speakers for our program, also conduct their own program on that. As for the others, the program just expanded because we would discover from another office, let's say the CHO that, "Before we started the community-based [program], we initially went to the barangays for drug clearing together with the PNP and IMA." So that's how we expanded our connections."* (MA, 30, female, urban, social work)

Another social worker in the urban area shared how her office worked with the police for the provision of food supplies as well as psychosocial interventions for case referrals by law enforcers:

> *"And then, sometimes when I have available goods, I bring food there. And then sometimes, we are also involved in activities such as lectures especially on counselling, since they feel that this is the forte of a social worker. This is the focus of our tie-up with PNP. And then if there is someone you really need to talk to, one-on-one, even in the family, that's when we intervene."* (MT, 64, female, rural, social work)

Individuals who have completed the required program for rehabilitation are transitioned from the rehabilitation facility to other agencies for provision of aftercare and reintegration services. At this point, the rehabilitation center holds a case conference with the agencies of the locality (i.e., social work, health, police, barangay) in which the client is residing to discuss what services have been provided, and the assistance needed by the individual when he is returned to the community:

> *"We all attend the entire meeting, including the PNP. We listen to the entire discussion… It's only the social worker who leads the discussion. We only speak after the discussion regarding the things we can contribute for the clients once they get discharged."* (MC, 37, male, urban, health)

Collaboration is a more structured degree of partnership, which is typically covered by formalized agreements and/or procedures. Collaboration is the predominant degree of partnership observed in the study site, particularly as it relates to the partnership between the rehabilitation center and other agencies.

Local government units are encouraged to shoulder all or part of the expenses related to rehabilitation through a cost-sharing scheme being implemented by rehabilitation facilities. This is especially true for clients who are considered indigent, or who cannot afford to pay for such rehabilitation services. An agreement exists between the rehabilitation center and the local government unit to cover such funds transfer between agencies:

> *"In 2016, we came up with a memorandum of agreement with some local government units. We prioritized the localities where a lot of our referrals come from since the MOA that we have perfected will also be the basis of their payment."* (FO, 54 male, urban, rehabilitation center)

Another form of collaboration was between the rehabilitation center and the education department for the provision of alternative learning interventions to admitted clients who required educational services:

> *"[T]here was… a need for ALS program in … in our center, so what I did was to confer with our chief of hospital … about this. And then I explored with the division of schools… So I inquired with them and they said that they can provide ALS program in our center but we started first with a MOA, so a memorandum of agreement. So we drafted the MOA and then ah, our chief of hospital signed it and then the division of school superintendent. And after we had the MOA, they assigned an ALS-accredited teacher. So that was starting late 2017."* (JA, 59, female, urban, rehabilitation center)

The rehabilitation center in the rural site also entered into a collaborative partnership with a psychiatric hospital for the provision of consultation services and medications for admitted residents who had a co-occurring psychiatric disorder:

> *"[W]e had a MOA before. We were to provide services to them, at the same time, also provide medications... [T]hey asked our psychologist to go there because they need counseling for their patients but our offer of medications continued. And we were able to train their doctors … [s]o, they have an idea on how to manage patients taking anti-psychotic or antidepressant medications. So, right now, we provide medicines to them."* (ME, 63, female, rural, health)

Meanwhile, the rehabilitation center in the urban area has a continuing collaboration with the religious sector for the provision of spiritual services to admitted residents. Such partnership was with different religious denominations, depending on the population of clients in the rehabilitation center. One informant was from a Christian group:

> *"I also started there when it started in 2017, and I was accommodated as a spiritual provider but that was through a memorandum of understanding (MOU)… My partnership is through the memorandum of understanding. The MOU and the department that I belong to is the psych department."* (VS, 48, male, urban, religious group)

Sub-theme 3.2. Level

Level pertains to the focus of the partnership arrangement, which can be of two categories. Service-level means that the activities are mainly directed towards improving provision of services to the client, while system-level partnerships, which is focused on improving the administration of the program, as well as policy formulation and implementation.

In the study sites, most of the activities were at the service level, although it appears that there were attempts to have system-level partnerships by way of the local anti-drug abuse councils.

Activities under the service level include direct service provision to clients in the form of, for example, the partnership between the rehabilitation center and the education department for provision of educational services for individuals who were not able to complete formal schooling:

> *"So I decided there was a need for ALS program in our center because we had admissions, basically our patients, our residents who did not finish elementary and high school. then I explored with the division of schools, city division of schools here in [the city]. So I inquired with them and they said that they can provide ALS program in our center."* (JA, 59, female, urban, rehabilitation center)

Partnership between the rehabilitation center and four other agencies involved skills training and

livelihood education (e.g., meat processing, business registration, livestock) for residents to prepare them for economic opportunities that they can explore upon discharge:

> *"...[W]hile inside ... they are also taught skills like welding and other programs offered by TESDA. This is in preparation for when they leave the reformation house so at least they would have somewhere to go. We also have a communication with DOLE so they could get a job when they leave the facility."* (LB, 37, female, public health, rural)

> *"When TESDA comes in to give a lecture, they also bring with them their materials and training equipment. But we provide the materials our clients will be using. For example, when they are going to teach food processing like how to make longganisa, we provide the meat that our clients will use to prepare the longganisa."* (DR, 40, m, urban, anti-drug abuse council)

> *"So ... we usually schedule the lectures of DTI in the first and second quarters of the year and the Department of Agriculture in the third and fourth quarters of the year. So like December, we have a forthcoming lecture. Like with DTI, they usually lecture on entrepreneurship, ah starting a business, and the like. Related to commerce, that's it. And then like, registering business name, those kinds of things. How to grow a small business, those are the things lecture on. And there is also one on financial literacy, money management, which they've included in their lectures. And with the Department of Agriculture, we invite a DA specialist to talk about like last time ah mush-, last quarter uhm, mushroom production, vegetable production."* (JA, 59, female, urban, rehabilitation center)

The health sector agencies are also involved in two ways. First is in health teaching, which is focused on prevention and health promotion for clients undergoing rehabilitation:

> *"I was involved in the smoking cessation program. I conduct health teaching sessions where I explain to the clients the importance [of smoking cessation], including the diseases caused by smoking. Similar to that, [in terms of drug rehabilitation] I explain to them about illicit drug use. Then there are other programs handled by my colleague, for instance, they talk about HIV then tuberculosis."* (MC, 37, male, urban, public health)

The second involvement of the health sector is in the provision of clinical services to individuals admitted in rehabilitation facilities, as was done by the rural rehabilitation center when it entered into a partnership with a psychiatric facility for psychiatric consultation and medicines access for individuals with co-occurring disorders:

> *"[W]e were providing medicines for their clients with mental health conditions as well as providing one of our staff, one of our doctors, used to go there, once a month, to do psychiatric follow-up… [W]e offered our services because I know they had no psychiatrist, and their problem is they are also getting patients with psychiatric problem."* (ME, 63, female, rural, public health)

In addition to direct service provision, two other activities support this theme. First is the conduct of cross-training, or the joint training of staff coming from different agencies. This occurred once, wherein agencies (i.e., social work, health, law enforcement, religious group) from the urban site participated in a training on drug rehabilitation:

> *"[W]hile we were training in 2017, [religious group] and PNP told us that they were finishing up on spiritual rehabilitation during that time"* (MA, 30, female, urban, social work)

> *"MA was with me in the seminar … that was hosted by parole and probation (PPA). And in partnership with the local government …, at the same time the DILG. We attended for*

> *six days. These are in relation on how to do the program or to reach out to those people who are into drug addiction."* (VS, 48, male, urban, religious group)

Second is the conduct of a case conference prior to the discharge of a client from the rehabilitation center. During the case conference, a social worker, health worker, police officer and barangay official from the place of residence of the client are provided a summary of the client's progress in the facility, as well as any needs during discharge to the community:

> *"We are also invited during the case conference in the [rehabilitation center], together with the police ... And with us also are the nurses from the City Health Office and the barangay officials from the barangay of the client… In the case conference, the social worker in-charge in the [rehabilitation center] will be discussing the case [of the clients] from when they got admitted until they are discharged from the center. S/he will also discuss the programs [undergone] and the developments in the client. And then after their presentation, they will ask the different agencies about what they can commit for the aftercare of the client."* (MD, 35, female, urban, social worker)

All of the aforementioned activities fall under the service-level. The closest example of system-level in the data can be found through the joint meetings conducted by the local anti-drug abuse council. System level means that the focus is on the administrative and organizational aspects of the partnership, and the local anti-drug abuse council fulfils this role to a certain extent, but not fully since most of the meetings are for sharing of status reports and accomplishments. For example, during meetings of the anti-drug abuse council in the urban site, some agencies request for funding to support operations from the provincial governor, an act which goes beyond direct service provision:

> *"When they reported before, they'd obviously focus on their accomplishments and request for assistance from the provincial government."* (PD, 27, female, rural, anti-drug abuse council)

However, since the focus of the anti-drug abuse council tends to veer towards peace and order issues, drug rehabilitation is presented as part of the agenda, but the system level initiatives for drug rehabilitation are not given much attention:

> *"No because the CADAC meeting is always held together with the peace and order council meeting and most of the time, the conversation is focused on BPOC, the one for peace and order. And when it comes to CADAC, it's more on the drug-clearing, how many barangays are drug-cleared. By the time we try inserting that, we no longer have time."* (MA, 30, female, urban, social work)

Further, there is a perception that the rehabilitation program is under the ambit and is the responsibility of the health department, as emphasized by one informant who said, *"But that is not the scope of our responsibility in CADAC anymore because that's on DOH"* (DR, 40, male, urban, anti-drug abuse council)

Sub-theme 3.3. Type

Two types of partnership were proposed in the literature. It could be categorized as of the practice, or substantive, type if the partnership activities are implemented, with or without the benefit of a partnership agreement. Meanwhile, partnerships that only exist on paper, without actual activity implementation, are categorized as symbolic, or policy, type.

In the study sites, most of the partnerships are of the substantive, or practice, type since activities are actually implemented, whether it is supported by a formal partnership agreement or not.

For instance, the partnership between the rehabilitation center and the education department is covered by a memorandum of agreement, and there is follow-through with actual provision of learning services to residents:

> *"So I inquired with them and they said that they can provide ALS program in our center but we started first with a MOA, so a memorandum of agreement. So we drafted the MOA and then ah, our chief of hospital signed it and then the division of school superintendent. And after we had the MOA, they assigned an ALS-accredited teacher."* (JA, 59, female, urban, rehabilitation center)

Likewise, a memorandum of agreement supported the implementation of skills training for residents of the rehabilitation center:

> *"So we had a MOA with TESDA and so … we pick out the TESDA trainee and then they would look for a trainer for us. And then the trainer will give us the list of materials we need to make a purchase request for. So there's a process to be followed. And then, usually they would require 25 participants for the training because they don't want to overwhelm the trainer."* (JA, 59, female, urban, rehabilitation center)

A formal agreement was also part of the engagement of the psychiatric hospital to provide service to clients of the rehabilitation center in the rural site who had co-occurring disorders:

> *"[I]f I have a resident that needs psychological evaluation. The rehab center doesn't really have a registered psychologist. We do have a MOA with a partner agency, which is [psychiatric hospital]. We refer the psych evaluation of our residents there."* (RG, 30, male, rural, rehabilitation center)

The participation of religious organizations in providing spiritual services to residents of rehabilitation centers was also covered through an agreement document:

> *"I also started there when it started in 2017, and I was accommodated as a spiritual provider but that was through an memorandum of understanding. I provide for three of their programs. For their residents and for those in-house. Graduates from there are for aftercare. Others belong to the outpatient department."* (VS, 48, male, urban, religious group)

Some partnership activities were also implemented through a letter of invitation for the other agency to attend to the needs of residents of the rehabilitation center:

> *"It's from my own initiative when I saw other residents who have a higher capacity to start their own business. Those who said they were interested … So I asked permission from the management and coordinated with DTI and DA. So we no longer needed to have a MOA with them. We just need to (cuts off) every time we need a resource speaker from them. We just need to make a letter ahead of time."* (JA, 59, female, urban, rehabilitation center)

Some activities were even implemented through direct communication between the liaison officers of two agencies, as in this description of the partnership between the social work and police department in the rural area:

> *"So, he just goes here to the office, "Oh, Ma'am, this and that.", "Okay, no problem! Sure!" It is that quick. We don't have a MOA, we don't have a deed. Because … before the rapport and working relationship were already established, prior to the existence of that program."* (MT, 64, female, rural, social work)

However, one informant disagreed and mentioned that for some areas, most of the partnerships were only of the policy, or symbolic type. This means that the partnership only exists on paper on reports, specifically the audit reports submitted to national government agencies indicating

performance of different localities with respect to addressing the drug problem:

> *"Audits are based on set indicators. This is because the present administration realized that the drug problem is not just the problem of the PNP or PDEA. What they did was they involved the local government… We asked them to submit their documents and the programs they implemented to their respective DILG officers. Those who get a high score based on the set indicators are recognized and given incentives. Those who receive a low score, sometimes they are asked to come down to the office or are given a show-cause order by the DILG central office to call their attention regarding their irresponsibility and their being non-performing local government unit with regards to the anti-drug campaign."* (AM, 35, male, rural, anti-drug abuse council)

> *"What's actually happening is, it's all on paper, that's what happens. So, they have a mode of verification, they show proof of this but then in practice, they don't actually do it, Sir. That's what's happening, it's all on paper… [E]ven the local chief executive is not prioritizing the anti-drug campaign, especially the treatment and rehabilitation. On paper, it shows that they are spending [but there is no actual implementation]. In that case, there really won't be any improvement."* (GG, 42, male, law enforcement)

Another example of the symbolic type is the lack of follow-through to the promised financial support from local government units when it comes to cost-sharing for the expenses incurred for the rehabilitation of their constituents. While an agreement exists between the local government and the rehabilitation center for this purpose, actual transfer of funds will depend on the available budget of the local government unit:

> *"[W]e came up with a memorandum of agreement with some local government units. We prioritized the localities where a lot of our referrals come from since the MOA that we have perfected will also be the basis of their payment…*

> *"There are LGUs which fully support those coming from their municipalities but there are also those which have a hard time doing so due to their limited IRA. Therefore, they are unable to give 100% support to their constituents undergoing rehab… In my opinion, it [also] depends on their priority."* (FO, 54, male, urban, rehabilitation center)

6.3.4. Theme 4: Push and pull

This theme addresses the question on the challenges to collaboration experienced by the participating agencies.

The performance of different partnership arrangements is influenced by push (i.e., barriers) or pull (i.e., facilitators) factors, which are important considerations in the formulation of policies and programs related to interagency partnerships in drug treatment and rehabilitation. Specifically, this means harnessing or leveraging facilitating factors to promote interagency partnerships, while at the same time addressing or minimizing the effects of barriers. This theme shall present these push and pull factors at the contextual, organizational, staff, and client levels. Of note, policy and political issues shall be presented as a separate theme as these two factors can be considered as extraordinary events that affected the partnership arrangements.

The push and pull factors are summarized in the table on the next page, and discussed in the succeeding paragraphs.

Table 6-7. Push and pull factors to interagency partnerships

	Pull (facilitator)	Push (barrier)
Contextual	• Availability of resources • History of working together	• Competing programs • Trust with law enforcers
Organizational	• Leadership • Presence of boundary spanners • Communications system	• Staffing • Lack of cross-training
Staff	• Attitude towards collaboration • Male gender • Prior history of working with other agency counterparts	• Differences in professional orientation • Willingness to work with drug dependents • Female gender
Client	• Attitude towards collaboration	• Place of residence • Trust with provider

Sub-theme 4.1. Pull: Contextual level

Contextual level factors refer to those found in the broader environment in which the participating agencies are embedded.

The availability of resources to support drug treatment and rehabilitation facilitated collaboration of agencies as this ensured that agencies will be able to contribute to the services required by clients. Specifically, this refers to resource support provided by the national or local government:

> *"We have a separate budget in the city... In the past 3 years, the city … has allocated 3.5 million pesos for its anti-drug activities… It is different [from the budget of different agencies for their respective anti-drug activities]."* (DR, 40, male, urban, anti-drug abuse council)

> *"All funds come from the LGU. It is up to them how they can provide livelihood assistance and conduct their respective programs."* (GA, 42, male, urban, law enforcement)

> *"For us, although all agencies are just within the neighboring municipalities, we can easily access and communicate with their mayor, especially when we need something for our clients. If there are several clients from a certain municipality, we call for a donation."* (EB, 39, female, rural, rehabilitation center)

Agencies also typically have a prior history of working together outside of the drug rehabilitation field, which means that relationships are already established, and mandates and capabilities or each party, is already known to other organizations:

> *"[I]t's a known responsibility of the PNP. That's why they get used to us as their patients. We always bring clients to them. Compared to a store, it's like we're a regular customer… They're used to it. They're really used to it… Sometimes, we get to see each other during seminars. Government employees and officials who we know are also there."* (ED, 54, male, rural, law enforcement)

Sub-theme 4.2. Pull: Organizational level

At the organizational level, leadership, the presence of boundary spanners, and a communications system were deemed facilitators to collaboration.

Leadership is manifested in terms of the support of the head of the agency for activities supporting drug treatment and rehabilitation, as indicated by the education specialist in the urban area when referring to the head of the drug rehabilitation center:

> *"[W]e didn't have any problem. The good thing was when their leader makes a request for us to conduct a class in a Saturday because that's their only available time, they provide for the fare of our ALS teachers to help them."* (LJ, 46, female, urban, education)

Meanwhile, anti-drug abuse council focal person of the urban area expanded this to refer to all other agency heads:

> *"It is the goal of the department heads in the anti-drug abuse council for [the city] to be declared as the first drug-cleared city. That's why everyone in the LGU are very cooperative. They are quick to help whenever there are documents or human resource support needed."* (DR, 40, M, anti-drug abuse council)

This leadership should be distinguished from the leadership or mandate from chief executives (i.e., President, provincial governor, city/municipal mayor), which will be discussed in the next section.

Agency heads, however, have a broad and strategic view of the entire organization's activities, hence the *presence of boundary spanners and focal persons* who were specifically assigned to work in the area of drug rehabilitation facilitated partnerships. This is especially true since agencies also have other programs that they implement.

> *"I have a focal person to do that. I have a licensed social worker. We have too many programs and services so we need to delegate these."* (OM, 58, female, rural, social worker)

Another example is the work of counterparts from the education department and the rehabilitation center in the urban area in setting-up the educational program for client.

> From the rehabilitation center counterpart: *"[T]here was… a need for ALS program in … in our center, so what I did was to confer with our chief of hospital … about this. And then*

> *I explored with the division of schools… So I inquired with them and they said that they can provide ALS program in our center but we started first with a MOA, so a memorandum of agreement. So we drafted the MOA and then ah, our chief of hospital signed it and then the division of school superintendent. And after we had the MOA, they assigned an ALS-accredited teacher. So that was starting late 2017."* (JA, 59, female, urban, rehabilitation center)

> From the education department counterpart: *"The first thing that happened if I'm not mistaken, JA went to ask our superintendent if we can conduct an ALS program or ALS classes in the rehab. So our superintendent agreed to it and then we conducted an orientation there… Then came a lot of changes with our ALS program. We became K-12. We had another problem because our program there is only good for six months. They will not qualify for the portfolio assessment… JA called me to know what we can do about that."* (LJ, 46, female, urban, education department)

Similarly, the urban social work office had a permanent focal person in charge of liaising with the rehabilitation center:

> ***Interviewer:*** *And then, in your office, ma'am, are you the one who is really focused in there?*

> ***Interviewee:*** *Yes, just me. But sometimes, only if there are times I'm not around, then that's when there will be others who will come, but I'm really the one who is handling them.* (MD, 35, female, urban, social work)

The exchange of information on clients and services was facilitated by *formal and informal communication systems*, with the latter predominating for communication between boundary

spanners or focal persons during program implementation. As emphasized by one interviewee, "*What's really important is to have communications regardless of who we're going to interact with*" (OM, 58, female, rural, social work).

Agencies may have published directories that can be referred to when the need for communication arises. For instance, the courts make available their telephone number and email addresses that agencies can use for contacting them:

> *"Yes, we have the numbers of every court office and every branch of the court. We also have their email. So through that, we are able to follow-up."* (RG, 30, male, rural, rehabilitation center)

Meanwhile, the public health staff also has access to a directory of other agencies as reference:

> **Interviewee:** *Each agency has one person who is assigned to oversee. Hence, when I want something, for example, from the DSWD for a certain program to be enacted, I know who to contact. So, there weren't any problems with coordination.*
>
> **Interviewer:** *You can just directly call or text him/her?*
>
> **Interviewee:** *Yes.* (MV, 32, *female*, urban public health)

Informal communication systems, on the other hand, involve direct communication between staff of agencies, usually by sharing their personal number, as in the case of the rehabilitation center focal person and her counterpart in the livelihood training provider:

> *"For instance, with TESDA, I will give my number to the trainer. The trainer would then contact me or they would give the trainer's number to me so I can contact them."* (JA, 59, female, urban, rehabilitation center)

Similarly, the social worker of the rural area has direct contact with the social worker in the rehabilitation center in case referrals had to be made:

> *"[W]e have their [social worker in rehabilitation center] contact number. Sometimes, even our LCE would contact them, especially when it's after working hours. For instance, when there are clients who suddenly need to be transferred."* (OM, 58, female, rural, social work)

Sub-theme 4.3. Pull: Staff level

At the staff level, interviewees appeared to have a positive, or at least neutral, attitude towards collaborating with other agencies.

One example is the teacher from the education department who was assigned to handle learning activities inside the rehabilitation center:

> *"It was late 2017, early 2018, when we were just starting to provide the ALS program to drug dependents. So this ALS teacher was excited to be assigned to a drug rehab facility. Because he said, this is new, to cater to ALS learners who are recovering drug addicts. That's why he was happy to be assigned to our center."* (JA, 59, female, urban, rehabilitation center)

Male gender was considered as facilitating factor at the staff level since most, if not all, of the clients in rehabilitation centers are men. Hence, there was a preference for male counterpart from other agencies, especially those who directly interact or handle clients undergoing rehabilitation:

> *"I chose a male teacher for that because [JA] said that the learners are mostly men."* (LJ, 46, female, urban, education department)

> *"[T]here are two of us who handle the drug program... The other member is a male... Hence, during situations where one of us is needed in the rehabilitation center, it is him who goes. It is him who is sent to the area because he is a male."* (MV, 32, female, urban, public health)

In addition, prior experience of working with other agencies also facilitated collaboration as the individual staff already had working knowledge on how to interact with colleagues from another department:

> *"Actually, the one who manned the [reformation center] right here in our camp, that I worked with before when I was a Social Worker in [another town], he was our Chief of Police. So, when he moved here to the province, and he was given the responsibility for the [reformation center], and then I was the [head social worker], it really seemed like our working relationship was already established even before."* (MT, 64, female, rural, social worker)

Sub-theme 4.4. Pull: Client level

While clients did not have any direct involvement in interagency collaboration except for one. All other clients mentioned that they recalled meeting personnel of different agencies from the time of intake through to aftercare but could not recall having experienced an instance in which they were told, or where they witnessed, the agencies working together.

> *"It happened while at court. The judge, together with the police and social worker, talked to me and my family. The judge explained about my treatment because he is aware of the management in [rural rehabilitation center]. He said that if I continued to show good behavior, I can expect to finish the program in approximately a year. The police also gave some advice while the social worker was listening... It was the judge who personally called*

> *[rehabilitation center staff] that I will be transferred to [rural rehabilitation center]."* (ER, 23, male, rural, client)

This same client had a neutral attitude towards the process, in general:

> *"All other clients mentioned that they recalled meeting personnel of different agencies from the time of intake through to aftercare but could not recall having experienced an instance in which they were told, or where they witnessed, the agencies working together."* (ER, 23, male, rural, client)

Sub-theme 4.5. Push: Contextual level

Competing programs and trust with law enforcers were identified as contextual-level barriers to collaboration.

With the exception of the drug treatment and rehabilitation center, all other agencies mentioned that addressing the drug problem, in general, and contributing to drug rehabilitation efforts specifically, only formed part of their mandate. The availability of their staff to work with other agencies on drug rehabilitation activities was dependent on the other programs and projects that they need to implement, or as one respondent mentioned, *"each has their own work to do"* (OM, 58, female, rural, social work).

One example is the delay in the transfer of clients from one agency to another because the necessary release papers from the court have not yet been issued:

> *"[F]or example, a resident of ours is already for discharge. They've already completed the program so we've already written to the court that the patient is for discharge. Supposedly, it takes three to four business days to make the letter saying that the release*

> *form is approved or granted. Sometimes, that's the only thing that we wait for, and it takes weeks. We encountered a time when it was months, the patient really waited months so they could get out. But that happens, they said the judge was on vacation, and there were other cases wherein the original judge was transferred, and a new judge is now in charge. Those kinds of circumstances… The aftercare program still starts while he is still inside."* (RG, 30, male, rural, rehabilitation center)

Sometimes, case conferences for clients who are scheduled for discharge proceed even in the absence of other agency representatives, who are engaged with other work, so as not to delay the proceedings:

> *"[M]aybe … they became busy… That's why sometimes, the social workers in-charge in the rehab center will just tell us, "Let's just proceed, ma'am, so that this will be over. Because [if not], the program of the client will just get prolonged, and he will not graduate."* (MD, 35, female, urban, social work)

As will be discussed in the next theme, another competing program were the initiatives that arose as a result of the pandemic situation.

Another context-level barrier was the perception of law enforcers, particularly their role in the drug campaign, which affects the willingness of other agencies to work with law enforcers, as well as clients' willingness to continue with rehabilitation. For example:

> *"[D]uring the first time we were running the program with the PNP involved, when we interviewed them in the office, we asked them what they want to learn, "we want to learn about the law." So our understanding when we heard the law is that maybe we should invite the PNP. And after the PNP left, I asked for feedback from the participants. They said, "Why did they take pictures of us? Are they going arrest us again? Why do they have*

> *to be here?" So there is fear when they see the police. They'd start thinking, "Why are they here? Are they going to arrest us again, have we done something wrong?"* (MA, 30, female, urban, social work)

Another informant from the education field mentioned having lack of trust with law enforcers:

> *"We do not really coordinate often with the PNP. This is because, and I want to be honest with you, we do not trust our uniformed policemen brothers. I told him [police provincial commander] of our misgivings towards the PNP." That is the reality in the field."* (RC, 55, male, rural, education)

This perspective, however, is not true for all participants or agencies. For example, one social worker shared that she has been working with law enforcers for a good number of years:

> *"[T]he performance of our PNP is really [good], people are not [afraid]. Maybe many years before when people are afraid of the police, they are afraid of the military. Then people were aloof from the military. But now, no. The trust of our countrymen is also in the police because they also have a good accomplishment ... So, what happened is that the people's trust in the men in uniform returned. So no, the fear was lost, that if they should be trusted, no. We don't have that problem in [the province]."* (MT, 64, female, rural, social work)

Sub-theme 4.6. Push: Organizational level

Staffing and lack of cross-training were deemed barriers to collaboration.

Staffing pertains to turnover of staff assigned to handle the drug rehabilitation program:

> *"[T]he entire time I handled the program, they were the ones I talked to. Unlike with the other offices, sometimes I don't know who I should be speaking with. Because like the PNP,*

> *they get assigned to different areas when they get promoted. So the person I talk to constantly changes."* (MA, 30, female, urban, social work)

This can also pertain to limited number of staff, as in the case of psychologists:

> *"[T]he same happens with the results of the interpretations of the psychological tests… [W]e forward it to the psychologist in the mental hospital for checking. I guess they also have a lot of things to do, they don't immediately return the corrections of our interpretations. But the final checking is our basis for the interventions that we will do… I think there are only a few licensed psychologists.* (RG, 30, male, rural rehabilitation center)

Aside from psychologists, there also appears to be a lack in terms of the agency representatives who can liaise with barangay officials:

> *"It would be good if we could have a liaison officer for every agency in the barangay. We already have one from the CSWD. But I hope that the other agencies would also have liaison officers who may be able to help. So that the barangay can have a good [coordination] when it comes to drugs. And of course, in terms of information dissemination, especially for the PDEA, the PNP, the Intel, I hope that we can get information so that we can immediately take actions. [Right now], we don't even know that there are laboratories in our barangay because we are not aware, those kinds of things."* (AT, 49, male, urban, rehabilitation center)

Assessment of persons suspected of using drugs (i.e., for drug dependency) at the community level is also limited by the availability of trained physicians:

> *"As for the challenges, it would first be on the budget. Though not a major factor, there is a bit of limitation with the budget. Second would be our trained doctors before. So we had a limited number of doctors trained to assess the patients. Before, we only had three available doctors... So, it would have been better if we had more doctors so we can reach*

> *out to more people. And it would also be great if we can involve the private sector or the private physicians to help widen the reach of this program for the drug surrenderers. So that's basically the problem we had."* (LB, 37, female, rural, public health)

Cross-training when the urban area agencies were setting-up their program in 2018. As will be elaborated in the next section, cross-training was deemed important for agencies to share the same perspective, or at least understand, the nature of drug dependence.

Sub-theme 4.7. Push: Staff level

At the staff level, one barrier is the difference in perspective on drug addiction, particularly on the relapsing nature of addiction. This difference in perspective affects a staff's attitude towards drug dependents, and the treatment of such individuals who are found to be on their subsequent violation of the prohibition on drug use as provided in Republic Act No. 9165.

As emphasized by one law enforcer, there is a gap in the understanding of relapse between law enforcement agencies and those working in the rehabilitation field:

> *Actually, all of them, or most of them, do not share the same views. Others would think "these people have already been given treatment and rehabilitation, why did they come back? Because it's not effective." Okay, that's their mentality, but me—although I'm not from the health sector, I have formal training and I learned that. I learned that … relapse, are parts of recovery and we can't avoid having relapse, that's why there is relapse prevention. So, that's the problem of law enforcers like me at the PDEA and the police is that they get mad, "You never learn. You've already been reprimanded but you keep doing it." It's because they don't understand that it's not easy to undergo treatment and rehabilitation. Every time I lecture, when I give preventive education programs in schools*

and in the community, I tell them, the drug users, once they stop using drugs, they feel a lot of pain. It's as if they had their arm cut up without anesthesia. So, as much as they can tolerate it, they would. But if it comes to a point that they can't anymore, the only thing—the only solution for the pain is to take drugs again. That's when relapse comes in. And what's even more painful, a lot of law enforcers don't understand that. So, maybe there's a need to have a better understanding, for law enforcers like me, when it comes to treatment and rehabilitation, not just law enforcement." (GG, 42, male, rural, law enforcement)

The willingness to work with other agencies involved in drug rehabilitation, in particular to directly interface with clients, affects partnership. There was one instance reported in the course of data collection, where a female trainer on livelihood reported being "scared" of teaching inside the rehabilitation center:

Like there was an instance before where they were scared. I just picked it up from TESDA that maybe they were scared to provide training. I just picked it up from one female trainer for bread and pastry. We did that first in 2017. The bread and pastry. So of course, the trainer being female, her safety became one of the questions… [O]f course we told them that it's a controlled environment. Aside from us, staff of the female, the staff of occupational therapy, we have house parents who are like bouncers who will stand guard. (JA, 59, female, urban, rehabilitation center)

There were also reports of judges being "biased" against drug dependents:

"Some judges do not seem interested at all while some delay the hearing… Regarding this, there were rumors that a certain judge is biased against drug-users since his daughter was raped by a drug-user before." (ER, 23, male, rural, client)

Sub-theme 4.8. Push: Client level

The client's place of residence, specifically the distance from the service provider, affects their participation in collaborative activities of different agencies. In the preceding section, it was mentioned that some clients do not have money to cover transportation costs.

> *"But when it comes to us, because the clients know we aren't that strict, sometimes you'd call them for a session but they wouldn't even report or when they do appear, they'd be in a hurry even though they just had one session. The client wants to finish the three sessions immediately so he/she can work in Manila."* (MA, 30, female, urban, social work)

Some clients also reported having trust issues with providers, specifically law enforcers. The story of one client is an example, who indicated different experiences in the hands of arresting officers (i.e., the police) and the jail staff:

> *"With the police, you really can't defend yourself. There was a part that was like a hazing of some sorts where it got physical. But this never happened with the BJMP. Because [I feel safer] with the BJMP than with the police."* (PN, 29, male, rural, client)

6.3.5. Theme 5: Politics and pandemic

The larger context in which organizations operate have an impact on the purpose and nature of partnerships thus formed. In this study, the political climate following the 2016 national elections, and the occurrence of the COVID-19 pandemic in early 2020 affected collaboration between agencies. These are discussed separately from the preceding theme as these two events can be considered extraordinary circumstances in the sense that they may be events that will be hard to replicate in other contexts.

Sub-theme 5.1. Political climate

The political climate especially after the election of the new government in 2016 drove agencies work together as there was also a consequent increase in demand for drug treatment and rehabilitation services:

> *"[I]n 2016, Duterte became president, right? So, between that time when he started until his first year as president, the number of clients enrolling in rehab centers had declined instead of rising. This is based on the experience of other rehab centers as we were still new at that time. In 2017, when the flow from the community to the rehab centers became clearer, the number of rehab clients began increasing. However, when the aggressiveness of the Tokhang operation diminished, the number of cases also declined. It increased once again when the plea bargain started in the middle of 2018 or 2019. I do not remember well but it was then when it upsurged again due to the compulsory rehabilitation for those coming from plea bargain."* (FO, 54, male, urban, rehabilitation center)

One aspect that improved was the unification of the watchlist of drug personalities being maintained by the police and the drug enforcement agency, which facilitated identification and monitoring of those who were already provided services:

> *"Right now, we just have one. We now have a unified PDEA-PNP watchlist. So, that has been one of the improvements. Most of all, before 2016 ... [w]e don't have complete information about Juan dela Cruz, where he lives, maybe we just have the area where he's a resident but the other information—the birthday, marital status, current occupation, we have nothing. But in 2016, the influx of surrenderers in 2016, we were able to identify who they are, who are currently using, who has past history of use, who used to do it before and still continues to do it now. I would say, that's one of the major accomplishments of this administration. It's because they have been identified properly, there has been—what you*

> *call—the profile of the drug surrenderers who didn't have profiles before."* (GG, 42, male, rural, law enforcement)

Agencies at the local government unit level also started to be more active in participating in the drug program:

> *"When the barangay drug clearing was implemented before, they only cooperated for compliance, but they were not enthusiastic. Now, the war on drugs is the flagship program of the government and the measure of its success is the drug-cleared barangays. They started to actively participate then. The municipalities were even racing each other to be cleared."* (GA, 42, male, urban, law enforcement)

Another change was the clarification on the type of service required, hence the agencies involved, depending on the severity of drug dependence:

> *"[A]t the start of the current administration, in 2016 or 2017, those arrested for illegal drugs are automatically imprisoned. Once caught, they are imprisoned. That was the process. Now, what the national government does is those that are caught are checked. There is a process they go through. There are levels to their drug use; mild, moderate, or severe. If they are determined to have mild use, the interventions are less rigorous, such as community service or some spiritual activities. If the symptoms or the drug use are more severe, they undergo a longer process in the Bahay Pag-asa [transformation center]. I don't think this was done as systematically in the past administrations. We really have processes that we go through, because in the present administration, they crafted the community-based drug rehabilitation program which addresses the drug problem collectively and isn't reliant on PDEA, PNP or the government alone. It also includes the community.*" (AM, 35, male, rural, anti-drug abuse council)

Sub-theme 5.2. Pandemic situation

The pandemic, which started in 2020, affected the provision of drug treatment and rehabilitation services, as well as the capacity of different agencies to engage with each other during this period. Principally, this related to a shift in priorities for the different agencies, which were now focused on addressing the pandemic situation:

> *"The distinct challenge that I can see is the prioritization, since we all know that COVID-19 [is the priority], so instead of the anti-drug campaign, [the focus] is kind of shifted toward the health sector, to the COVID-19 response, the construction of isolation facilities, the distribution of relief goods, and all other social services… Prioritization [becomes a challenge] which is understandable given the situation."* (AM, 35, male, rural, anti-drug abuse council)

Since most offices adopted a bubble arrangement, physical interaction of staff between different agencies, and between staff and client, had to be limited, which resulted to a reduction in the number of rehabilitation-related activities that could be offered.

Waiting time for admission was prolonged as the number of clients who could be admitted became limited and additional testing protocols were put in place:

> *"But because of this pandemic, admitting individuals to the rehab program became harder. Unlike before when the accused could undergo rehab immediately. We now have to follow the DOH protocol. I think only ten people at a time is allowed to be admitted to the rehab center. The other accused have to wait for their turn. A lot of requirements are needed when you undergo rehab."* (AB, 52, male, urban, court)

Another example is that the health teaching for clients undergoing rehabilitation in the urban site had to be halted:

> *"[R]egarding the health teaching, we were no longer able to conduct one. The clients are also afraid of going to our office in the RHU since that's where we also do swab testing. Hence, we do not carry out this activity in the meantime."* (MC, 37, male, urban, public health)

Other agencies, meanwhile, were involved in other pandemic-related activities:

> *"The only problem we encounter during the pandemic is the case conference since it is now conducted online. So sometimes we are no longer complete… [S]ometimes it's just me in [social work department], and then the client then the family of the client. Like that, sometimes the PNP, and then me. It's not that much, you know, unlike when we really had to go there in the center, we're complete… [M]aybe it's because of network [issues] or they became busy, especially the PNP."* (MD, 35, female, urban, social work)

The rehabilitation center itself was affected by the pandemic, and had to limit admission of clients:

> *"One issue that emerged then was there was a COVID outbreak in the DOH rehab center. One of their doctors died. And they said that the virus was very virulent. Almost 50% of their personnel were infected. That led to problems with the accused that were supposed to undergo rehab. Meanwhile, if the accused were to be brought there, they might die."* (AB, 52, male, urban, court)

One positive aspect that emerged from the pandemic, however, was the attendance to meetings of different agency heads. Specifically, because of the possibility of attending meetings remotely, the participation rate increased as compared to the pre-pandemic period:

> *"The challenge we faced was when we were still doing face-to-face [meetings], we found it difficult to keep the attendance [high]. The members would have several meetings or had simultaneous programs or activities they were working on to the point that it was hard for*

> *them to even send a representative. In a way, this has improved because we can do the meeting virtually via Zoom. That's it. So wherever they are and at any time, they can join for as long as they have a gadget with them, so that's it."* (PD, 27, female, rural, anti-drug abuse council)

6.4. Reflections on Themes

The foregoing data reflects the two-pronged strategy adopted under Republic Act No. 9165, or the Comprehensive Dangerous Drugs Act of 2002, which emphasizes a balance between demand and supply reduction strategies. That is, law enforcement approaches would be used to address drug trafficking, while rehabilitation would serve as the mechanism to eventually reintegrate individuals who use drugs back into society.

More specifically, prohibition appears to be the predominant position taken by informants from the law enforcement as well as executive offices, which is aligned with their mandate under Republic Act No. 9165. According to this Act, manufacture, trafficking, possession, and subsequent offenses related to use are punishable by both imprisonment, which can range from a few months to a life term, and fine. Following the Supreme Court's decision in the 2017 case of *Estipona vs. Hon. Frank E. Lobrigo* (Resolution G.R. No. 226679), individuals caught in possession of small quantities of drugs may plead to a lesser offense to reduce their penalties, which results to commutation of sentence to rehabilitation. Meanwhile, rehabilitation, which appears to be the perspective of professions directly involved in handling drug personalities during the rehabilitation process, is the course of action taken for an individual's offense related to drug use when processed in accordance with Republic Act No. 9165. This will result to commitment to a rehabilitation program for a minimum of six months, followed by 18 months of

aftercare, depending on the severity of drug dependence. The description of the rehabilitation program by the respondents, mainly in the health and social work fields, points to a combination of medical, behavioral, and social support activities that are intended to help the drug user reintegrate into the community at a later time, and has some features of harm reduction (i.e., non-judgmental service provision, as reflected in the use of the term "resident" when referring to drug users undergoing rehabilitation). Rehabilitation in this sense also has some feature of medicalization, although this was not explicitly mentioned during the interviews, as detoxification is offered as part of the initial service provided to individuals exhibiting withdrawal symptoms as indicated in DDB Board Regulation No. 7, series of 2019.

It is important to note that, while law enforcers agree to the provision of rehabilitation services, it is only limited to an individual's first offense for drug use. This means that for subsequent offenses, a drug user, as provided under Republic Act No. 9165, will be incarcerated instead of rehabilitated, a position which does not align with the current understanding of addiction as a chronic, relapsing condition (Volkow, Koob, & McLellan, 2016).

This difference in perspective on addiction and the rehabilitation process, while generally influenced by the current policy enshrined in Republic Act No. 9165, has an effect on the working relationship not only between service providers and clients (e.g., law enforcers and drug users), but also between providers from different agencies with different perspectives on the issue, especially as they deal with individuals who are considered as "repeat offenders." As emphasized by one informant, law enforcers have a tendency to get mad if a person is caught using drugs again, noting how these drug users have been previously given a chance to reform their ways. That is to say, the individual and organizational attitude of law enforcement agencies towards previously rehabilitated drug users is not positive. Processing of drug users who are

considered repeat offenders also is limited to law enforcement agencies and the courts, to the exclusion of other agencies who may be able to provide rehabilitation services during this period.

To address this issue, having a widely shared understanding of the relapsing nature of drug addiction, especially among agencies outside of the "helping professions", is an important first step. However, amendment to the current policy under Republic Act No. 9165 and removing the penalties for a subsequent offense under drug use would appear to have a more significant impact on changing the perspectives of different agencies on the issue of drug addiction and rehabilitation.

With reference to the second theme, three categories of purpose for partnerships were identified under this theme, namely because of resource scarcity, legitimacy, and mandate. It bears pointing out that the issue of scarcity and legitimacy fall under the ambit of resource dependence theory, while statutory and executive mandates are coercive mechanisms to attain isomorphism under institutional theory. The observation of these three reasons for collaboration in the study sites point to the possibility that partnership of agencies in the rehabilitation of persons who use drugs can be explained by both the resource dependence and institutional theories, lending credence to the suggestion in the literature that these two theories are not mutually exclusive but can actually be used simultaneously to explain the reason for interorganizational partnerships (Hillman, Withers, & Collins, 2009). Thus, institutional theory can also be used to explain partnership between agencies in the drug rehabilitation field, which is predominated currently by the resource dependence theory. This appears to be logical since organizations may be compelled or driven to work with other agencies for a variety of reasons.

From the foregoing data, it could be stated that in the base scenario (i.e., after 2002 when the

anti-drugs statute was promulgated, but before 2016 when the new administration took over), the operative purpose for partnership between agencies was a combination of resource scarcity and mandate, specifically statutory mandate. That is, agencies that bring individuals from the community to the rehabilitation center, and that take individuals from the rehabilitation center back to the community for reintegration do so in compliance with their stated roles and responsibilities under Republic Act No. 9165. Meanwhile, the rehabilitation center during this base scenario also partnered with other agencies during the period of rehabilitation to address resource scarcity, specifically as it relates to services required by residents/clients that are not available within the rehabilitation facility (e.g., education, livelihood). This can be contrasted with the period after 2016 when the drug problem was identified as a national priority agenda. At this time, additional purpose on legitimacy and executive mandate came to the fore, such that agencies wanted to both align with the directives of the President, provincial governor, or city/municipal mayor, as well as receive incentives in the form of public recognition on their work as it relates to the country's war on drugs.

Organizations directly involved in the provision of services during the period of rehabilitation, such as the rehabilitation center, social work, health, education, livelihood, and religious sectors, appear to be driven mainly by resource scarcity, and the purpose for collaboration has remained stable between these two periods. However, organizations involved in bringing in clients from the community to the rehabilitation center, and taking rehabilitated individuals from the rehabilitation facility back to the community (e.g., law enforcement, local government) appear to be more sensitive not only to executive mandates, but also addressing issues of legitimacy, especially since the incentive system did not come to the fore until the issuance of DILG Memorandum Circular No. 2018-01 in 2018, or two years after the President issued a directive

for all government agencies to work together in addressing the drug problem.

Identification of the purpose for collaboration has implications in the design of policies or programs that require interagency partnerships. Such drivers affect not only whether agencies will comply or participate in the implementation of such policy or program but will also influence the extent to which such participation will be sustained over time.

The third theme describes the actual practice of collaboration between agencies involved in drug treatment and rehabilitation. Such practice can be characterized in terms of *degree* (i.e., level of intensity and formality), *levels* (focus of the collaborative), and *type* (collaboration in policy or practice).

In terms of level, collaboration appears to be the most predominant degree as practiced by agencies involved in the process of drug rehabilitation. Collaboration refers to a partnership arrangement that is typically structured, and where autonomous agencies work together for a common goal. In the case of the study sites, the common goal is principally the completion of services required by individuals undergoing drug treatment rehabilitation. However, it appears that collaboration is mainly practiced by agencies that are directly involved in the provision of services during the rehabilitation process. Other agencies such as law enforcers and anti-drug abuse councils appear to operate at the information and communication degree, which is exemplified by joint meetings for reporting of status and updates on programs, and sharing of data on program accomplishments. Relating this to resource dependence theory, it can be surmised that agencies would want to preserve a certain degree of autonomy in their relationship with other agencies. Stated another way, the agencies appear to be involved in certain aspects of the rehabilitation process, but do so with certain limits on the centralization of management and

decision-making, which is consistent with the provision of Republic Act No. 9165, which mandates the role of different agencies, but does not go to the extent of creating a separate organization that will handle all such rehabilitation-related services.

With respect to level, partnerships were at the service level, and were focused on the provision of clinical, psychosocial, financial, educational, and spiritual services to clients undergoing rehabilitation. In addition, there were also case conferences, where the status of individuals who are for discharge from the rehabilitation center are discussed between the case manager and the counterparts in the receiving locality (i.e., social worker, health workers, police, barangay official). While there were some aspects of activities that could be attributed to system level (e.g., request for funding presented during the meeting of the anti-drug abuse council), these are quite limited to provide support a claim of the presence of service level initiatives in the study sites. One possible explanation as indicated by one informant is the perception that the rehabilitation program is "owned" by the Department of Health, and hence, the extent to which other agencies can influence the policy and program direction is perceived to be limited. Relatedly, it could be surmised that other agencies respect the "expert" view of the Department of Health when it comes to drug treatment and rehabilitation, privileging such position to the extent that other agencies do not interfere with policy formulation and implementation. This stance is supported by resource dependency theory, which posits that organizations that enter into partnership with other agencies do so with the intent of retaining their own autonomy. In this case, the limit appears to be on the provision of services only.

Lastly, on the matter of type, agency partnerships are mainly of the substantive type, which means that activities are implemented, with or without the benefit of a governing agreement. The presence of a "perfected agreement" is meant to spell out the responsibilities and expectations of

each party, and appears to be an agency requirement, especially if resources are to be shared, or staff to be assigned to another unit for a period of time. In this sense, the agreement appears to be a formality that agencies need to document the relationship between them, and such agreement strengthens the subsequent implementation of activities. While substantive type partnership is predominant, especially for agencies directly involved in the drug rehabilitation process, other agencies may be involved only at the symbolic, or policy level. This was particularly directed to local government units that were submitting reports of their accomplishments and involvement in addressing the drug problem through documentation, which one informant, who was involved in the audit of such reports, felt existed only on paper or were documented for compliance purposes only, and could be related to the incentive system being implemented to reward agencies based on their contribution to addressing the drug problem.

Overall, it can be surmised that agencies directly involved in the rehabilitation process (i.e., direct handing of drug dependents undergoing treatment and rehabilitation) tended to have partnerships that were of the collaboration degree, service level, and substantive type.

Theme four highlighted the positive, or pull, factors that can be leveraged to support interagency collaboration, as well as negative, or push, factors that should be minimized or mitigated to advance partnership between agencies.

While several factors have been mentioned in this theme, a few are worth highlighting.

Among the facilitating factors, the work done by staff, particularly boundary spanners, in linking partner organizations together, including the maintenance of a communications system, appears to be crucial in establishing and sustaining partnerships. While the formal assent by heads of offices is important in initiating partnerships, subsequent follow-through actions, including

liaising with other agencies, addressing challenges encountered, and seeking solutions to address such issues, fall within the purview of the assigned focal persons or counterparts from the partner agencies. Most of these linkages are completed through informal means such as direct communication between focal persons, which cuts through the bureaucracy had formal channels been taken. On the one hand, this highlights the importance of designating focal persons when establishing partnerships between agencies, and such focal person should be given certain discretion to address concerns about the partnership at his/her level. On the other, however, there has to be resource support (e.g., communications allowance) to enable these boundary spanners or focal persons to complete their task without resorting to mobilizing their personal resources.

Having prior history of working together, whether at the organizational or staff levels, also contributes to the functionality of partnerships as this means that organizations are aware of the mandates, capabilities, and even nuances of other agencies. This will, in turn, have an impact on the expectations between agencies, and the extent to which activities can be implemented. This may be considered as a low-hanging fruit among the facilitating factors, as there are many instances of interagency work among organizations in a given area outside of the drug rehabilitation field (e.g., child protection, peace and order).

Among the hindering factors, the perception of the role of law enforcers in the drug program appears to have the most salience since it affects the willingness of other agencies to work with law enforcers, as well as the willingness of clients to participate in joint activities with law enforcers present. Contributing to this perspective, as emphasized by one informant, is the involvement of law enforcers in the violent war on drugs, as played out in the news media, which paints police officers as having a very negative attitude towards drug personalities. Relatedly, law enforcers may also have a different professional orientation with regards drug addiction, one

that is informed by a prohibitionist perspective. Attempts at furthering interagency collaboration, then, should focus on training police officers on the rehabilitation perspective, as well as fostering dialogue between different agencies to level off on their understanding of drug addiction and how to address the drug problem.

As was mentioned in the first theme, one of the drivers or motivators for the intensification of the interagency work not only in the drug rehabilitation field, but also in addressing the drug problem overall, was the election of President Rodrigo R. Duterte in 2016, who placed the drug problem as a centerpiece of his administration's agenda, alongside poverty reduction and elimination of corruption in government. While the anti-drug statute has been in place since 1972, and was amended in 2002, the participation of agencies, especially those tasked with identifying and bringing drug personalities from the community to the rehabilitation facility, can be considered as lackluster or even lukewarm. Only after the role of these agencies, with corresponding sanctions and incentives, was spelled out in, among others, DILG Memorandum Circular No. 2017-64 and DILG Memorandum Circular No. 2018-01 was there a noticeable increase in collaborative activities resulting to a subsequent surge in demand for drug rehabilitation services. Likewise, the national mandate, which has been cascaded to the localities, resulted to mobilization of resources for the establishment of additional rehabilitation centers (e.g., the rehabilitation center in the urban site was inaugurated in 2017). In addition to compliance to a mandate, such action can be explained by the need of the agencies to demonstrate legitimacy, or that their behavior is appropriate and proper within the institutional environment in which they are operating. To the extent that the political climate of 2016 to 2022 can be considered as a boon for interagency collaboration in drug treatment and rehabilitation, it can also be argued that the end of such political events (i.e., end of term) may also result to a

later change in the participation of agencies, especially when the new dispensation shifts its focus to other concerns. While this may not be an issue for local chief executives who will be re-elected by their constituencies, the reverberations for a change in administration at the national level may be more profound. At this juncture, the effect of the election of President Ferdinand R. Marcos, Jr. this 2022 is still unknown, although he has indicated during his campaign that he will pursue the drug policy of his predecessor.

Likewise, the pandemic situation has also affected interagency collaboration, much as it has affected the work of other agencies and institutions that had to operate within the restrictions imposed to comply with minimum public health standards to prevent the spread of infection. As mentioned by informants, this has been felt more in the setting of drug rehabilitation, which can be considered as a closed and congregate setting in which infection may rapidly spread. Hence, the adoption of bubble set-up resulted to a diminution in terms of the intensity of activities between agencies, including those between personnel of agencies working together, as well as between the staff of other agencies delivering services to the residents of drug rehabilitation facilities. Another factor that affected the partnership was the shift in focus of the different agencies from addressing the drug problem, to addressing the pandemic situation in their communities. For instance, law enforcers were assigned to checkpoints to restrict movement of persons, social workers were mobilized to provide food assistance to families affected by the lockdown, and health workers were tasked with vaccinating individuals against COVID-19 (incidentally, all of these activities also affected the conduct of data collection for this research, which took place during the pandemic period). While the pandemic situation may be deemed an extraordinary event, it can be argued that it may have provided a glimpse of what will happen if organizations change their focus from the drug problem to another concern, whether it is brought

about by a natural or political event. This points to the need to ensure sustainability of partnership activities to minimize the consequences of such extraneous circumstances.

6.5. Chapter Summary

In closing, I try to answer the research questions mentioned at the beginning of this chapter.

First, the collaboration of agencies involved in the treatment and rehabilitation of persons who use drugs can be explained by their compliance with the provisions of Republic Act No. 9165 and related regulations, which defines their roles and responsibilities before, during, and after administration of a rehabilitation program (i.e., *statutory mandate*), as well as the recognition that residents of drug rehabilitation centers require services that can only be provided by other agencies (i.e., *resource scarcity*). These can be considered as the baseline scenario since the drug rehabilitation program of the Philippines has been in place since 2002 when the most recent iteration of the anti-drugs statute was promulgated. The directives of the President in 2016, cascaded to local chief executives, (i.e., *executive mandate*), coupled with the incentive system developed in 2017 (i.e., *legitimacy*), increased the participation of agencies in the drug rehabilitation process.

Second, in terms of perspective, workers in the health, social, and education fields tended to uphold the idea of rehabilitation for drug dependents. That is, they advocated for the provision of services that will address the complex needs of persons who use drugs so that they can be reintegrated into society. Likewise, their stance takes into account the chronic, relapsing nature of drug addiction. In contrast, law enforcers and executives take the prohibitionist view, and are for the enforcement of penalties for violation of Republic Act No. 9165, including imprisonment

and fine for those found to have subsequently violated the provision on drug use (i.e., penalty for subsequent offenses under Section 15 of Republic Act No. 9165). This difference in perspective affects the view of some workers and clients in terms of working with other agencies.

Third, the practice of collaboration can be described in terms of *degrees* (level of intensity and formality), time), *levels* (focus of the collaborative), and *type* (collaboration in policy or practice). In the study sites, what was observed in terms of degree were information sharing and communication, co-operation and coordination, and collaboration. In terms of level, partnership arrangements were focused on the delivery of services to clients, or were at the service-level. In terms of type, the partnerships implemented their activities, and are at the substantive type. All of these point to partnerships that were formed with the intention of retaining a certain degree of autonomy for each agency, while at the same time demonstrating to others (i.e., higher authorities) that joint activities are being implemented.

Fourth, this analysis identified challenges to collaboration at the contextual, organizational, staff, and client levels. This includes the effect of the political climate on the extent to which organizations work with each other.

Last, the COVID-19 pandemic mainly had a negative effect on the activities of different agencies, specifically a reduction in joint activities as a result of restrictions in interactions/movement, poor communications infrastructure, and the shift of attention of most agencies to pandemic-related activities.

7. Conclusion and Implications

In the Philippine – a lower-middle income Southeast Asian country where drug dependence remains an important public health concern – existing drug rehabilitation policies require collaboration between providers of drug rehabilitation service, social welfare services (including education and employment), legal services, and the private sector to ensure that the complexity of the combined medical, mental, social and legal concerns of persons who use drugs (PWUD) is adequately and properly addressed beginning from intake in the drug rehabilitation facility, through to aftercare and reintegration in the community.

The objective of this research was to describe the practice of interagency collaboration in the context of drug treatment and rehabilitation in the Philippines. Specifically, the study aimed to:

1. critically review the rationale for, understanding of, and attitude towards collaboration among agencies involved in drug treatment and rehabilitation;

2. critically review the structure and composition of, and activities in, collaborative arrangements in terms of: (1) degrees, or level of intensity and formality; (2) levels, or the focus of the collaborative; (3) type, or a distinction between collaboration on in policy and practice; and (4) stages, or the development of partnership over time;

3. identify and discuss the goals and outcomes within such collaborative arrangements;

4. determine the benefits and costs of collaboration;

5. describe the facilitators and barriers to interagency collaboration at the context, organizational, staff, and client levels; and

6. discuss the impact of the COVID-19 pandemic on different aspects of interagency collaboration.

The research objectives were addressed using a multiple case study design. For purposes of the current research, the case was taken to mean the collaboration or partnership between the selected Drug-Abuse Treatment and Rehabilitation Centers and agencies in the public health, social welfare, and criminal justice fields. Consistent with case study methodology, data were collected from multiple sources to generate case descriptions. Specifically, the following sources of evidence were examined: (i) documentation, (ii) focus group discussion, and (iii) semi-structured interviews.

Collected data were viewed through the lens of two main theories that have been used to explain the rationale for collaboration. A resource dependence perspective argues that organizations operate in a complex and uncertain environment where resource is scarce. Hence, to secure resources and enhance organizational autonomy, while maintaining legitimacy, organizations form partnerships (or interdependencies) with other related organizations. Meanwhile, institutional theory posits that the formation of collaboratives is driven by the need to be isomorphic with the institutional environment. That is, partnerships are formed either as mandated by the state through policies, statutes, or regulations; from the need to conform with the practice of other organizations in the same field of practice; or pressure from the public or stakeholders. These two theories, it has been suggested, are not mutually exclusive, but can coexist, such that organizations enter into partnerships to address both internal and external needs.

7.1. Summary of Study 1: Scoping review

A scoping review of over 5,000 records from four databases was conducted to describe the current empirical research landscape on collaboration in the context of drug treatment and rehabilitation. From the 54 papers that met the eligibility criteria, the following important findings emerged.

First, there is a preponderance of evidence emanating from a North American context concerning description or evaluation of initiatives that were instituted at the level of collaboration or cooperation. Factors that helped or hindered the implementation of these initiatives were also reported, and these were primarily those pertaining to the contextual or organizational dimensions. Since the reported initiatives were derived from grant funding, it could be argued that the reported observations and outcomes about the partnerships were "artificial" in nature in that these are short-term projects that were dependent on external funding.

Second, the reported collaborative arrangements were limited to partnership between two organizations, primarily those providing health and social services. While this may be driven by the goals of the grant mechanism, it is important to point out that such arrangements fail to capture the complexity of the often intersecting medical, social, economic and legal needs of PWUD who present for treatment and rehabilitation.

Lastly, while there have been attempts in the literature to define collaboration, and even devise a typology for the spectrum of partnership arrangements, most of the included papers in this review tended to apply the terms "cooperation", "coordination", "collaboration", and "integration" rather loosely when describing their initiatives.

7.2. Summary of Study 2: Focus Group Discussion

Seven synchronous online focus group discussions, each lasting between 60 to 90 minutes and moderated by the researcher, were conducted with a total of 27 participants (range: 2 to 8 participants each session).

In terms of the structure and composition of the collaborative arrangements, the focus group discussion showed that there was variation in terms of participating agencies in the collaborative arrangements. Among the seven groups that participated in the focus group discussions, two mentioned having two partners only, two indicated having three partners, while the remaining three groups had four or more partners. It is interesting to note that only the law enforcement agencies in both the rural and urban areas had similarities in terms of their identified partners. The extent to which other agencies were tapped or involved depended on the kinds of services needed by PWUDs and those available in the agency, or on the reportorial and administrative pathway stated in local regulations.

Two mechanisms of participation were identified. Some agencies provided direct services to individuals undergoing rehabilitation, which includes the provision of clinical, psychosocial, spiritual, educational, financial services (e.g., partnership between a drug rehabilitation facility and a hospital, or with the education department), whereas others, primarily law enforcers, only referred PWUDs to the agencies providing services, and monitored them during rehabilitation and after reintegration into the community.

The initiation and maintenance of partnerships was affected by factors at the contextual, organizational, and staff levels. Among the drivers for collaboration are the inclusion of drug

rehabilitation outcomes as an indicator for the existing incentive/reward system for local government units; shared goal that is supported by formal or informal delineation of roles and responsibilities between participating agencies; and established lines of communication, both through official and personal channels. Meanwhile, barriers included the negative image of law enforcers from both the perspective of PWUDs and providers; availability of qualified staff who can provide the requested service and coordinate the activities with other agencies; and competing programs, projects and activities that agencies needed to implement aside from addressing the needs of PWUDs.

7.3. Summary of Study 3: Individual Interviews

A total of 28 participants from drug rehabilitation centers, social work offices, law enforcement agencies, public health departments, courts, education department, anti-drug abuse council, religious groups, and former clients of drug rehabilitation centers consented to be interviewed for this study.

In terms of professional perspective, law enforcement and legal fields tended to ascribe to prohibition as an overarching approach to rehabilitation (i.e., regulation of drug use through penalties), whereas those from the “helping” professions such as health, social work, and education services favored rehabilitation (i.e., a combination of medicalization and harm reduction approaches.

Organizations had different reasons or purpose for entering into partnership arrangements with other agencies. The three reasons for collaboration observed in the data closely mirrored those mentioned in the literature. Specifically, the primary reason for collaboration is resource scarcity,

where one agency recognizes that it is not capable of providing a service to address the needs of a PWUD but is aware of another organization that is able to do so. A second reason is legitimacy, which in linked with the public recognition given by the previous administration for localities that are able to send identified PWUD to rehabilitation facilities. Lastly, informants mentioned that some partnerships are mandated by existing statutes such as the Republic Act No. 9165, as well as by the directive and pronouncements of then President Rodrigo R. Duterte who launched a nationwide campaign to address the country's drug problem.

The practice of collaboration between agencies can be characterized in terms of level of intensity, focus, and type. Based on the description given by informants, partnerships were principally at the level of either collaboration, or information sharing and communication, and the focus was on improving the provision of services at the provider-client interface. While not all of the partnerships are supported by formal documentation such as Memorandum of Agreements, nonetheless activities such as referrals and service provision were implemented.

Supporting implementation of collaborative activities included availability of resources in the partner agencies; a prior history of working together in other programs or activities, both at the institutional and individual levels; support from the head of office or agency for drug treatment and rehabilitation activities; presence of formal or informal boundary spanners or liaison officers; and availability of communication systems. Meanwhile, competing programs and priorities of agencies (i.e., programs and initiatives other than drug rehabilitation); availability of staff dedicated to providing services related to drug treatment and rehabilitation; lack of opportunity for cross-training of staff between agencies to generate shared perspectives on drug rehabilitation; and differences in professional orientation and attitude towards drug dependence.

The larger context in which the participating agencies operated also impacted partnerships, specifically with the national agenda to curb the drug problem espoused by then President Rodrigo R. Duterte during his term from 2016 to 2022. All agencies of government were mobilized to contribute to this agenda, with a consequent rise in demand for drug treatment and rehabilitation services in various localities across the country.

Lastly, the pandemic situation, which began in 2019 and resulted to the Philippines having the world's longest lockdown (extending until early 2022), also negatively affected the delivery of drug rehabilitation services, and of the implementation of partnership arrangements, due to the need to comply with minimum public health standards. Thus, there was limitation in terms of interaction between agencies, and the transfer of PWUDs from one service provider to another. This was further compounded by the mobilization of staff of other agencies to implement pandemic-related work.

7.4. Discussion

This study was initially premised on the idea that there are different approaches and perspectives to drug rehabilitation (i.e., prohibition, harm reduction, medicalization, legalization), each of which has specific philosophical basis and assumptions of the drug-use problem (Abadinsky, 2014). Relatedly, agencies, and the professionals working within each office, may bring these assumptions with them, and may affect the way they work with other partners. In this study, there was a clear delineation in perspectives between agencies involved in drug supply reduction (i.e., courts, law enforcers) and drug demand reduction (i.e., rehabilitation center, public health, social work, education, religious group), with the former espousing a prohibitionist stance while

the latter advocate for a combination of medicalization and harm reduction. The prohibitionists clearly expect drug users to be able to stop using drugs outright, and to be able to maintain abstinence after undergoing the required period of rehabilitation. Meanwhile, participants who come from agencies that have a medicalization and harm reduction perspective emphasize the chronic relapsing nature of drug addiction, and the need for developing individual agency and creating a supportive environment that will prevent relapse.

This difference in perspectives on rehabilitation on interagency collaboration influenced the willingness of agencies to work with each other. For instance, informants from the urban social work office mentioned that they try to minimize the presence of law enforcers during the rehabilitation sessions (hence, the sessions are conducted separately per agency) as some participants have expressed fear that they are being profiled by police officers. Schools are also reluctant to notify police officers of suspected drug users within their institutions, and preferring to instead refer them discreetly for rehabilitation, apprehensive of the possible harsh treatment that the drug user might face at the hands of law enforcers, particularly during the period of the government's intensified war on drugs.

It is noteworthy, however, that the actual impact of the difference in perspectives on interagency collaboration was not as large as anticipated. One possible reason, and as will be discussed in the succeeding paragraphs, is that there is a statutory and executive mandate requiring agencies to work together to address the drug problem. Hence, any difference in perspective will have to be put aside so that agencies can work towards this common goal, and this is supported by findings from the focus groups showing various configurations of partnerships between agencies. Another possible reason is that agencies have had experience working with each other previously in programs or activities outside of the drug problem (e.g., social workers, law enforcers, and

teachers jointly handling cases of children in conflict with the law), which may have allowed their staff to establish professional (and sometimes personal) working relationships with each other. In fact, this aspect of prior working experience was cited by informants in this study as an important facilitator to collaboration.

Previous studies researched interagency collaboration using two predominant theories: resource dependence or exchange, premised on resource scarcity (Guo & Acar, 2005; He, 2015, 2017; Smith & Mogro-Wilson, 2008; Welsh et al., 2016); and institutional theory (Guo & Acar, 2005; Smith & Mogro-Wilson, 2008). At the outset, this study, influenced by the work of Hillman and colleagues (2009), proposed that these two theories, while having different assumptions and concepts, are not mutually exclusive but can simultaneously explain why organizations choose to collaborate (i.e., they are not mutually exclusive). The study findings support this assertion.

In the course of the data collection, there was consistent evidence that the rationale for collaboration among agencies involved in drug treatment and rehabilitation were a combination of the need to augment unavailable, but required, services (e.g., a rehabilitation center does not have a teacher, but admitted residents need educational intervention); statutory mandate (i.e., Republic Act No. 9165 and related issuances clearly assign roles and responsibilities to each agency throughout the rehabilitation process); executive mandate (i.e., President Duterte's pronouncement that addressing the drug problem during his term is a top government priority); and modelling (e.g., some localities receiving the Seal of Good Local Governance award, which included their drug rehabilitation programs, served as benchmark for other localities). While outside of the remit of this work, it can be surmised that resource scarcity and statutory mandate were the predominant reasons for interagency collaboration since these arose from the provisions of the *Comprehensive Dangerous Drugs Act of 2002*. Executive mandate and modelling came

much later on or after 2016 after the elected government at that time declared an intensified war against illegal drugs and developed a two-pronged strategy of demand and supply reduction that required a whole-of-government approach by way of the *Philippine Anti-Illegal Drug Strategy*.

Relating the findings to the models of interagency collaboration, the partnership arrangements between agencies in the Philippines involved in drug treatment and rehabilitation can be characterized as being more informal (*degree*); focused on service delivery (*element* and *level*); at the implementation and maintenance phases (*stage*); and of the substantive *type*.

Drawing on Konrad's (199) hierarchical services integration framework, models of partnership observed in this study tended to either be at the level of information sharing and communication (e.g., different agencies reporting on their initiatives and accomplishments during the regular meeting of the local anti-drug abuse council); cooperation and coordination (e.g., referrals between the barangay officials and social work office for suspected); and collaboration (e.g., shared goal between the psychiatric hospital and rehabilitation center for common patients, but two agencies operating autonomously). It appears that there is an implicit understanding among the agencies that they need to work together even without the need for formal agreements. In fact, when the absence of signed agreements was raised with informants, they responded by saying that there was no need for one since what they are doing is part of their institution's mandate, whether seen broadly (e.g., the social work department provides case management services for referred individuals) or specifically within the drug rehabilitation process (e.g., the social work department is assigned the responsibility for managing the aftercare component).

Consistent with the degree of collaboration mentioned above, agencies were also observed to employ service provision as a means of executing collaborative arrangements (Addiction and

Mental Health Collaborative Project Steering Committee, 2015; Bolland & Wilson, 1994; Centers for Disease Control and Prevention, 2009; Claiborne & Lawson, 2005; Fletcher et al., 2009; He, 2015; Konrad, 1996; Messeri et al., 2003; Reilly, 2001; Rush, 2014; Wenzel et al., 2004). That is, the focus of the partnerships was on improving service provision at the provider-client interface. One possible reason for this is that there might be a delineation of work between the front-line provider offices from which most of the informants for study were sourced, vis-à-vis the high-level executive offices of these agencies at the national level. The prevailing anti-illegal drug law in the Philippines has created the Dangerous Drugs Board as the national policy-making body on drug-related matters, while a 2017 executive order created the Inter-agency Committee on Anti-illegal Drugs. Agencies are represented in these two bodies by government officials of cabinet-rank, and a perusal of their main functions point to system-level administration and planning activities.

With reference to the facilitators and barriers to interagency collaboration, study findings highlighted the importance of three of the four factors initially identified from the literature: contextual (i.e., broader environment external to the initiative), organizational (i.e., internal to the organization or unit involved in the initiative), and staff (i.e., knowledge, skills, and attitude of organizational personnel involved in collaboration). A few points will be highlighted in this discussion. First, as mentioned above, agencies have different perspectives on drug rehabilitation, and having a shared understanding through orientation, discussion and cross-training was deemed beneficial in strengthening partnerships. An example was the briefing for lawyers and judges given by the rehabilitation professionals, which allowed the officers of the courts to appreciate the complex nature of the drug problem that is rooted alteration of physiological pathways in the brain. Second, previous experience of agencies working together,

whether in the drug rehabilitation field or another program or activity, contributed to a smooth working relationship as there is already prior awareness the mandates, responsibilities and capabilities of each agency. This previous working experience also aided in the establishment of lines of communication, as well as identification of focal persons or boundary spanners who linked agencies with one another. Third, it bears pointing out that extraneous factors such as changes in national or institutional leadership, and emergence of other priorities (e.g., pandemic) influenced the extent to which agencies collaborated with one another positively or negatively. Thus, a strong executive mandate was identified by informants as being strongly favorable to collaboration; however, the opposite can also hold true. Further, the pandemic also resulted to a shift in priorities, with many agencies limiting their participation in drug rehabilitation activities. This, in part, may be related to the informal nature of the partnerships noted in the two cases under study, which point to a challenge in sustaining the existing institutional arrangements in the face of negative external, contextual pressures.

Lastly, this study was undertaken to contribute to a predominantly North American literature on interagency collaboration in drug treatment and rehabilitation. While the main study findings generally align with what is already known in the literature, there are key contextual differences in the Philippine setting that readers will need to consider when interpreting the study and when applying the extant literature to other settings. First, while the country's drug policy, as enshrined in the Comprehensive Dangerous Drugs Act of 2002, emphasizes the need for interagency collaboration for drug treatment and rehabilitation, its operationalization is dependent on two other policy sources: (a) subsequent regulations and issuances of different agencies such as the Dangerous Drugs Board and the Inter-agency Committee on Anti-illegal Drugs; and (b) the pronouncements and agenda of the president (i.e., the extent to which the drug

problem will be considered a priority). This means that, while there is an overarching framework for interagency collaboration that is supported by statute, its implementation over the years may vary depending on the two other policy sources (e.g., after each election cycle). Second, the Philippines, since 1991, operates on a devolved governance system where certain government services are funded and implemented by local government units at the provincial, city and municipal levels. The resource level for each locality will naturally vary and this may be an important factor affecting collaboration between agencies following the resource dependence theory's premise. Further, local chief executives (i.e., governors and mayors) also have a role to play in defining the extent to which interagency collaboration in the drug treatment and rehabilitation field are implemented in their areas of jurisdiction by specifying the executive mandate for such collaborative arrangement. Third and finally, the informal nature of collaborative arrangements observed in this study may be related to an informal, personal behavior pervasive in Philippine society in general and in the bureaucracy specifically (Hodder, 2010). Thus, informants for this study did not deem it necessary to have signed terms of reference or agreements for partnerships delivering drug treatment and rehabilitation services. Instead, there was a reliance on prior working history, implied roles and mandates, and direct lines of communication, and boundary spanners who served as liaison between the organizations. Despite the absence of formal agreements, the collaborative arrangements seemed to work, but the experience with the pandemic highlighted the fragile nature of partnerships, which could be put on hold for other institutional priorities, and which ultimately may affect the provision of services to drug dependents requiring treatment and rehabilitation.

7.5. Limitations and future study

This case study research examined interagency collaboration in the context of public drug treatment and rehabilitation centers. A public-sector focus was deliberately selected for this study since the majority of providers at the time this study was proposed were government-owned. Furthermore, the private facilities existing at the time of study proposal offered rehabilitation services drug and for other forms of addiction (e.g., alcohol, gambling), which may impact the kind of collaborative arrangements that are formed in contrast to public facilities which cater purely to drug dependents. Thus, a future direction for study is to examine collaboration from the perspective of private rehabilitation centers[2], and compare this with the collaborative arrangements of government-owned facilities identified in this study.

Following the concept of a whole-of-society approach, it is also important to recognize the potential or actual role of the commercial sector, as well as international donors, in collaborating with providers of prevention, treatment and rehabilitation services for drug addiction. Since 2016, there have been several related initiatives[3] that were intended to aid the Philippine government in its fight against illegal drugs. This is another potential avenue for future research, examining not only the components of the collaborative arrangements drawing from this study's findings, but also exploring other aspects such as the possibility of these sectors influencing drug policy (e.g., an international donor attaching a condition to a grant), as well as ethical dimensions of such partnerships (e.g., possibility of conflicting goals of the commercial sector and the health

[2] At the time of this writing, there are over 40 privately-owned drug treatment and rehabilitation centers recognized by the Philippine Department of Health (link)

[3] Examples of these initiatives are the 10,000-bed rehabilitation facility donated by Chinese philanthropist Huang Rulun and inaugurated in 2016 (PCOO, 2016); a local corporation's pledge of 1-billion pesos to establish drug rehabilitation centers (dela Paz, 2016); and a USAID-funded project to expand community-based drug rehabilitation in the country (USAID).

department's advocacy).

This study was able to determine models, including elements or components, of collaborative arrangements in the drug treatment and rehabilitation context in the Philippine setting. Outside the remit of this research, and another aspect that could be considered in the future, is the development of an instrument or tool that can measure the various aspects of collaboration in the context of drug treatment and rehabilitation, similar to the ones used in other areas of practice (Antonio & Li, 2023). This tool, in addition to capturing aspects or components of a partnership, can also be further developed to evaluate collaborative arrangements as to their functionality (e.g., Is the partnership able to operationalize all identified elements?), effectiveness (e.g., Is the partnership able to achieve its stated objectives and intended outcomes?), and appropriateness (e.g., Are the organizations at an optimal level of partnership, or are aspects of collaboration that could be maximized?). The tool can be developed using the concepts and elements identified from this research.

7.6. Implications of findings

There are several research, policy and practice implications of the findings mentioned in this paper.

First, the absence of a universally accepted definition of *collaboration*, in general as well as in the context of drug treatment and rehabilitation, as well as the frequent interchangeable use of related terms such as "cooperation" and "partnership" points to the need to arrive at a theory-informed and empirical conceptualization and definition for this concept. The research presented in this paper already laid the foundation by providing the starting point for such a definition.

That is, that collaboration can be understood in terms of the four elements of participants, partners, process, and purpose, and can be described in terms of the five dimensions of degrees, elements, levels, type, and stage. In the short-term, it would also be beneficial if researchers can be explicit in their definition and conceptualization of collaboration to facilitate collation and comparison of findings across the literature.

Second, and related to the previous point, future research may consider the development of validated tools that would measure collaboration, taking into account the components of each element and dimension of collaboration. Such tool can indicate extent to which collaboration is present and being practiced between two or more organizations through a combination of documents review, interviews and observations. One potential challenge in this regard, however, is the wide variation in terms of collaborative arrangements between different agencies operating in different contexts. As mentioned in the preceding section, the tool can also be expanded to be able to measure functionality, effectiveness, and appropriateness of a collaborative arrangement.

Third, the models of collaboration described in this paper offered a snapshot of partnerships in the context of residential drug treatment and rehabilitation in the Philippines, which was the predominant mode in force at the time that the research was conducted. As the Philippine Department of Health is preparing for the scale-up and launch of a model of community-based drug treatment and rehabilitation in the country, it might be instructive to examine collaborative arrangements from this scenario, especially since the target implementers of community-based drug rehabilitation are local government units and civil society organizations. The Drug Abuse Treatment and Rehabilitation Centers involved in this study are under the ambit of the national government, which may have, to an extent, facilitated the formation of partnerships with other agencies. Further, since PWUD who are eligible for community-based drug rehabilitation are

those considered with milder forms of drug dependence, the types, intensity and complexity of services they require may not be the same as those confined in residential facilities, who have more severe forms of drug dependence.

Fourth, since the political and policy milieu was identified as an important factor that either supported or hindered inter-agency collaboration, a follow-up study among agencies working with DATRCs may be warranted with the change in government leadership following the 2022 National and Local Elections. The current dispensation, while still keen on pursuing the country's anti-drug policy, emphasized a shift towards a more public health approach to addressing the drug problem. A follow-up study will provide information on how changes in the political and policy landscape impact implementation of interagency collaboration in the context of drug treatment and rehabilitation in the Philippines.

Fifth, in terms of policy, the Philippine government, as well as the national agencies overseeing drug treatment and rehabilitation, will need to consider the need to formulate a policy to define, clarify, operationalize and measure interagency collaboration in drug treatment and rehabilitation. This includes, among others, specifying considerations in forming partnerships (i.e., goal, purpose, and intended outcomes); identifying agencies that are mandated to participate in collaborative arrangements (i.e., which will be the lead agency, which are the partner agencies); delineating the roles and responsibilities of partner agencies (i.e., both in terms of delivering the services or sharing resources, as well as managing the partnership itself); and developing tools to monitor implementation of collaborative arrangements. Further, guidance resources will have to be developed (e.g., manuals or playbooks) to support formation and maintenance of collaborative arrangements between agencies. These resources can guide agency heads or liaison officers in more deliberately identifying partner agencies and their potential

contributions; developing the partnership model depending on combinations of elements and dimensions; and initiating linkage with potential partners. Training and education on this information on partnerships and interagency collaboration should be developed, either as stand-alone events or to be integrated in existing training activities on drug treatment and rehabilitation.

Finally, in the area of practice, agencies intending to form partnerships may want to consider the various facilitators and drivers at the contextual, organizational, staff, and client levels when forming partnerships with other agencies and organizations. At a more pragmatic level, this means, for instance, defining the expectations and potential contributions from partner institutions (e.g., whether it will be limited to referral for services, or there will be resource sharing; extent and duration of partnership); assigning dedicated staff who will serve as liaison between organizations; levelling-off expectations and organizational and professional perspectives (i.e., on drug rehabilitation) at the beginning of the partnership; and conducting periodic update meetings between partners. Use of information and communications technology, when available, can be explored to facilitate collaboration (e.g., use of videoconferencing facility when conducting meetings between agencies). Drawing on the insights from the effect of the pandemic and leadership changes, forging formal agreements between partner agencies may also be considered to minimize, if not totally avert, the potential impact of these extraneous factors on the partnership as well as the capacity to deliver services to target clients.

This study identified models of interagency collaboration in the context of drug treatment and rehabilitation in the Philippine setting. While existing practices for partnerships exist, further improvements in terms of operationalization can be considered, including a more structured approach to partnership building that is guided by national policies and guidelines. As the

Philippines pivots towards a public health approach to solving the drug problem in its attempt at a more humane and evidence-informed policy and program, the need for better practice of interagency collaboration becomes more relevant.

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APPENDICES

Appendix 1. Letter of invitation for focus group discussion

<Date>

<NAME OF HEAD OF OFFICE>
<Name of Office/Agency>
<Address>

Subject: Invitation to online group discussion, <Date of FGD>, <Time of FGD>

Dear **<NAME OF HEAD OF OFFICE>**,

I am Carl Abelardo T. Antonio, a PhD student in the Department of Applied Social Sciences, The Hong Kong Polytechnic University, where I am conducting a research titled “In search of an inter-sectoral collaborative model for drug rehabilitation in the Philippines: A case comparison study”. Further details on this project can be found in the attached project abstract.

By way of this letter, I would like to invite three (3) to four (4) representatives from your agency to a meeting/group discussion to explore the above topic. The intent of the discussion, which will last for about 60 to 90 minutes and will be conducted online using Zoom, is for me to gain an understanding of your office’s experience in collaborating with other agencies (i.e., drug rehabilitation center, social welfare, public health), and help further shape the research project that I will be undertaking.

My proposed schedule for this activity is on <Date of FGD>, <Time of FGD>. Kindly let me know if this schedule works for your personnel, otherwise we can explore an alternative date/time that is more convenient for your staff. After this, I will be providing the Zoom link and the outline of topics we will be covering during the meeting.

Please feel free to get in touch with me through this email at carl-abelardo.antonio@ if you have any questions or concerns.

Thank you very much and I am looking forward to hearing from you.

Respectfully yours,

CARL ABELARDO T. ANTONIO

PROJECT BRIEF

Project title:	In search of an inter-sectoral collaborative model for drug rehabilitation in the Philippines: A case comparison study
Researcher:	Dr. Carl Abelardo T. Antonio PhD Student, Department of Applied Social Sciences, The Hong Kong Polytechnic University
Supervisors:	*Supervisor:* Dr. Jessica CM Li *Co-Supervisor:* Dr. Judy YM Siu
Abstract:	Drug dependence is a major public health and social concern in the Philippines, a lower-middle income country in Southeast Asia. Around 2% of the population are current drug users, which is equivalent to approximately 1.8 million Filipinos aged 10 years and older. As a response, the Philippines instituted a national policy that aims to control drug supply while at the same time providing services to reintegrate drug users into society. The latter is through provision of treatment and rehabilitation services under the ambit of the Department of Health. Collaboration is a key strategy to enable organizations involved in drug treatment and rehabilitation to address the complex medical, mental, social, and legal problems confronting people who use drugs. One important challenge in treatment and rehabilitation is the fragmentation of service provision across different agencies, resulting in a weak continuum of care. The aim of this research is to describe and review the current process and framework of interagency collaboration in drug treatment and rehabilitation in the Philippines using a multiple case study design so as to propose a feasible model of collaboration. Data will be collected from multiple sources (i.e., (1) documentation, (2) focus group discussion, and (3) semi-structured interviews) to generate case descriptions of two selected cases. This research will address a research gap in the topic of collaboration in drug rehabilitation, which is predominantly North American in orientation and derived from short-term project demonstration grants, by offering a real-world perspective on collaboration from the Philippine context. This study will also serve as input to the development of guidelines in the operationalization of collaboration in the local setting as well as in other jurisdictions with similar conditions.

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Appendix 2. Letter of invitation for interview

<Date>

<NAME OF HEAD OF OFFICE>
<Name of Office/Agency>
<Address>

Dear **<NAME OF HEAD OF OFFICE>**,

I am Carl Abelardo T. Antonio, a PhD student in the Department of Applied Social Sciences, The Hong Kong Polytechnic University, where I am conducting a research titled “In search of an inter-sectoral collaborative model for drug rehabilitation in the Philippines: A case comparison study”. Further details on this project can be found in the attached project abstract.

By way of this letter, I would like to **invite you or your representative to an interview on <Date of interview>, <Time of interview>** to explore the above topic. The intent of the interview, which will last for 45 to 60 minutes and can be conducted through a phone call or via an online platform (i.e., Zoom or Google Meet), is for me to gain an understanding of your office’s experience in collaborating with other agencies (i.e., rehabilitation center, social welfare, law enforcement) involved in the drug rehabilitation field. Kindly let me know if this schedule works, otherwise we can explore an alternative date/time that is more convenient for you.

Please feel free to get in touch with me through this email at carl-abelardo.antonio@ if you have any questions or concerns.

Thank you very much and I am looking forward to hearing from you.

Respectfully yours,

CARL ABELARDO T. ANTONIO

PROJECT BRIEF

Project title:	In search of an inter-sectoral collaborative model for drug rehabilitation in the Philippines: A case comparison study
Researcher:	Dr. Carl Abelardo T. Antonio PhD Student, Department of Applied Social Sciences, The Hong Kong Polytechnic University
Supervisors:	*Supervisor:* Dr. Jessica CM Li *Co-Supervisor:* Dr. Judy YM Siu
Abstract:	Drug dependence is a major public health and social concern in the Philippines, a lower-middle income country in Southeast Asia. Around 2% of the population are current drug users, which is equivalent to approximately 1.8 million Filipinos aged 10 years and older. As a response, the Philippines instituted a national policy that aims to control drug supply while at the same time providing services to reintegrate drug users into society. The latter is through provision of treatment and rehabilitation services under the ambit of the Department of Health. Collaboration is a key strategy to enable organizations involved in drug treatment and rehabilitation to address the complex medical, mental, social, and legal problems confronting people who use drugs. One important challenge in treatment and rehabilitation is the fragmentation of service provision across different agencies, resulting in a weak continuum of care. The aim of this research is to describe and review the current process and framework of interagency collaboration in drug treatment and rehabilitation in the Philippines using a multiple case study design so as to propose a feasible model of collaboration. Data will be collected from multiple sources (i.e., (1) documentation, (2) focus group discussion, and (3) semi-structured interviews) to generate case descriptions of two selected cases. This research will address a research gap in the topic of collaboration in drug rehabilitation, which is predominantly North American in orientation and derived from short-term project demonstration grants, by offering a real-world perspective on collaboration from the Philippine context. This study will also serve as input to the development of guidelines in the operationalization of collaboration in the local setting as well as in other jurisdictions with similar conditions.

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Appendix 3. Information sheet and consent form

THE HONG KONG POLYTECHNIC UNIVERSITY
香港理工大學

INFORMATION SHEET

In search of an inter-sectoral collaborative model for drug rehabilitation in the Philippines: a case comparison study

You are invited to participate in the above project conducted by Carl Abelardo T. Antonio, who is a post-graduate student of the Department of Applied Social Sciences in The Hong Kong Polytechnic University. The project has been approved by the PolyU Institutional Review Board (PolyU IRB) (or its Delegate) (Reference Number: HSEARS20210616001).

The aims/objectives of this project to describe and review the current process and practice of interagency collaboration in drug treatment and rehabilitation in the Philippines.

You are invited to participate in an online focus group discussion, which will take you about 60 to 90 minutes, together with around five other participants. The discussion will be conducted online using Zoom platform and will be audio-recorded for purposes of analysis. The researcher will guide the discussion by offering questions related to your perceptions and practice on interagency collaboration.

The information you provide as part of the project is the research data. Any research data from which you can be identified is known as personal data. Personal data does not include data where the identity has been removed (anonymous data). We will minimize our use of personal data in the study as much as possible, specifically by refraining from asking for names or personal identifiers during the discussion proper. The researcher and his supervisor will have access to personal data and research data for the purposes of the study. Responsible members of The Hong Kong Polytechnic University may be given access for monitoring and/or audit of the research.

All information related to you will remain confidential. Audio recordings and their corresponding electronic transcriptions will be kept in a secure medium. However, since data will be collected in the form of a discussion with other participants, the researcher does not have any control over what participants may do with the information that they were able to hear from the discussion. Participants will be reminded that, while the discussion is public in nature, anonymity and confidentiality of data shared within the focus group should be maintained. The information collected will be kept for three years after project completion/publication or public release of research results. The Hong Kong Polytechnic University takes reasonable precautions to prevent the loss, misappropriation, unauthorized access or destruction of the information you provide.

You have every right to withdraw from the study before or during the discussion without penalty of any kind.

If you have any questions, you may ask the researcher now or later, even after the study has started.

You may contact Carl Abelardo T. Antonio (tel. no.: +63922892 / email: carl-abelardo.antonio@) of PolyU under the following situations:

a. if you have any other questions in relation to the study;
b. if, under very rare conditions, you become injured as a result of your participation in the study; or
c. if you want to get access to/or change your personal data before (the expiry date).

In the event you have any complaints about the conduct of this research study, you may contact Secretary, PolyU Institutional Review Board in writing (institutional.review.board@polyu.edu.hk) stating clearly the responsible person and department of this study as well as the Reference Number.

Thank you for your interest in participating in this study.

Dr. Chi Mei Jessia Li
Principal Investigator

Hung Hom Kowloon Hong Kong 香港 九龍 紅磡
Tel 電話 (852) 2766 5111 Fax 傳真 (852) 2784 3374
Email 電郵 polyu@polyu.edu.hk
Website 網址 www.polyu.edu.hk

THE HONG KONG POLYTECHNIC UNIVERSITY
香港理工大學

INFORMATION SHEET

In search of an inter-sectoral collaborative model for drug rehabilitation in the Philippines: a case comparison study

You are invited to participate in the above project conducted by Carl Abelardo T. Antonio, who is a post-graduate student of the Department of Applied Social Sciences in The Hong Kong Polytechnic University. The project has been approved by the PolyU Institutional Review Board (PolyU IRB) (or its Delegate) (Reference Number: HSEARS20210616001).

The aims/objectives of this project to describe and review the current process and practice of interagency collaboration in drug treatment and rehabilitation in the Philippines.

You are invited to participate in a semi-structured interview, which will take about an hour. The interview will be conducted online using Zoom platform and will be audio-recorded for purposes of analysis. The researcher will be asking questions related to your perceptions and practice on interagency collaboration.

The information you provide as part of the project is the research data. Any research data from which you can be identified is known as personal data. Personal data does not include data where the identity has been removed (anonymous data). We will minimize our use of personal data in the study as much as possible, specifically by refraining from asking for names or personal identifiers during the discussion proper. The researcher and his supervisor will have access to personal data and research data for the purposes of the study. Responsible members of The Hong Kong Polytechnic University may be given access for monitoring and/or audit of the research.

All information related to you will remain confidential. Audio recordings and their corresponding electronic transcriptions will be kept in a secure medium. The information collected will be kept for three years after project completion/publication or public release of research results. The Hong Kong Polytechnic University takes reasonable precautions to prevent the loss, misappropriation, unauthorized access or destruction of the information you provide.

You have every right to withdraw from the study before or during the discussion without penalty of any kind.

If you have any questions, you may ask the researcher now or later, even after the study has started.

You may contact Carl Abelardo T. Antonio (tel. no.: +63922892 / email: carl-abelardo.antonio@) of PolyU under the following situations:

d. if you have any other questions in relation to the study;
e. if, under very rare conditions, you become injured as a result of your participation in the study; or

f. if you want to get access to/or change your personal data before (the expiry date).

In the event you have any complaints about the conduct of this research study, you may contact Secretary, PolyU Institutional Review Board in writing (institutional.review.board@polyu.edu.hk) stating clearly the responsible person and department of this study as well as the Reference Number.

Thank you for your interest in participating in this study.

Dr. Chi Mei Jessia Li
Principal Investigator

Hung Hom Kowloon Hong Kong 香港 九龍 紅磡
Tel 電話 (852) 2766 5111 Fax 傳真 (852) 2784 3374
Email 電郵 polyu@polyu.edu.hk
Website 網址 www.polyu.edu.hk

THE HONG KONG POLYTECHNIC UNIVERSITY
香港理工大學

CONSENT TO PARTICIPATE IN RESEARCH

In search of an inter-sectoral collaborative model for drug rehabilitation in the Philippines: a case comparison study

I _____ hereby consent to participate in the captioned research conducted by Dr. Jessica Chi Mei Li and Carl Abelardo T. Antonio.

I understand that information obtained from this research may be used in future research and published. However, my right to privacy will be retained, i.e. my personal details will not be revealed.

The procedure as set out in the attached information sheet has been fully explained. I understand the benefit and risks involved. My participation in the project is voluntary.

I acknowledge that I have the right to question any part of the procedure and can withdraw at any time without penalty of any kind.

Name of participant _____

Signature of participant _____

Name of researcher _____

Signature of researcher _____

Date _____

Hung Hom Kowloon Hong Kong 香港 九龍 紅磡
Tel 電話 (852) 2766 5111 Fax 傳真 (852) 2784 3374
Email 電郵 polyu@polyu.edu.hk
Website 網址 www.polyu.edu.hk