BOARD RESOLUTION NO. 4
Series of 2018

SUBJECT: ESTABLISHMENT AND OPERATION OF PILOT COMMUNITY-BASED TREATMENT DRUG ABUSE RECOVERY FACILITIES (RECOVERY CLINICS AND HOMES)

WHEREAS, Section 77 of Republic Act No. 9165 or the Comprehensive Dangerous Drugs Act of 2002 (the “Act”) declares that the Dangerous Drugs Board (the “Board”) is the policy – making and strategy – formulating body in the planning and formulation of policies and programs on drug prevention and control;

WHEREAS, to ensure sound policy formulation and development, Section 81 (d) of the Act provides that the Board has the power and duty to initiate, conduct and support scientific, clinical, social, psychological, physical and biological researches on dangerous drugs and prevention and control measures;

WHEREAS, Section 2 of the Act mandates that it is State policy to provide effective mechanisms or measures to re-integrate into society individuals who have fallen victims to drug abuse or dependence through sustainable programs of treatment and rehabilitation;

WHEREAS, the illegal drugs problem is a priority of the current administration, and it is essential that the State provide necessary interventions to individuals who wish to reform themselves and do away with the evils of illegal drug abuse;

WHEREAS, the Department of Health, in cooperation with the Board and certain local government units, intends to conduct a pilot-testing of community-based recovery clinics and recovery homes which aim to provide immediate and accessible intervention to drug users;

WHEREAS, recovery clinics will provide outpatient services to users who submit themselves voluntarily for intervention through group treatment methods while recovery homes will accept clinical referrals from recovery clinics and provide an increased level of treatment intensity for patients not fully stable with outpatient care provided by recovery clinics.

WHEREFORE, be it RESOLVED, as it is hereby RESOLVED, for the Department of Health to establish and operate pilot community-based drug abuse treatment recovery clinics in the following areas:

a. Ifugao;
b. Tarlac City, Tarlac;
c. Pasay City;
d. Calapan City, Oriental Mindoro;
e. Mandaue City, Cebu; and
f. Compostela Valley;

Bd. Res. Establishment and operation of community-based treatment drug abuse recovery facilities (Recovery Clinics and Homes)
RESOLVED FURTHER, that the establishment of recovery homes shall be sourced from funds allocated by the Department of Health and partner agencies / entities;

RESOLVED FURTHER, that the establishment and operation of pilot community-based drug abuse treatment recovery facilities shall comply with the formulated guidelines attached to this Resolution as Annex “A,” and such guidelines will take effect once said facilities have been established and respective personnel properly trained;

RESOLVED FINALLY, that the Department of Health submit regular updates and/or reports to the Board for the purpose of determining the feasibility of establishing and operating said facilities in other communities.

APPROVED and ADOPTED this 24th day of January, in the year of Our Lord, 2018 in Quezon City.

[Signature]
Secretary CATALINO S. CUY
Chairman, Dangerous Drugs Board

Attested:

[Signature]
Undersecretary EARL P. SAAVEDRA
Secretary of the Board

Bd. Res. Establishment and operation of community-based treatment drug abuse recovery facilities (Recovery Clinics and Homes)
SUBJECT: Initial Guidelines for the Establishment of Pilot Community-Based Treatment Drug Abuse RECOVERY FACILITIES (Recovery Clinics and Recovery Homes)

I. RATIONALE

"The state shall provide effective mechanisms or measure to reintegrate into the society individuals who have fallen victim to drug abuse or dangerous drug dependence through sustainable programs of treatment and rehabilitation."

Section 2: RA 9165 s. 2002

Addressing the drug problem is a priority of the current administration. From the beginning of Oplan Tokhang (Operation Double-Barrel, Knock and Plead) in July, 2016 to its temporary suspension on January 27, 2017; 1.18 Million already surrendered to authorities (1,110,113 of them were "drug users," while 79,349 of them were "drug pushers").

To deal with the unusual situation, the Dangerous Drugs Board (DDB), in consultation with the Department of Health (DOH), issued Board Regulation #4 series of 2016: Guidelines on Assessment of Individuals Who Voluntarily Surrender and Determination of Appropriate Intervention (Annex 1). This resolution describes an algorithm for a proper referral system from the ADACs (Anti-Drug Abuse Councils) to CBTPs (Community Based Treatment Programs) and to outpatient or residential facilities.

A court order is required for admission to Drug Abuse Treatment and Rehabilitation Centers (DATRCs); a Drug Dependence Evaluation (DDE) completed by an authorized physician with referral for admission to a DATRC generates the court order. Majority of drug using surrenderers do not meet severity criteria for compulsory confinement in DATRCs (estimated range:1 to 11%). Having voluntarily surrendered to authorities and not meeting severity criteria for detention, most surrenderers deserve voluntary pathways (devolved of court order) to access affordable and affordable treatment and rehabilitation services that are privacy-protected following the DOH policy on patient’s rights.

In addition to the pre-existing compulsory system (police holding facilities, DATRCs and their aftercare facilities), this guideline will shape the initial development of an entirely separate and fully voluntary system (composed of outpatient Recovery Clinics and residential Recovery Homes). These form the basis for the Philippine model of voluntary care. These services will be located within the community and close to the affected families. Program designs will protect patient rights, will offer safe, non-
punitive, and quality programs suited to the family centered Filipino culture. There will be local design flexibility to accommodate local resources.

**Epidemiology:** In a 2015 survey, there were 1.8 (Dangerous Drug Board data) to 3 (Phil. Drug Enforcement Agency data) Million drug users in the Philippines. The United Nations World Report on Drugs estimated that only 0.6% to 1% (10,800 to 30,000) may need residential treatment; however, 3 to 4% (54,000 to 120,000) may need structured outpatient care; whereas a 95% majority (1,710,00 to 2,850,000) can be managed by community-based ADACs and local services.

**Compulsory Facilities:** As of December 2016, there were 48 DOH accredited DATRCs in the country, with 45 residential treatment centers and 3 non-residential or outpatient treatment facilities. Of the 45 residential treatment centers, 14 are managed by the DOH and 5 are managed by Local Government Units (LGUs) and the rest are privately owned and operated. Of the 3 outpatient treatment facilities, 2 are managed and operated by DOH. The total number of authorized residential beds in government (1,720 beds) and private (1,664 beds) DATRCs can accommodate only about 3,384 residents.

An inter-agency task force established per Executive Order No. 4 (Annex 3) was tasked to assist in the establishment of DATRCs. Through coordination with various donors, Memorandum of Agreements (MOA) were forged for the establishment of DATRCs in Bataan, Bicutan, Davao, Bohol and Bukidnon. A temporary pre-fabricated residential facility of 1,500 beds out of 10,000 beds Mega DATRC was opened in Nueva Ecija in November 2016, to immediately respond to the sudden influx of surrenderees. However, an average of only less than 150 drug dependents sought admission.

**Philippine Health Agenda (PHA):** PHA seeks to establish one DATRC in every region of the country by 2022. There are five (5) remaining regions without DOH DATRCs (CAR, MIMAROPA, NIR, SOCCSARGEN and ARMM). A budget of PHP 2.6 Billion was allotted for these areas in 2017 for possible operationalization by 2019. By 2022, PHA also aimed to establish a CBT program in every community. Most of the ADACs, which are the key points to community-based referrals in barangays, municipalities, provinces and cities, are not fully functional and frequently not sustained because of reliance on volunteers, job order temporary or co-terminus staff.

As Oplan Tokhang is about to be resumed, surrenderees will be expected which will add up to the current large gap between the number of drug users needing intervention and the availability of treatment and rehabilitation services at the LGU level, hence, it is extremely necessary to provide available, affordable and accessible services within the communities such as the community-based Substance Use Disorder Recovery Clinics and Recovery Homes.
II. GOALS AND OBJECTIVES:

GOALS:

Primary goal of this guideline is to organize the initial development of voluntary pathways recovery facilities approved and supported by DOH and DDB.

Intermediate goals: (1) develop Standard Operating Procedures (SOPs), (2) to refine the crafted guidelines and procedures that will be used in scaling up to other LGUs and (3) to develop structured trainings and modules for the development of recovery facilities and capability building especially for community-based clinical and counseling skills.

Long-term goals: (1) scale-up to other LGUs and (2) develop Best Practices sites as model/demonstration programs and training sites.

SPECIFIC OBJECTIVES:

1. To provide initial guidelines for pilot community-based Recovery Clinics (outpatient substance abuse treatment clinics) and Recovery Homes (halfway houses for patients in drug abuse treatment).
2. To develop these programs as fully voluntary treatment pathways of care approved and supported by DOH and DDB.
3. To initiate an iterative process of guideline and SOP development to serve as more complete guides for future programs.
4. To select outstanding programs as Best Practices for future demonstration and training sites.

III. GENERAL SCOPE AND COVERAGE

This pilot project is in collaboration among the DOH, LGUs and development partners:
- LGU eligibility as pilot site must provide appropriate site, must guarantee funding for staff salary support and operational costs.
- DOH will provide technical and regulatory assistance, capability building, negotiate with domestic and international funding sources and coordinate with LGUs, partners and stakeholders.
- European Union and WHO Philippines will provide technical assistance to DOH on focused consultations, clinical materials, and staff training.
- Other development partners may provide infrastructures in accordance with DOH standards and recommendations

Voluntary Pathways Recovery Facilities: Pilot Recovery Clinics and Recovery Homes will be managed by LGUs with DOH guidance. Admission will be on a voluntary basis not requiring court order, located in LGUs. Medical professionals shall provide decision-making about treatment options, maintain confidential medical records and observe patient's rights and privacy. This can be considered as Community-Based
Treatment versus Community-Based Support provided by UBAS (Ugnayan ng Barangay at Simbahan), ADACs and the civil society.

- **Recovery Clinics** shall follow all the licensing requirements of DOH HFSRB (Health Facility Services and Regulatory Bureau) for outpatient DATRC. It will be located within LGUs not attached to DATRCs or regional offices but must be attached or near an LGU hospital or health center. It will accept consultation and treatment requests from all LGU citizens who voluntarily want to be helped for drug abuse or drug dependence. Persons who are court-ordered will be referred to DATRCs.

- The primary function of a **Recovery Home** is to offer an increased level of care for moderate risk drug user patients who are not fully stable in a clinic or living at home setting, but do not require rigid treatment at the DATRCs. It will provide in-patient evidence-based less rigid substance abuse intervention and treatment with special focus on job skills training and job placement mechanisms.

IV. DEFINITION OF TERMS

1. **Community-Based Treatment and Rehabilitation Program**: This is something of a misnomer, suggesting that all interventions in the community are forms of treatment. We prefer to make a clear distinction between treatment (carried out by medical professionals) and support (carried out by lay persons). This is not to say that support is somehow less important. Vocational services are, for example, absolutely essential for sustained recovery in persons who are unemployed and lack significant job skills.

2. **Rehabilitation**: This a long-term, often lifelong, process of making the psychological, vocational, social and spiritual changes necessary to live a life without drug use. Rehabilitation recognizes that drug dependencies are chronic relapsing medical disorders requiring tolerance of slips and relapses and recognizing a need for repeated episodes of care. For this reason, patients with premature departures from recovery facilities are welcome to return for care.

3. **Recovery Clinic**: A community-based outpatient medical treatment facility built in or near a local government hospital or health center that will treat patients who voluntarily submitted themselves for intervention.

4. **Recovery Home**: A community-based residential facility that serves to increase the level treatment intensity for patients not fully stable in outpatient care in a Recovery Clinic. It accepts only clinical referrals from the Recovery Clinic or from an authorized physician specialist in the community or from a DOH-accredited physician. It will provide evidence-based substance abuse intervention and treatment with a special focus on job skills training and job placement mechanisms (most likely to be provided by MOA-supported linkages with community resources).

5. **Voluntary basis**: Fully voluntary means that patients are as free to enroll in treatment as they are to quit treatment at will. Voluntary means that there is no
court order and no legal coercion. It also means that there are no consequences or punishments, and no reports to police or civil authorities, for premature departures from care or for positive urine tests.

6. **Local Government Unit (LGU):** Local governments in the Philippines are divided into three levels: (1) provinces and independent cities; (2) component cities and municipalities; and (3) barangays.

7. **Drug Dependence Evaluation (DDE):** A procedure conducted by a DOH-accredited physician to evaluate the extent of drug abuse of a person and to determine whether he/she is drug-dependent. High severity ratings automatically lead to a court order that mandates 6-12 months in a compulsory DATRC, and 18 months of aftercare.

8. **Step-up services:** Referral of drug users (who cannot be fully managed at home or in an outpatient setting but do not require residential drug rehabilitation treatment) to a Recovery Home.

9. **Step-down services:** Referral of a person to a lower level of care intensity.

10. **Drug Abuse Treatment and Rehabilitation Center (DATRC):** A locked, compulsory facility that typically relies on a modified Therapeutic Community (TC) model of care. It accepts drug users whose DDE level of dependency is severe and referred by one (1) DOH-accredited physician for voluntary confinement or by two (2) DOH-accredited physicians for compulsory confinement. The term of treatment and rehabilitation specified in the 2002 law is 6-12 months with an additional 18 months of aftercare.

11. **Matrix Model:** The Matrix Model is a cognitive-behavioral curriculum for use in diverse kinds of treatment programs. It organizes teaching modules, but does not provide an operations manual for clinic operation. It is modularized and manualized, and it includes a strong family component and an emphasis on relapse reduction. It was developed by Richard Rawson, PhD, and colleagues at UCLA in the 1980’s for cocaine dependence and subsequently adapted for methamphetamine dependence. It is evidence-based, and supported by research.

12. **Aftercare:** Services that help recovering patients to adapt to everyday community life, after completing an initial residential phase of treatment.

13. **Drug Surrenderers:** Anyone who surrenders to authorities as a “drug user” or a “drug pusher.”

14. **Motivational Interviewing:** A non-confrontational method of interviewing patients who are ambivalent about their drug use and any need to stop. The method seeks to promote self-reflection based on one’s own beliefs and goals, and it promotes a recognition of the difference between beliefs and realities. It seeks to convert ambivalence into direction.
V. GENERAL GUIDELINES

1. On Pilot Sites: DOH will select LGU partners for participation in this pilot project, based on their location, their documented support for staff salaries, space, agreement to accept on voluntary basis no court order required and no DDEs nor urine drug testing. This guideline is limited to the pilot programs. Future programs will have refined guidelines and SOPs generated from this pilot phase.

2. On non-pilot sites: LGUs will remain free to develop DOH licensed community based facilities outpatient centers and DOH acknowledged recovery homes aside from the voluntary pathway pilot sites, but shall abide by the final guidelines to be issued that will be generated from pilot sites of voluntary care.

3. Piloting Sequence of Actions: (1) to determine implications of this Guideline with potential stakeholders, (2) to open pilot Recovery clinics and Recovery Homes in LGUs, (3) to refine Guidelines from the pilot phase, (4) to develop SOPs, (5) to develop training modules, (6) scale up recovery facilities in diverse locations following piloting and (7) to select Best Practices as models and training sites.

4. The Philippine Voluntary Care Model: A voluntary care model has very significant differences from the pre-existing compulsory care model utilized by DATRCs. The Recovery Clinic must be considered the most important component of the new voluntary system. Because it is an outpatient clinic without provision for 24/7 services, it is less expensive than residential care, it relies heavily on group treatment methods, it is highly efficient because a single clinician can simultaneously work with 8-10 patients in a single group meeting. Patients eat and sleep at home.

Below is a graphic representation of the Phil.model of voluntary treatment for drug abuse:

The Philippine Model of Voluntary Treatment for Drug Abuse
5. Community "treatment" versus community "support". The use of the term "treatment" is limited to medical services provided by DOH professionals. "Support" refers to important services provided by lay persons working in non-medical settings. Maintenance of this boundary is essential for patient privacy.

6. On referring cases: ADACs and community workers will be able to directly refer persons to the Recovery Clinic (where walk-in self-referrals are also accepted), but not to the Recovery Home. This is because the residential, extended nature of Recovery Homes makes them precious resources that should not be used as hotels; they are best used as step-up services for Recovery Clinics that are struggling to maintain stability in one of their ongoing cases. In addition, DOH-accredited physicians may refer to Recovery Homes in communities where there is no recovery clinic but with trained physician.

7. What will NOT be done in the Recovery Facilities:

- There will be no punishment systems such as verbal humiliation and the likes.

- There will be no DDEs performed nor urine drug testing. In a truly voluntary system, patients may occasionally receive a confidential medical recommendation to transfer to a secure facility, but it should not be coerced or enforced with a doctor-generated court order.

- There will be no interference with voluntary departures and terminations of care.

- It will not accept self-referrals or referrals from community agencies.

- There will be no releases of confidential medical records (protected by Philippine law) without being fully informed Release of Information (ROI) forms having been understood and signed, or compelling legal court orders.

- There will be no monitoring reports on individual patients submitted to civil or police authorities. Anonymous and aggregated data for large cohorts of patients may be shared with ADACs and LGU officials to support local planning.

8. Recovery facilities will not replace existing DATRCs. Voluntary system is a new pathway. It adds to, but does not replace, the existing compulsory DATRC pathway. The voluntary system is neither a feeder/screening service for DATRC placement, nor is it a step-down system for DATRC aftercare (unless court orders have been vacated). The DATRC system is whole and comprehensive, is being greatly expanded, and it will handle step-down and aftercare within its own (compulsory) system of resources. The relationship between the existing and the voluntary pathways can be seen in the graphics below:
VI. SHARED GUIDELINES OF RECOVERY FACILITIES:

The pilot LGUs must comply with all required set of standards herein formulated for the recovery facilities following the standard framework below. This section summarizes requirements that are common to both kinds of facilities. Subsequent sections describe requirement unique to each kind of facility.

1. Admission Criteria:
   1. Adults, ages 18 years old and above. Recovery clinics will accept men and women, Recovery Homes will accept only men.
   2. Pregnant women may be admitted to Recovery Clinics if enrolled in pre-delivery medical care and are compliant with that care.
   3. Must be physically and mentally fit. Individuals with mild to moderate depression may be admitted, particularly because chronic methamphetamine use often produces such a persistent symptom.
   4. Resident of the locality.
   5. Priority shall be given to drug surrenderers who are members of 4 P’s (Pantawid Pamilyang Pilipino Program).

2. Exclusion Criteria:
   1. Diagnosis of Axis-I Major Psychiatric Disorders (Psychosis, Bipolar Disorder, Schizophrenia).
   2. Children and Adolescents.
   3. Pending or ongoing court cases.
   4. Court orders for compulsory treatment or aftercare.
   5. Unwilling to agree to basic program rules about attendance and behavior.
3. Local Sustainability of the Recovery Facilities Program: Institutionalizing the recovery clinic or home thru passage of a local ordinance in the city, municipal or provincial level, for the allocation of appropriate budgetary requirement and staffing pattern is strongly advised. An LGU's willingness to do so is one measure of local "investment."

Community support services rely on civil society and other government departments. It is important to forge MOAs or MOUs with networks and partner agencies, especially TESDA for vocational services.

Good working relations with civic authorities require periodic data analyses of anonymous and aggregated data. Metrics must go beyond abstinence vs. relapse and must include measures of employment income, family relations, marital satisfaction, and overall assessments of progress. DOH will provide periodic audits of guidelines compliance and interview patients for opinions about the program.

4. Confidentiality of Medical Records: Recovery facilities shall observe confidentiality of medical records according to DOH policies. ADACs and civic officials have a right to meaningful feedback from programs they are supporting. Thus, recovery facilities must be prepared to generate periodic reports based on large cohorts of patients. These reports should be anonymous so no individual information is revealed, and they should be based on aggregated data. In voluntary care, patient privacy and medical record confidentiality must be protected.

Privacy of Medical Records in Voluntary Treatments

- Police
- DOH
- Community ADAC
- Public Officials
- DOH Compulsory Care
  - TRCs
  - MegaCenters
- Medical Records Privacy Protections
- DOH Voluntary Care
  - Recovery Homes
  - Outpatient Clinics

9
5. **Development of Standard Operating Procedures (SOP)**

SOPs will be developed during the duration of the pilot phase. Some SOP chapters will be common to all facilities; others will be unique to the facility location and operations. Recovery Clinics within medical settings must include copies of SOPs that are required by the medical center.

Below is the suggested list of SOP chapters. Prior to opening and admitting patients, patient enrollment forms, a template for an initial clinical evaluation, and a daily schedule should have been already developed. SOPs across many different facilities will not be identical.

**Suggested Initial SOP Chapters:**

1. **Description of Program**: What can patients expect from the program? What are the goals and objectives? How long is the duration of care? What is the process for admission referrals?

2. **Admission Criteria**: What are inclusion and exclusion criteria, referral procedures, and assessment forms?

3. **Admission Procedure**: Expectations for patient and family engagement. Is there a waiting list? If so, how is it to be managed?

4. **Weekly Schedule of Activities**:

5. **Instruments, Tools, and Questionnaires**: This chapter should provide copies only of tools in actual use.

6. **Patient Medical Records**:
   
   a) **Content**: Copy of a complete empty record, including templates for patient care notes and summaries of team case discussions for the individual patient.
   
   b) **Privacy/Confidentiality**: Copy of relevant Philippine laws and precautions in place in the Recovery facility.

7. **Clinic Records**:
   
   a) **Administrative Records**
   
   b) **Personnel Records**, including supervision notes and performance evaluations.
   
   c) **Data Management**

8. **The Matrix Model**:

9. **Management of pregnant women**: This applies to Recovery Clinics, but not to Recovery Homes.

10. **Management of Slips and Relapses**:

11. **Urine drug testing**: Programs participating in the selected pilot programs will not perform urine drug testing. This is because the pilot programs will make treatment plan and discharge decisions based on clinical factors and clinical assessments. The purpose is to avoid
ruling on urine testing or counts of positive results as a basis for discharge and termination decisions. Such important decisions will be made by considering all available psychosocial factors. Discharge will be a clinical decision based on a review of total case progress.

12. Discharge Criteria
   a) Regular program completion
   b) Premature discharge Against Medical Advice (AMA)
   c) Treatment abandonment
   d) Discharge with referral recommendation
   e) Administrative discharge

13. Program Metrics & Evaluation: Periodic assessments entered into a database for analysis of aggregated results. Some possibilities are listed below. Please note that we want to measure progress, not perfection. This is why we look for patterns of change over time.
   a) Days of drug use in prior 30 days
   b) Days of paid employment in prior 30 days
   c) Days of criminal engagement in prior 30 days
   d) Days of family contact in prior 30 days
   e) Patient satisfaction with program, with staff
   f) Patient self-rating of personal progress
   g) Scoring system for job skills

14. Accreditation and Licensing: DOH

15. Continuing Education Requirements:

6. Community Support Linkages

Community Treatment is delivered by DOH accredited medical professionals while Community Support is provided by lay persons.

Community providers offer many kinds of important support services that cannot be offered by medical clinicians. The most important are vocational services that offer job skills training and work internships and remedial education for basic literacy skills.

1. TESDA: to provide job training and skills development
2. DOLE: assist in job placement
3. CSOs: Civil Society Organizations – partners to link with other service providers
4. DSWD: assist in the initial and continuing care, provide 4Ps provisions
5. DepED: for Alternative Learning System
7. Medical Clinics
8. Legal Aid
9. Faith-Based Organizations: provide spiritual support

VII. GUIDELINES FOR RECOVERY CLINICS

1. General Description:
   a. A recovery clinic shall be specific for Substance Use Disorder (SUD);
   b. It shall be built within or near a local government hospital or health center within the LGU (municipality, the city or province) in order that specialized consultations (e.g., for psychiatric symptoms) or evaluations (e.g., for medical symptoms) may be completed. This proximity makes it possible to utilize physicians on a part-time or on-call basis.
   c. It should serve all drug users who voluntarily enroll in the clinic program, open during office hours. If there is a partner recovery home in the vicinity, the recovery clinic will utilize this facility as a step-up program for intensified care;
   d. Outpatient care programs should offer several kinds of services. The primary educational curriculum will consist of a structured Matrix Intensive Outpatient Program (MIOP). Other program components will be developed during the pilot phase such as:
      1. Intake Assessment via a structured intake information form. This will lead to an individual treatment plan.
         a) The patient will enter a standard group-oriented program, but the individualized treatment will focus on unique issues such as marital distress or particular family problems or emerging psychiatric issues.
         b) Part of the assessment must include a description of job skills and job history.
      2. Individual Counseling
      3. Group Therapy (the primary mode of treatment delivery)
      4. Group Psycho-education (Matrix Model will be the primary model)
      5. Family Education Meetings and Multi-Family Groups
      6. Community Support Linkages

The clinic must comply with the checklist licensing requirement of DOH HFSRBF for non-residential DATRC (Annex 3).
2. Ideally, there must be one Recovery Clinic per Inter Local health Zone (ILHZ)

3. **Staffing Pattern:**

<table>
<thead>
<tr>
<th>Recovery Clinic Staff</th>
<th>Number</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. DOH Accredited Physician</td>
<td>1</td>
<td>on call</td>
</tr>
<tr>
<td>2. Licensed Psychologist / Psychometrician</td>
<td>1</td>
<td>part time</td>
</tr>
<tr>
<td>3. Licensed Social Worker</td>
<td>1</td>
<td>full time</td>
</tr>
<tr>
<td>4. Trained Medical Doctor or Counselor or Nurse</td>
<td>1</td>
<td>full time</td>
</tr>
<tr>
<td>5. Security Officer (basic training requirements completed)</td>
<td>1</td>
<td>full time  part of hospital or health center security</td>
</tr>
</tbody>
</table>

VIII. GUIDELINES FOR RECOVERY HOMES:

1. **Program Description**

   a. A recovery home is a halfway house for psycho-social stabilization of persons suffering from mild to moderate drug dependence who cannot stably cope in their habitual environment (own home and routine or regular contacts) and/or patients who cannot be fully managed in an outpatient setting.

   b. This is a treatment facility will provide therapeutic structure and teaches recovery tools in a less intensive and rigid manner than DATRCs, with a special focus on job skill training and job placement programs. Such component programs will require LGU support for working linkages with corporate entities, local businesses, and government agencies such as TESDA.

   c. It is to be situated within the LGU, accessible, available, and affordable for the most affected populace, most of which are economically and vocationally disadvantaged.

   d. Admission referrals must be made by a Recovery Clinic managing the patient or a DOH trained physician.

   e. Step down patients from a highly intensive residential program with a court order shall continue aftercare within the DATRC system. If the court order is lifted and the patient will agree on a voluntary basis, then they can be admitted to the recovery home program.

   f. Although Recovery Homes are entirely voluntary, there are mandatory rules that must be followed.
Matrix Intensive Outpatient Program (MIOP) will be the basic drug education and relapse reduction curriculum. It is a manual-based program, including handouts for patients that form the basis for therapeutic sessions. It integrates several evidence-based techniques including cognitive-behavioral, motivational enhancement, education and family approaches to target patient’s behavioral, emotional, cognitive and relational issues. The basic program treatment will rely on group methods.

This treatment facility is fully voluntary from admission to discharge. A minimum stay is 4 months and the maximum is 12 months. The decision about the most appropriate length of stay is a staff decision.

In case the patient prematurely terminated his program and would want to be enrolled again, there will be a standard evaluation process formulated by the facility manager and staff.

Recovery Home Services: Recovery Homes are halfway houses for drug dependent patients who require an extra measure of stabilization above the level that can ordinarily be provided in a community clinic or home environment. They are not hotels, and residents will be expected to participate in therapeutic or vocational activities outside during daytime hours and return by curfew. Each Recovery Home will offer a recovery group meeting on a daily basis in the evening. Chores and shared duties will be part of the rules structure and expectations of participation.

Clinical Evaluation: The clinical history will specify why a Recovery Home is indicated for optimal care. It will describe individual goals for each patient, with a particular emphasis on vocational issues and a plan for improving vocational skills and employability.

Linkages: Many services depend on community or government agency providers, it is important to include the nature of the linkage activities in patient progress notes. There should be a means of assessing a patient’s attendance and compliance in externally run programs.

Therapeutic Services: A recovery home is meant to help a patient engage in his community; it is not simply another form of residential treatment. This means that the majority of activities will take place outside of the Recovery Home. The Recovery Home environment is a shared milieu with rules (such as no smoking, chores, and curfew hours) and expectations for participation in activities. However, the following therapeutic services will be offered within the home itself.

1. Individual Counseling
2. Evening Group Meetings
3. Family Meetings
4. Drug Education Meetings

Vocational & Educational Services: Seeking and maintaining employment is a key to stability, but many patients in a Recovery Home will lack education, training, and job experience. Recovery Home staff cannot realistically provide vocational services. Vocational and educational services will typically have to be provided by
working linkages with government agencies (such as TESDA) or with Civil Society Organizations (CSO).

1. Livelihood Training
   i. Vocational and Skills Training
   ii. Employment(Job Placement Assistance
   iii. Educational Programs

2. Recovery Home Procedures:

Recovery Home is a step-up facility for individuals engaged in treatment. Admission requires a referral from a Recovery Clinic or from a treating DOH trained medical doctor. The referral should include a progress report and clearly stated reasons for the referral. Telephone referrals will be arranged with the referring clinic or physician. Any such contacts with outside providers or agencies will require a consent form signed by the patient in order to discuss otherwise confidential information.

Upon admission, an intake interview will be conducted. Whenever possible family members, spouses and partners, and significant others will also be interviewed for collateral data. Key family members should also be interviewed separately in order to facilitate gathering of information that they might be hesitant to reveal in the presence of the patient himself.

Patient and family member and significant others will be given an orientation to the program and their responsibilities to program participation. They will be encouraged to ask questions and to discuss the program components.

The patient will be asked to sign an agreement with the rules of the program and will agree to attendance and compliance with program components. Family members and significant others will be asked to agree to attend family meetings and any requested individual meetings, but will not be required to sign consent documents attesting to their agreement (for them, a verbal agreement, noted in the patient record is sufficient).

b. Recovery Home Discharge:

The minimum time in the program is defined as 4 months; and, the maximum is defined as one year (these parameters will be reviewed and revised if necessary during the pilot phase).

A successful discharge from the program is not defined by how much time has passed, but rather by what the patient has achieved in terms of drug abstinence, therapy participation, and outside linkage work. In other words, it is a clinical assessment made by the staff.

There are five (5) kinds of discharges:
i. **Regular program completion:** A certificate of program completion will be provided. If vocational training has been completed this information should be included in the patient's successful discharge packet. Please note that the program does not and will not certify drug abstinence or drug relapse.

ii. **Premature discharge Against Medical Advice (AMA):** This signifies a premature departure from care based on the patient's free choice, but against the advice of treating staff. No certificate of completion is offered. The medical record discharge note will record an AMA Discharge. No report to authorities will be made.

iii. **Treatment abandonment:** This signifies a disappearance from care without contact or information from the patient. This will be noted in the patient record and no report to authorities will be made.

iv. **Discharge with referral recommendation:** This type of discharge signifies that the 24/7 structures of the Recovery Home have not been sufficient to support and stabilize the patient. The patient may be discharged as unsuitable for this level of care and be given a recommendation to refer himself to a secure DATRC. However, please note that no DDE will be done, and no report to authorities will be made. This decision must be made on comprehensive clinical grounds based on overall compliance, progress, and performance.

v. **Administrative discharge:** This is a discharge based on a clinical decision (irrespective of the patient's wishes). It is usually reserved for cardinal offenses. The recommendation for an administrative discharge may come from one or more staff; but, the final decision rests with the director of the Recovery Home (and the staff recommendation may be overturned).

**Criteria for Administrative Discharge:**

1. Significant threats of violence to staff or other patients in the milieu.
2. Violence against staff or other patients
3. Drug dealing or drug purchases on the premises of the Recovery Home.
4. Theft or destruction of Recovery Home property or property of other patients.
5. Significant refusal to comply with house rules.
c. Ideally: 1 (one) Recovery Home per ILHZ

d. Recovery House Staffing

<table>
<thead>
<tr>
<th>Staffing for 25 to 50 beds</th>
<th>Status</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. DOH Accredited Physician</td>
<td>On call</td>
<td>1</td>
</tr>
<tr>
<td>2. Licensed Psychologist/Psychometrician</td>
<td>Part time</td>
<td>1</td>
</tr>
<tr>
<td>3. Licensed Social Worker</td>
<td>Full time</td>
<td>1</td>
</tr>
<tr>
<td>4. DOH trained Medical Doctor, Nurse or Counselor</td>
<td>Full time</td>
<td>1</td>
</tr>
<tr>
<td>5. House Parents</td>
<td>Full time</td>
<td>3</td>
</tr>
<tr>
<td>6. Dormitory Managers</td>
<td>Full time</td>
<td>3</td>
</tr>
<tr>
<td>7. Security Officers (with basic training requirements completed)</td>
<td>Full time</td>
<td>3</td>
</tr>
</tbody>
</table>

IX. PHYSICAL LAY-OUT OF RECOVERY FACILITIES (ANNEX 2)

X. CHECK-LIST OF REQUIREMENTS FOR RECOVERY FACILITIES (ANNEX 3)

Submitted by:

MA. VILMA V. DIEZ MD, MHA, PHSAE, MNSA CESO IV
Director III