RESEARCH ARTICLE

Evaluating community mental health and substance use treatment integration in the Philippines: Policy and practice implications

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ABSTRACT

Background: In recent years, both mental health (MH) and substance use (SU) have emerged as important issues among Filipinos. Not all clients need specialized services and can be treated in non-specialized settings. However, no previous study has examined integration of MH and SU in the Philippines.

Objectives: This qualitative study explored the current practices, gaps, and potential for integration of MH and SU treatment in communities.

Methodology: In-depth interviews were conducted among eight subject matter experts from five Department of Health (DOH) Centers for Health Development and three local government units. Data was analyzed using Framework analysis and the SAMHSA-HRSA Framework.

Results: Findings suggest very low levels of integration of mental health and substance use services given inadequate resources and divergent policies and governance structures. However, findings show the potential for integration of community-based drug rehabilitation (CBDR) and community-based mental health (CBMH) especially for low and moderate risk clients.

Conclusion: CBDR programs appear to be a promising model for care and lay the groundwork for implementation of CBMH. However, policy changes are needed to decriminalize drug use and implement an integrated flow for MH and SU. In addition, incorporating screening and early interventions in primary care are key to decreasing mental health inequity in the Philippines.

Keywords: *Community mental health, community-based drug rehab, dual diagnosis, integrated care, Philippines*

Introduction

Substance misuse and mental disorders co-occur at much higher rates than chance and are associated with poorer health outcomes and criminal justice system involvement [1]. Comorbid substance use in psychiatric patients in low- and middle-income countries (LMICs) range from 51% up to 69% [2]. The impact of mental, neurological, and substance use (MNS) illness is more devastating in LMICs where resources and interventions are scarce [3]. The Lancet Commission on Global Mental Health suggested efforts of collaboration and integration are especially necessary to close the treatment gap in LMICs [4]. Given limited specialists, integrating MNS services into general healthcare systems is key to access [5].

Dialogue between associations of mental health (MH) and substance use (SU) elicited a framework of the continuum of service delivery depending on severity [6]. Twenty-nine percent (29%) of people will have a low severity of substance use and mental illness (Quadrant I) and can be treated adequately within primary care. Twenty percent (20%) will have low severity of substance use but high severity of mental illness (Quadrant II) and can be treated in MH systems. Twenty-nine (29%) are in Quadrant III, with high severity of substance abuse and low severity of mental illness. These individuals can be treated in substance use treatment systems. Finally, less than a quarter (22%) are in Quadrant IV (high severity in both substance abuse

and mental illness), requiring treatment in state hospitals, prisons, emergency rooms, and integrated practices [6].

The SAMHSA-HRSA Center for Integrated Health Solutions [7] proposes six levels of integration of health care from minimal collaboration to full collaboration in a transformed/merged integrated practice. These are further divided into three main categories: (1) communication, (2) co-location, and (3) integrated. The first two levels require minimal to basic collaboration in separate locations. The third and fourth levels require physical proximity, and the last levels require integrating the practices involved in service provision (Table 1).

Substance use and Mental Health in the Philippines

Integration is important in under-resourced countries such as the Philippines, with only one (1) psychiatrist per 200,000 individuals [8] and one (1) psychologist per 100,000 individuals [9]. Psychiatric disorders are under-reported due to the extreme stigma placed on mental illness and Filipinos are much more likely to seek help from family or friends rather than trained MH professionals [10].

A study of Community Based Drug Rehabilitation (CBDR) clients found that 49% are low-risk users and of these, 86% are low risk for MH illness. The study also reports that 36% of CBDR clients are moderate-risk users and of these, 81% are low-risk for MH illness [11]. Similarly, a study looking at the quality of life and MH of people who use drugs (PWUDs) in CBDR reported a prevalence of moderate to severe psychological distress was 70% and probable post-traumatic stress disorder (PTSD) was 28% [12].

The implementation of CBDR in the Philippines appears to be more mature compared to Community-Based Mental Health (CBMH) due to the previous government's war on drugs and its policies mandating LGUs to provide CBDR, given the volume of clients who "surrendered" for treatment [13].

However, a challenge to integration is differences in perspectives of policies governing MH and SU. The Comprehensive Drugs Act in 2002 (RA 9165) criminalizes drugs, thus interventions for drug use have traditionally been handled by criminal justice or inpatient settings [14]. However, a policy that begins to acknowledge the relationship of MH and SU is the Dangerous Drug Board (DDB) Regulation No 7 of 2019 that described a client flow for drug treatment in the Philippines that contained provision for SU and MH screening for persons who use drugs [15] (Figure 1).

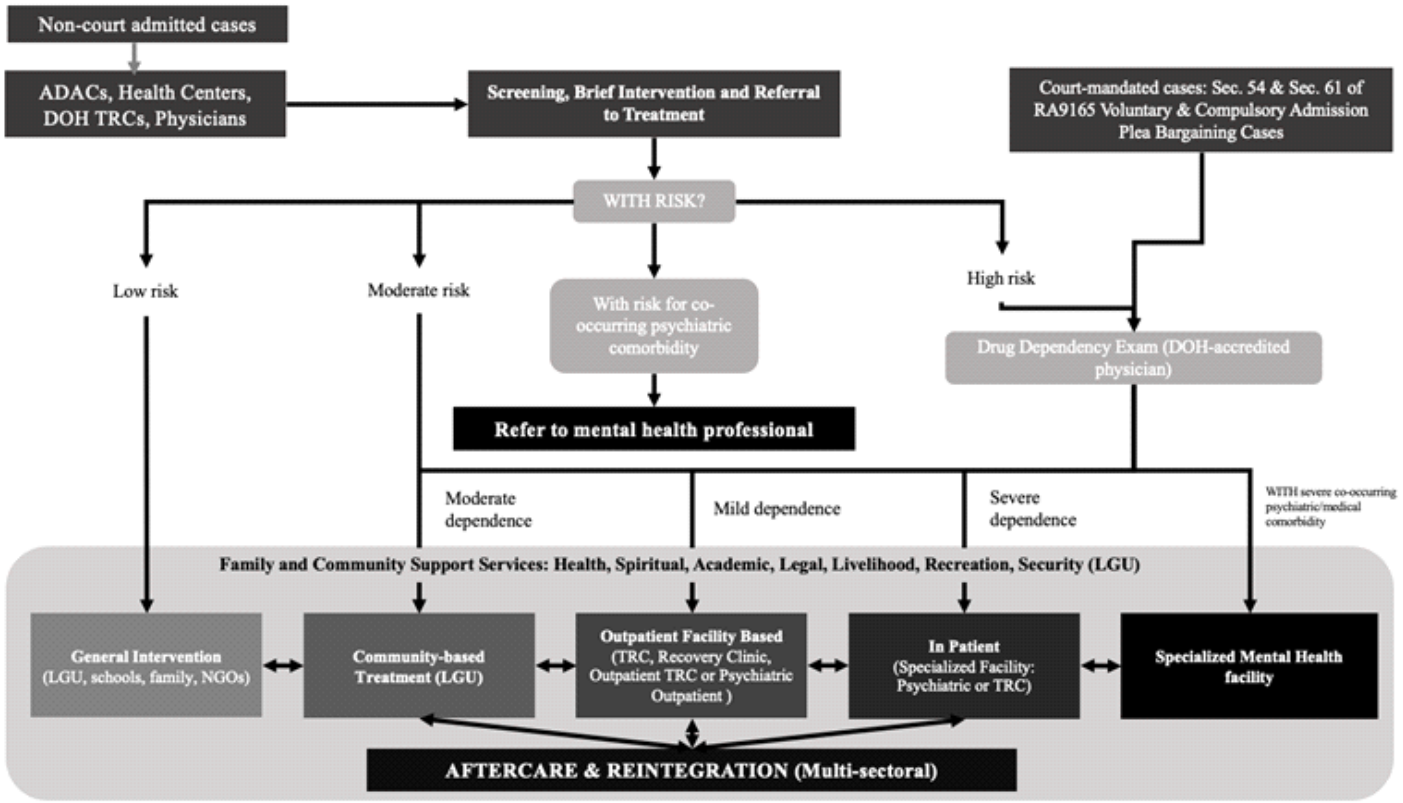

Figure 1. *National Client Flow for Treatment and Rehabilitation (DDB, 2019)*

In 2017, the Philippine Mental Health Act (Republic. Act No. 11036) was signed. It calls for integration of primary MH services as part of the basic health services [16]. It requires all local government units (LGUs) to create their own programs for wellness promotion, prevention, treatment, and rehabilitation. Additionally, it recognizes substance dependence as a mental illness. However, despite these mandates, CBMH is underdeveloped [17]. One explanation is that the law placed the accountability for CBMH with DOH rather than LGUs. Unfortunately, only 3 to 5% of the country's health budget is allocated for MH, and 70% of this is spent on inpatient care [18].

To date, no study has examined the possible integration of MH and SU in the Philippines. Thus, this study aims to explore the current practices, gaps, and potential for integration of MH and SU treatment in communities.

Methodology

Sampling

To understand community implementation of MH and SU services, key informant interviews were conducted in five regions and three LGUs. As this was a pilot study, the research team focused on program managers of SU and/or MH programs. The subject matter experts were MH and SU treatment coordinators from Department of Health (DOH) Regional offices (called Centers of Health Development or CHD) and program managers of LGUs. The LGUs were in Luzon, Visayas, and Mindanao. Recruitment was made through convenience sampling based on recommendations from the research team and DOH.

Data Collection

Ethics approval was completed through Ateneo de Manila University. A total of eight (8) semi-structured in-depth interviews were conducted from April to May of 2022. An interview guide was developed that was based on the WHO Systems Framework [19,20]. This framework was utilized in the development of the interview guide to ensure a comprehensive review of all essential components (Service delivery, healthcare workforce, medical products/ technologies, information systems) impacting integration, even domains not included in other frameworks (financing, leadership and governance). The interviews lasted 45 minutes to 1 hour and 10 minutes and were completed through via Zoom. All participants were provided informed consent prior to enrollment. Interviews were transcribed by the research team through the utilization of the program OtterAI, and words which were spoken in Filipino were translated into English. The transcripts were de-identified.

Table 1. *Levels of Integration*

Relationship	Key Elements	Level
Coordinated	Communication	1: Minimal Collaboration
		2: Basic Collaboration at a distance
Co-Location	Physical Proximity	3: Basic Collaboration onsite
		4: Close collaboration onsite with some system integration
Integrated	Practice change	5: Close collaboration approaching integrated practice
		6: Full collaboration in a transformed/merged/integrated practice

Table 2. *Summary of levels of integration of CBDR and CBMH in the Philippines*

Health Systems Building Blocks based on the WHO	Philippines level of Integration based on SAMHSA HRSA Framework
Leadership and Governance	Level 1 Minimal Collaboration; Separate governance structures
Health workforce	Level 2 Basic Collaboration at a distance Separate workforce with some task-sharing
Health Information	Level 1 Minimal collaboration in data-gathering and analysis
Health Financing	Level 1 Minimal Collaboration; Separate budgets and under-resourced
Service Delivery	Level 2 Basic Collaboration of services in separate facilities or locations
Social Services and Support	Level 2 Basic Collaboration with units providing support services

Data Analysis

Framework analysis [21] was used in processing the data. It entailed five key activities: familiarization, construction of the thematic framework, indexing, charting, and interpretation. In familiarization, transcripts were read by the team and coded them by themes. The team reviewed the coded data and discussed discrepancies in codes to have consistent indexing amongst all members. Once consistent, the entirety of data was indexed. In charting, coded segments were converted to a series of tables, corresponding to themes and subthemes. Lastly, in mapping and interpretation, patterns and conclusions were extracted. Additionally, analysis was done to determine the level of integration utilizing the SAMHSA-HRSA Framework [7] as this describes the key elements to consider when integrating physical health and mental health services.

Results

The results are summarized according to health systems building block (Table 2).

Leadership and Governance

MH and SU have separate laws that govern their implementation: For MH, it's the Mental Health Act (Republic. Act No. 11036 of 2017) [16], for SU, the Comprehensive Drugs Act of 2002 (RA 9165) [14], Dangerous Drugs Board (DDB) regulations, DILG memorandum circulars and DOH Department Orders. A participant highlighted the divide stating, "the mental health law says very little about drug use. Most of the laws that we have are basically about the penal side of the drug problem. It's on the supply and addiction side. And that's 90% of the job of PDEA and Dangerous Drugs Board."

Separate policies for MH and SU lead to CBDR and CBMH programs being managed separately. In some LGUs, CBDR is managed by the anti-Drug Abuse Councils under the Office of the Mayor or by the Social Welfare department. In contrast, CBMH programs are managed by the City Health Office. The range of government collaboration required is wider for SU compared to MH. Other than the DOH, national agencies such as the DDB, Philippine Drug Enforcement Agency (PDEA), Department of Social Welfare and Development (DSWD), and the Department of the Interior and Local Government (DILG) all have specific guidelines and procedures that influence service delivery of CBDR.

As such, leadership and governance of CBMH and CBDR appears to be at level two integration with some coordination among agencies especially with regards to SU. However, a major challenge cited was the numerous and sometimes conflicting national policies. As a respondent explains, "at the peak of the Philippine government's war on drugs, a main motivation for PWUDs to go through treatment was to get themselves off the drug watch list. The DDB's guidelines specify a delisting process. However, according to PDEA and the Philippine National Police (PNP), there is no such thing as de-listing and those on the list will simply be marked inactive. Consequently, even those who have graduated in a drug treatment program are still visited by the police leading to continued stigma and discrimination." This suggests diverse perspectives in the governance of MH and SU.

Healthcare Workforce

A major challenge for both MH and SU is the lack of a trained health workforce. Respondents from CHDs reported training general practitioner (GP) physicians and some nurses trained by the DOH on mhGAP but there are still not enough trained providers. Training is fragmented with capacity building and training for Drug Dependency Examinations (DDE) being separated from training on mhGAP, and those being trained on SBIRT not receiving mhGAP training and vice versa. As such, doctors performing DDE may not be adequately trained to assess MH illness and vice versa. Respondents noted lack of CBMH services due to the lack of manpower, capacity, and programs, "One of the challenges really in our area is the lack of manpower or training when it comes to mental health issues, like psychological first aid."

Although the workforce for MH services are health professionals, the workforce for CBDR is much broader. An LGU respondent shared that outreach for CBDR is being done by law enforcement. Police officers or barangay tanods (police volunteers) identify PWUDs and bring them to CBDR. A coordinator stated, "the PNP helps us also identify because they have surveillance in place there to identify potential cases, PWUDs, that may be at risk or using or there are drugs that are available in the locality. After detection, we invite them to go for treatment."

In terms of health workforce, the workforce for SU and MU appears to be separate and level of coordination is at level 2 because there is some task-shifting and sharing of resources. For example, in some LGUs, health personnel are involved in screening and DDE. Some barangay health workers are also trained in Screening, Brief Intervention and Referral to Treatment (SBIRT) [15,23].

Unfortunately, a challenge reported was the lack of job security of health personnel creating constant turnover. As one subject matter expert recounted, "We have some people that are well-trained, but they are just job orders (contractual). They can leave anytime and if that happens, each of them has more than 300 cases being managed. Now if one person leaves, what will I do with that 300?" Given the lack of a permanent workforce, many LGUs also rely on spiritual/religious workers (clergy and pastors) to provide CBDR treatment. Challenges are the lack of accountability and sustainability due to the high turnover of volunteers that lead to a lack of trained CBDR facilitators.

Health Information

There is limited integration of information management of CBDR and CBMH. Some LGUs have a database recording PWUD's socio-economic profiles and symptom severity. Client information on MH diagnosis and treatment is sparse due to the lack of data managers and infrastructure. A participant shared, "we have data, but we are not able to manage it because we don't have a data management system. We don't have capacity. We are not statisticians, we are not epidemiologists, we are just providers of services. Like I said, it's a shame when these don't get documented."

The major barrier cited is the absence of an integrated data management system with information on MH separated from SU. Client data for PWUDS in CBDR are reported in the database of DILG and DDB by anti-drug abuse councils/office whereas patient data of persons who use drugs in DATRCs is collected in a separate system. Due to the separate systems with limited sharing and analysis of information, the level of integration with regards to information management can be described as level 1 (minimal collaboration).

Healthcare Financing

Because health services are devolved in the Philippines [24], LGUs are primarily responsible for financing both CBDR and CBMH. However, the funds for MH and SU are sourced separately. CBDR is funded primarily by LGUs, whereas MH services are financed by the DOH with some allocation from the local government. However, the lack of budget was commonly cited as a challenge in implementation of CBDR and CBMH. Some LGUs were provided funds by the DDB to put up facilities for CBDR. Others sought help from private entities, international development partners, non-government organizations or faith-based organizations. Costs of treatment for those with severe drug dependence are mostly borne by treatment and rehabilitation centers (DATRCs) funded by the DOH. However, some DATRCs still require out-of-pocket costs due to inadequate funding. Some LGUs have budgets to subsidize inpatient treatment but other LGUs don't and transfer this cost to clients. Key informants acknowledged that many clients cannot afford these costs.

In the Mental Health Law, it is the DOH that is responsible for funding CBMH facilities. However, a major barrier is that funds for MH are shared with other non-communicable diseases (NCD) with higher prevalence. This leaves MH services underfunded as a whole. A participant explains, "the mental health budget is only 1% of the total budget of the Public Health Management. Before, as one of the NCD programs, the budget that we get are usually the leftovers from other programs like diabetes hypertension, smoking, kidney, senior citizens, etc." In terms of integration, SU and MH are funded separately and there appears to be no sharing of resources at the regional or community level.

Service Delivery

The different governance, human resources, information management and source of resources impact service delivery. Not surprisingly, MH and SU service delivery integration is at level 2 with basic coordination in terms of referral. For SU, as mandated in the national client for drug treatment, LGUs screen PWUDs for both MH and SU using WHO's Alcohol, Smoking and Substance Involvement Test (ASSIST) and Self-Reporting Questionnaire (SRQ). Low and moderate risk PWUDs are treated under the CBDR programs. CBDR treatment consists of modules based on cognitive behavioral therapy, motivational interviewing, and mindfulness. Length of programs depend on risk level (three to four sessions for low-risk users and 15 to 34 sessions for moderate risk PWUDs). However, respondents reported barriers to service delivery such as limited trained service providers and resources.

Those at-risk for MH illness are supposed to be referred to MH services. However, a key gap identified was the lack of services for MH. Some LGUs refer clients to rural health units or to general practitioners trained on WHO's Mental Health Action Gap program (mhGAP) [22]. Some regions had no active community-based programs and only had inpatient MH facilities in psychiatric wards in hospitals. In addition, although there are drug abuse treatment and rehabilitation centers (DATRCs), they don't necessarily offer services to mental health clients. Moreover, some DATRCs cannot accommodate voluntary clients because they are inundated by court-mandated clients. Although a few DATRCs do house both voluntary and

mandatory clients, some respondents suggested this was not ideal. Services are being performed by different service providers and collaboration of delivery of services for screening and treatment is minimal.

Social Ecosystems, Support and Services

Interviews elicited a new theme not identified in the WHO Systems Framework, which was social ecosystem and the importance of social support and services. Stigma within the community was identified as a major barrier for both MH and SU clients and impedes individuals from seeking help. Both MH and SU share common social determinants and recovery capital. For example, family and family support are important factors for client recovery for both MH and SU clients. Family issues were also underlying causes of both MH and SU issues. Social issues such as poverty, unemployment, and a lack of education were also identified as risk factors for both MH and SU.

Social services related to family, educational attainment, and employment needs are important recovery capital and the onus is on LGUs to provide this. Providers report doing basic coordination with other units within the LGU – family services, social work, public employment services office, education, etc. However, they recount difficulties in developing a holistic provider care network that addresses all these needs. As a respondent shared, "we need to support their (client's) support system, which we do not usually do yet in the Philippines. We cannot do it alone and not all families are capable of caring for their loved ones. That is my dream, that our community provides those services."

Enabling Integration

Input from the respondents showed some recognition of the need for integration, given realities on the ground, but also the need for technical guidance and political will to make this a reality. One respondent emphasized the importance of integration stating "We are intending to merge because as much as possible, right, there is a correlation between mental health with substance use... our resources are the same. And with this devolution, I think it would be more effective and efficient in the context of the UHC (Universal Health Care), to merge. Because the implementors are the same. And the sense of ownership and the sense of direction would see more the context of the benefits." The need for technical support was also highlighted, "To build absorptive capacity we need technical capacity so that we, the local government own this program. We need capacity building and assistance to develop local laws. We also need technical assistance to put together the research component. So that our policies and laws are sound or evidence based."

Discussion

Globally, there is a growing call to scale up the integrated delivery of mental, neurological and substance use (MNS) services and ensure that they are made accessible in non-specialized settings [25]. This study validates previous findings of bottlenecks in delivery of community-based mental health services due to limited trained healthcare workers, fragmentation, and lack of resources [16, 25]. Key points of fragmentation is that MH and SU services are managed separately with distinct personnel, locations, and information systems. Table 3 summarizes implications on improving the integration of MH and SU services at the community level based on the gaps identified.

Results suggest that governance structures of MH and SU are fragmented. Although MH services are managed by health offices, there are variations on who manages CBDR services. In some LGUs, it is managed by the Office of the Mayor or social services unit. Other countries have addressed fragmentation by establishing a single integrated agency overseeing both substance abuse and mental health services at the community level [26], a direction the Philippines can take.

This study highlights the previous government's punitive approach and RA 9165's criminalization of drug use. This punitive perspective overshadows the fact that the Mental Health Law acknowledges drug dependence as a mental illness. This dissonance suggests needed revisions to the RA 9165 law to enable coherence in policies and practice. In 2021, DOH launched its 7 Healthy Habits campaign that includes SU [27]. However, a stronger and more sustained advocacy is needed to change decades of criminalizing drug use to a public health-based framework [28]. For example, the current guidelines of DILG for the composition of anti-drug abuse councils stipulate that the Chief of Police is the vice-chair [29]. This law-enforcement oriented structure tips the lack of balance towards supply reduction rather than demand reduction.

Discussants expressed challenges with inconsistent training and high turnover trained amongst CBDR providers. Other LMIC countries have built upon established mhGAP training programs to further integrate SBIRT training as a means of scaling up services [30]. Another potential solution to address the bottleneck in capacity is for DOH to accredit training providers rather than conducting training themselves and utilize a cascade model in scaling up training for MH and SU[31].

The results highlight the fragmentation in information management systems. Currently, information on CBDR clients is collected by DILG and DDB for community-based programs whereas information on DATRC clients is collected by DOH. MH clients in health facilities are collected separately as well. Previous studies have utilized a holistic information management system managed by the health sector for data on MH and SU to be coherent and be utilized for decision-making and planning [32]. Respondents report the involvement of law enforcers in outreach for PWUDs. Police utilization expands outreach for CBDR but may reinforce drug use as a crime rather than a health issue as information on PWUDs is stored by the DDB. A study among barangay officials handling CBDR interventions, also found differences in goals and a lack of coordination between the police force and the community leaders creates a tension in delivering services [33].

A key challenge found in this study was both MH and SU are inadequately funded. CBMH and CBDR programs are supposed to be funded by the local government. However, there is no stipulation on the level of funding nor where resources for MH will come from. The Mandanas ruling and Special Health Funds present opportunities for increased funding at the local level [34]. The implementation of Universal Health Care (UHC) [35] also presents opportunities for MH and SU screening and treatment within primary care. The DOH is pilot testing a MH package under the UHC [36]. However, SU is not included in this package. Thus, another implication would be packages supporting integrated MH and SU as defined in the country's mental health act. Specific guidelines on the level and source of funding for MH and SU are needed with advocacy on the economic benefits of public MH investment among the country's leadership being a crucial step [37]. A study on CBDR showed that the costs of CBDR are 12-16% the cost of inpatient treatment [38] with benefits 4.5 times the cost. However, there is a dearth of evidence on the cost effectiveness of CBMH programs.

Our study found limitations in substance use service delivery and limited and inconsistent referral capabilities for MH services. While there is no best consensus on how to provide integrated services, an established method is embedding screening and services for SU clients within primary care [39,40]. Health centers and barangay health facilities can

Table 3. *Summary of Gaps and Implications for Enabling Integration of CBDR and CBMH*

Domain	Gaps	Implications
Leadership and governance	• Separate policies and governance structures • Policies and structures are driven from the criminalization of drug use	• Integrate governance structure of MH and SU • Strengthen role of health in structures related to drug use (anti-drug abuse councils)
Healthcare workforce	• Lack of and separate workforce for MH and SU • Fragmented training on MH and SU • Limited capacity for training MH and SU in communities	• Provide permanent positions for substance use and mental health workers • Integrate trainings for MH and SU services from screening to treatment to aftercare • Decentralize training capacity to accredited training providers to address bottlenecks
Health information	• No integration of MH and SU information management system • Data on PWUDS managed by law enforcement and not managed by health	• Identify key information and integrate MH and SU data in primary care information management systems • Create system for data sharing among information systems managers that ensure confidentiality and privacy of sensitive patient information
Health Financing	• Lack of budget for LGUs for MH and SU services • Lack of funding from DOH for community-based mental health services	• Include in policies the allocation of a specific portion of local government unit budget for an integrated MH and SU services • Include screening and treatment of MH and SU in Universal Health Care along the primary care providers network
Service Delivery	• Fragmented service delivery of MH and SU • Lack of coordination between MH and SU providers • Gaps in services for high-risk MH clients	• Have an integrated client flow for mental health and substance use; explore one-stop shop model for integrated MH and SU service delivery in primary care facilities, communities, schools and workplaces • Improve health care provider network for MH and SU • Expand drug abuse treatment and rehabilitation centers to cater to high-risk mental health clients
Social ecosystem and support service	• Stigma for both MH and SU • Lack of holistic programs addressing social determinants of MH and SU	• Institutionalize stigma reduction information and education campaigns to frame MH and SU as public health concerns • Enhance referral and provision of social services

become one-stop shops for integrated MH and SU service delivery. For example, instead of BADAC focals or police outreach, integrated outreach for MH and SU may be done by barangay health workers. The General Intervention for Health and Wellbeing Awareness program that was developed by DOH in partnership with the USAID RenewHealth project has evidence on improving both well-being and reducing SU [41,42]. Evaluation studies of Katatagan, Kalusugan at Damayan ng Komunidad (KKDK) that is being implemented for moderate-risk PWUDs also report improvements in life skills, coping behaviors, family support, family functioning, wellbeing and recovery capital [43,44]. However, the capacity of community health workers who are already burdened with primary health care tasks needs to be considered [45,46]. Given the lack of MH professionals found in this study, having a health care provider network for MH and SU is critical for referral to specialists.

Results discussed the importance of social determinants of MH and SU. Capacity building for both health and allied health professionals in all settings and provision of adequate wrap-around support to prevent relapse. A broader service delivery network that includes social services such as employment, livelihood training, faith-based organizations is needed [47]. It is important to identify common tools and early intervention programs that integrate MH and SU that can be provided by service providers in various settings including communities [48], schools [49], and workplaces [50]. Potential service providers may include health workers, and allied health (social workers, CBDR personnel, faith-based volunteers, teachers). The need for better collaboration and coordination between various government and non-government stakeholders has also been a recurring finding in other studies on CBDR [51,52].

Findings also include stigma and family support heavily impacted help seeking and treatment retention. Studies suggest the prevalence of stigma for both persons with MH [53] and even more so with drug users [54]. A review of the social determinants of MH reveals that unemployment and financial strain are linked to poor MH. Other social determinants are discrimination, quality of family relationships, urbanization [55]. Studies on Filipino PWUDs report that drug use is associated with unemployment, financial issues, peer influence, personal and family problems [56] and lack of education [8]. The results highlight the importance of acknowledging and addressing the conditions that may influence MH and SU and need to go beyond treatment and implement a holistic approach to social determinants. However, the results also suggest the importance of integrated prevention programs for MH and SU particularly for at-risk youth or vulnerable groups.

Finally, respondents recognized the need for integration but also articulated the need for technical guidance to make this a reality. However, given the devolution of health systems to LGUs, having a one-size-fits-all approach to integration may not be possible. Table 3 presents a possible tool developed by the authors using SAMHSA's integration framework. This tool might be useful for LGU leadership in determining their current level and strategizing potential areas of integration of MH and SU services.

Overall, this qualitative study provides a snapshot of gaps and opportunities for integration of MH and SU at the community level. Although regional sampling covered both MH and SU services through CHDs, a limitation of the study was that

Table 4. *Possible integration strategies by stage of service delivery*

CLIENT CASCADE	COORDINATION (Communication)	CO-LOCATION (Physical Proximity)	INTEGRATED (Practice Change)
Prevention and Outreach	Separate SBCC (social behavior change) advocacies and materials but staff refer clients	Separate SBCC advocacy events or materials but co-located	Integrated medical mission/outreach Integrated prevention programs and platforms
Screening	Separate screening with referral	Separate screening but MH and SU co-located	Integrated screening for MH and SU in primary care or in settings
Treatment	Separate treatment program and providers	Separate treatment and providers but co-located	Integrated early interventions Shared providers
Support and Sustain Services	Separate support services and programs but staff refer clients	Separate support services and programs but co-located	Integrated support services or system for either MH or SU clients
Institutionalize	Separate CBDR and CBMH staff but communication occurs between them Separate IMS Separate budget	Separate CBDR and CBMH staff but they are co-located Separate IMS but co-located Separate budget but with cost-sharing	CBDR and CBMH managed by same office Integrated IMS Integrated budget

LGU respondents mostly managed CBDR programs. This was because no LGUs had dedicated CBMH program managers. Future studies may include municipal health officers and rural health doctors who work within the community to provide more in depth understand their experience providing care at the local level. These doctors may also provide insight into providing substance abuse and mental health treatment in those seeking primary healthcare. Another major limitation to this study is the lack of sampling across multidisciplinary sectors. Given this was a pilot study in understanding areas of integration, the sampling was kept to the level of the healthcare system and to selected sites However, future studies may wish to explore larger samples to obtain quantitative data. Researchers may also wish to consider other major sectors (police, government officials, clergy) delivering MH and/or SU in order to understand integration across sectors.

Conclusion

In 2022, the DOH shifted its structure to improve integration of SU and MH. This study provides information on needs to enable such integration. Overall, findings suggest low levels of integration of SU and MH service at community levels. Currently, there are only minimal CBMH programs. However, the presence of CBDR programs presents a promising model and lays the groundwork for implementation of CBMH. If integration is to be successful, much needs to be done beginning with revising RA 9165 that criminalizes drug use and creating a policy for integrated flow of CBMH and CBDR. In addition, embedding both services within either a health or social service structure is important for integration. Finally, providing adequate resources both financial and human is key to ensuring that the promise of integrated MH and SU services is fulfilled.

Acknowledgement and Disclosure of interest

The researchers would like to thank the American people, through the United States Agency for International Development (USAID) (Agreement no. 72049219CA00004) under the USAID Renewhealth Project: Expanding Access to Community Based Drug Rehabilitation in the Philippines implemented by University Research Co., LLC. The funders played no role in research design, data collection, data analysis, manuscript writeup or decision to publish. The findings and conclusions expressed in this article are those of the authors alone and do not necessarily reflect the views of the USAID or the United States Government. Finally, the authors wish to thank Dr. Yolanda Oliveros and Madison Ethridge for their review and inputs on this article.

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