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Concretizing occupational justice principles in Philippine community-based drug rehabilitation practice settings

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ABSTRACT

Background: The substance addiction and rehabilitation situation in the Philippines is a complex health and social crisis that has plagued individuals, groups, and communities in the past decades. While pluralistic and critical approaches to address the drug demand reduction issue are available, hegemonic practices continue to eclipse evidenceinformed approaches underpinned by resiliency and occupational justice perspectives.

Methodology: This case study utilized a qualitative and interpretive approach to describe the practice processes of localized community-based drug rehabilitation programs in selected Filipino communities and to propose concrete practice processes to improve the development and implementation of the local community-based drug rehabilitation. Two independent focus group discussions were conducted. Participants were health care professionals, community workers, and citizens who have an affinity to the substance addiction rehabilitation setting. Framed by the Participatory Occupational Justice Framework, specifically the practice process "engage collaboratively with partners," qualitative data extracted from the focus group discussions were thematically analyzed.

Results: Three themes emerged: (1) Changing perspective: starting from the community; (2) Better together: collaboration and coordination in substance addiction and rehabilitation; and (3) "Juan for All, All for Juan": contextualized strategies in substance addiction and rehabilitation. The findings in the case study reaffirm the value of shifting from an individualistic (symptom-eradication) to populational (social and systemic interventions) perspectives in developing community-based drug rehabilitation programs.

Conclusion: To reify occupational justice and resiliency approaches, proposed strategies include understanding drug use from critical and occupational perspectives, enacting social modeling and mentorship, promoting inter-agency and inter-professional collaborative practices, and infusing culturally appropriate strategies in the development and implementation of local community-based drug rehabilitation programs.

Keywords: *Philippines, occupational therapy, community-based drug rehabilitation program, qualitative*

Introduction

The "war on drugs" is one of the primary campaigns instigated by President Rodrigo Roa Duterte in 2016 to eradicate the crime of using and selling illicit drugs [1]. While the war on drugs campaign rhetorically hopes to engender productivity, peace, and order among citizens, the addiction science community perceives the approach as harmful, ineffective, and inhumane [2,3]. The professional and scientific communities, which mainly depend on evidence-informed knowledge, practice, and policies, are silenced by the reinforcement of a "police-centric and militaristic" approach to address the various issues plaguing Filipino society today [4].

A prominent part of the campaign was the "Oplan Tokhang." In the Philippine Visayan language, the term "tok-hang" is derived from the words "tok-tok" (to knock) and "hang-yo" (to talk). The idea of this police-led operation plan was to go around the community informing citizens about the ill effects and negative consequences of illicit drug use and warning about drug users and sellers [5]. One of the

results of the Oplan Tokhang is the congregation of surrenderers in the nearby village hall where they are profiled and warned. An empirical study by Estacio [6] revealed that 90% of those who surrendered in a Filipino community were mild users of illicit drugs — a report contrary to the narrative published by mass media and law enforcers [6]. Herewith, the same study suggests that the government shifts from a vulnerability paradigm to a resiliency paradigm [6].

A vulnerability paradigm perceives drugs as a powerful chemical object that is harmful and evil and thus should be criminalized, whereas a resiliency paradigm views drugs and drug use from a social constructionist perspective that is the drug problem is perceived as a product of social relations and meaning-making that could be resolved through social learning processes and actions [7]. The war on drugs campaign, including all its mechanisms, espoused by the Duterte administration is an example of a practice underpinned by a vulnerability paradigm. Alternatively, practices that can be employed to build more drug-resistant communities under the resiliency paradigm are characterized by a community-based drug rehabilitation (CBDR) program that is responsive, sustainable, protective, and rights-respecting to the citizens who use or have used illegal drugs [6,8,9].

Occupational Science and Addiction Sciences

Most articles in addiction sciences in the Philippines were written by authors who largely belong to the disciplines of psychology, behavioral sciences, public health, and psychiatry [1-17]. While this illustrates how the field of addiction sciences is both interdisciplinary and transdisciplinary, occupational science is one of the emerging disciplines that aims to contribute to this growing field [18-22]. Occupational science is the study of humans as occupational beings who are viewed to occupy their time with and engage in daily life activities they hold personally or collectively meaningful [23]. The intersection of occupational science with addiction sciences views substance use as an occupation that is constantly shaped by social constructions [19]. In other words, occupational scientists are now foregrounding the discourses in understanding substance use from the nuanced experiences of people rather than underscoring the negative consequences experienced by people from drug use to inform occupational therapy practice, public health interventions, and drug policies. A growing recognition of the concept "dark side of occupation" [24] allows for a critical understanding of underexplored or "hidden" occupations or activities such as using illicit substances. Such perspectives underpin the resiliency paradigm as advocated by addiction scientists and practitioners in the Philippines.

Occupational science is one of the academic disciplines that inform occupational therapy, a professional practice that allows occupational therapists to promote the therapeutic use of activities to enable people to participate, engage, and find meaning in daily life. With the expansion of occupational therapy's scope of practice and knowledge, addressing the causes of injustices and inequality that decrease occupational participation has become an emergent role among occupational therapists [25–29], specifically in substance addiction and rehabilitation settings [10,11]. Espousing the enablement of equitable access to participation in occupations is a concept called "occupational justice".

Occupational Justice: Theory-Practice Dissonance

Occupational justice highlights people as occupational beings who can achieve health by living in a just society where they can have diverse opportunities and equitable resources towards occupational participation in varied contexts. In theory, the concept of occupational justice is facilitated mainly by occupational therapists along with other health and social care professionals involved in justice work. However, Townsend and Wilcock also recognized that some occupational therapists are more interested in the methods and techniques of occupational therapy practice than in activism [30]. As a concept, occupational justice is considered both an aspect of context and an outcome of occupational therapy intervention [31]. However, a critical review revealed that occupational justice cannot be readily translated in occupation-based or occupation-focused practices due to a theory-practice dissonance [32]. This dissonance is reinforced when advocacy, activism, and serving marginalized populations are employed within practice contexts that embrace medical hegemony [33] and profession-centric activities [32].

For instance, in Philippine drug rehabilitation centers, occupational therapists are employed and expected to operate in institutions as health care providers who take care of "patients". Working beyond their designated roles can be seen as deviant and unnecessary, which discourages them from broadening their clinical and analytic lens to identify and address environmental and system-level barriers to participation [34]. Although it is understandable as to why many occupational therapists from traditional and statutory

settings see ambiguity in infusing justice in their everyday practice [35], it is important to appreciate the value of orientation and education on occupational justice. By doing so, occupational therapists can realize how they can help in identifying injustices across the micro, meso, and macro levels of human functioning [34] and in redressing health issues such as drug addiction beyond the ontological framework of biomedical constructs but through the lenses of social, occupational, and justice determinants of health [36]. Additionally, occupational justice must be framed as a part of a larger interdisciplinary discourse to influence policies and practices that will promote justice-oriented social change by the enablement of participation of groups and populations [32] who face complex health and social concerns.

Bridging Disciplines, Professions, and the Theory-Practice Divide

The complexity of the drug use problem in the Philippines cannot be resolved by one agency, profession, or discipline. Clearly, CBDR practices underpinned by the resiliency paradigm necessitate the involvement of different professionals, community players, sectors, government agencies, academics, and all potential stakeholders [37]. While hegemonic models grounded on behavioral change, faith-based, and functionalist approaches are largely employed by the government [12], the focus of interventions has been reduced to behavioral outcomes and crime-eradication rather than addressing social, occupational, and justice determinants affecting individuals and the community's drug-using crises [13, 38].

The participation of various disciplines and professional groups is crucial in mitigating the theory-practice divide by designing practices grounded on a framework such as the Participatory Occupational Justice Framework 2010 [28]. The POJF 2010 (see Figure 1) is a tool for social change that profiled six critical practice processes that galvanize collaborative partnerships to achieve occupational justice for community and populational practice [28]. While the framework follows a non-linear progression, a typical starting and finishing point would be "raising consciousness of occupational injustice" and "inspiring sustained advocacy or closure," respectively [39]. Recently, the POJF 2010 was used to inform substance addiction and rehabilitation practice in the Philippines with the hopes of enabling all the six practice processes [13]. However, due to the time-bound limitations of the study by Sy and colleagues [13], the findings were only able to actuate the first critical practice process (i.e., raising consciousness of occupational injustice), and consequently offered evidence-based suggestions for the other critical practice processes.

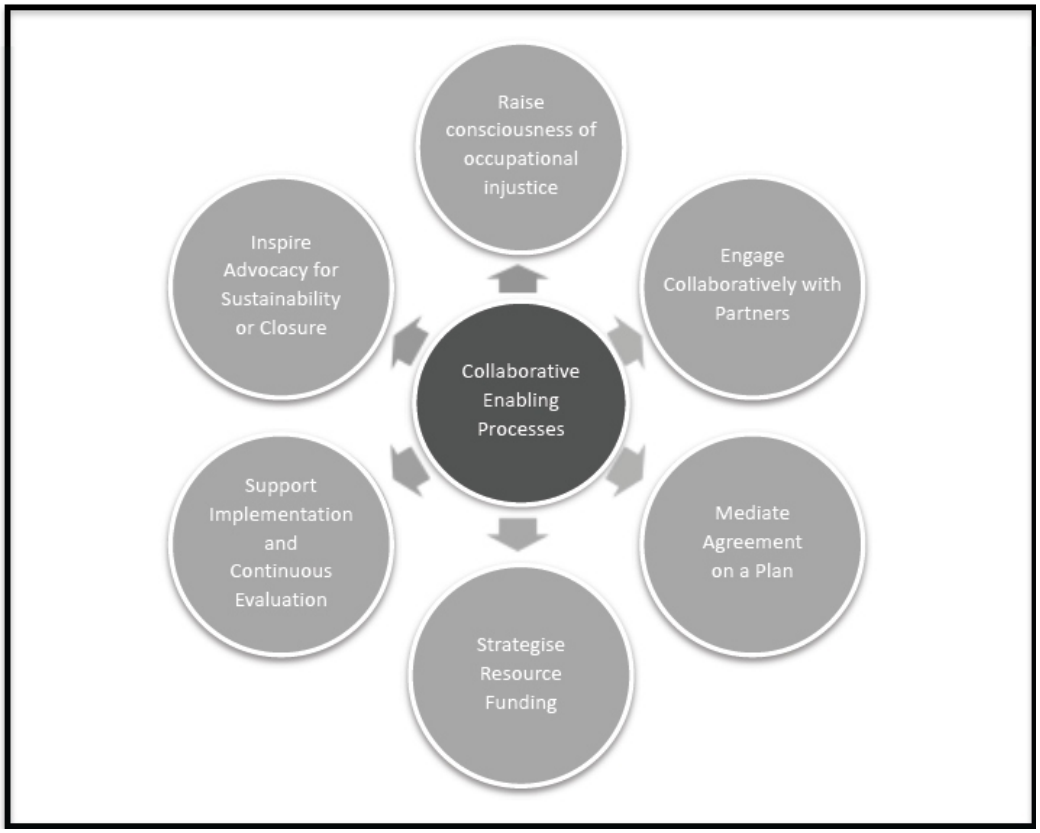

Figure 1. *Participatory Occupational Justice Framework (POJF 2021). Permission to use granted by Whiteford and Townsend..*

Although the POJF 2010 has been used by occupational scientists and occupational therapists researching in occupational justice [13], the terms and guide questions used in the framework are fairly straightforward which foster mutual understanding between professional groups and people [28]. For instance, in substance addiction and rehabilitation settings, the first practice process may be strategically initiated by occupational therapists [11,13], whereas the succeeding practice processes can be fully enacted through the participation of all possible stakeholders underpinned by collaborative practices. This is not to say that we are privileging the POJF 2010 over other frameworks, but are rather describing the POJF 2010 while being aware of existing frameworks applied in local CBDR programs such as the Map of Adaptation Process (MAP) framework [9] and rights-based model [7]. Evidence has already shown that the legalistic, medical, and moralistic solutions towards substance use and addiction underestimate the complexity of substance use as a phenomenon and blindly neglect that the drug problem is but a symptom of deeper structural and systemic ills rooted in social inequality and injustice and the powerlessness among the Filipino people [3,7,38]. Given this position, we hope to reify these POJF practice processes by describing how practitioners and community stakeholders were able to co-create solutions and program approaches.

Purpose

The purpose of this case study was to describe the practice processes of localized community-based drug rehabilitation programs in selected Filipino community-based drug rehabilitation settings. Framed by the Participatory Occupational Justice Framework 2010, specifically the practice process "engage collaboratively with partners," the case study aimed to propose concrete practice processes to improve the development and implementation of the local community-based drug rehabilitation based on focus group discussions.

Methodology

This case study utilized a qualitative and interpretive approach [40] where data sets were extracted from two independent focus group discussions (FGDs), one in 2017 and one in 2019. A case study design was deemed apt in addressing the research objectives in order to provide a systematic understanding of meanings, contexts, and processes by considering multiple perspectives in explaining practice occurrences in occupational therapy through sound evidence [40-42].

Following the POJF 2010 as the primary framework for this case study, the second enablement process referring to "engage collaboratively with partners" would be highlighted. While the data gathered and processed were non-exhaustive, the emergent themes from this case study could offer additional contributions to the on going CBDR program development in the country, potentially bolstering the enactment of the succeeding enablement processes in the POJF 2010. All participants were given an informed consent signifying that their participation was subjected to the principles of the Declaration of Helsinki. This study has an ethics approval from the Tokyo Metropolitan University Research Ethics and Safety Committee (reference number 17016).

Data Sampling and Collection

Purposive sampling was employed to obtain data from participants who are direct stakeholders within the area of CBDR. The two FGDs were done in separate periods (2017, n = 14; 2019, n = 17) and locations (university and community) to ensure a diversity of perspectives, narratives, and interpretations would be curated from the participants. While the sample was taken from only two different sites, this case study did not aim to generalize its findings, but rather to identify theoretical themes that can later inform the CBDR program development process.

The first focus group discussion (FGD 1) was held in 2017 and was composed of 14 mental health professionals (psychiatrists, occupational therapists, psychometricians), community workers (social workers, community leaders, community volunteers), and service users (people who are recovering from drug use). The participants were recruited from a bigger research project [11] done for the first author's doctoral dissertation that was focused on describing the role of occupational therapy in substance addiction and rehabilitation (SAR). The discussion was held in a room located in a university in Manila and was facilitated by three of the authors (MS, MPNR, and RCDR) after a seminar and data collection for a separate research project. The aim of FGD 1 was to gather input from the participants on the following: (1) participants' roles in the CBDR; (2) their knowledge and insights about people who were using illicit substances, environmental supporters, and barriers; and (3) proposed programs and approaches to contextualize CBDR. Specific questions asked during the FGD are outlined in Table 1. The discussion via an open forum lasted for approximately 60 minutes. The discussion concluded with a summarization of discussion highlights. Notes were duly taken by the authors during the entire FGD.

Table 1. Questions asked during the FGDs

	Questions
1	What are the possible roles of health and social health care professionals/workers in substance addiction and rehabilitation?
2	What could be the motivations behind the person who uses and abuses illicit substances?
3	How can we possibly provide environmental support(s) or impose barrier(s) to people with substance use disorder (SUD)?
4	What kind of community, health, and social programs using activities could possibly fit Filipinos with SUD at this time?

Table 2. Descriptions of the two focus group discussions

Focus Group Discussion	Location for the FGD Year done	Number of participants	Composition of the group	FGD flow
FGD 1*	Higher education institution; 2017	14	• Mental health professionals (psychiatrists, occupational therapists, psychometricians) • Community workers (social workers, community leaders, community volunteers) • Service users (people who are recovering from drug use)	• Quantitative data collection • Optional and free seminar on drug addiction and rehabilitation in the Philippines • 60-minute focus group discussion • Summary
FGD 2	Community that implements a CBDR program; 2019	17	• Community workers (community leaders, community workers, and social care workers) • Selected residents from a small community in the city of Manila	• 20-minute didactic • 10-minute instruction for the workshop • 60-minute FGD where the participants were asked the questions (see Table 1) and answered using the *manila* paper and colored marker pens • Summary

Note: FGD I was part of a larger study that collected both quantitive and qualitative data [22].

The second focus group discussion (FGD 2) was held in 2019 in a local community where a CBDR program was in place in accordance with the national campaign against the use of illicit drugs. The FGD lasted for approximately 90 minutes with the permission of the *barangay* captain. This group was composed of 17 participants comprising community workers (community leaders, community workers, and social care workers) and selected residents from a small community in the city of Manila. The group was facilitated by three of the authors akin to the first group. The aim of the FGD 2 was similar to the first one, however, the discussion was implemented differently. Before the FGD, a 20-minute didactic was given and a 10-minute instruction for the workshop. The participants were divided into three smaller groups to answer the questions based on the FGD aims using manila paper and marker pens. Moreover, doing a workshop-type activity enabled the participation of stakeholders through different means not limited to speaking up such as writing, sharing thoughts in a smaller group, and using non-verbal communications to approve or disapprove ideas within a group. This type of collaborative activity was deemed more appropriate for the second group of participants to ensure that everyone had a chance to participate. After the workshop, each small group presented its outputs that were reflective of their answers to the FGD questions. Aside from the actual writings on their manila paper, field notes during the discussion were also collected. A summary of the description of the two FGDs is summarized in Table 2.

Data Analysis

A total of 31 participants from the two FGDs contributed to producing data that were subjected to an inductive thematic analysis [42]. The four authors who contributed to this article participated in the thematic analysis guided by the six-phase guide proposed by Salminen *et al*. (1) become familiar with the data, (2) generate initial codes, (3) search for themes, (4) review themes, (5) define themes, and (6) write the analysis and interpretations. Initially, the authors coded separately (Steps 1 and 2), then convened as a group to discuss the developed themes (Steps 3 to 5). Steps 4 and 5 were done iteratively until the authors reached data saturation. Data saturation was reached when the data being analyzed considered multiple perspectives and generated themes that would answer the research objectives [43].

To ensure that the qualitative data sets were analyzed well, trustworthiness and rigor strategies were employed [44]. These strategies included having more than one person analyzing data, having a detailed list of participants' demographic profiles and descriptions, conducting regular meetings online among the researchers to discuss emergent themes and conflicting interpretations, as well as deciding on the next steps in the process of collection and analyses of data, and finally, generating of field notes during the data collection to further enrich the data. The guide questions used were similar for both FGDs. The second FGD was conducted to confirm if the narratives from the first FGD will have intersections or contradictions with the second one. Employing these strategies contributed to the credibility, conformability, and transferability of the data which contributed to the overall trustworthiness of the current study [44].

Result

After the inductive thematic analysis, three (3) themes emerged: Changing perspective: starting from the community (Theme 1); Better together: collaboration and coordination in Substance Addiction and Rehabilitation or SAR (Theme 2); and, Juan for All, All for Juan: contextualized strategies in SAR (Theme 3). Each theme is described with supporting quotations from the participants extracted from the two FGDs.

Theme 1: Changing Perspective: Starting from the Community

The first theme suggests that CBDR programs may need to veer away from merely looking at symptom control into creating supportive environments where mentorship and community-led programs can be cultivated.

From the analyses, it was seen that the participants' exchanges unearthed their own views on the current drug crises and consequently opened discussions about preventive measures and creative solutions. In the two FGDs, the participants were jointly recounting current CBDR programs that highlight preventive care, with Tracy, a participant from FGD 1, suggesting that "A good prevention program involves mentorship where there is one-on-one correspondence between a model citizen and a citizen who is recovering from drug addiction…" Tracy also added that "a model village can be emulated by other villages" when it came to CBDR programs. While most programs are implemented from a top-down approach, there was a recurring theme among the participants on employing bottom-up approaches. This was articulated by Ramon (licensed counselor, participant from FGD 1), "The government should start their efforts and actions, that is, start from the community…"

In the two FGDs, the participants were jointly recounting current CBDR programs that highlight preventive care such as with the use of modeling. Both groups agreed that providing an opportunity for model citizens or recovered persons who use drugs (PWUDs) to mentor recovering PWUDs. Similarly, other villages can also be emulated from "model villages" that implement best practices in terms of CBDR program implementation. While most programs are implemented from a top-down approach, there was a recurring theme among participants on employing bottom-up approaches where the government should start their efforts and actions from the grassroots.

Theme 2: Better Together: Collaboration and Coordination in SAR

While this case study was led by occupational therapists, the FGDs revealed that the key players in CBDR programs involved a diverse group of people, professions, and agencies. From the citizens who use and do not use drugs to the professionals and non-professionals who work on the grassroots of CBDR programs, collaboration and coordination were perceived as sustainable approaches to co-create solutions to address this large-scale crisis. From a micro perspective, Robert (occupational therapist, participant from FGD 1) suggested having "…transition programs [that] collaborate with private institutions where work may be provided." In the two FGDs, participants collectively mentioned the need to strengthen the coordination between public, private, and non-government agencies, law enforcement, and the church to engender collaborative governance in the development, implementation, and evaluation of CBDR programs. The inter-agency coordination can be made possible through interprofessional collaboration, a strategy that begins with the recognition of key persons involved to improve health and social care outcomes. According to Elmer (village chieftain, participant from FGD 1):

"…local chief executives can initiate community-based SAR through the aid of public and private offices and entities that can provide financial support and other physical aid, while the professionals mentioned can work together in targeting different facets and needs of people recovering…."

In both FGDs, several participants expressed how state-funded programs, such as those implemented in the drug rehabilitation and treatment centers, could be replicated by

integrating them into existing CBDR programs. Alma (occupational therapist, participant from FGD 1) emphasized that close coordination between the CBDR and Technical Education and Skills Development Authority could provide more opportunities for job training to those recovering in the communities.

The FGDs did not end without recognizing the roles of the various key players who were deemed essential in CBDR programs. Participants across the two groups came from diverse backgrounds with professional roles (i.e., chief executives, barangay health workers, people in the welfare sector, religious sector, teachers, private and public offices and entities, and family members of people with SUD) implying a breeding ground for collaborations and conflicts. By embracing a change in perspective (Theme 1), collaboration and coordination can sustain the implementation of CBDR programs and enhance conflict management capabilities among identified key players.

Theme 3: "Juan for All, All for Juan": Contextualized Strategies in SAR

Translated as "one for all, all for one," the last theme literally means that all the members of a group support each of the individual members, and vice-versa. This theme utilized the word "Juan" to denote "one". In Filipino culture, the name "Juan" (pronounced as hwahn), a common Filipino name, represents a Filipino individual. Since the name "Juan" and "one" are homonymous, these words are commonly interchanged to convey a cultural undertone when describing a person from the Philippines.

Participants from both FGDs agreed to the idea that one way of contextualizing the CBDR programs is to actuate culturally-appropriate strategies. Considering new and different perspectives (Theme 1) and collaborative approaches (Theme 2) in SAR entails openness to opportunities to integrate cultural values within practices. For instance, Carlo, a participant from FGD 1 suggested, "Perhaps we can propose a new word for 'rehabilitation', as it gives a negative connotation to the public in order to improve the process". When asked by the moderators to elaborate on his suggestion, he explained that relabeling can help deface the stigma attached to SAR and could potentially encourage more, especially young people, to take part in the recovery and reintegration programs.

Moreover, a list of activities to be integrated into the CBDR programs was suggested by the participants in FGD 2 such as sports and physical activities, job training, wall painting, clean-up drives, self-care campaigns, family-care, and drug education seminars, community contests, and religious observance among others. Going deeper into the accounts and outputs from the FGDs revealed how cultural nuances underpinned the activities suggested such as basketball and volleyball among sports activities, competitions like beauty pageants, singing and dancing contests, bingo games, ritualistic activities for the Catholic Church, and small-scale enterprise training.

While most of these activities and programs are to be done by "all for Juan", Maria (occupational therapist, participant from FGD 1) proposed to "....give roles to the citizens [who use or used drugs] during their recovery period...." This proposal hopes to complete the equation: "Juan for all".

Discussion

While there is a need to recognize that a total change of perspective is not feasible, micro-transformations through evidence-informed policies and programs in the SAR settings are more doable. This is to say that shifting from a vulnerability to resiliency paradigm may take time, resources, and a deeper understanding of the drug crises. A paradigm shift entails critical thinking where drug use and addiction should be seen from critical perspectives. One way to do that is by deconstructing the doing of illicit drug use from an occupational perspective where drug use is considered an occupation. While occupations have traditionally been attributed to activities that occupy people's time, give them meaning, and lead towards positive health and well-being, Twinley's concept on the "dark side of occupation" challenges this notion [24]. She argues that some occupations, including using illicit drugs, while health aversive, can occupy people's time, give meaning to them, and can help people participate in daily life [18–22,45]. Considering multiple perspectives in understanding a social phenomenon can allow for the passing of evidence-based policies and program development surrounding CBDR practices in the country.

Moreover, anchoring our actions from a resiliency paradigm entails not only building CBDR programs per se, but intentionally engaging in social learning processes and actions [7]. This case study suggests that mentorship and modeling are examples of social learning processes. Modeling can be done through social participation interventions that aim to (re)establish social and communication skills, help prioritize routines and roles, and facilitate education and work coaching leading to enabling occupational justice outcomes [13]. Although the concept of mentoring or peer mentoring has been widely used in institutionalized SAR programs, mentoring

practices must be continued when individuals return to the community. Although there is a paucity of peer mentoring studies in the context of CBDR, a review study revealed that peer mentoring can potentially reduce substance use, improve engagement, reduce human immunodeficiency virus (HIV) risk behaviors, and improve substance-related outcomes [46]. Examining the drug crisis beyond the individual is a sub-theme that recurred across the FGDs. This revelation foregrounds how engaging with partners requires all stakeholders to actuate micro transformations by considering contexts and environments, and not only symptom-eradication, in designing programmatic interventions [33].

Following the focus on collaborative practice, a study identified that sectoral government collaboration along with community engagement, human resources capacity, funding support, and a diversified source of revenue are pivotal determinants for community sustainability [47]. Other ways to further galvanize sustainable CBDR programs include building support from key individuals and agencies which entails embedding changes in the operations of the agency, filling a critical gap in the sector, and planning realistically for future ownership [48]. Employing these strategies leads to what is often referred to as "collaborative practice" where multiple health and social care workers provide comprehensive services by working with patients, their families, carers, and communities to deliver the highest quality of care across settings [49]. Through collaborative practice, resources are expanded to rural and underserved communities within SAR settings [37]. The second enabling process of the POJF 2010 promotes collaborative practice which entails partnership between experts and the community in all dimensions of SAR practices including service delivery, community development, education and training, documentation, and public communication among others. By recognizing the scope of work within the partnership, micro transformations in practice can be initiated and community ownership of the CBDR program can be expected.

The *barangay* system, the smallest unit of government in the Philippines, acts as the starting point for local governance and leadership which include planning, budgeting, and executing community-level engagements [15]. These engagements are crucial in initiating community development measures and actuating culturally appropriate approaches such as the resiliency paradigm. Moreover, within the context of promoting occupational justice, we have to note that the contemporary barangay has its own justice system where community leaders and elders provide alternative dispute resolution to those in conflict through speedy, cost-efficient, and non-adversarial processes [15, 16]. While not exactly similar in nature, the concept of occupational justice (framed within POJF 2010) and the justice system of the contemporary *barangay* have intersections that mirror the ancient Filipino custom called "Bayanihan." According to Ang [17]:

Bayanihan is also known as *tulungan* (help) or *damayan* (aid), a system of mutual help and concern which has become the backbone of family and village life throughout the Philippine archipelago. It may also be expressed as *pagkakaisa* (to be one; to be united). The people who get together or unite to execute a job are the *magbabayani*.

While often used to coin advocacy works and projects, *bayanihan* must be perceived as more than just a terminology or slogan, but rather a tradition that has a potential to inform contemporary approaches in building the *barangay*. Underpinning practices and approaches with Filipino cultural elements can allow for a more nuanced way of conceptualizing plans for and evaluating the impact of community programs [10], such as in CBDR. This suggests a reinforcement of unorthodox practices within SAR settings such as relabeling SAR programs intentionally and sensitively, encouraging citizen accountability and ownership, and enabling participatory approaches during community reintegration of citizens who (mis)use illicit drugs.

Conclusion

This case study described the practice processes of localized community-based drug rehabilitation programs in the Philippines. Framed by the Participatory Occupational Justice Framework 2010, the case study aimed to recognize the existing gaps and consequently propose potential solutions based on the outcomes of the focus group discussions. Eventually, three themes emerged that articulated what the second practice process (engage collaboratively with partners) constitutes in the SAR setting within a Filipino context: Changing perspective: starting from the community (Theme 1); Better together: collaboration and coordination in SAR (Theme 2); and, Juan for All, All for Juan: contextualized strategies in SAR (Theme 3). Like in any qualitative inquiry, potential biases can be seen in self-reported data. However, the findings from this case study aim to provide a systematic manner of considering critical perspectives that inform practices across the fields of occupational therapy, occupational justice, and substance addiction and rehabilitation. This case study then suggests that micro transformations, through enabling social learning, systemic interventions,

and critical and occupational understanding of drug use, can aid in foregrounding a resiliency paradigm in the SAR setting (Theme 1). The paradigm shift can then be enacted through intentional collaborative practices (Theme 2) and culturally appropriate approaches (Theme 3) that can activate other practices processes towards sustainable advocacies and resilient communities.

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