Development of Community-Based Mental Health Interventions in The Philippines: An Ecological Perspective

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ORIGINAL RESEARCH PAPER

Development of Community-Based Mental Health Interventions in The Philippines: An Ecological Perspective

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Abstract

Although urbanization is linked to modernization and economic growth, it is also associated with overcrowding, population density, poverty, inadequate social services, and violence, all of which put the urban poor at risk of environmental health problems and other dangers. Moreover, experiences of environmental and psychological adversity increase vulnerability to mental health disorders. Unfortunately, in low resource countries, mental health treatment is largely inaccessible to the poor. This paper describes the challenges in the development and implementation of community-based mental health interventions in the Philippines. It summarizes the internal and external resilience factors and vulnerabilities of clients. It also highlights the key drivers and barriers to establishing community-based mental health interventions in the Philippines.

With an urbanization rate of 45.3%, the Philippines is considered a highly urbanized nation. However, urbanization has brought about a myriad of economic and social problems. A study by the Human Cities Coalition (2016) suggested that the steep increase in urbanization has contributed to a 300% increase in inequality in the country. Congestion, combined with ineffective urban planning and land management, has led to more than a third of the Philippines' urban population living in slum areas that are riddled with crime. Moreover, unemployment and the lack of basic urban services make the urban poor vulnerable to environmental health risks as well as the danger (Human Cities Coalition, 2016).

Concomitant with urbanization and its problems is the issue of mental health. Stressors such as overcrowded and polluted environments, high levels of violence, and employment migration are associated with an increase in mental health disorders (Srivastava, 2009). A study by Reddy and Chandrashekar (1998) revealed a higher prevalence of mental disorders such as anxiety and depression in urban rather than rural areas.

The World Health Organization's (WHO, 2010) public health pyramid suggests four tiers of a mental health service delivery. The first tier include specialized interventions delivered by mental health professionals. The second tier includes focused, non-specialized interventions delivered by trained community mental health workers. The third tier includes family and community support services and programs. The fourth tier involves providing for community members' basic needs. Unfortunately, many citizens in low- and middle-income countries cannot access mental

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health care because of the lack of resources and mental health professionals (De Silva, Samele, Saxena, Patel & Darzi, 2014). In these contexts, mental health interventions delivered by ordinary community health workers are critical (Rahman, Malik, Sikander, Roberts & Creed, 2008). Unfortunately, there is a dearth of research on community-based mental health interventions in low-income countries. This paper seeks to contribute to the literature by describing the development and implementation of community-based mental health interventions in the Philippines. Using a psych-ecological systems perspective, it describes the development of a community-based intervention for disaster survivors and another intervention in drug addiction recovery. It presents the outcomes as well as the common challenges facing the implementation of community-based interventions.

Community-Based Interventions

The term community-based intervention (CBI) has taken on different meanings and applications. McKleroy et al.' s (2003) typology classified CBIs into four types. The first type is communities as settings for interventions. These are interventions that aim to change community members' behaviors to reduce the risk of disease. The second type of CBI is where the community as a whole is the target of change. The goal of this type of intervention is to create healthy environments by facilitating systemic changes in public policy, institutions, and the delivery of services. The third type of CBI is the community as a resource in designing and delivering interventions. The fourth type of CBI is where the community itself is both the target and agent of change. With the first two types, the conceptualization and implementation of the intervention may be conducted primarily by external change agents in consultation with the community. In the third type, a community's internal resources are marshaled to change health behaviors although interventions may be designed by external resources outside the community. The fourth type of intervention harnesses the natural capacities of communities to help their own community members.

Psycho-Ecological Systems Model

Although CBIs can target individuals, what differentiates them from psychological interventions is the recognition of the role of context. Socio-ecological theories, such as that of Bronfenbrenner (1979), view individual behaviors not only as a product of individual knowledge, values, and attitudes, but as a result of a host of social influences. This type of theory suggests that individuals are embedded within interdependent systems, including the people they associate with, the organizations they belong to, and the communities where they live. Bronfenbrenner's ecological theory describes a number of systems that influence individuals. The microsystem is the layer closest to the individual and typically includes the family, school, and neighborhood. The meso-system describes the connection between the structures in a person's microsystem (i.e., church and neighborhood; parent and church). The exo-system is a greater, wider setting which may not directly impact upon a person but may indirectly affect him/her. This may include the extended family, local government, business and industry, and social services agencies. A final layer is the macrosystem that includes cultural beliefs, customs and rituals, and political dynamics.

Building on Bronfenbrenner's model, Reeb et al. (2017) proposed the psycho-ecological systems model (PESM) that highlights individual vulnerabilities and resilience factors. Vulnerabilities are internal risk factors such as low self-esteem, maladaptive behavior, mental illness, and risky behavior. On the other hand, resilience factors are internal characteristics that promote adaptation and enable people to overcome challenging situations. These may include intelligence, adaptive coping skills, and good health. In addition, the PESM also adds another system to Bronfenbrenner's model–the supra-macrosystem that includes the international/global system.

The PESM model suggests that the development of CBIs should begin by identifying individual resilience and vulnerability factors. Reeb et al. (2017) also suggested the importance of understanding an individual's receptivity to and readiness for

interventions. At the same time, they also emphasized the importance of understanding a community's social context and the external factors that may shape individual behaviors. This framework suggests that changing individual behavior may require changes in the capacity of family support, social network influences, neighborhood characteristics, organizational policies and practices, community factors, public policy, the physical environment, and the community culture (Reeb et al., 2017). McKleroy et al. (2003) contend that understanding a community's ecology can lead to the development of more appropriate interventions and more refined methods for addressing complex public health problems, such as infant mortality, violence, and substance abuse.

Using the PESM model, this study investigated the design and implementation of community-based mental health interventions in the Philippines; one in the context of post-disaster and the other in the context of substance abuse. Specifically, it examined the internal and external factors that influenced each CBI's development. Moreover, it identified the common supports and challenges encountered during the implementation of community-based mental health interventions.

Methods

This study involved comparative case studies (Yin, 2003) using secondary data from project publications as well as reflections from personal involvement in these projects.

Case One: Katatagan: A resilience intervention for Filipino Disaster Survivors

In November 2013, the deadliest typhoon in the history of the Philippines affected 16 million, killed over 6,000 and displaced four million Filipinos (NDRMMC, 2014). Half a year later, the World Health Organization estimated that 80,000 survivors were at risk of mental health disorders and were in need of mental health services (WHO, 2014). However, beyond the provision of post-disaster interventions such as Psychological First Aid, the country did not have access to any evidence-based mental health interventions for survivors who were

still experiencing trauma symptoms months after the disaster.

To fill this need, the Psychological Association of the Philippines (PAP) embarked on the development of a mental health intervention for disaster survivors in the recovery phase. The design process brought together psychologists from all over the country who were involved in post-Haiyan recovery efforts, and a volunteer clinical psychologist with extensive experience in disaster recovery from Palo Alto University, USA, who served as resource person and consultant. The subject experts identified the needs, protective factors, and vulnerabilities of survivors. They noted the vulnerabilities of survivors included inadequate resources, a lack of information on services, and the inefficient delivery of services. They also noted a lack of stakeholder coordination and turf wars between government institutions. Another critical gap was the lack of mental health professionals. This gap was exacerbated by the fact that in the worst-hit areas, natural caregivers such as social workers, teachers, and health workers were themselves survivors and traumatized (Hechanova et al., 2015).

However, psychologists also noted protective factors among survivors; including a strong faith in God (90% of the population are Catholics/Christians), family and community support, and a sense of humor amidst adversity. Despite these protective factors, psychologists noted that some survivors were showing signs of trauma including body pains, palpitations, inability to sleep, alcohol and drug use, guilt, anxiety, irritability, inability to concentrate, and hopelessness (Hechanova et al., 2015).

A resilience program was designed as a focused, non-specialized intervention for survivors who were experiencing mild to moderate anxiety. To respond to survivors' psychosocial needs, the intervention focused on key elements of resilience: self-efficacy, managing physical reactions, managing emotions, managing cognition, problem solving, social support, and giving hope. The intervention was eventually named Katatagan (Filipino for strength or resilience). It consisted of six modules: Kalakasan (finding and cultivating strengths), Katawan (managing

physical reactions), Kalooban (managing thoughts and emotions), Kapakipakinabang na Gawain (engaging in regular and positive activities), Kalutasan at Kaagapay (seeking solutions and support), and Kinabukasan (moving forward) (Hechanova et al., 2015).

Katatagan was founded on cognitive behavioral therapy (CBT) and mindfulness that both have a robust evidence base for helping disaster survivors. Structured modules were designed to be delivered in small groups of 5–8 participants in one and a half hours. Modules included a centering mindfulness exercise, psychoeducation, a structured learning experience, and reflections on application. In recognition of the protective role of spirituality, groups were given the option to close with a prayer. The designers implemented a process of module design, manual development, review, finalization, and translation before it was pilot-tested (Hechanova et al., 2015).

Findings on Evaluation and Implementation. Initial pilot testing was conducted among college students in a city that suffered the most casualties from Super Typhoon Haiyan. To ensure that the intervention was offered to those who needed it most, pre-testing was conducted among students, and those with elevated anxiety symptoms were invited to participate. The study used a quasi-experimental longitudinal design with an intervention group (n=35) and a nonintervention group (n=30). Coping behaviors, posttraumatic stress symptoms, depression, and anxiety were measured at pre-intervention, post-intervention, and follow-up after six months. Those in the intervention group demonstrated significant decreases in anxiety, stress, and depression post-intervention but these changes were not sustained during the follow-up. Small effect sizes (.00 to .33) were obtained for all outcomes. Evaluation from participants and facilitators revealed generally positive feedback although facilitators did suggest some modifications to the program (Flores, 2018).

The Katatagan intervention was also implemented among adult survivors by volunteer psychologists in other cities affected by the Super Typhoon. The second study utilized a longitudinal design and researchers administered surveys measuring self-efficacy in resilience skills in each module before, immediately after, and six months after the intervention. Given the urgency and lack of mental health workers in the affected communities, the intervention was facilitated by volunteer psychologists who delivered the intervention as part of medical missions.

Results revealed significant improvements from pre to post-test scores in all six areas. In addition, the sixth-month follow-up scores were significantly higher in five of the six skills: harnessing strengths, seeking solutions and support, managing physical reactions, moving forward, and seeking solutions and social support. Overall effect size was medium (d=.69; ranged = .33 to .83). However, there was a lack of significant improvement in two coping self-efficacy measures (managing thoughts and emotions, and positive activities). The authors noted that the module on managing thoughts and emotions appeared to be the most difficult for participants, and suggested the need for booster sessions to strengthen this ability (Hechanova, Waelde & Ramos, 2016).

A third study was conducted among displaced survivors eighteen months post-disaster and was delivered by trained paraprofessionals as facilitators rather than psychologists. A quasi-experimental and mixed-methods design was used to compare a treatment group with a control group before, immediately after, and six months after the intervention. Participants were displaced survivors in temporary resettlement site eighteen months after the disaster. The majority were women as there appeared to be reluctance among men to seek help. Results revealed a significant time and group interaction for both anxiety ($F(1, 105).=3.89$, $p<0.05$) and resilience ($F (1, 105)=.4.68$, $p<0.03$). The intervention groups had lower anxiety scores and higher resilience scores post-test compared to the non-intervention group, whose anxiety scores did not change considerably over time. The intervention group scores showed that anxiety was lowest immediately after the intervention but increased somewhat over time. However, anxiety scores six months later remained significantly lower than before participants went through the intervention. In addition, resilience scores continued to increase over

time. There was no time x group interaction for adaptive coping (Hechanova et al., 2018).

Follow-up focus-group discussions with displaced survivors revealed a number of continuing challenges that may have affected the decrease in adaptive coping behaviors. A major challenge was the subhuman conditions in the resettlement community. At that time, the national government agency responsible for camp management had pulled out and transferred this responsibility to the local government. However, there was no oversight from the local government and community members struggled daily due to the lack of access to water, food, electricity, education, social services, and employment opportunities. Moreover, although the site was supposed to be temporary, survivors had been there for eighteen months and there was no clear communication about plans for permanent resettlement. The only help the community received was occasional assistance from non-profit organizations (Hechanova et al., 2018).

Case Two: Community-Based Drug Recovery Intervention

The Philippines, like other countries worldwide, has always struggled with the issue of illegal drugs. However, its salience was heightened when President Rodrigo Duterte came into power in June 2016 and proclaimed a 'war' against illicit drugs. This campaign involved both supply reduction (shutting down drug laboratories and arresting drug suppliers) and demand reduction (community officials/local police going to the homes of known users asking them to voluntarily surrender and receive treatment). About 1.18 million drug personalities surrendered and the Philippine's Dangerous Drug Board reported that 90% of these were low to mild-risk users who could be treated in the community (Cepeda, 2016).

Unfortunately, the Philippines did not have a history of community-based drug rehabilitation (CBDR). Like many countries in Asia, illicit drug use was treated primarily using incarceration or through residential treatment (Vuong et al., 2017). With over a million potential clients for CBDR, communities were hard-pressed to develop programs. The CBDR programs that emerged were mainly diversion programs that included recreational activities (e.g., sports activities, aerobics, Zumba, etc.), counseling, religious activities (e.g., bible study, prayer groups), and community service (e.g., street cleaning, tree planting, etc.). Despite the diversion programs, "surrenderees" continued to lapse into drug use and drug-related arrests, and extra-judicial killings began to mount. By June 2018, the Philippine National Police reported a total of 149,265 arrests and 4,500 drug-related killings (Talabong, 2018). What was clearly lacking was evidence-based drug recovery treatments that could be delivered by community members.

Given the urgency of the need, the PAP developed a community-based drug intervention. The design team embarked on a cultural adaptation of existing evidence-based programs using the Map of Adaptation Process" (MAP): 1) assessment of needs and risk factors; 2) designing the intervention based on cultural and contextual nuances; 3) training of facilitators and pre-testing of materials; 4) pilot-testing; and 5) implementation and continuous evaluation (McKleroy et al, 2006).

The development of the CBDR intervention utilized a participatory action-research approach in a community that had an active Anti-Drug Abuse Council and a strong partnership with the church and police (Ugnayan ng Barangay at Simbahan). As part of needs analysis, interviews were conducted with drug users from an urban poor community. Results confirmed that the majority of users were low to mild-risk users, and only 15% were at moderate risk. The majority of users were male, poor, uneducated, and unemployed. About two-thirds of respondents reported adverse childhood experiences, such as physical and emotional abuse, or neglect (Hechanova et al., 2018).

Peer and family influence was the often-cited factor that led to first use. Although there were those who used drugs for recreational purposes, some reported using drugs to stave off hunger, or to work longer and harder. Most of the interviewees were unaware of the negative effects of illicit drug use, but were motivated by their families to stop using, or by fear of death. Although more than half reported that they have tried to stop using, the majority had lapsed more than once. Although

recovering users had the intention and desire to stop, the majority lacked adaptive coping skills and knowledge about how to do so (Hechanova et al., 2018).

In a design workshop, the researchers reported the results to a group of addiction professionals, mental health professionals, community leaders, stakeholders, and recovering users. They presented a draft intervention framework and theory of change. Participants were also asked to examine existing evidence-based materials-the Matrix Intensive Outpatient Program (MIOP) (SAMHSA, 2006) and the UNODC Trainer's Manual on community-based services for people who use illicit drugs in Southeast Asia (2015). Stakeholders affirmed the relevance of the programs but raised concerns about the suitability of some materials given participants' low literacy levels. They suggested the need to simplify concepts and use creative and active interventions rather than cognitive approaches. Given the lack of resources, stakeholders also suggested minimizing the materials or equipment needed. Finally, stakeholders proposed the inclusion of spirituality in the design of modules (Hechanova et al., 2018).

The community-based drug intervention was named Katatagan Kontra Droga sa Komunidad (Resistance to Drugs in the Community). It consisted of fifteen modules; twelve were individual modules and three were family modules. The first six individual modules focused on drug recovery skills: 1) Understanding Drug Addiction; 2) Importance of Change; 3) Coping with Cravings; 4) Managing Triggers; 5) Saying NO to Drugs; and 6) Adopting a Healthy Lifestyle. The next modules focused on life skills: 1) Managing Thoughts & Emotions; 2) Relating to Others; 3) Restoring Family Relationships; 4) Problem Solving; 5) Recognizing My Strengths; 6) Finding Meaning and Planning for the Future. The family modules included: 1) Understanding Drug Use; 2) Drug Use and the Family; and 3) Families Recovering from Drug Use.

The modules utilized four theoretical foundations: motivational interviewing (MI); CBT; mindfulness; and family systems theory. Motivational interviewing (Miller & Rollnick, 2012) was used to make clients reflect on the benefits and risks to them and their family. MI tools such as the assessment ruler were used to facilitate clients' reflections upon their readiness to change. Beyond being embedded as a design element, MI skills (including reflective listening, rolling with resistance) were taught to facilitators.

Cognitive behavioral therapy (Beck, 1970) that has the broadest evidence base for drug recovery (Magill & Ray, 2009), was used to help people understand what drives them to use, and the link between drug use, emotions, and cognition. CBT was incorporated into the modules on managing cravings and triggers. CBT was also used to improve life skills such as managing negative emotions.

There is emerging literature on the effectiveness of mindfulness-based relapse therapy (Li, Howard, Garland, McGovern, & Lazar, 2017) as a means to help recovering users gain control of their cravings. Mindfulness was used in centering exercises and to manage cravings, stress, and negative emotions.

Finally, the family modules were designed using Minuchin's (1974) structural family theory. The modules sought to help family members understand how their dynamics may influence drug use or recovery. The modules also used de Shazer and Berg's (1986) solution-focused therapy to help families set goals and plan for the future.

Given the Philippines' collectivist culture, the intervention was designed to be delivered in small groups. The importance of the arts in the Philippine culture was also harnessed in the use of creative activities. Recognizing the role of religion, the groups were encouraged to start and end the sessions with a prayer or inspirational song of their choice (Hechanova et al., 2018).

Once the intervention design was finalized, 111 community facilitators took a five-day training workshop where they were that taught facilitation skills. Participants were asked to simulate facilitation of the modules while they were being coached by a psychologist. Pre and post-workshop surveys revealed a significant change in perceived competence in facilitation ($F_{(1, 110)}=3.85$, $p<.01$); motivation ($F_{(1, 110)}= 3.05$; $p<.01$), and commitment to facilitate ($F_{(1, 110)}= 2.00$, $p<.05$). Community facilitators

revealed that they appreciated the module design and content, the manual, use of simulations, and coaching. They also reported that the workshop increased their knowledge of drug use, changed their attitudes, made them more empathetic, and strengthened their commitment to help recovering users (Hechanova, Alianan, Calleja, Acosta & Yusay, in press).

Findings on Evaluation and Implementation. The intervention was pilot-tested with thirty-five low to mild-risk illicit drug users in an urban community in Metro Manila. However, only fifteen participants were able to complete all fifteen modules. In general, participants were predominantly male and in their mid-30s, married, and about half were unemployed (Hechanova et al., 2017).

Surveys were administered pre, mid, and post-intervention. They measured substance dependence, adaptive coping skills, and psychological well-being; and were administered before the first module, after the sixth module, and after the twelfth module. Paired sample t-tests, revealed small but significant effect sizes on drug use recovery (F (1,23)= 2.77, p<.05) and family support (F(1,23) = 2.58, p<.05).

Post-program focus-group discussions and interviews were conducted with participants. Feedback revealed that the ability to manage participants' cravings and avoid triggers of drug use were the most common skills acquired from the course. Participants also reported that the program helped them improve their family relationships. Focus-group discussions with family members revealed that participants became more responsible, and would even reach out to friends who were still using to encourage them to seek help. They also reported improvements in family relationships as a result of the intervention (Hechanova et al., 2018).

Despite promising outcomes, field observations revealed a number of challenges in the delivery of the intervention. A major challenge was the dearth of personnel to deliver the interventions. In some communities, this was addressed by using volunteers, especially among church groups. However, the downside was the lack of accountability and

consistency in the attendance of volunteer facilitators (Hechanova et al., in press).

In addition, although all the community facilitators were trained prior to deliver the program, field observations revealed an uneven quality of facilitation. Although field coaching was offered, not all community facilitators were comfortable being monitored and coached (Hechanova et al., 2017).

Another major challenge was participant attrition. Some participants stopped attending because they lacked money for transportation. Others dropped out when they found employment that conflicted with the schedule of the intervention. Initially, the sessions were held during weekdays, and there was a clamor for Sunday sessions. However, in a predominantly Catholic country where Sunday is considered a day of rest and worship, it was a challenge for local government to recruit facilitators willing to run sessions on this rest day (Hechanova et al., 2018).

Field observations also highlighted safety and security issues. The presence of extra-judicial killings was a real concern and although there were no accounts of KKDK participants being threatened or killed, the presence of police who dropped by to monitor the program made participants uneasy. Participants also reported that pushers continued to tempt participants; some even going as far as offering drugs for free (Hechanova et al., in press).

Participants also cited the continued presence of stigma in their community. To some extent, this can be attributed to the Philippine Drug Law (RA 9165) and the punitive approach to drug demand reduction. Statements of government leaders that addicts are "not human" (Viray, 2017) were echoed at the community level, with some barangay officials and local law enforcers using the terms "peste" (pest) and the extra- judicial killings referred to as a form of "pest control." Other community leaders viewed lapses as a failure of treatment, or the inability of users to reform, rather than being part of the recovery journey (Hechanova et al., 2017).

Another major challenge was the lack of resources in communities. Communities did not have private venues for sessions, dedicated budgets for training facilitators, food, materials,

and salaries or allowances for community facilitators (Hechanova et al., 2017).

Still, yet another barrier was the bottleneck in screening. The Philippine Drug Law requires that recovering users participate in a drug dependency assessment prior to treatment. However, only doctors accredited by the Department of Health are allowed to conduct assessments, and there are only about 500 accredited doctors nationwide. As a result of this, there was a large backlog of prospective participants, and a study on the implementation of CBDR revealed that less than 15% have actually been treated (Hechanova, de Guzman, Calleja, & Canoy, 2018).

Families were both a recovery capital as well as a barrier. Recovering users who had the support of their family recovered better than those who were isolated. However, majority of recovering users had experienced adverse childhood conditions, suggesting the need for universal prevention programs, such as family and parenting programs (Hechanova et al., 2018).

Finally, a major barrier was the apparent turf war between government agencies. Local government units were confused by the contradictory messages from the various government agencies involved. Both the Department of Health and the Department of Interior and Local Government issued guidelines for the implementation of CBDR that were not necessarily consistent. There was also confusion between the police and local government in terms of who would be the target of drug assessment and treatment. There were reported quotas for "surrenderees" that resulted in some individuals who had not used for a number of years, or even decades, still being included in the "drug watch" list. At a local level, there was also inconsistent support for CBDR. In some instances, the city government was supportive but there was no support at the community level or vice versa (Hechanova, de Guzman, Calleja and Canoy, 2018).

Despite these barriers, there were also enablers of CBDR. An important enabler was good governance. Notably, some community leaders took a holistic approach and provided complimentary interventions such as physical exercise, spiritual programs, and livelihood and employment in some communities. Community support and donations from church groups were important for providing the venue, food, and materials for the program. In general, it was observed that communities with better support had better attendance and recovery rates (Hechanova, de Guzman, Calleja and Canoy, 2018).

Citizen engagement and a strong relationship between community leaders, the Church, and the police were also critical. Spiritual activities became a common part of CBDR. In some communities, it was mainly church volunteers who implemented the CBDR program (Hechanova et al., 2018).

Another enabler was the social support that developed within the groups themselves. It was observed that midway through the treatment, the groups became cohesive and became important sources of social support for members. They would pick each other up on the way to the session and became a source of support outside the sessions (Hechanova et al., in press).

Discussion

Resilience Factors and Enablers

The development of community-based interventions for disaster survivors and recovering drug users highlights common resilience factors and enablers (see Table 1). At the individual level, spirituality appears to be a resilience factor in both dealing with disasters and recovering from drug use. Nakonz and Shik (2009) suggested that religion influences how Filipinos cope in a number of ways. Filipinos cope by seeking divine intervention and by praying for the strength to deal with their situation.

Another resilience factor, particularly post-disaster, was the use of humor to deal with adversity. This is consistent with other studies that show that humor is often used to help detach or distance oneself from traumatic situations or as a means of emotional regulation (Kuiper, 2012). However, Kuiper also notes that there is growing research indicating that humor is not a unidimensional construct, that when it is affiliative and self-

Table 1. Common Enablers and Barriers in the Delivery of Community-Based Intervention

	Resilience Factors/Enablers		Vulnerabilities/Barriers	
	Disaster Intervention	**Drug Recovery Intervention**	**Disaster Intervention**	**Drug Recovery Intervention**
Individual	Spirituality as recovery capital Sense of humor amidst adversity	Spirituality as recovery capital;	Poverty Lack of information on sources of support Belief that disaster was a punishment from God Poor coping skills	Poverty Lack of knowledge on effects of drugs Unemployment Lack of education Poor coping skills
Microsystems (Family, Neighborhood)	Family as recovery capital Community as recovery capital	Family as motivator for change and recovery capital Community as recovery capital		Adverse childhood experiences Substance use in the family Peer users
Meso-system connections between Micro and Exo-system		Partnership between Church and communities		
Exo-system (Community, Church)	Presence of NGOs/ volunteers	Involvement of church in delivery of CBDR Good governance in some communities	Lack of mental health workers Inadequate provision of basic needs of survivors Governance- no clear plans communicated about permanent resettlement Lack of resources	Lack of mental health workers and accredited doctors Lack of community workers to facilitate intervention Not all communities provided holistic services for reintegration especially in providing employment or livelihood; Lack of programs for families, children etc. Drug-infested communities;

Table 1 (cont'd). Common Enablers and Barriers in the Delivery of Community-Based Intervention

	Resilience Factors/ Enablers		Vulnerabilities/ Barriers	
	Disaster Intervention	Drug Recovery Intervention	Disaster Intervention	Drug Recovery Intervention
Macro (Culture, Government Institutions)		Government drive against illegal drugs raised	Government workers themselves were survivors; Inefficient delivery of services; Turf war among government agencies; national government and local government lack of resources delivery of program; lack of access to water, food, electricity, education, social services, and employment opportunities;	Stigma failures in supply reduction; Extra-judicial killings; Stigma; Bottlenecks due to drug law; Punitive drug law; Lack of resources
Supramacro	International humanitarian aid; Support from international organizations	Evidence-based intervention manuals; Assistance from international organizations		

enhancing, it is adaptive, whereas aggressive and self-defeating humor can actually be maladaptive (Kuiper, 2012).

At the microsystem level, both the family and community appear to be important resilience factors. In the case of disaster survivors, family and community members were a source of both social and instrumental support. The group intervention format also enabled survivors to feel as if they were not alone. In the case of drug recovery groups, peer support groups also become a source of motivation to remain in the program and stay sober. Hechanova, Waelde, & Ramos (2015) suggested that because social support is highly valued by Filipinos, group-based interventions were a good healing environment. Engelbrecht and Jobson (2016) suggested that group therapies are effective in collectivist cultures because they reduce isolation, shame, isolation, helplessness, and passivity.

At the meso-system level, citizen engagement may be critical for the delivery of community-based interventions. Non-profit organizations and churches were sources of instrumental support because volunteers filled resource gaps. Concomitantly, at the exo-system level, good governance was key to a sustainable and holistic approach to recovery. At the macrosystem level, the government drive against drugs motivated some users to surrender and seek treatment voluntarily. Finally, at the supramacro level, the presence of international humanitarian aid and international agencies provided both financial, human and intellectual resources that aided the development and implementation of CBIs.

Vulnerabilities and Barriers in the Implementation of Community-Based Interventions

These two cases also highlighted a number of common vulnerabilities and barriers in the implementation of mental health CBIs. At the individual level, poverty and its consequences (poor education, unemployment) may explain the lack of adaptive coping skills.

At the microsystem level, adverse childhood experiences, substance use among family members, and peer users were risk factors for substance use. At the exo-system level, a lack of both physical and human

resources was vital barriers to the implementation of CBIs. Poor governance at the community level was also a barrier, in both disaster and drug recovery interventions. In the case of disaster recovery, the failure of local government to provide timely assistance and clear communication about future plans may have eroded survivors' adaptive coping behaviors. For drug recovery, community leaders' inability to provide holistic support as well as eliminate drugs from the community made it difficult for recovering users to remain sober.

At the macro level, the inefficient delivery of services and turf wars between government agencies, especially national government and local government departments, were barriers to delivering both disaster and drug recovery programs. In the case of drug recovery, national policy and government directors and the presence of extra-judicial killings appeared to reinforce stigma against drug users. In addition, a lack of resources at the national government level was a barrier to providing holistic support to both disaster survivors and recovering users. In the case of recovering users, the inability to curb the supply of substances was a barrier to sustained recovery.

CBIs from an Ecological Perspective

Beyond common enablers and barriers, the case studies highlighted intersections across the various systems influencing the design and implementation of mental health CBIs.

Stigma and help-seeking. Both disaster and drug recovery interventions sought to help individuals develop resilience skills. However, for individual interventions to be effective, people first need to want help. In the case of drug addiction recovery especially, the propensity to seek help appears to be influenced by microsystems (family, community members, and leaders) as well as macrosystem factors. Studies have revealed that Filipinos are reluctant to seek help especially from professionals (Tuliao, 2014). Hechanova and Waelde (2017) explain that this may be because of shame (they do not wish to tarnish their dignity or damage the reputation of their family) or stigma (believing that seeing

mental health professional means they are crazy, or a reluctance to open up to strangers). Given such reluctance, the punitive approach by the government might be both a bane and boon. On the one hand, the fear of getting killed may motivate some users to seek help. However, the fear of being targeted may also prevent others from seeking help.

The disaster case study noted that male survivors appeared reluctant to seek help. This has also been validated in a study of Filipino male responders which reported that certain ideologies of masculinity may prevent males from seeking help. Specifically, males who believe in assertive dominance; that males need to endure pain, be aggressive, and defend their honor, are less likely to seek help. The study also reported that those who adopted this ideology were more likely to report vicarious trauma (Agbayani, Villaflor, Villaret, & Hechanova, 2019). Given the reluctance to seek help, microsystem factors (family and peer support) and exo-system factors (presence of volunteers from church and non-profit organizations) may be especially useful, because Filipinos are more likely to seek help from family, friends, community leaders, and local healers than from professionals (Hechanova & Waelde, 2017). However, macrosystem factors may also be a barrier. Cultural stigma may influence the willingness of community members to provide support for recovering users. The current drug legislation and its punitive approach reinforce this stigma and may also discourage help-seeking. This suggests that re-shaping attitudes alleviate stigma remains important.

Resources for community-based mental health interventions. Both case studies highlighted the lack of resources for community mental health interventions. This reflects the lack of importance given to mental health or a lack of capacity for intervention design. A positive development, however, was the passing of the Philippine Mental Health Law in 2018, which aims to provide affordable and accessible mental health services. This will permit the allocation of a budget and resources to deliver mental health services where they are needed most.

Governance and a sustained and holistic approach to recovery at various levels. In both cases, turf wars, a lack of coordination, and lack of systemic thinking were identified barriers to sustainability. These remain critical because resilience and recovery from disaster and drug use cannot be addressed by a one-off intervention. Substance abuse is a chronic disease that requires proper venues for recovering users to access continued support. Both recovering users and disaster survivors also have other needs beyond the psychosocial that must be addressed to ensure their continued recovery. UNODC (2008) suggested the importance of five types of recovery capital: 1) human capital (good health, knowledge, and skills); 2) physical and financial assets (income, property, investments and infrastructure); 3) natural capital (natural resources from which livelihoods); 4) social capital (social networks, membership and relationships that provide social support); and 5) institutional and community capital (support from national government and its line agencies, policies, prevention mechanisms, infrastructure and professional support, psychoeducation programs, synergy of all participating entities). It was noted that communities that are successful take a holistic approach to delivering these types of capital.

Designing and Implementing Community-Based Mental Health Interventions

Beyond the enablers and barriers, a number of lessons can be learned from these cases. In this section, we focus on three ideas: the incorporation of culture in intervention design; the use of participatory approaches; and the evolving role and competencies of psychologists.

Incorporating culture in designing interventions. Both cases highlighted the importance of contextualizing interventions and ensuring that interventions are culturally appropriate. This includes ensuring that the language, methodologies, and materials are appropriate for the target clients. In addition, it is also important for the interventions to harness existing protective factors, such as spirituality and family. A study shows that among

Filipinos, health and mental health decisions are made within the family (Nadal, 2011). Spirituality has also been identified as an important resilience factor among Asians (Jang & Wang, 2009; Hechanova et al., 2015).).

Another cultural adaptation of both interventions was the use of groups. Given scarce mental health resources, groups are a practical means to reach as many clients as possible. Groups are also useful in collectivist cultures where social support is highly valued (Hechanova, Waelde, & Ramos, 2015).

Participatory action research and design. Both cases utilized participatory action research and design process. Collins et al. (2018) suggested several advantages to utilizing community-based participatory action research (CBPR). First, CBPR is responsive and respectful of individual needs, preferences, and values and can strengthen accountability to clients. CBPR is also consistent with the principle of justice, autonomy, and community beneficence. Moreover, CBPR makes interventions more culturally and contextually relevant and facilitates co-creating research, policies, and programs. Finally, CBPR also builds the capacity of communities to implement interventions and results in has improved outcomes for community members (Collins et al., 2018).

Field supervision and coaching. Both cases highlighted the importance of training community members as well as providing field supervision and coaching. This validates literature that states that training and supervision are essential for the success of community-based programs. Rahman, Malik, Sikander, Roberts and Creed (2008) reported that mental health issues could be stressful for health workers and strong supervisory mechanisms and peer groups may need to be in place to prevent their burnout.

Competencies in developing and implementing mental health CBIs. Community problems are often multi-faceted and complex. Hence, the development and implementation of mental health CBIs require a number of roles and competencies.

Social change agent. Kelly (1970) suggests that those involved in developing community-based interventions act as change agents and need to understand how change is managed, and how to facilitate change through the empowerment and participation of stakeholders. Thus, beyond specific skills in diagnosis, intervention design, and evaluation, community psychologists need to be able to employ an ecological and systems perspective as well as long-term thinking (Wolff, 2014).

Partner and collaborator. Kelly (1970) suggested that an important competency of community psychologists is the ability to work with other disciplines, professionals and stakeholders. A multi-disciplinary approach implies being willing to learn from any field, practitioner, or community member who can help to provide solutions. Collaborative skills are important and the ability to listen and engage others is developed by working in the field.

Interventionist. Developing community-based interventions is a process beginning with understanding needs, identifying one's theory of change, designing the intervention, module development, pilot-testing, and finally evaluation. Wight (2015) suggested that evaluation may comprise a number of phases . The pilot-testing phase provides important information on the acceptability, content, delivery, facilitators' competency requirements, and the possibility of scaling up to a larger population. Once an intervention is deemed feasible, more rigorous evaluation is necessary to provide sufficient evidence that the intervention is working as intended.

Trainer and coach. Working with paraprofessionals require psychologists to take on the roles of trainer and coach. One study showed that expert-led train-the-trainer strategies and a combination of workshops and supervision are key to delivering evidence-based treatments (Martino et al., 2010).

Conclusion

These two case studies highlighted the enablers and barriers in the provision of post-disaster and drug recovery support in the Philippines. Results suggest the need to take an ecological and systemic lens in developing and implementing mental health CBIs. Although

the use of mental health CBIs is still in its infancy in the Philippines, initial outcomes suggest that CBIs are promising solutions to addressing the mental health needs of vulnerable populations. Given the lack of resources in developing economies, CBIs may play a valuable role in helping urban poor communities help themselves.

Declaration of Conflicting Interest

The author(s) declared that there are no conflicts of interest with respect to the authorship or the publication of this article.

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