REVISED PROTOCOL WHEN HANDLING CHILDREN ALLEGEDLY INVOLVED IN DANGEROUS DRUGS

Juvenile Justice and Welfare Council

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REVISED PROTOCOL WHEN HANDLING CHILDREN ALLEGEDLY INVOLVED IN DANGEROUS DRUGS

Juvenile Justice and Welfare Council

Mandate

JJWC is a policy-making, coordinating and monitoring body tasked with the implementation of the Juvenile Justice and Welfare Act, as amended, through its member and coordinating agencies.

Vision

A Council leading a society that promotes and protects the rights of children at risk and children in conflict with the law under a restorative justice and welfare system.

Mission

To institutionalize a restorative justice and welfare system for children at risk and children in conflict with the law through the effective implementation of the law and coordination among stakeholders in a protective and enabling environment.

Goals

To prevent children at risk from committing crimes and to ensure that children in conflict with the law are rehabilitated and reintegrated with their families and communities. To strengthen institutional partnerships in pursuing collectively and effectively the Council's mission.

Organizational Functions

- Policies, Plans and Program Development
- Advocacy and Social Mobilization
- Research and Data Management
- Technical Assistance to Agencies, LGUs and Stakeholders
- Coordinating, Monitoring and Evaluation of the implementation of RA 9344 as amended

Acknowledgement

Juvenile Justice and Welfare Council Member Agencies:

- Department of Social Welfare and Development
- Department of Justice
- Department of Education
- Department of the Interior and Local Government
- Department of Health
- Commission on Human Rights
- National Youth Commission
- Council for the Welfare of Children
- League of Provinces of the Philippines
- League of Cities of the Philippines
- League of Municipalities of the Philippines
- Liga ng Mga Barangay sa Pilipinas
- People's Recovery, Empowerment and Development Assistance (PREDA) Foundation
- Center for the Prevention and Treatment of Child Sexual Abuse (CPTCSA)

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Consulted and Validated with different Stakeholders and Children

- United Nations Children's Fund (UNICEF) Philippines
- United Nations Office on Drugs and Crime (UNODC)
- Philippine Drug Enforcement Agency (PDEA)
- Tambayan Center for Children's Rights, Inc.
- Children's Legal Rights and Development Center (CLRDC)
- Amaya Lay (ALAY) Mindanao
- Bahay Tuluyan Foundation Inc
- Child Alert Mindanao
- NoBox Philippines
- Medical Action Group (MAG)
- GITIB, Inc
- Bidlisiw Foundation, Inc.
- Terres Des Hommes Germany
- **Makati City**: Social Welfare Department Office, Barangay for the Protection of Children, PNP-Women and Children Protection Desk
- **Caloocan City**: Social Welfare Department Officer, Anti-Drug Abuse Council
- **Taguig City**: Social Services Department, Anti-Drug Abuse Council & PNP-Women and Children Protection Desk
- **Malabon City**: City Social Welfare and Development Department, Anti-Drug Abuse Council, PNP-Women and Children Protection Desk & Barangay for the Protection of Children
- **Quezon City**: Social Services Department & PNP-Women and Children Protection Desk & Barangay for the Protection of Children
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Table of Contents

Background and Statement of Policy

a. The implementation of PNP's Oplan Tokhang in July 2016 combined with an intensification of Barangay Drug-Clearing Operations resulted to a significant number of "surrenderers" who are alleged users or pushers of dangerous drugs. Of these, at least from July 2016 to October 2018, around 27,000 were below 18 years old. This volume of child "surrenderers" gave rise to confusion, challenges and questions on how to apply or interpret copious guidelines and regulations issued by different government agencies, which issuances were crafted mainly to contemplate adult surrenderers and not minors.

b. Events at that time underscored an urgent need to create a specialized protocol for handling children allegedly involved in illegal drugs. By way of response, DDB Regulation No. 6, series of 2019, was crafted.

c. After a total of 26,967 minors recorded as surrenderers to date (as of December 2021) and with continuing developments in the government's war against drugs since its approval on July 2019, this protocol on children under DDB Regulation No. 6 is set for review.

d. Having the benefit of observing how cases of children allegedly involved in illegal drugs are handled and of understanding better the challenges and limitations faced by duty bearers since the birth of Oplan Tokhang in 2016, DDB revises its 2019 protocol to: (1) make it more responsive to special needs and circumstances of children in the context of the drug war and (2) ensure that the rights of children under the UN Convention on the Rights of the Child and national laws on child protection are respected, protected and fulfilled at all stages of implementation of Oplan Tokhang and other anti-illegal drugs programs of the government.

Definitions and References

The following terms used in this Protocol mean:

- **BADAC** - Barangay Anti-Drug Abuse Council
- **BCPC** - Barangay Council for the Protection of Children
- **CAR** - Child-at-risk or a child who is vulnerable or at-risk of behaving in a way that can harm him/herself or others, or vulnerable and at risk of being pushed and exploited to come into conflict with the law because of personal, family and social circumstances[1]
- **Child** - any person who is below 18 years old
- **CICL** - Child in conflict with the law or a child who is alleged as, accused of, or adjudged as, having committed an offense under Philippine laws
- **Dangerous drugs** - as defined under Republic Act No. 9165 or the Dangerous Drugs Act of 2001; interchangeably referred in this Protocol as "illegal drugs"
- **Diversion program** - the program that a CICL is required to undergo after being found responsible for an offense, without resorting to formal court proceedings
- **Drug dependency examination** - 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 a drug dependent or not, which includes history taking, intake interview, determination of the criteria for drug dependency, mental and physical status, and the detection of dangerous drugs in body specimens through laboratory procedures
- **Intervention** - generally refers to programmatic approaches or systematic social protection programs for children that are designed and intended to: (a) promote the physical and social well-being of the children; (b) avert or prevent juvenile delinquency from occurring; and (c) stop or prevent children from re-offending[2]
- **LSWDO** - the local social welfare and development officer at the city or municipal level or in its absence, the provincial social welfare and development officer or its equivalent

1 Such as, but not limited to, the following: (1) being abused by any person through sexual, physical, psy-chological, mental, economic or any other means and the parents or guardian refuse, are unwilling, or unable to provide protection for the child; (2) being exploited including sexually or economically; (3) being abandoned or neglected, and after diligent search and inquiry, the parent or guardian cannot be found; (4) coming from a dysfunctional or broken family or without a parent or guardian; (5) being out of school; (6) being a streetchild; (7) being a member of a gang; (8) living in a community with a high level of criminality or drug abuse; and (9) living in situations of armed conflict. [RA 9344 as amended]

2 As defined in the Revised Rules and Regulations Implementing RA 9344, as amended by RA 10630

- **MDT** - multi-disciplinary team (in Section 41 of this Protocol) that will work on the individualized treatment and care plan for the child who is screened to be of moderate or high risk for drug abuse and dependence and for the child's family

- **PWUD** - Person Who Use Drugs

- **Rehabilitation** - a dynamic process directed towards the physical, emotional/ psychological, vocational, social and spiritual change to prepare a drug dependent for the fullest life compatible with his capabilities and potentials and render him/ her able to become a law abiding and productive member of the community without abusing drugs

- **Surrender** - refers to an act of voluntarily approaching or submitting oneself to government for the sole purpose of undergoing screening and possibly treatment and rehabilitation and must not be construed as the surrender contemplated by the Revised Penal Code or any other penal law

I. Scope and Application

Section 1. Scope

1.1. This Protocol will apply to the handling of any child who is identified or suspected to be allegedly involved in dangerous drugs or who comes into contact with a person in authority as a result of, or in connection with, the anti-illegal drugs campaign initiated either by the national or local government. This includes any child:

a. whose name is **found or included in government lists** of suspected drug personalities for Oplan Tokhang, barangay drug clearing operations, or any similar anti-illegal drugs campaign of the government [See Item III in page 8];

b. who submits or surrenders as a result of, or in connection with, the anti-illegal drugs campaign of the government (also referred in this Protocol as a Child at Risk or "**CAR**") [See Item IV in page 13]; or

c. who is apprehended or who submits/surrenders for alleged violations of Republic Act No. 9165 other than use of dangerous drugs (also referred in this Protocol as a "**CICL**") [See Item V in page 19].

1.2. In this Protocol, persons-in-authority include law enforcement officers, local government (provincial, city, municipality, barangay) officials, or any other representative of government performing a role in its campaign against dangerous drugs.

Section 2. Children not covered by this Protocol

This Protocol will **not apply to** the following children allegedly involved in dangerous drugs:

a. Child who files an application to the DDB for voluntary confinement for treatment and rehabilitation under Board Regulation No. 3, Series of 2007 (Rules Governing Voluntary Confinement for Treatment and Rehabilitation of Drug Dependent).

b. Child who might be found positive under the random drug testing programs in schools. Children subjected to random drug testing in schools are governed by DDB Regulation No. 6, series of 2003[3] as amended by DDB Regulation No. 3, series of 2009.

c. Child who seeks treatment in private rehabilitation centers. Private rehabilitation centers accredited by DOH, while under no legal obligation to report to law enforcement agencies or barangays the names of children who seek treatment and rehabilitation (e.g., for the purpose of checking if child's name is in the list of drug personalities) must observe this Protocol to the extent that it is applicable.

Section 3. When treated a Child-at-Risk (CAR)

If a child submits or surrenders to a person-in-authority in connection with any anti-illegal drugs campaign of the government for allegedly ***using*** dangerous drugs (but not for other alleged violations of RA No. 9165 or other penal offenses), the child will be treated a CAR and handled in accordance with all provisions (except Item V) of this Protocol.

Section 4. When treated a Child in Conflict with the Law (CICL)

A child allegedly involved in dangerous drugs will be recorded and handled as a CICL if the child:

a. is apprehended for an alleged offense under RA No. 9165; or
b. submits or surrenders for an offense under RA No. 9165 (e.g., courier of illegal drugs) other than use of dangerous drugs.

Said child will be handled in accordance with existing procedures for CICL consistent with RA No. 9344 as amended and with all provisions of this Protocol except Items III and IV.

3 General Guidelines For The Conduct Of Random Drug Testing For Secondary and Tertiary Students.

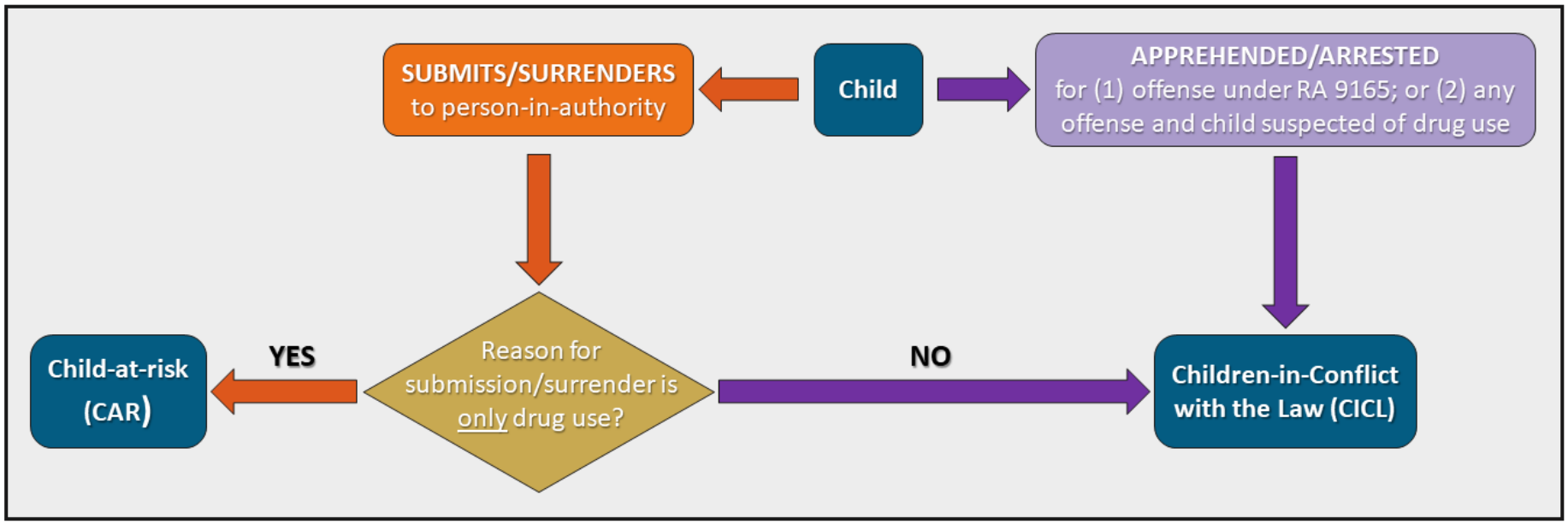

Figure 1: Sections 2 and 3 of Protocol (See also Annex A)

II. General Provisions When Handling Children Allegedly Involved in Dangerous Drugs

Section 5. Using procedures developed for children, not for adults

5.1. All persons with duties and responsibilities under this Protocol will:

a. always treat children in a manner respectful of their dignity, taking into consideration their best interest. Children covered by this Protocol shall be accorded their rights without discrimination as guaranteed by the UN Convention on the Rights of the Child. In every stage of the process, they shall be given an opportunity to express their views, which shall be given due weight in accordance with the age and maturity of the child.

b. use child-appropriate and child-sensitive approaches and processes when handling children allegedly involved in dangerous drugs.

When doing so, these duty bearers will principally use this Protocol in conjunction with other administrative issuances/orders/regulations specified herein to the extent that they are appropriate for children.

5.2. Children allegedly involved in dangerous drugs will not be handled or treated in the same manner as adults. **Procedures found in administrative issuances/orders/regulations developed primarily for handling of adult PWUD[4] will *not* be applied to children allegedly involved in dangerous drugs.**

5.3. Any person-in-authority having contact with the child who is apprehended, who voluntary submits/surrenders, or who is invited to submit/surrender shall ensure that the child will ***not*** be:

a. required to execute any affidavit of undertaking or waiver;
b. subjected to any strip search;
c. subjected to the taking mug shots and fingerprints;

4 Not to be used when handling children unless the issuance/order/regulation specifically mentions the applicability to children of a procedure:
- DDB Reg. No. 3 (03 August 2016), Guidelines on Handling Voluntary Surrender of Drug Personalities
- DDB Reg. No. 4 (19 September 2016), Oplan Sagip - Guidelines on Voluntarily Surrender [sic] of Drug Users and Dependents and Monitoring Mechanism of Barangay Anti-Drug Abuse Campaigns"
- Command Memorandum Circular No. 16-2016 (01 July 2016), PNP Anti-Illegal Drugs Campaign Plan - Project; "Double Barrel"
- DIDM IMPLAN [Impact Analysis For Planning] re PNP Anti-Illegal Drugs Campaign Plan Project: "Double Barrel" (03 August 2016)
- DILG Memorandum Circular No. 2018-125, Guidelines for the Implementation of Community-Based Drug Rehabilitation Program (08 August 2018)

d. covered by any photo or video recording;
e. detained together with adult offenders; and
f. subjected to any cruel, degrading or inhuman treatment or punishment.

Section 6. Confidentiality and privacy.

6.1. All persons handling a child allegedly involved in dangerous drugs will ensure that the child's privacy and the confidentiality of the child's case are respected at any stage under this Protocol.

6.2. Any activity or interaction with the child at any stage of this Protocol (e.g., during implementation of treatment and care programs) will not be done or implemented in public places.

6.3. All records involving said children (e.g., results of drug tests, drug dependency examination) are privileged and confidential. These records will be handled and kept by the LSWDO managing each child's case.

a. As the case manager, the LSWDO will handle each child's record in accordance with the data privacy policy of DSWD and the provisions of Republic Act 10173 or the Data Privacy Act.

b. Subject to the discretion of the LSWDO or case manager, information from the child's records may be accessed by persons with duties and responsibilities under this Protocol. Information to be disclosed to them will be limited those deemed by the case manager to be relevant in the proper delivery of treatment and care for the child.

c. The record of a child shall only be maintained by the LSWDO for a period of five years from the time of completion of treatment program or any other period to be prescribed by the DSWD. During and beyond that period, measures shall be taken to ensure that the child's record remains confidential at all times.

6.4. Persons with duties and responsibilities under this Protocol will undertake all measures to protect the child's identity (e.g., maintaining a separate system of recording) such as but not limited to non-disclosure of records to the media, maintaining a separate recording system for children, and adopting a system of coding to conceal material information which will lead to the child's identity. The disclosure of confidential records may only be done upon order of the Court.

6.5. Immediately after the child undergoes screening and is established to be either moderate or high risk (under Item VI of this Protocol), the record of said child will be included in the Yakap Bayan Information System of the DSWD, which serves as the repository of information on children allegedly involved in dangerous drugs. A child who is found to be low risk for drug abuse and dependence will not be recorded in the Yakap Bayan Information System or any other registry or list on children allegedly involved in dangerous drugs. (See also Section 20.2 of this Protocol.) This is without prejudice to the recording of required information in the mandatory registration required under RA 9344 as amended.

6.6. Any information on children allegedly involved in dangerous drugs will not be included in the Integrated Drug Monitoring and Reporting System (IDMRIS) of the DDB. Instead, the DDB shall request the consolidated statistical report from JJWC to completely account for the number of children recorded as allegedly involved in dangerous drugs needed for policy and research development.

Section 7. Children not mixed with adult PWUD

At any stage of this Protocol (i.e., when approaching children and/or their families under Item III; during submission, surrender or apprehension under Items IV and V; during screening, assessment and implementation of treatment programs under Items VI and VII), the child alleged involved in dangerous drugs will be handled separately from and will not be mixed with adult PWUD.

Section 8. Not use children as assets or informers

No child allegedly involved in dangerous drugs as described in Section 1.1 of this Protocol will be used by any person-in-authority as an asset or informant to identify, pursue or apprehend other suspected drug personalities.

III. Protocol on Children Included in Lists of Suspected Drug Personalities

Section 9. Separate names from adult suspected drug personalities

9.1. When verifying names in list/s of suspected drug personalities received from other government agencies/units or when putting together its own list of suspected drug personalities (as part of the Barangay Drug Clearing Operations, Oplan Tokhang, or any similar anti-illegal drugs campaign of the government), any government office or unit will ensure that names of children will be separated from those of adult suspected drug personalities.

a. When a list is put together by the drug officer at the community level, names of children are to be separated before the list is sent to ADAC. Before that list is sent, the BADAC will recruit the assistance of BCPC to ensure that names of children are separated from adult drug personalities.

b. At the ADAC level, *the ADAC must coordinate with* the social welfare officer to again review the list and take the necessary steps to separate names of children from the list of adult drug personalities.

c. In all other government offices or units where lists of suspected drug personalities are created or verified (e.g., PDEA, PNP), efforts must also be taken to ascertain if names of children are separated from names of adult drug personalities.

9.2. The separation of names of children in these lists at the earliest possible time is intended to ensure that children allegedly involved in dangerous drugs are handled through child-appropriate approaches and are not treated in the same manner as adult suspected drug personalities or PWUDs.

Section 10. Standards when including children in drug lists

10.1. When the BADAC, ADAC or any other government office or unit puts together, reviews or verifies list/s of children who are suspected drug personalities, it shall be guided by the following standards:

a. When putting together a list of children who are suspected drug personalities, the BADAC or any other agency or unit where the list originates will ensure that:

1. the basis or reason for inclusion of each child's name in the list is indicated; and
2. the person preparing the list (e.g., barangay captain; head of BADAC) must attest that said list was put together in good faith and the indicated basis/reason to include each identified child is a result of reasonable efforts to confirm suspicion of involvement of the child.

b. When verifying or validating the list of children who are suspected drug personalities, the ADAC or any other agency or unit that reviews the list will ascertain the existence and legitimacy of the basis or reason for inclusion of a child's name. Otherwise, the name of the child must be removed from the list.

10.2. The DILG in coordination with DSWD will draft the appropriate administrative issuance or guidelines to adequately guide the BADAC, ADAC and all other government offices or units when putting together, reviewing or verifying lists that may contain names of children who are suspected drug personalities and to ensure that children are not arbitrarily included in these lists.

Section 11. Persuading children included in lists

11.1. Children whose names are included in lists of suspected drug personalities are to be encouraged or persuaded to submit for screening and assessment and to possibly undergo treatment and rehabilitation.

11.2. When persuading children suspected of involvement in dangerous drugs to surrender or submit for screening and possible treatment and rehabilitation under this Protocol, a person-in-authority will strictly observe the rules indicated under this Section 11. Persuading under this Protocol includes any form of encouraging, inviting, or *paghangyo* of a child to submit or surrender to, or even be interviewed by, any person-in-authority in connection with the child's alleged involvement in dangerous drugs.

a. Any initiative to persuade children suspected to be involved in dangerous drugs to surrender or submit will be done **only through or in the presence of** their parent/s, guardian/s or any of their adult relatives. A person-in-authority will not approach or talk to children suspected of involvement in dangerous drugs without the presence of at least one parent, guardian, adult relative.

b. When visiting the house of or when approaching and talking to the child, the person-in-authority must be accompanied by an LSWDO or in his/her absence, a member of BCPC or of a DSWD-accredited non-government organization. The child or his/her family will not be forced to talk to a person-in-authority and refusal to do so will not be taken against them.

c. Submission or surrender under this Protocol must be voluntary. Persuasion will be only done by informing the child and his/her family of the benefits of undergoing screening, treatment and rehabilitation under this Protocol. No force, threat or intimidation, whether directly or indirectly, will be used.

d. If the child whose name is among those listed as an alleged drug personality does not submit or surrender under this Protocol, the BCPC and LSWDO will continue to monitor the situation of said child and when needed, again initiate steps to persuade to submit or surrender. The BCPC and LSWDO will also closely monitor and determine if there are valid reasons (e.g., case of child abuse by parents) to initiate steps to obtain custody of the child under other child protection laws and regulations.

IV. Protocol When A Child Submits or Surrenders For Alleged Drug Use: Child At Risk (CAR)

Section 12. Child who submits or surrenders is a CAR

12.1. As stated in Section 3, a child allegedly involved in dangerous drugs will be treated a CAR if the child submits or surrenders to a person-in-authority in connection with any anti-illegal drugs campaign of the national or local government for allegedly using dangerous drugs (but not for other alleged violations of RA No. 9165 or other penal offenses).

12.2. There is submission or surrender under this Protocol when children, by themselves or through their parents/guardian:

a. approach or surrender to any person-in-authority as a result of any government campaign against illegal drugs (e.g., Oplan Tokhang; barangay drug clearing programs);

b. are convinced or encouraged by any agent of government to enroll, join, or submit to a treatment / rehabilitation program; and

c. are referred or enrolled by their parents/guardians to be part of a treatment / rehabilitation program of the LGU.

Procedures under this Item IV will be faithfully observed when handling a CAR immediately after submission or surrender.

12.3. Each LGU will ensure that its referral desk for children who surrender or submit will be different from the referral desk used for adults who surrender.

Section 13. Who to notify when CAR submits or surrenders

13.1. Once a child attempts to submit or surrender, on his/her own initiative or with the assistance of a parent or adult relative, the person-in-authority will immediately notify and ensure the presence of an LSWDO when talking to the child. If the LSWDO is not available, the person-in-authority may seek assistance of members of the BCPC or a DSWD-accredited non-government organization until such time that an LSWDO or any social worker is available.

13.2. If the child is unaccompanied when submitting or surrendering, the person-in-authority will immediately notify the child's parents or guardian and request for

their immediate presence in the barangay or the children's and women's desk and to bring any proof of age of the child to confirm minority. If parents or guardian cannot be found, the nearest adult relative will be notified.

13.3. If the child who submits or surrenders refuses to inform his/her parents, the LSWDO will investigate the reason for refusal, assess the implication of reason to child's seeking of treatment, and initiate ways to make the child understand the need to inform the parents or guardian. If the child's reasons are deemed justified, the LSWDO shall explore options under Section 14.3.

Section 14. Consent for valid submission or surrender

14.1. The child is not deemed to have voluntarily submitted or surrendered without the consent given by parents or guardian. This consent to be obtained or confirmed by the person-in-authority or the LSWDO must include consent for the conduct of screening and assessment of the child (under Item VI) and later, intervention or treatment (under Item VII). **The process below cannot continue without said consent.**

14.2. In the process of obtaining/ascertaining consent, the child will be given an opportunity to be heard, i.e., child's views will be given due weight by parents before consent is given. When doing so, the parent or the LSWDO will ensure that the child understands the purpose and consequences of surrender/submission, intervention or treatment, and where applicable, aftercare treatment.

14.3. In the event that a parent/guardian is incapacitated or uncooperative or for any other valid reason that consent cannot be obtained from the parent/guardian, the LSWDO will:

a. search for the nearest relative of the child who is supportive of the child's voluntary submission or surrender to talk to the child and to obtain the consent of the parent; or

b. initiate the appropriate action (e.g., petition for involuntary commitment) where deemed necessary.

Also, custody of the child may also be retained if justified under RA 7610[5] (e.g., cases where child is also deemed a victim of psychological and physical abuse, neglect, cruelty, sexual abuse and emotional maltreatment) and the child must be handled in accordance with said law[6].

5 Special Protection of Children Against Abuse, Exploitation and Discrimination Act (17 June 1992).

6 If child who allegedly uses drugs is also an offended party under RA 7610, refer to Sec. 28 of the law: Sec. 28. Protective Custody of the Child. – The offended party shall be immediately placed under the protective custody of the Department of Social Welfare and Development pursuant to Executive Order No. 56, series of 1986. In the regular

Section 15. Intake and handling after submission or surrender

15.1. After the CAR validly submits or surrenders, the person-in-authority, preferably with the assistance of an LSWDO, members of BCPC, or a DSWD-accredited non-government organization shall:

a. conduct an **intake** by obtaining only the child's personal circumstances (i.e., only the information essential to update statistical records of government) using the CAR intake form (Annex C) in the presence of the child's parents; and

b. record the information obtained in a separate CAR **registry** for children who submit or surrender for allegedly using dangerous drugs, which system of recording will be linked to the Juvenile Justice and Welfare Council registry on CAR and CICL Cases.

15.2. When handling the CAR who validly submits or surrenders, the person-in-authority will be guided by the best interest of the child and will:

a. conduct the intake in a child-friendly area, preferably a separate room, or in any available room that will ensure confidentiality of the process;

b. use an interpreter if the child cannot understand the language or local dialect or a mental health professional if the child suffers from a disability that affects the ability to understand the person handling; and

c. conduct the process using an approach that is culture and gender-sensitive.

15.3. A person-in-authority (or any of their agents) will **not** investigate or interview the child to elicit any information that may relate to alleged illegal activities. Any in-depth interview of the child may only be done by an LSWDO under Section 17.2. Once questions outside personal circumstances of the child are asked, the person-in-authority shall ensure that the constitutional and statutory rights of the child (such as provisions under R.A. No. 7438[7] and the implementing rules and regulations of R.A. No. 9344 as amended) shall be strictly and fully upheld at all times favorable to the CAR. The CAR, however, shall not be considered under arrest, detention, or investigation for this purpose.

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performance of this function, the officer of the Department of Social Welfare and Development shall be free from any administrative, civil or criminal liability. Custody proceedings shall be in accordance with the provisions of Presidential Decree No. 603

7 An Act Defining Certain Rights of Person Arrested, Detained or Under Custodial Investigation as well as the Duties of the Arresting, Detaining and Investigating Officers, and Providing Penalties for Violations Thereof (27 April 1992)

Section 16. Removal from list after submission or surrender

16.1. The person-in-authority will ensure that the fact of CAR's submission or surrender, after the parents are informed, is known to the BADAC of the barangay where the child resides. The BADAC will ensure that the name of the child (and any record on the child) is removed from any list of drug personalities under any of the government's anti-drug campaigns such as Oplan Tokhang and the ongoing barangay drug-clearing operations upon the child's:

a. completion of general intervention (for children who are LOW RISK for drug abuse and dependence);
b. completion of the treatment program (for children who are MODERATE or RISK for drug abuse and dependence)

16.2. The BADAC will take all steps to ensure that the name of the child who submitted/surrendered is also removed from the list/s of suspected drug personalities used by any law enforcement agency. Once notified, law enforcement agencies in possession of any list of suspected drug personalities shall cause the removal of the name of the child in said list.

Section 17. LSWDO as case manager of CAR

17.1. Immediately after intake and personal circumstances are recorded under Section 15.1., the person-in-authority will turn over the handling of child to the LSWDO who will manage the case of the CAR from screening until general intervention, treatment and care, and aftercare. If an LSWDO is not yet available, the person-in-authority after due notification of the LSWDO may first refer the child to a screening process as described in Item VI below.

17.2. The LSWDO will as part of the case management process:

a. proceed with an interview of the child that will be done in the presence of the parent/s or guardian of the CAR;

b. also interview the parents or guardian as well as other persons having charge of the child as part of an assessment of the child's family and community and the development of a social case study and eventual treatment and care plan on the child; and

c. explain to the child and the child's parents or guardian the consequences of the child's acts with a view towards providing counseling, treatment and rehabilitation[8].

8 Adopted from Section 21(i) of RA 9344 and Rule 29 of its RIRR.

17.3. The child will be referred by the LSWDO (or by the person-in-authority if the presence of the LSWDO is not yet available) to a screening process to determine the child's level of risk from drug use and dependency, and if needed, to a subsequent assessment process as defined under Item VI of this Protocol.

17.4. If upon the assessment of the LSWDO there is any indication that the child is abandoned, neglected, or abused (e.g., parents or guardians suspected or found to be involved in the drug trade or using dangerous drugs), the LSWDO when deemed appropriate or necessary will proceed in handling the case in accordance the provisions of Republic Act No. 7610.

17.5. Unless assessed by the LSWDO to be dependent, abandoned, neglected or abused[9] as defined under Republic Act No. 7610, the child's physical custody will be returned to the parents or guardian even pending completion of the assessment of the child and the case study report of the LSWDO.

9 In these cases, refer to provisions on voluntary or involuntary commitment of children (under PD 603) and on protective custody (under EO 56, s.1986)

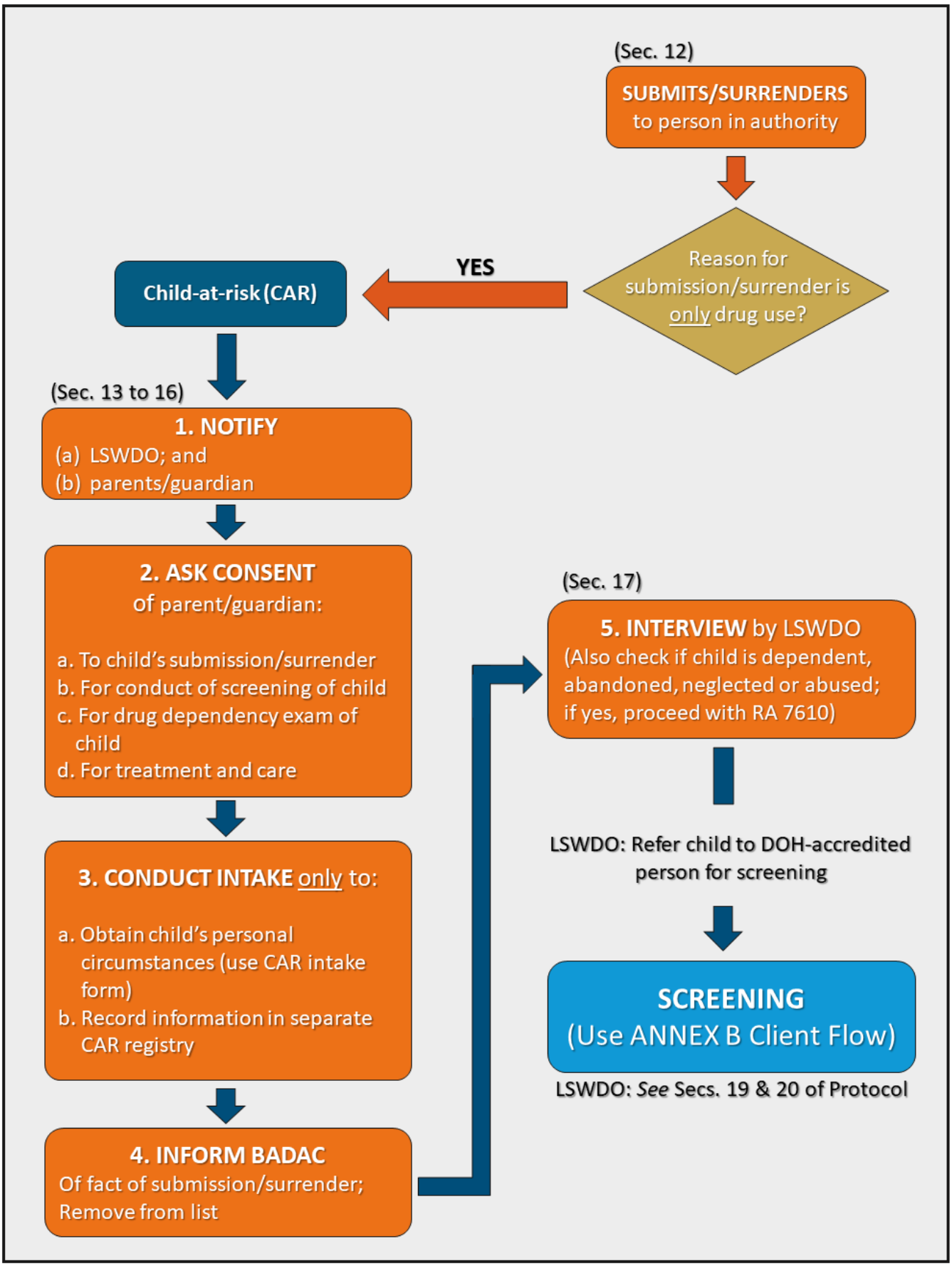

Figure 2: Item IV, Sections 12 to 17 of Protocol (See also Annex A)

V. Protocol on children who are apprehended or arrested: CICL

Section 18. If child is determined a CICL

18.1. As stated in Section 4, a child allegedly involved in dangerous drugs will be treated as a CICL if the child:

a. is **apprehended** (e.g., through court order; in buy bust operations;[10] valid warrantless arrests; during implementation of search warrant operations and controlled delivery) for an alleged offense under RA No. 9165; or

b. submits or surrenders for allegedly committing an offense under RA No. 9165 (e.g., courier of illegal drugs) **other than use** of dangerous drugs.

18.2. The child will be **primarily** handled in accordance with established procedures for CICL (e.g., PNP Manual in Handling Cases of CICL[11] and the IRR of RA 9344, as amended). **In addition** to the procedures followed when handling a CICL, the child will be referred to a screening process to determine the level of risk from drug use and dependency, and if needed, to a subsequent assessment process as defined under Item VI.B.

10 Refer also to PNP Manual.
11 Philippine National Police Manual, PNP-NSU-24-1-16 (WCPC)

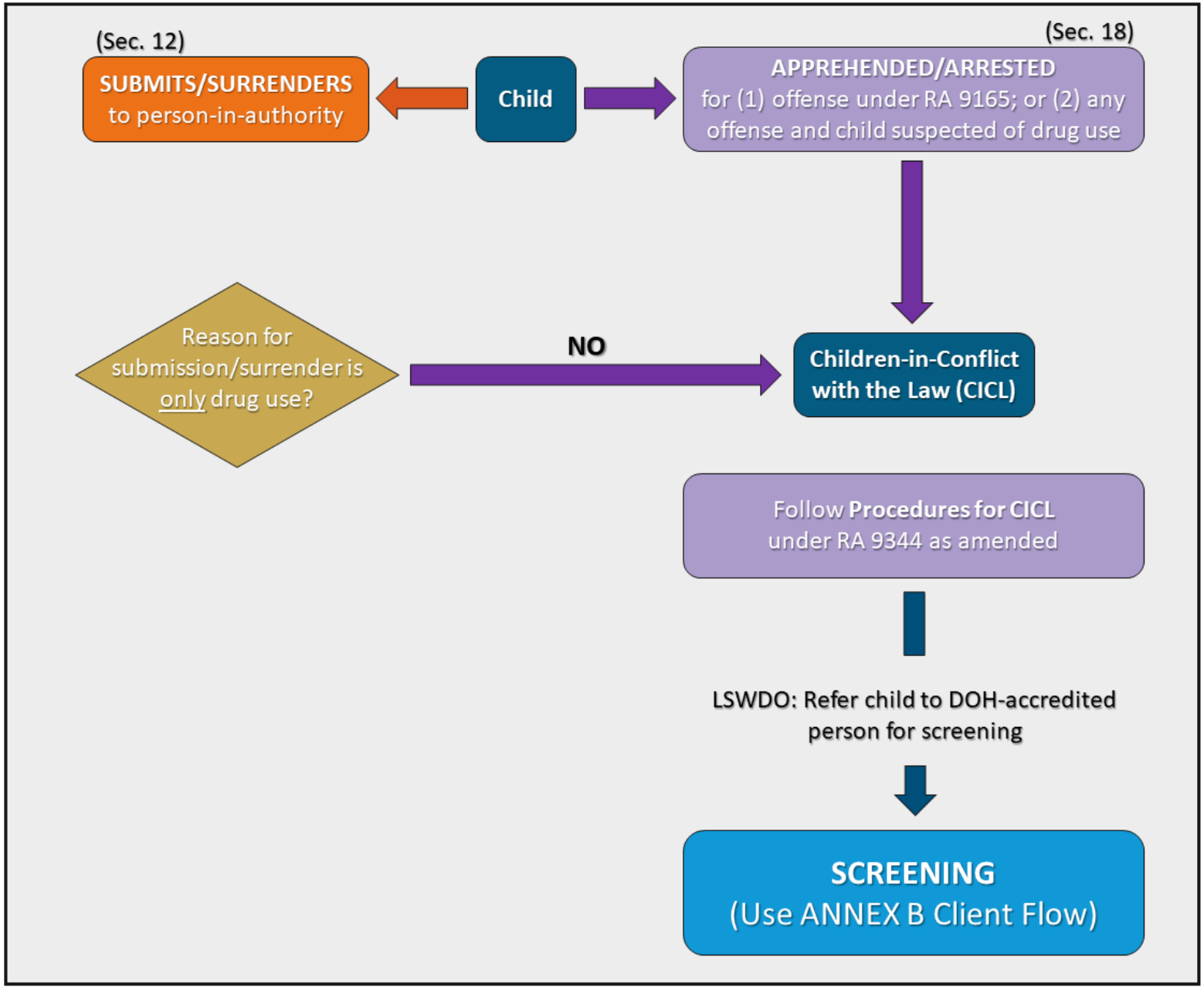

Figure 3: Item V of Protocol (See also Annex A)

VI. Screening and assessment

Protocols for screening risk and assessing extent of use/dependency will differ between children classified as CAR under these guidelines[12] and those classified as CICL[13].

A. Screening and assessment of CAR

If the child allegedly involved in dangerous drugs is classified as CAR under this Protocol, the following steps will be taken:

Section 19. Referral of CAR to screening and if needed, assessment

19.1. The LSWDO handling the case of the CAR will, after the interview under Section 17[14], refer the child:

a. to undergo **screening** by a person trained and certified by DOH to conduct it in order to determine the child's level of ***risk*** for drug dependency (Section 20 below), and

b. if needed (depending on the result of screening), to undergo a subsequent **assessment** through a drug dependency examination in order to determine extent or severity of use or dependency of the child (Section 21).

19.2. When referring the CAR for screening, the LSWDO will include with the referral form/letter:

a. a copy of the case study intake form to facilitate the conduct of screening and assessment;[15] and

b. the parental consent (or a proxy consent granted by courts) secured for the conduct of screening and assessment.

12 Submits or surrenders for alleged use of dangerous drugs (See Section 3 for complete description of CAR under this Protocol)

13 Submits or surrenders for an alleged offense under RA 9165 other than use of dangerous drugs. (See Section 4 for complete description of CAR under this Protocol)

14 The LSWDO will as part of the case management process: (a) proceed with an interview of the child that will be done in the presence of the parents or guardian of the CAR; and (b) also interview the parents or guardian as well as other persons having charge of the child as part of an assessment of the child's family and community and the development of a social case study and eventual treatment and care plan on the child;

15 Section 3E of the DDB BR 4 s.2016

Section 20. Screening tools for CAR risk for drug abuse and dependence

Upon receiving a referral from the LSWDO, the person trained to use any of the DOH-recognized screening tools to determine risk for drug abuse and dependence (e.g., ASSIST[16], CRAFFT+N[17]) will proceed with the screening of the CAR to determine the child's level of risk ***for drug abuse and dependency and other problems as a result of current pattern of drug use.*** (See Annex D - Corresponding risks per screening tool)

Section 21. If CAR is LOW RISK for drug abuse and dependence

If after screening, the child is determined to be of 'LOW' RISK for drug abuse and dependence, the LSWDO will indicate such finding in the CAR's record and take steps to ensure that:

21.1. The child, after receiving general and brief interventions (as described in Item VII), will no longer be required to undergo any of the remaining steps under this Protocol. The LSWDO will conduct an assessment of the CAR's life (including child's family circumstances and environment) to better inform the general and brief interventions to be given the child and to recommend other interventions that address factors contributing to the child's level of risk.

21.2. The child's name and information will not be recorded in the Yakap Bayan Information System of DSWD or in any other registry of children allegedly involved in dangerous drugs.

21.3. The child's name will be removed from any list of drug personalities maintained by law enforcement agencies or any list used for the government's anti-drug campaigns such as Oplan Tokhang and the ongoing barangay drug-clearing operations.

Section 22. If CAR is MODERATE or HIGH RISK for drug abuse and dependence

22.1. If after screening, the child is determined to be of 'MODERATE' or 'HIGH' RISK for drug abuse and dependence, the LSWDO will endorse the CAR to a DOH-accredited physician for further assessment of severity of use and dependence of the child through a drug dependency examination.

16 ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test)
17 CRAFFT + N (CAR, RELAX, ALONE, FORGET, FRIENDS, TROUBLE + NICOTINE) - a clinical as-sessment tool designed to screen for substance-related risks and problems in adolescents.

22.2. The endorsement to any DOH-accredited physician, whether public or private, will be made within seven working days from completion of administration of the drug screening tool. Expenses will be shouldered by the family or the child unless certified indigent by the LSWDO.

22.3. When endorsing the child with “moderate” or “high” risk for drug abuse and dependence to the DOH-accredited physician, the LSWDO will:

a. include in the referral form or letter a brief indication of details on the child that may be relevant to the conduct of drug dependency examination;

b. provide results of the screening test bearing an assessment of the child’s level of risk for drug abuse and dependence; and

c. ensure that the appropriate consent has been granted for the conduct of a drug dependency examination. If parental consent cannot be secured, the LSWDO will obtain a proxy consent as may be granted by the courts.

22.4. Every LGU has the discretion, if deemed aligned with the best interest of the child, to require the child to undergo both screening and assessment regardless of level of risk for drug abuse and dependence provided that the consent of parents is obtained.

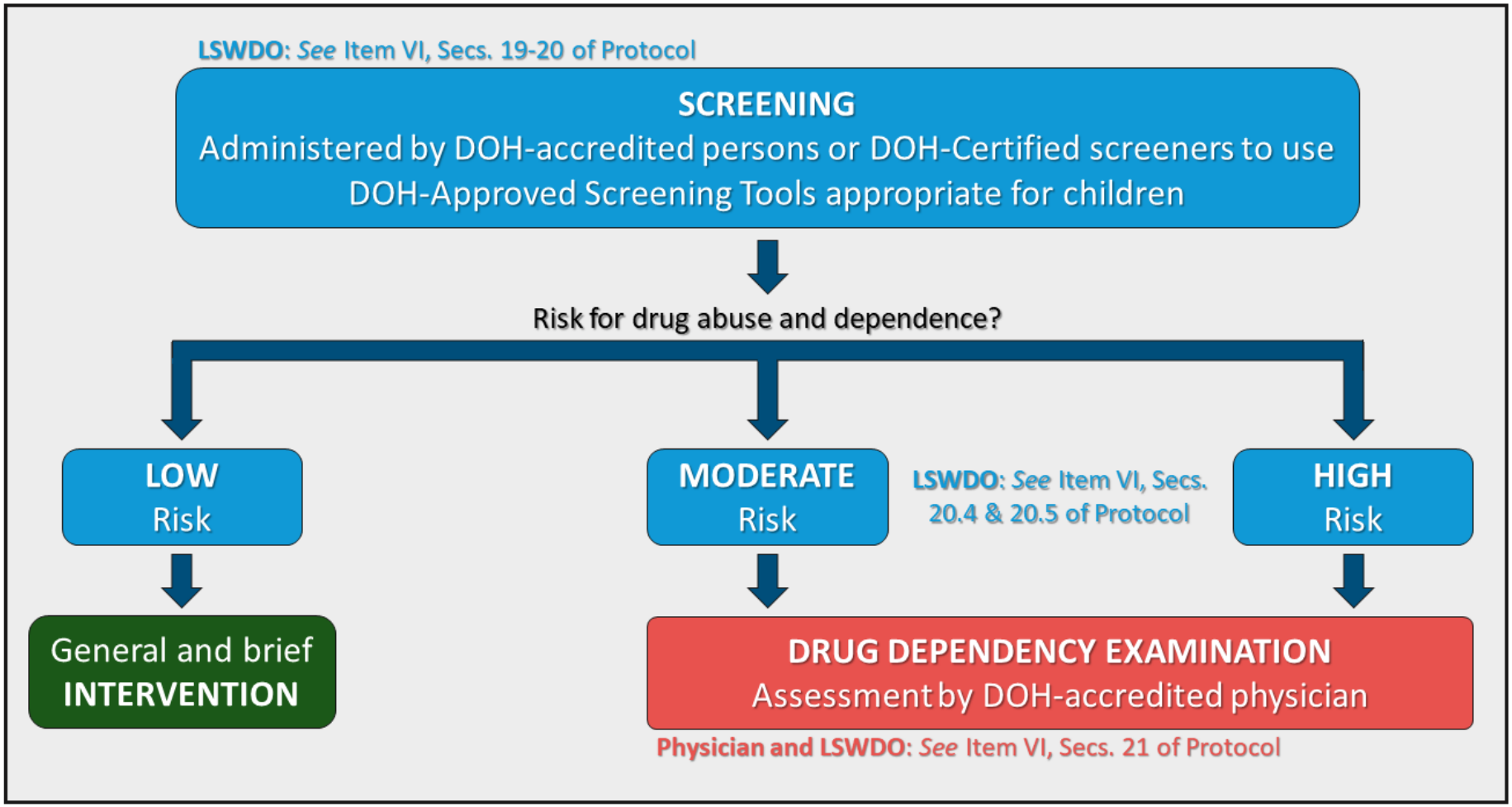

Figure 4: Sections 19 to 40 of Protocol (See also Annex B)

Section 23. Subsequent assessment via drug dependency examination

23.1. Upon receiving a referral from the LSWDO, the DOH-accredited physician will conduct a drug dependency examination.

23.2. The physician who conducted the drug dependency examination will give the LSWDO: (a) the results and (b) a corresponding recommendation and referral on the appropriate treatment and care to be given the child. Based on the physician's assessment, an appropriate treatment and care program will be prepared in accordance with Item VII of the Protocol.

23.3. The LSWDO will inform only the following of the result of the child's screening and assessment and the corresponding treatment and rehabilitation program to be given: (a) Parents of CAR; and (b) BADAC where child was recorded as a CAR.

Section 24. Custody pending conduct of screening and assessment

Pending conduct of the drug dependency examination, the CAR's physical custody will remain with the parents or guardian unless commitment of the child is justified under: (a) R.A. 9344 as amended in the case of a CICL; (b) R.A. 7610; or (c) provisions for compulsory confinement under R.A. 9165.

B. Screening and assessment of CICL

A child allegedly involved in dangerous drugs, when classified as CICL under this Protocol, will be handled in accordance with existing procedures for CICL consistent with RA No. 9344 as amended or the Juvenile Justice and Welfare Act. For further guidance, the following will be observed with respect to screening, assessment, or any form of drug testing to be done on the CICL:

Section 25. Court order for CICL in facility

As a rule, a CICL allegedly involved in dangerous drugs can only be subjected to any form of screening, assessment, or drug testing by the government pursuant to an order or directive of the court. This CICL includes those who are in a facility for: (1) committing an offense under RA 9165 while acting with discernment; *(2) acting without discernment but best interest to be placed in a youth care facility*; or (3) above 12 years old and committed an offense under RA 9165 and mandatorily placed in a special facility under Section 20-A of RA 10630 amending RA 9344[18].

18 SEC. 20-A. Serious Crimes Committed by Children Who Are Exempt From Criminal Responsibility. – A child who is

Section 26. If the CICL is not in a facility

In other cases where a CICL committed an offense under RA 9165 and may not be in a facility due to exemption from criminal liability (e.g., CICL below 12 years old is apprehended as a drug courier), the LSWDO will:

a. assess if there is sufficient basis to cause the voluntary or involuntary commitment of the CICL for other grounds such as a determination of neglect, abandonment or abuse. Once a child is committed to a facility other than Bahay Pag-asa (i.e., DSWD centers and facilities), Section 24 will apply.

b. with LCPC's assistance, take all needed action for the implementation of intervention programs (as required under RA 9344) that address factors contributing to the child's involvement in dangerous drugs and risk of drug use/abuse.

Section 27. Results of screening, assessment and other tests

The result of any screening, assessment or drug testing on a CICL will only be known to the following:

a. court handling the CICL's case;
b. LSWDO or court social worker handling the CICL;
c. where applicable, the Intensive Juvenile Intervention and Support Center (IJISC) of the facility having custody of the CICL;
d. any other person or office authorized by the court to be informed of such result.

above twelve (12) years of age up to fifteen (15) years of age and who commits parricide, murder, infanticide, kidnapping and serious illegal detention where the victim is killed or raped, robbery, with homicide or rape, destructive arson, rape, or carnapping where the driver or occupant is killed or raped or offenses under Republic Act No. 9165 (Comprehensive Dangerous Drugs Act of 2002) punishable by more than twelve (12) years of imprisonment, shall be deemed a neglected child under Presidential Decree No. 603, as amended, and shall be mandatorily placed in a special facility within the youth care faculty or 'Bahay Pag-asa' called the Intensive Juvenile Intervention and Support Center (IJISC).

VII. Interventions and Treatment

Section 28. When to give intervention or treatment program

28.1. If after conduct of screening a child is found to be of **low risk for drug abuse and dependence**, the child will be given general and brief interventions in accordance with Secs. 37 to 40 below in addition the provisions under Items A and D.

28.2. If after conduct of screening a child is found to be of **moderate or high risk for drug abuse and dependence**, the child will further undergo a drug dependency examination to assess severity of use and dependence, i.e., determine level of substance use disorder (SUD), and the appropriate treatment plan to be given:

a. If the child has **mild SUD**, the treatment will be in accordance with Secs. 42 to 45 below;

b. If the child has **moderate or severe SUD**, the treatment will be in accordance with Secs. 46 to 49 below

A. General provisions for intervention or treatment

Section 29. Consent to undergo intervention or treatment

An intervention or treatment program may only commence with a valid consent (from parent, guardian; proxy consent as provided under Sec. 14 of this Protocol) or upon court order. With this consent or order is the agreement to administer random drug test during the treatment and care program.

Section 30. If child needing intervention or treatment for drug use is a CAR (under Secs. 3 and 12 of this Protocol)

Regardless of the CAR's level of risk, the intervention or treatment program to be given must address both the child's vulnerability to and risk of: (a) behaving in a way that can harm him/herself or others, *and* (b) being pushed and exploited to come into conflict with the law because of personal, family and social circumstances.

Section 31. If child needing intervention or treatment for drug use <u>is a CICL</u> (under Secs. 4 and 18 of this Protocol)

If the child needing intervention or treatment is a CICL, regardless of the child's level of risk and/or substance use disorder, the following must be observed:

a. The intervention or treatment program intended to address a CICL's drug use **is distinct from** the intervention and diversion programs given under the Juvenile Justice and Welfare Act. Under the Juvenile Justice and Welfare Act[19], an intervention program for the CICL[20] is designed to prevent children from re-offending while a diversion program is one that a CICL[21] is required to undergo after being found responsible for an offense[22].

b. The intervention or treatment intended to address the CICL's drug use may (upon determination of LSWDO or social worker handling CICL's case and with the assistance of the local health office) be given **prior to or simultaneous with** the intervention program[23] or diversion program[24] required under the Juvenile Justice and Welfare Act[25].

c. If the CICL is required to be placed under a center-based intervention pursuant to the Juvenile Justice and Welfare Act, the intervention or treatment needed to address the child's risk or substance use disorder will be determined by the MDT or the center in charge of the CICL's case.

d. If the treatment needed to address a CICL's drug use is in-patient or center-based (e.g., residential drug treatment facility), the child will first complete said treatment program before an intervention or diversion program required under the Juvenile Justice and Welfare Act may be commenced.

Section 32. General factors to consider when planning intervention or treatment for any child

32.1. Regardless of the child's determined level of risk (based on screening) or assessed SUD (based on drug dependency examination), every plan for intervention or treatment must be crafted keeping in mind the specific:

19 R.A. 9344 as amended by R.A. 10630
20 CICL who is under the law found to be exempt from criminal liability (e.g., below 15 years old)
21 CICL who is not exempt from criminal liability (e.g., above 15 years old and acted with discernment)
22 Based on the R.A. 9344 as amended by R.A. 10630 and its implementing rules and regulations.
23 For CICL that are exempt from criminal liability (e.g., below 15 years old)
24 For CICL not exempt from criminal liability (e.g., 16 years old and assessed to have acted with discern-ment at the time of commission of offense).
25 R.A. 9344 as amended by R.A. 10630.

a. drivers or reasons for child's use of dangerous drugs or other substances;
b. risks and vulnerabilities faced by the child; and
c. psycho-social and educational needs of the child.

32.2. As such, all intervention or treatment plans should be child-friendly, strengths-based and focused on the specific needs and circumstances of each child as assessed by the assigned case manager. (Relate to Section 33 below)

32.3. Services to be included in a intervention or treatment plan may be provided individually or with other children undergoing programs under this Protocol.

32.4. All duty bearers will consider the use of different modalities (e.g., face-to-face, virtual, blended) when giving interventions or treatment to children to ensure that services are delivered regardless of constraints presented by existing circumstances.

Section 33. Consider child's family circumstances and environment

As part of case management, the LSWDO must conduct a multi-dimensional assessment of the child's life — including child's family circumstances and social environment (including but not limited to: peers having influence on drug use, community sources of drugs, community disorganization, and norms) — to better inform the intervention or treatment to be given each child and to recommend other interventions that address factors contributing to the child's risk of drug use and/or substance use disorder.

Where available, the LSWDO, with the assistance of the local health office, may use tools developed by DSWD to aid the conduct of such multi-dimensional assessment. These tools may also guide a LSWDO when making recommendations on the treatment and care to be given affected children.

Section 34. Guidance when crafting community-based treatment and care

All intervention or treatment programs to be given at the community-level will be crafted in accordance with the principles in the Guidance for Community-Based Treatment and Care Services for People Affected by Drug Use and Dependence in the Philippines[26] issued by the DOH together with the DDB and with the support of the United Nations Office on Drugs and Crime. (See Annex E)

26 https://www.ddb.gov.ph/images/unodc_publications/CBT_Guidance_Doc_Philippines_Final.pdf

Section 35. Comprehensive Local Juvenile Intervention Program

Components of intervention or treatment plans may also be drawn from interventions found in each locality's Comprehensive Local Juvenile Intervention Program (CLJIP). Each locality will endeavor to periodically improve its CLJIP by including more programs that respond to the needs of children involved in dangerous drugs.

Section 36. If child has co-occurring morbidities

If the child has co-occurring morbidities (or health concerns other than a substance use disorder), the child will be referred by the physician to a special facility appropriate to the needs of the child.

B. Interventions if LOW RISK for drug abuse and dependence

Section 37. Determining general interventions for low risk child

General interventions will be given a child screen to be low risk for drug abuse and dependence. The participation of a child's parents or guardians in these interventions is required to ensure that their objectives are accomplished.

As part of case management, the LSWDO will initially determine these general interventions for purposes of identifying and making appropriate referrals to providers of interventions to be given the child. This initial determination will be based on the provisions of item A above and the guidelines below.

Section 38. Objectives of interventions for low risk child

While intervention plans will vary depending on each low risk child's specific circumstances (see Sections 32 and 33), every plan must include general interventions that facilitate psycho-education of the child on:

a. Risks, effects and other consequences (e.g., legal) associated with use of drugs and other substances (e.g., nicotine and alcohol);

b. Emotion management (or the child's ability to be aware of and constructively handle both positive and challenging emotions); and

c. Refusal skills (i.e., child's ability to say "no" to substance abuse; knowing how to avoid taking substances when offered and how to stay away from situations in which drugs may be abused; knowing where to safely report and to ask for help or guidance).

Section 39. Possible general interventions if low risk

General interventions aimed at accomplishing the above objectives may be based on but not limited to any of the following[27] to the extent that they are consistent with the best interest of the child:

a. Interventions to be given without participation of family (e.g., adolescent counseling, peer group sessions);

b. Education (e.g., drug awareness interventions; awareness-building and educational activities; educational assistance; access to alternative learning systems; formal scheduling);

c. Programs for parents or guardian (e.g., enhanced parent effectiveness service; effective monitoring of children on drug use and other issues; orientation on laws involving children and on where to seek help or assistance; anger management for parents); and

d. Programs that may be given jointly to the child and the family (e.g., orientation and briefing on the program to be given the child; family counseling; seminars/education sessions on ill effects of drugs to individuals, family and community).

Section 40. Optional recovery support services for low risk children

When deemed necessary by the LSWDO, the following optional recovery support services may be given to the child:

a. Self-development programs with community involvement (e.g., music / arts programs; sports activities; involvement in activities of youth groups, values formulation sessions, development of life goals);

b. Community care interventions (e.g., skills training, livelihood opportunities, job placement, cash for training or work programs, life skills development);

c. Education/school-related interventions (e.g., programs that address difficulties in classes, experiences of bullying, and other possible problems and issues in school);

27 Drawn from DOH Administrative Order No. 2017-0018 (Guidelines for Community-Based Treatment and Support Services for Persons Who Use Drugs in Primary Health Care Settings) dated 29 August 2017 to the extent the treatment and support services are consistent with the best interest of the child.

d. Psychological, social and/or spiritual support services (e.g. recollection, retreat, faith-based sessions); and

e. Other activities and programs that may cover any or all of the following domains: medical, livelihood/employment for the child's family, alcohol/drugs, legal, family, social, and psychiatric.

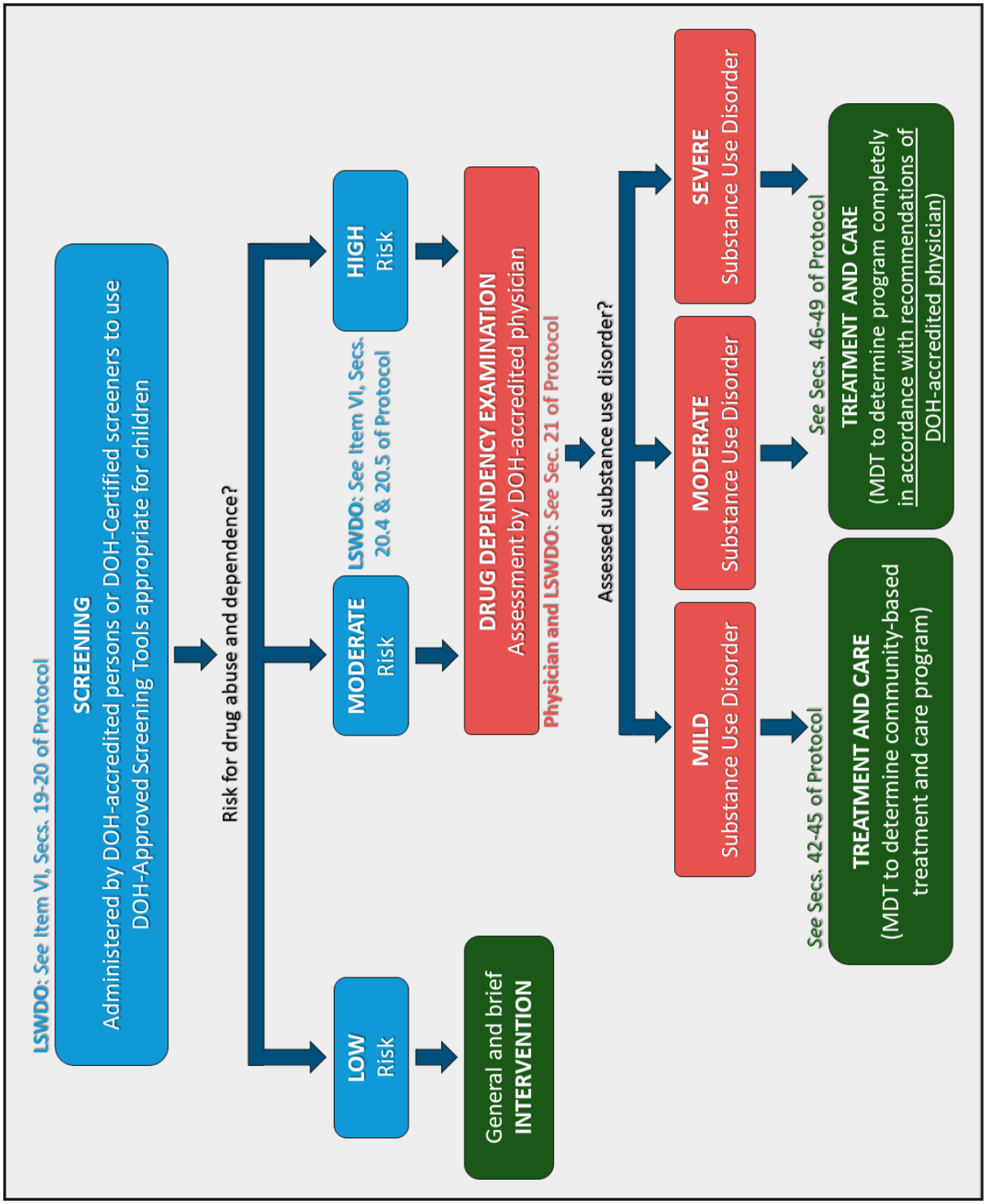

Figure 5: Interventions and Treatment under Protocol (See also Annex B)

C. Treatment if MODERATE or HIGH RISK for drug abuse and dependence (Treatment based on severity of SUD)

Section 41. Program formulation for child after drug dependency examination

41.1. The child with moderate or high risk (after screening) is further subjected to a drug dependency examination and regardless of resulting severity of SUD (mild, moderate or severe), the LSWDO will upon receipt of the drug dependency examination results convene within five working days a multi-disciplinary team (MDT) that includes at least a physician, a BADAC representative and a BCPC member.

41.2. The MDT will:

a. review the drug dependency examination results, the corresponding case file of the child, and other relevant documents (e.g., case study report); and

b. in accordance with the recommendations given by the physician who conducted the drug dependency examination, determine the appropriate treatment program for the child including a determination if the program will be community-based, outpatient, in-patient or center-based.

Section 42. Objectives of treatment for MILD Substance Use Disorder

Even if treatment programs for a child with mild SUD vary depending on each child's specific circumstances, treatment to be given must include activities or services that facilitate psycho-education of the child on:

a. Risks, effects and other consequences associated with use of drugs and other substances (e.g., nicotine and alcohol);

b. Emotion management (or the child's ability to be aware of and constructively handle both positive and challenging emotions);

c. Refusal skills (i.e., child's ability to say "no" to substance abuse; knowing how to avoid taking substances when offered and how to stay away from situations in which drugs may be abused);

d. Development of child's life skills (ability to relate to others in a positive way, demonstrate adaptive problem-solving); and

e. Relapse prevention (ability to identify and avoid triggers of use and manage cravings).

Necessarily, the level of participation of parents or guardians in treatment programs for children with mild SUD will be more intensive (e.g., implementation of more family/parenting modules) when compared to the level of involvement needed when dealing with children who are low risk.

Section 43. Possible activities or interventions if child has MILD SUD

43.1. The MDT will recommend a treatment plan that includes activities and services focused on the accomplishment of the above-enumerated objectives. These activities and services may include:

a. Structured interventions;
b. Behavioral modification programs;
c. Counseling;
d. Motivational interviewing;
e. Implementation of modules and services that all focus on the above objectives (e.g., relapse prevention)

43.2. In addition, the MDT may recommend the inclusion in the treatment plan of any or a combination of the following:

a. Interventions to be given without participation of family (e.g., adolescent counseling, peer group sessions);

b. Education (e.g., drug awareness interventions; awareness-building and educational activities; educational assistance; access to alternative learning systems; formal scheduling);

c. Programs for parents or guardian (e.g., enhanced parent effectiveness service; effective monitoring of children on drug use and other issues; orientation on laws involving children and on where to seek help or assistance; anger management for parents); and

d. Programs that may be given jointly to the child and the family (e.g., orientation and briefing on the program to be given the child; family counseling; seminars/education sessions on ill effects of drugs to individuals, family and community)[28].

Unless the MDT recommends otherwise, the above activities and services will be implemented at the community-level.

Section 44. Detoxification for child with Mild SUD

If the physician that conducted the drug dependency examination finds it necessary to have the child undergo detoxification, the MDT will ensure that the implementation of the detoxification program will be given priority over behavioral interventions planned for the child.

Section 45. Recovery support services for child with Mild SUD

If deemed necessary by the MDT, recovery support services available to children who are low risk (Section 40) may also be given to children assessed with mild SUD. In addition, children with mild SUD can be advised to attend relevant support programs (e.g., narcotics anonymous, faith-based programs and peer recovery programs) as part of the treatment program up until they are receiving after care services.

Section 46. Objectives of treatment for MODERATE or SEVERE SUD

The physician and LSWDO handling the child's case, in consultation with members of the MDT, will formulate more specific objectives for the treatment given to a child with either moderate or severe SUD in addition to the objectives of treatment programs given a child with mild SUD[29].

For a child assessed to have moderate or severe SUD, the treatment and care program — whether in-patient, structured outpatient or community-based — will be designed and implemented completely in accordance with the recommendations of the DOH-accredited physician.

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28 Similar to general interventions proposed to be given to children screened to have a low risk for drug abuse and dependence

29 1. Facilitate psycho-education of the child on: (a) Risks, effects and other consequences associated with use of drugs and other substances (e.g., nicotine and alcohol); (b) Emotion management (or the child's ability to be aware of and constructively handle both positive and challenging emotions); (c) Refusal skills (i.e., child's ability to say "no" to substance abuse; knowing how to avoid taking substances when offered and how to stay away from situations in which drugs may be abused); and 2, Focus on: (a) relapse prevention of the child; (b) development of the child's life skills; and (c) imple-mentation of more family/parenting modules.

When possible, children having moderate or severe SUD will be given treatment at the community-level unless the MDT finds compelling reasons to recommend in-patient or structured outpatient treatment.

Section 47. Possible activities and services for MODERATE or SEVERE SUD

In addition to medical interventions/treatments appropriate for a child with moderate or severe SUD, among the activities and services that may be considered by the MDT to be included in the treatment for these children are:

a. Activities or interventions that may be given a child with mild SUD (Section 41) but adjusted according to the specific objectives of the treatment to be given a child with moderate or severe substance use disorder and the child's specific circumstances (see Section 31[30]);

b. Structured outpatient modalities that include the children and their families, i.e. community reinforcement and family training (CRAFT), life and recovery skills;

c. Individual and family therapy or counseling; and

d. Behavior modification programs that include the children and their families (i.e. cognitive behavioral therapy, contingency management, motivational enhancement therapy)

Section 48. Recovery support services for child with MODERATE or SEVERE SUD

If deemed necessary by the MDT, recovery support services available to those assessed with mild SUD may also be given to children assessed with moderate or severe SUD, keeping in mind their specific circumstances, as well as to their parents and other family members. Among these support services are:

a. Self-development programs with community involvement (e.g., music / arts programs; sports activities; involvement in activities of youth groups, values formulation sessions, development of life goals);

b. Community care interventions (e.g., skills training, livelihood opportunities,

30 The plan for treatment and care must be crafted keeping in mind the specific: (a) drivers or reasons for the child's use of dangerous drugs or other substances; (b) risks and vulnerabilities faced by the child; and psycho-social needs of the child.

job placement, cash for training or work programs, life skills development) for children and/or parents;

c. Education/school-related interventions (e.g., programs that address difficulties in classes, experiences of bullying, and other possible problems and issues in school);

d. Psychological, social and/or spiritual support services (e.g. recollection, retreat, faith-based sessions);

e. Attendance in relevant support groups (e.g., peer recovery groups) as part of the treatment program up until they are receiving after care services.

f. Other activities and programs that may cover any or all of the following domains: medical, livelihood/employment, alcohol/drugs, legal, family, social, and psychiatric.

Section 49. If the child must undergo center-based treatment

49.1. If the child must undergo a center-based treatment program, the MDT will coordinate with a DDB-authorized representative for the processing of a petition for confinement at a drug treatment facility that can cater to the needs of the child. The DDB-authorized representative will file a petition for confinement at the Regional Trial Court. During pendency of the petition, with appropriate orders coming from the court, the child will remain in the custody of the drug treatment facility. The designated center submits a progress report to the Court with notice to the social worker and the MDT. ***In the absence of a residential drug rehabilitation facility for minors in the area, the DOH-accredited physician shall recommend a program for the child.***

49.2. If the child avails of voluntary submission to drug treatment and rehabilitation, the program to be given will be in accordance with DDB Regulation No. 3, Series of 2007 (Rules Governing Voluntary Confinement for Treatment and Rehabilitation of Drug Dependent) and DDB Regulation No. 1, Series of 2009 (Guidelines for the Rehabilitation of First-Time Offenders Under Section 15 of RA No. 9165 Who Are Not Drug Dependents) to the extent that said regulation serves the best interest of the child.

D. Implementation of Intervention and Treatment

Section 50. Providers and implementors

The intervention or treatment program for the child, while determined by the LSWDO (for low risk) or MDT (if child is with mild, moderate or SUD), will be implemented with the assistance of available providers of service at the community level, including but not limited to the:

a. Local health office / facility;
b. LCPC or BCPC;
c. NGOs that may or may not be part of the LCPC or BCPC;
d. ADAC;
e. Schools (see Section 51 below).

The case manager must ensure that persons designated by the above offices or units are adequately trained in giving interventions to children.

Section 51. Interventions separate from adults

51.1. If interventions, activities and other services for treatment of children are to be delivered by implementors who are also part of the community-based drug rehabilitation program (CBDRP) for adults, these implementors/providers must ensure that the intervention or treatment activities/services are delivered in a child-appropriate manner.

51.2. If an intervention or treatment program is implemented at the community-level, the LSWDO and the LGUs will ensure that the child will **not be mixed** with adults and their programs will not be implemented in public places.

Section 52. School involvement in treatment and care programs[31]

If parents agree to inform the school the child is attending, the creation and implementation of an intervention or treatment plan may be done by the LSWDO or the MDT in coordination with the school consistent with the Guidelines and Procedures on the Management of Children-at-Risk (CAR) and Children in Conflict with the Law (CICL) under Department of Education Order No. 18, series of 2015.

31 NOTE: *To re-confirm with TWG on degree of school involvement, when optional.*

Section 53. Additional guidelines on implementing intervention or treatment

53.1. Only a licensed counselor, psychologist or psychiatrist may provide **counseling** services to the child. Other service providers such as psychometricians or rehabilitation practitioners may provide counseling services only under supervision by a licensed counselor, psychologist or psychiatrist.

53.2. Intervention or treatment plans given to the child at the community-level will be **funded** by ADACs of LGUs. LGUs may also source funds from the LCPC and will also endeavor to obtain assistance from non-government organizations, faith-based groups, and other government agencies (e.g., DepEd).

53.3. Drug testing may be required by the LSWDO or the MDT charged with the intervention/treatment program of the child only for therapeutic purposes and to monitor patient compliance with the program. Such drug testing activity must be recorded in the child's case record and must not require the official forms from accredited laboratories.

Section 54. Monitoring progress

54.1. As case manager, the LSWDO will be in charge of monitoring and evaluating the progress of an intervention or treatment program given a child. If the program is community-based, the LSWDO may obtain the assistance of other implementors and providers(under Sec. 49) when monitoring the child's progress.

54.2. If a treatment program is structured outpatient or in-patient, the social worker at the recovery clinic will, in coordination of the MDT, take charge of monitoring and evaluating the progress of the child.

54.3. If the child is referred to a center-based treatment, the social worker at the center will take charge of monitoring and evaluating the progress of the child.

Section 55. Certificate of Completion

Upon successful completion of an intervention or treatment program, the child shall be issued a certificate of completion[32] signed by:

a. the LSWDO as case manager (for low risk child)
b. the physician or any authorized representative of the MDT (for child with mild, moderate or severe SUD).

32 Note: This is different from the "Certificate of Community Program Completion" issued to adult PWUDs.

VIII. Aftercare and Social Reintegration

Section 56. No aftercare program for low risk children

Aftercare services will only be given to children who underwent a drug dependency examination and assessed to have mild, moderate or severe SUD. Children found to be low risk for drug abuse and dependence (after receiving brief, general interventions under Item VII of this Protocol) will no longer go through an aftercare program.

Section 57. Timing: after completion of treatment program

57.1. Recovering children who use drugs (RCWUD) who have undergone appropriate and prescribed treatment in Item VII of this Protocol shall be provided with an aftercare and social reintegration program as described in the sections below. Once the child is done with treatment, the MDT shall prepare endorsement of cases to an LGU reintegration team.

57.2. If the child completed a center-based treatment program, the Center will endorse the child's case to the LSWDO for commencement of aftercare and social reintegration.

57.3. If the RCWUD is a CICL that also has to complete a diversion program or other court requirements (depending on nature of case and penalty), aftercare will be implemented after completion of the diversion program.

57.4. While the child is undergoing treatment, the LSWDO and those identified to be part of the reintegration team has to work with the family and community for adequate transition and reintegration.

Section 58. Implementors of aftercare and social reintegration program

58.1. Aftercare and reintegration programs will be created and implemented by *the LGU's BCPC through a multi-disciplinary team with the LSWDO as the case manager. In addition to the BCPC and the local social welfare and development office*, this team may also include the BADAC and local health service providers.

The following may also provide support in the implementation of the aftercare and reintegration program:

a. Barangay Referral and Rehabilitation Desk Officers

b. Anti-illegal Drugs Focal Point Persons from government offices
c. Police personnel and other law enforcement groups present in the LGU
d. Other community-based stakeholders such as community leaders and volunteers and representatives from faith-based organizations and the academe.

58.2. The aftercare and reintegration program will be **overseen** by the LSWDO in close coordination with the BADAC, BCPC and the LGU reintegration team.

58.3. The LGU reintegration team shall thoroughly review the documents that were turned-over by the MDT and then convene with the child and his/her family to plan the 18-month aftercare intervention. The team shall explore how recovery agreements, as discussed with the child and family, shall affect the family's values system and situation giving paramount priority to the child's best interest and safety. After the goal-setting process, the aftercare program shall be sealed through a contract signed by the child, the family, and the reintegration team.

Section 59. Objectives of aftercare and social reintegration for RCWUD

59.1. All aftercare and reintegration programs and services are created to assist both CAR and CICL in their recovery journey and facilitate their social reintegration. These programs and services shall be consistent with DSWD's Yakap Bayan Program, particularly the overarching framework it provides for RCWUDs (see Annex F and the social reintegration framework for RCWUDs), and with all other guidelines to be issued by the DSWD and the DOH on this matter.

59.2. Under the Yakap Bayan Program, the overall goal is for the child to be successfully reintegrated to their families and social environment. Aftercare and social reintegration measures aim to prevent or reverse social exclusion of RCWUDs, to facilitate their recovery process, and to help sustain treatment outcomes. As part of achieving this goal, the program aims to: (a) prevent relapse among RCWUDs; (b) address risk factors[33]; and (c) sustain protective factors[34].

59.3. An aftercare and reintegration program shall also contain provisions that refer to building the capacity of parents or guardians who will receive the child as well as of the communities where the child resides to be able to provide them a supportive recovery environment.

33 Risk factors are characteristics at the biological, psychological, family, community, or cultural level that precede and are associated with a higher likelihood of negative outcomes.

34 A protective factor is something that helps to prevent problems.

Section 60. Aftercare and social reintegration services

To achieve the above objectives, the LGU reintegration team may choose from the following aftercare and social reintegration services, systems, and mechanisms:

a. Services for RCWUDs

1. Relapse education and prevention
2. Life skills education on:
   - Identifying and managing internal and external triggers
   - Identifying and coping with high-risk situations
   - Refusal skills (assertiveness to avoid dangerous drugs and other substance use and abuse)
3. Behavioral change session to establish attitudes:
   - Belief that using drugs is harmful and risky
   - Motivation/readiness to change: self-efficacy to maintain abstinence and continuous dedication to not use

b. Services for families of RCWUDs

1. Family Sessions on positive communication and/or conflict resolution
2. Family drug therapy session
3. Capacity building on gender sensitive and child-centered, child-rearing practices
4. Availability of family during drug therapy sessions
5. Provision of services to age-differentiated needs of RCWUDs
6. Interventions to address family violence
7. Housing services to address non-conducive housing structure and condition

c. Peer support group

Strengthening peer support system of RCWUDs by providing services/activities that aimed at:

1. Promotion of peer support and positive influence
2. Formation of positive role model
3. Emotional support (unconditional positive regard, acceptance, empathy, sense of community)
4. Openness and honesty
5. Informational support (sharing tips and good practices)
6. Handling peer conflict and negative influence
7. Positive managing of peer pressure
8. Handling difficulties in establishing, maintaining positive peer relationships
9. Dealing with aggression and delinquency

10. Handling bullying experience: victim or perpetrator

d. School-Based Interventions for RCWUDs

1. Implementation of the DepEd child protection policy
2. Availability of individualized program for students
3. Publication and distribution of materials on dangerous drugs
4. Curriculum integration of drug abuse awareness and prevention
5. Conduct of activities about dangerous drug prevention and awareness by student councils
6. Scholarship for RCWUDs
7. Availability of learning materials
8. Provision of psycho-social services (counseling, mentoring)
9. Provision of facilities for recreation, vocational training, extracurricular activities, etc.
10. Conduct of programs/workshops/ seminars about dangerous drugs
11. Compliance monitoring of school policies
12. School head support of the National Drug Education Program implementation
13. Availability / development of capabilities of guidance counselors, Barkada Kontra Droga (BKD) coordinators, and homeroom advisers
14. Involvement of school health & nutrition personnel
15. Capacity building opportunities to deal with RCWUD
16. Online sessions on mental health promotion to cope with the negative effects of COVID19

e. Neighborhood/Community Interventions

1. Availability of recreational programs, projects and services for RCWUDs and their peers
2. Opportunities for RCWUDs' community reintegration
3. Availability of faith-based resources and after-school activities

Section 61. LGU interventions to support aftercare and reintegration

61.1. To ensure effective delivery of aftercare and reintegration programs, each LGU will also take necessary action that support:

a. Policies, programs & services for RCWUDs & their families – psychosocial support, access to basic services (health, education), family mediation, legal assistance, economic strengthening of households)
b. Child protection policies and mechanisms
c. Budgetary requirements for RCWUDs' social reintegration

d. Human resource requirement including training of professionals and community-based providers for needed interventions
e. Budgetary allocation for BCPCs
f. Interagency Monitoring Task Force to monitor the child protection mechanisms
g. Active role of Sangguniang Kabataan (SKs) to help RCWUDs
h. Establishment of Special Drug Education Center (SDEC)
i. Organization of Strong Neighborhood Attachment
j. Barangay buddy system for CICL
k. Referrals of RCWUDs to other services

61.2. Expenses for aftercare and reintegration programs may be primarily drawn from the funds of the local social welfare and development offices of the LGU.

Section 62. Administration of Multi-Dimensional Reintegration Tool (MDRT)

The multi-dimensional reintegration tools (MDRT) developed by DSWD shall be used by the LGU reintegration team:

a. to assess the needs of RCWUDs, their families and communities where they reside to prepare them for social reintegration; and

b. to monitor and evaluate the recovery progress of RCWUDs.

These tools are designed to help deepen understanding of the dimensions described in the social reintegration framework for RCWUDs (Annex F).

Section 63. Administration of Multi-Dimensional Reintegration Tool (MDRT)

63.1. The data drawn from the use of MDRT shall be shared to the DDB and DSWD as baseline for continual improvement of policies and programs as deemed necessary.

63.2. Reports of statistical data (not specific information) on RCWUDs undergoing aftercare and reintegration services shall be submitted to the Anti-Drug Abuse Council – Reporting System (ADAC-RS) for onward submission to the Integrated Drug Monitoring and Reporting Information System (IDMRIS) of DDB. Any information on children allegedly involved in dangerous drugs will not be included in the IDMRIS and only statistical data shall be transmitted to higher ADACs as confidentiality of cases shall be observed at all times. On the other hand, the LSWDO is required to submit a Quarterly Report on the implementation of Yakap

Bayan Program to the PSWDO and DSWD Field Office. The Field Office shall then consolidate these reports from LSWDOs which shall be submitted to the DSWD Program Management Bureau and Social Technology Bureau.

Section 64. When to recommend for another treatment

In case of relapse or when the reintegration team deems necessary based on the multi-dimensional reintegration tools use, the child will be referred back to the MDT with a recommendation for another round of treatment.

IX. Other provisions

Section 65. Additional role of LGU

65.1. When implementing this Protocol, all LGUs will strictly observe the funding requirements under Section 51 of RA 9165, Section 5(e) of Executive Order No. 66, series of 2018[35], and Sections V(A)(3) and (A)(4) of DILG and DDB Joint Memorandum Circular No. 2018-01 dated 21 May 2018[36].

65.2. All LGUs are also enjoined to hire an LSWDO in line with the Magna Carta for Social Workers.

Section 66. Penalty clause

Any person found violating the provisions of this Regulation shall be criminally liable under Section 32 of RA 9165 without prejudice to corresponding administrative sanctions.

Section 67. Modification, repeal and interpretation

This Regulation repeals Board Regulation No. 6, series of 2019 and modifies provisions in all other administrative issuances/orders/regulations deemed inconsistent with this Regulation.

In case of doubt in interpretation of this Regulation and any other administrative issuance, order or regulation, the interpretation upholding the best interest of the child will be favored.

Section 68. Separability

In the event that any section, paragraph, sentence, clause, or word of this Regulation is declared invalid for whatever reason, other provisions shall not be affected thereby.

Section 69. Effectivity

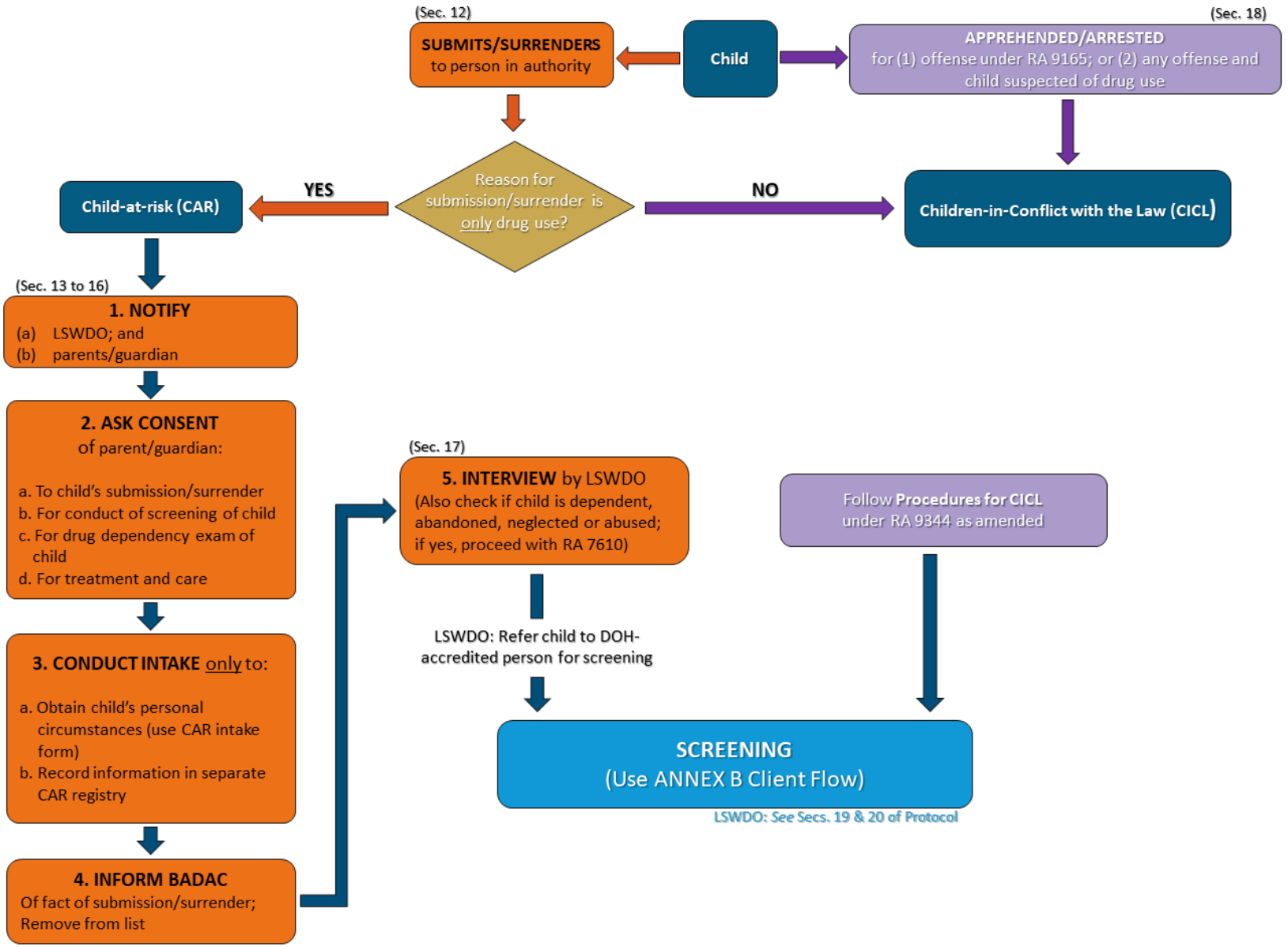
This Regulation takes effect _____ days after its publication in _____

35 Institutionalizing the Philippine Anti-Illegal Drugs Strategy
36 Implementing Guidelines on the Functionality and Effectiveness of Local Anti-Drug Abuse Councils

ANNEXES

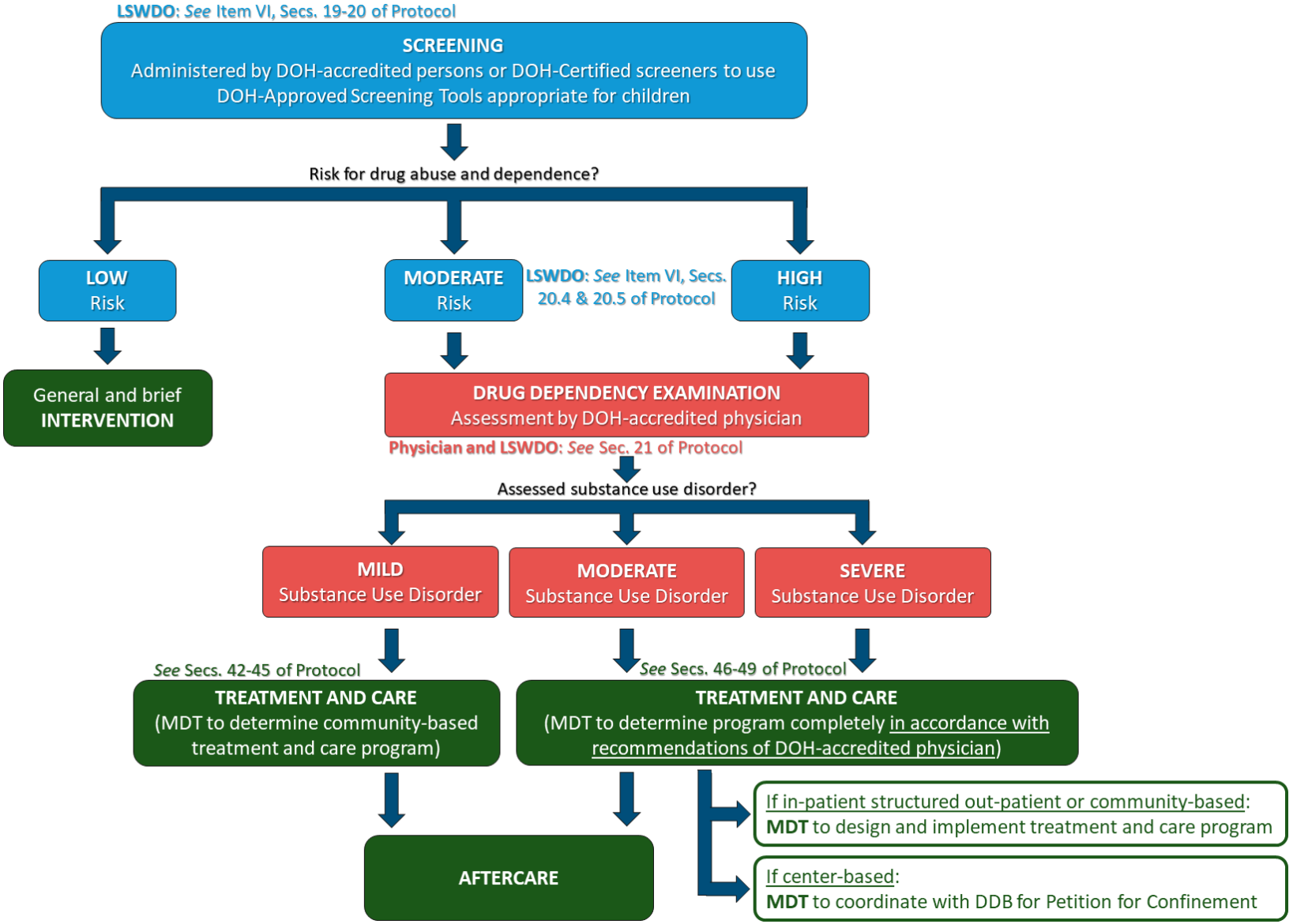
Annex A

Process Flow on HANDLING CHILDREN ALLEGEDLY INVOLVED IN DANGEROUS DRUGS



Annex B

Process Flow from SCREENING to AFTERCARE of children allegedly involved in dangerous drugs



Annex C

Intake Form

BCPC Form No. 1

Republic of the Philippines
Province of _____
City/Municipality of _____
Barangay _____

INTAKE FORM FOR BARANGAY COUNCIL FOR THE PROTECTION OF CHILDREN (BCPC)

I. Profile of the Child:

Name: _____Nickname/ Alias: _____Age: _____
Sex: _____ Gender: _____ Date of Birth: _____
Place of Birth: _____
Address: _____
Highest Educational Attainment: _____

II. Family Background:

Name	Relationship	Sex	Age	Civil Status	Educational Attainment	Occupation/ Income	Remarks

III. Status of the Case:

Category of Child Involved: ☐ Children in Conflict with the Law (CICL)
☐ Children at Risk (CAR) [Check whichever is applicable]
_____ Neglected _____ Abandoned
_____ Orphaned _____ Abused

Place and data of alleged offense committed:
_____
Case/ Offense: _____
Name of Apprehending Officer: _____

Intake Form (Page 2)

Office of Apprehending Officer: _____
Contact Number: _____
Place of Apprehension: _____ Date and Time: _____

IV. Record of previous offense/s or violation/s committed, if any (please indicate):

Offense	Status of the Case	Period of Implementation	Period Covered

V. Remarks/ Other significant information, e.g. physical appearance, distinguishing mark(s) in the body, etc.:

_____
_____
_____
_____
_____

VI. Action Taken, if any (please specify):

_____
_____
_____
_____
_____

Date and time accomplished: _____

_____
Name & Signature of Duty-Bearer

_____ _____
Name & Signature of the CICL/CAR Name & Signature of the Parent
Date: _____ Date: _____

Received and filed this ____ day of _____, 20_____.

_____
Name and Signature of Punong Barangay

Annex D

Screening Tools for Children

RISK LEVEL	ASSIST	INTERVENTION/TREATMENT
LOW	0-3 EXCEPT 0-10 Alcohol	• General Intervention (Item VII, Secs. 37-40 of Protocol)
MODERATE	4 – 26 EXCEPT 11-26 Alcohol	• Referral to DOH-Accredited Physician for DDE • Treatment program determined by MDT (Item VII, Secs. 42-48 of Protocol)
HIGH	27 +	

RISK LEVEL	CRAFFT-N	INTERVENTION/TREATMENT
LOW	0 - 1	• General Intervention (Item VII, Secs. 37-40 of Protocol)
MODERATE	2 - 4	• Referral to DOH-Accredited Physician for DDE • Treatment program determined by MDT (Item VII, Secs. 42-48 of Protocol)
HIGH	5 - 6	

SRQ (Self reporting Questionnaire)
---to screen for presence of
(+) Somatoform/neurosis (SRQ 20)--- score : 8 or more
(+) Psychosis (SRQ 21 to 24) score 1 or more
(+) Convulsion/ seizure D/O (SRQ 25) score of 1

Annex E

Principles for a substance abuse Treatment

The nine principles of drug dependence treatment, as outlined by a UNODC-WHO 2008 discussion paper, provide guidance for gradually implementing quality treatment to those in need:

Principle 1: Availability and accessibility of dependence treatment
Treatment services need to be available, accessible, affordable and evidence-based to deliver quality care for all people in need of support.

Principle 2: Screening, assessment, diagnosis, and treatment-planning
Comprehensive assessments, diagnosis and treatment planning are the basis for individualized treatments that address the specific needs of each patient, and that will also help to engage them into treatment.

Principle 3: Evidence-informed dependence treatment
Evidence-based good practice and scientific knowledge on dependence should guide interventions.

Principle 4: Dependence treatment, human rights, and patient dignity
Treatment interventions should comply with human rights obligations, be voluntary and provide the highest attainable standards of health and well-being.

Principle 5: Targeting special subgroups
Several groups within the larger population of those affected by dependence require special attention, including adolescents, women (including pregnant women), individuals with co-morbid disorders (either mental or physical), sex-workers, ethnic minorities and homeless people.

Principle 6: Dependence treatment and the criminal justice system
Dependence should be seen as a health care condition, and dependent individuals should be treated in the health care system rather than the criminal justice system with community-based treatment offered as an alternative to incarceration where possible.

Principle 7: Community involvement, participation, and patient orientation
Community-based treatment responses to drug and alcohol abuse and dependence can promote community change and active involvement of local stakeholders and support for community funding models.

Principle 8: Clinical governance of dependence treatment services
It is important that treatment services have clearly defined policies, treatment protocols,

programs, procedures, a definition of professional roles and responsibilities, supervision, and financial resources.

Principle 9: Treatment systems: policy development, strategic planning and coordination of services

A systematic high-level policy approach to substance use disorders and individuals in need of treatment, as well as a logical, step-by-step sequence that links policy to needs assessment, treatment planning, implementation, and to monitoring and evaluation is most beneficial.

Annex F

DSWD Yakap Bayan Program Framework for Recovering Children Who Use Drugs

The Yakap Bayan Program (YBP) developed by DSWD shall serve as an overarching framework in providing Aftercare and Reintegration Services for recovering children who use drugs. YBP is a holistic intervention to assist Recovering Children Who Use Drugs (RCWUDs) in their recovery journey and to facilitate their social reintegration.

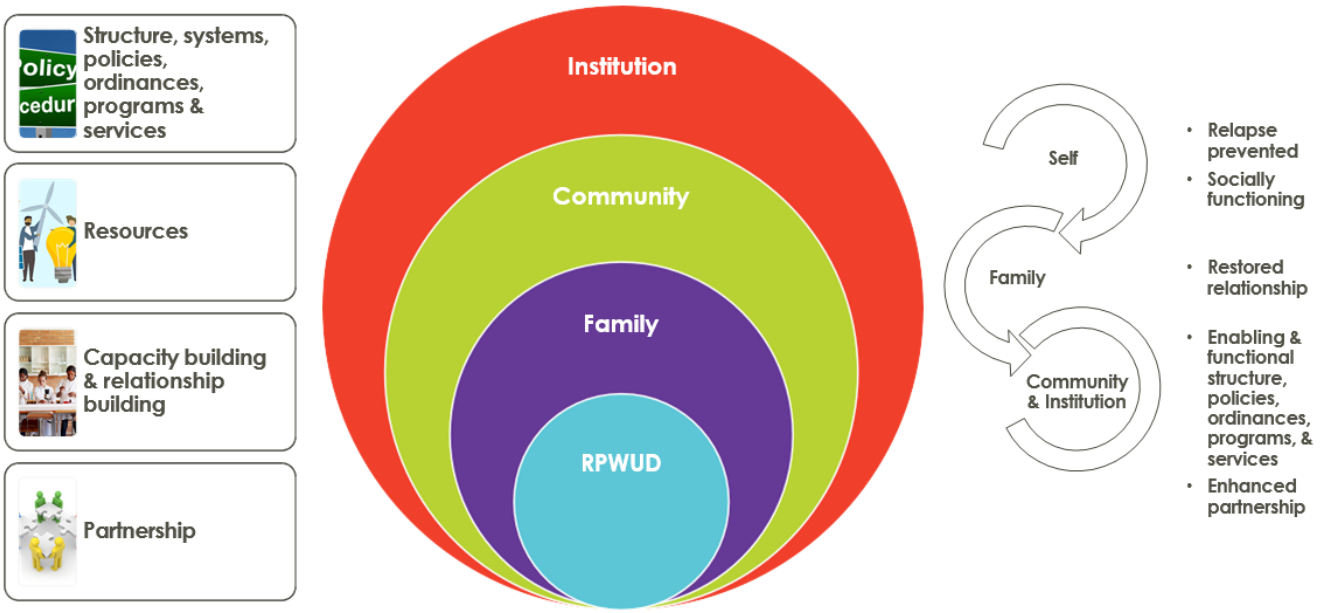
The RCWUD framework of the Yakap Bayan Program adopts the General System Approach, which states that human behavior is shaped by multiple systems of influence family, school, peers, community/neighborhood. Further, it considers the development of every person as related to each other and organizations.

The framework considered that not only parents influence children but children also influence their parents. Change can arise at any level of the family system and change at any level can stimulate change in an individual member.[1] The FST views adolescence functioning as a reciprocal condition and a product of patterns and interactions in which drug use is embedded. A family systems orientation examines the emotional connections, harmony and communication among families that influence and are influenced by adolescent drug use.

The ultimate goal is to swap problematic or disagreeable behaviors with more positive, desirable behaviors.[2] In the case of the RCWUDs, behavior change may stem from their interaction with, and the quality of support from the various sub-systems (family, peers, school, church, community, and institution) identified in the framework.

1 Binoy Paul and Victor Paul. Factors of Reintegration of Children in Conflict with Law in Journal of Dharma 45, 1 (January-March 2020), 105-124 © 2020 Journal of Dharma: Dharmaram Journal of Religions and Philosophies (DVK, Bangalore)

2 Cocchimiglop, Sarah (May 13, 2021). What Is Behavior Modification? Psychology, Definition, Techniques & Applications. Retrieved from https://www.betterhelp.com/advice/behavior/what-is-behavior-modification- psychology-definition-techniques-applications/



The framework proposes that change begins with the RCWUDs themselves, and that change is facilitated with the help of the family, the social groups/peers, the school, the community, and the institution. If the protective factors in all dimensions are in place and sustained, and if the risk factors also in all dimensions are effectively addressed, then relapse would be prevented, and eventually the RCWUD would be successfully reintegrated socially and psychologically into their social environment.

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