Service Delivery of Drug Abuse Treatment and Rehabilitation Centers in Region III

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ABSTRACT

This descriptive study aimed to evaluate the delivery of Drug Abuse Treatment and Rehabilitation Centers (DATRCs) in Region III, determine the best practices, identify the challenges in implementing rehabilitation programs, and propose an action plan to address the identified challenges. There are three accredited DATRCs in Region III, but only two responded positively to inclusion in this study. There were two sets of respondents who received questionnaires for data collection- the medical staff and administrative personnel (n=16 from DATC 1 and n=24 from DATRC 2) and the patients/clients (n=100 from DATRC 1 and n=150 from DATRC 2). The respondents were selected using purposive sampling.

The study's findings revealed that the medical staff, administrative personnel, and patients generally had positive assessments of the services delivered at the DATRCs, as their ratings on the services were "very satisfactory" and "outstanding." The highest satisfaction rating was on the implementation of the Matrix Intensive Outpatient Program, followed by Screening and Assessment of Persons Who Use Drugs (PWUDs) and Drug Dependency Examination (DDE) (Severity of use). All three services delivered were outstanding. However, Community - Based Drug Rehabilitation Program received the lowest rating (fair). The most pressing problems identified were inadequate employee benefits, absence of regularization, and fast medical and administrative personnel turnover. For patients, financial constraints include attending rehabilitation sessions regularly. For the best practices, the centers provided patient-centered, holistic, and evidence-based treatment approaches despite the challenges experienced.

The study concluded that the DATRCs in Region III managed to abide by the standards of rehabilitation treatment protocols, leading to the positive evaluation of the centers' delivery of services, except for the implementation of community-based drug rehabilitation. Moreover, there were persistent challenges needing resolution should the government desire success in its fight against drug dependence in the country.

The study recommends revisiting the mandates of DOH and DDB to oversee the establishment of drug rehabilitation centers, investigate the problems identified in the study, and implement measures to address them.

Keywords: Community-Based Drug Rehabilitation Centers, Dangerous Drug Board, Drug Rehabilitation Centers, Rehabilitation Programs, Treatment Approaches

INTRODUCTION

Drug addiction or dependence on illegal drugs is becoming a burden to the world. The number of individuals involved in drug use has increased to 292 million in 2022, which comprised a 20% rise over 10 years (United Nations Office on Drugs and Crime, 2024). Among the youth, the National Center for Drug Abuse Statistics (2025) in America reported that an estimated 2.08 million aged 12-17 used drugs (mainly marijuana) in 2020; among 18 to 25 years old individuals, 11.89 million used drugs; and 4,777 Americans aged 15 to 24 died from illicit drug overdoses in one year, accounting for 11.2% of all overdose deaths.

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Drug addiction harms the health of the abusers, which raises the likelihood of mental health issues, chronic diseases, and death. Drug dependence puts a heavy burden on families and communities, increasing exposure to accidents, injuries, and violence (World Health Organization, 2024; Junio, 2021).

The middle class and wealthy nations have more severe drug problems and addiction concerns than the poorest nations, contrary to popular belief. In addition, children from wealthy families are two to three times more likely to abuse drugs than children from low-income families (Nierenberg, 2017). This trend of children from affluent families into drug addiction is due to many factors, which include the pressure they feel when many have high expectations of them; some have money to access illegal drugs, absent parents, influence from friends, and lack of friends.

In the Philippines, the estimated number of Filipinos in drug abuse reached 1.7 million in 2019. Except for patients receiving care through community-based programs, there were only 5,277 documented admissions to inpatient and outpatient facilities in the same year. This is an affirmation of the report of the World Health Organization that only one out of six of the 35 million reported cases of drug dependents have access to rehabilitation centers or treatment programs (Junio, 2021).

There are public and private drug rehabilitation treatment facilities available to help willing drug abusers to be rehabilitated. These facilities aim to help patients make positive changes in their lives by equipping them with the proper tools that could help rectify maladaptive behaviors. Patients learn healthy coping skills, impulse control, emotional regulation skills, and drug-refusal strategies that can help them avoid relapse in the long run Unilab Medical Education and Development (UMED), 2018; National Institute for Drug Abuse (NIDA), 2016].

Drug rehabilitation centers range from fundamental facilities to luxury treatment centers. Budget and insurance coverage levels are usual determinants of the type of facility a patient attends. While luxury centers offer more amenities, they may not be the best treatment centers. Patients should weigh options before making a final decision on where to receive treatment for drug addiction (Valley Spring Drug Rehabilitation Center, 2025).

Before treatment, a patient undergoes an intake evaluation from an addiction counselor or mental health professional. The evaluator gathers as much information as possible regarding patterns of drug or alcohol abuse, medical history, mental state, physical problems or conditions, vital signs such as blood pressure, past detox or rehabilitation experiences, living conditions, financial situation and legal status, violence or suicide risk and cognitive, sensory or physical disabilities. The person conducting the evaluation uses this information to help create an individualized treatment plan tailored to suit the prospective patient's needs (Felman, 2018).

Counselors may also help improve emotional regulation skills to avoid relapse. Group counseling allows one to practice sober social skills and the coping strategies learned in individual counseling. Family therapy sessions can help repair broken relationships, improve communication, and build conflict-resolution skills (National Library of Medicine, 2023).

Medications such as methadone and "Suboxone" may be used in combination with behavioral therapy. These are usually used in replacement therapy to reduce the symptoms of withdrawal and opioid addiction. Once the rehabilitation program ends, the treatment team will create an aftercare or relapse prevention plan with ongoing support. Ongoing support may include individual therapy, group counseling, self-help group meetings (e.g., 12-step, SMART Recovery), alum programs, or sober living homes (American Society of Addiction Medicine, 2016).

In the Philippines, former President Rodrigo Duterte's "War on Drugs" campaign was instrumental in solidifying his strongman image and boosting his popularity (Lasco & Yarcia, 2022; Rocamora, 2017). Based on the report of the United National Higher Commissioner for Human Rights, the campaign resulted in a staggering average of 40 deaths per day from drug-related operations between July 1, 2016, and November 27, 2017 (Human Rights Watch, 2017).

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In response, Local Government Units (LGUs) established drug rehabilitation centers like *Bahay Pagbabago*, while numerous reformatory facilities quickly emerged across various barangays. The urgent need for treatment for individuals struggling with drug use became a shared concern among stakeholders, including the Philippine National Police (PNP) and the Philippine Drug Enforcement Agency (PDEA). President Ferdinand Marcos, Jr., continued the program of curbing drug addition and the strategy was to reduce supply and demand. Abalos acknowledged the effectiveness of this anti-illicit drug campaign, because it is being done with minimal loss of life. President Marcos recognized the significance of lowering demand by implementing the Value of Life and Avoid Drugs BIDA (Buhay Ingatan, Droga'y Ayawan) Project (Bangsamoro Information Office, 2024).

Drug rehabilitation enables the deepening of understanding of the physical and psychological effects of substance use, significantly contributing to the ability of individuals to recognize the consequences of their behavior, make informed decisions, and empowered to take ownership of their recovery process, thereby increasing the likelihood for a drug-free future (Sapnu, 2018).

The underlying determinants of drug dependence require examination, including its potential correlation with behavioral addictions, economic deprivation, and systemic governance structures. Addressing these complexities necessitates an interdisciplinary approach integrating public health, social policy, and law enforcement frameworks to develop sustainable, culturally responsive rehabilitation models.

This paper explores these pressing concerns by examining major rehabilitation centers in Region 3. With the author also serving as the program head of one of the country's pioneering outpatient recovery facilities, this study provided findings that would help the researcher enhance the administration of rehabilitation centers (Tecson, 2021). In addition to individual counseling, patients in rehabilitation often participate in group therapy. Patients with similar addictions meet under the direction of a counselor. This allows them to form friendships and to have fellowship with one another. These close personal bonds aid patients on their road to recovery. This is one of the benefits of engaging in the services of Drug Recovery Clinics. However, there are still issues that hinder the optimal services at drug treatment centers (Dangerous Drugs Board, 2018). Hence, studies should still be conducted as findings may serve as the basis for enhancing the services of drug treatment centers.

As a facilitator and the Program Head of a Drug Recovery Clinic – Drug Testing Laboratory, the researcher deemed it crucial to evaluate the treatment delivery offered at the Drug Abuse Treatment and Rehabilitation Centers (DATRCs) in Region III. The findings were the basis for developing an action plan to enhance the treatment services at the DATRCS further. This study is aligned with Sustainable Development Goals 3 (Good Health and well-being), 10 (reduced inequalities), and 16 (Peace, Justice, and Strong Institutions) by the United Nations (UN), expected to be realized by 2030 (UN, n.d.).

Statement of the Problem

This study aimed to evaluate the delivery service of DATRCs as a basis for improving the Government Approach in the region. Specifically, the study answered the following questions:

1. How do the medical and administrative staff evaluate the delivery of services in their respective DATRC described in terms of:

   1.1.Screening and Assessment of Persons Who Use Drugs (PWUDs);

   1.2. Drug Dependency Examination (DDE);

   1.3. Matrix Intensive Outpatient Program (MIOP);

   1.4. Individual Counseling;

   1.5. Family Counseling and Support;

1.6. Psychological Testing and Services;

1.7. Psychiatric Services;

1.8. Spiritual Enhancement;

1.9. Recreational Program; and

1.10. Skills and Recovery

2. What are the best practices in drug treatment and rehabilitation among the DATRCs as perceived by the medical staff and administrative personnel?

3. What problems and challenges are encountered when delivering services in DATRCs?

4. Based on the findings, what action plan can be proposed to reintegrate evolving approaches in DOH-accredited Government-owned DATRCs?

5. What are the implications of the study to Public Administration?

Scope and Delimitation of the Study

The study focused on evaluating the services of DOH-accredited government-owned Drug Abuse Treatment and Rehabilitation Centers (DATRCs) in Region III, which include screening and assessment of persons who use drugs (PWUDs), drug dependency examination, medical and mental evaluation, Matrix Intensive Outpatient Program, individual counseling, family counseling and support, psychological testing and services, social and psychological intervention, psychiatric services, spiritual enhancement, recreational programs, and skills and recovery.

This study evaluated only the services directly implemented by DOH-accredited DATRCs. While community-based screening is part of the broader drug rehabilitation ecosystem, it is implemented at the barangay or municipal level and thus excluded from the DATRCs' service rating tables. However, as noted in earlier drafts, its absence in some areas is used as a basis for system decongestion, early intervention, and enhanced access recommendations.

The best practices implemented in DATRCs, and the challenges faced by the staff were identified and analyzed in the study. The findings resulted in the development of a proposed action plan aimed at enhancing services in DATRCs and securing government support for better outcomes in the recovery and rehabilitation of patients. The study was conducted from January 2024 to February 2025.

The study focused on PWUDs who are currently undergoing or have completed recovery treatment and aftercare at the two DOH-accredited government-owned Drug Abuse Treatment and Rehabilitation Centers (DATRCs) in Region III.

LITERATURE REVIEW AND RELATED STUDIES

Drug Abuse and the Effects

Drug addiction, known as substance use disorder (SUD), is a disease that impacts a person's brain and behavior. Regular substance abuse can alter brain chemistry. Long after the initial intoxication fades, these changes may persist. The intense pleasure, exhilaration, and calmness that a substance induces are referred to as intoxication; the sensations vary depending on the substance. A person may develop tolerance to a chemical with repeated use, necessitating higher doses to experience these effects. Moreover, quitting may lead to withdrawal symptoms and strong urges to resume use, which are often accompanied by anxiety (American Psychiatric Association, 2025).

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Drug abuse or substance abuse is a condition that leads to the inability to control the use of a legal or illegal drug or medicine (Mayo Foundation for Medical Education and Research, 2025). Drug addicts frequently have one or more coexisting diseases, which may include lung illnesses, stroke, cancer, or mental health disorders. Additionally, using drugs can make one more susceptible to diseases. Sharing injectable supplies or engaging in risky behaviors like condom-less intercourse can result in HIV and hepatitis C, a dangerous liver illness. Following bacterial exposure from injectable drug usage, endocarditis (infection of the heart and its valves) and cellulitis (infection of the skin) may develop (National Institute of Drug Abuse, 2020).

Moreover, according to the Cleveland Clinic (2024), SUD is a mental health illness in which a problematic pattern of substance use impairs one's health and quality of life. Over time, substances alter the way your brain works. Until the effect wears off, they release dopamine, a neurotransmitter that makes you feel happy. Even if it is unhealthy, the body and brain want to maintain this positive sensation. It can have a big effect on relationships, education, job, and emotional health. Additionally, it frequently poses a threat to life. There are three levels of SUD- mild, moderate, and severe. This condition is treatable, and that assistance is accessible when needed.

Treatment for Drug Abuse

The initial stage of drug abuse is withdrawal management. At this point, drug use is halted, allowing drug users to eliminate the drug from their systems. Since withdrawal symptoms can be challenging on both physical and mental levels, a healthcare professional may suggest medications to alleviate these effects, depending on their severity. After detoxification, therapy continues, and medications may be prescribed. Treatment for substance use disorder (SUD) is highly individualized. Throughout recovery, drug users may require various forms of treatment at different times. There are several treatment options available, including short-term care, long-term therapeutic communities, as well as inpatient and outpatient settings. Types of treatment for drug abuse include pharmacological interventions, substitution therapy, psychological approaches such as counseling, support groups, and rehabilitation (Mandal, 2025).

The Department of Health and Aged Care of Australia (2025) suggested methods for overcoming drug abuse. Firstly, quitting drugs begins when individuals acknowledge that there is a problem. The next step after recognizing the issue is to consult a specialist. The specialist will assist patients in obtaining the appropriate professional therapy for those struggling with drug addiction. After meeting with a specialist, patients must avoid triggers, such as staying away from places where drugs are accessible; avoiding friends who use drugs; learning to resist temptation; developing coping strategies for stress; relaxing without drugs; and engaging in activities like exercise or listening to music. Additionally, setting rehabilitation objectives can help maintain focus and alleviate stress throughout the process. Both short-term and long-term goals should be realistic, quantifiable, and specific.

Drug Rehabilitation Centers

Rehabilitation is a process of treating drug and/or alcohol addiction. This could involve a mix of psychotherapy and medical care. Addicts have the best chance of managing their addiction over the long term through the carefully planned process of rehabilitation (American Addiction Centers, 2024). Rehabilitation centers also offer a safe and protective environment for patients. The counselors are cognizant about the situation of the patients, and they do their best to provide services that will provide treatment for them. The counselors are experts in handling varied types of drug addiction, and they offer personalized management services. A safe environment provides patients with a feeling of safety and protection (Wisdom Treatment Center, 2021).

There are types of rehabilitation centers which include in-patient rehabilitation centers offering intensive treatment services for patients with severe drug addiction; outpatient rehabilitation centers offering flexible treatment services for patients who are allowed to live at home and not disengage from their normal routine or work but still undergoing therapy sessions; and dual diagnosis center specializing in treating people with co-occurring substance abuse and mental health disorders (Hauck, 2024).

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In Texas, types of rehabilitation include drug and alcohol detox, which begins therapy immediately, often requiring in-person treatment and using medication to reduce withdrawal symptoms and cravings; residential treatment programs where patients spend several weeks to months living at the rehabilitation center focusing on recovery and healing; intensive outpatient programs that allow patients to live at home, but require them to go to the center for most days of the week over an extended period; partial hospitalization programs that provide care for both mental health disorders and addiction while allowing patients to live at home; and outpatient treatment, which has fewer appointments tailored to patients' needs (Fort Behavioral Need, 2021).

Drug Abuse Treatment and Rehabilitation Centers (DATRCS).

The DATRCs in the Philippines operate under the Department of Health (DOH). The mission is: " To help individuals with drug abuse problem through a specialized treatment program in a homey atmosphere with the aim of rebuilding their lives, making them better and more productive citizens." The vision is: "To be the center of excellence in providing holistic treatment to persons who use drugs."

The DATRC's mission and vision emphasizes a comprehensive and compassionate approach to drug rehabilitation. The center aims to provide support to people who abuse drugs in their journey towards recovery by offering a specialized treatment program in a nurturing, home-like environment. The mission and vision support the desire to be a center of excellence through a holistic approach- physical, physiological, mental, spiritual, and emotional. The treatment approach also fosters personal growth and reintegration into society. Through evidence -based interventions, skilled professionals (medical counselors), and a supportive community, the DATRC aspire to transform lives, empowering individuals to recover and become more productive citizens (Department of Health, n.d.).

Drug Abuse Treatment Methods.

A crucial element of reducing drug demand is the treatment and rehabilitation of drug addicts. Through long-term treatment and rehabilitation programs, Republic Act 9165, also known as "The Comprehensive Dangerous Drugs Act of 2002," as amended (the "Act"), establishes effective mechanisms or measures to reintegrate individuals who have become victims of drug abuse or dangerous drug dependence into society. The Department of Health accredits treatment and rehabilitation centers using standard drug treatment modalities or approaches. The standard treatment approaches are multidisciplinary team approach where patients avail of the services of a team composed of psychiatrist, psychologist, social worker, occupational therapist, or practitioner of other related disciplines in collaboration with the family and the drug dependent; therapeutic community approach which views that addiction is a symptom of more complex psychological problem rooted in an interplay of emotional, social, physical and spiritual values so the program must be structured and the community is used as a medium for behavioral and attitudinal transformation; Hazelden-Minnesota Model which views addiction as a disease and an involuntary condition caused by factors largely outside a person's control so, didactic lectures, cognitive behavioral psychology, twelve steps principals and biblio-therapy are needed; spiritual approaches highlighting turning away from addiction and renewing relationship with the Lord; and eclectic approach which aims to apply a holistic approach in the rehabilitation program (Dangerous Drugs Board, n.d.).

Moreover, Bufo (2024) offered other therapeutic methods which are cognitive behavioral therapy (CBT) which helps in addressing causes of addiction as well as identify, avoid, and handle situations where they are likely to relapse and use drugs or alcohol; rational emotive behavior therapy (EBT) which is a form of CBT but the emphasis is more on rational and irrational beliefs and the idea that the types of beliefs a person adopts determine their thoughts and behaviors; holistic therapy which focuses on interconnectedness of all aspects of who an individual is, and effective treatment programs evaluate and address all the underlying components that contribute to the addiction; and drug therapy using medications for treatment.

Drug Addiction Screening and Assessment.

Drug screening tests are questions about the drug addiction of individuals. These screening tests check drug use or misuse and determine the best treatment for patients. Some tests could show low, moderate, or high risk

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for complications from drug use. Some of the screening tests include Drug Abuse Screen Test or DAST-10 which includes ten yes-or-no questions about how much and how frequently drugs are used, whether the drugs are interfering with life or health; Tobacco, Alcohol, Prescription medication , and other Substances use (TAPS) that asks questions about tobacco, alcohol, and other substance abuse; Cut-down Annoyed, Guilty Eye-opener (CAGE) which checks for alcohol misuse, but it is also used for drug use; Car, Relax, Alone, Forget, Friends, Trouble (CRAFFT) which is designed for teens and includes yes or no questions about drug and alcohol use; and Screening, Brief Intervention, and Referral Treatment (SBIRT) which helps identify, reduce, and prevent risky substance use and find the best treatment. This focuses on helping one understand how substances affect life so they can make positive changes (National Library of Medicine, 2024).

The Center for Substance Abuse Treatment (n.d.) mentioned the minimum information for evaluation of drug abusers: acute intoxication and/or withdrawal, biomedical conditions and complications, emotional/behavioral conditions (e.g., psychiatric conditions, psychological or emotional/behavioral complications of known or unknown origin, poor impulse control, changes in mental status, or transient neuropsychiatric complications), treatment acceptance or resistance, relapse potential or continued use potential, and Recovery/living environment. Evaluation along these elements helps the evaluator confirm that a substance abuse problem exists and recommends an appropriate level of care. The evaluation process determines a patient's health issues, level of interest in and preparation for treatment, and viable treatment options using a combination of clinical interviews, personal history collection, self-reports, laboratory testing, and other collateral reports where necessary. Additionally, it offers details about a patient's social, educational, familial, and professional strengths and weaknesses. Like screening, it may be repeated if clinical evidence shows that evaluation is necessary.

Community Based Drug Rehabilitation Program.

Challenges in Community-Based Rehabilitation were sought in the study by the University Research Co. (2022). Common barriers to CBDR implementation include a lack of resources, facilities, and equipment. Dedicated funding is crucial, with LGUs allocating between 0.04% to 0.53% of their budgets for CBDR. Most LGUs lack permanent staff and rely on volunteers, though some have hired full-time personnel. Staff-to-client ratios range from 1:25 to 1:92, averaging 1:45. Challenges include participant attrition due to scheduling conflicts, which some LGUs address by offering sessions on weekends or after work. Family involvement is also a concern. Additionally, some community officials do not prioritize CBDR, viewing drug use as a personal failure rather than a rehabilitative issue.

Another study by Hechanova et al. (2022) examined the benefits, drawbacks, and results of community-based drug rehabilitation initiatives in local governments throughout the Philippines. Narratives from 38 leaders, program implementers, and respondents in five local government units that conducted community-based drug rehabilitation were gathered and analyzed using a multi-case study research approach. The study used the World Health Organization's Health Systems paradigm to identify enablers and challenges related to workforce, information systems, leadership, funding and resource availability, and service delivery. Beyond these, the importance of context and culture—especially the impact of poverty, community, and stigma—emerged as a distinctive theme. Despite these obstacles, clients, providers, and leaders report favorable outcomes, such as enhanced health and well-being, client access to services, and social and financial safety.

Treatment Modality

To treat individuals who suffer from stimulant use disorder, the Matrix Intensive Outpatient Program (MIOP) Model of addiction treatment integrates various evidence-based therapeutic approaches. The Matrix Model is an integrative treatment model designed to directly address the needs of individuals with stimulant addiction by strategically combining evidence-based therapies. Respondents in the Matrix Model undergo a 16-week intensive outpatient treatment program in which they receive various evidence-based therapies in a highly structured setting. Although the Matrix Model's creators initially targeted individuals with stimulant addiction, some researchers looked at the model's potential benefits for treating addiction to other substances, such as opioids. A patient may be able to overcome their stimulant addiction by participating in a program that includes several forms of substance use treatment during treatment. The goals of the matrix model are to

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understand the addiction and relapse, develop relapse prevention skills, develop healthier social behaviors, reinforce healthier coping skills, and become involved with the 12-step and other types of support groups (Mosel, 2024).

Individual Counseling.

Patients can discuss their difficulties in a private, secure setting during therapy. Recovering persons can speak with a treatment therapist directly during these one-on-one sessions. Patients can talk about their individual experiences using drugs or alcohol during a particular treatment session. They can discuss the detrimental effects addiction has had on their life. They can collaborate with a therapist to pinpoint the root causes and triggers of their substance abuse. This enables them to start formulating a plan to deal with those problems healthily. The goal of individual therapy is to enhance emotional and behavioral well-being. Throughout the healing process, it assists patients in attending to their unique and specific needs. Among the objectives of individual therapy are enhancing the person's cognitive abilities, promoting transformation in the lives of people in recovery, and giving direction and assistance during the healing process (Crabbe, 2025).

Family Counseling.

The benefits of family involvement in drug addiction recovery are critical. When families clearly understand addiction and its impact, they can provide stronger emotional support and create a stable environment suitable for drug recovery. More engaged families also help set realistic expectations about treatment and recovery outcomes, thereby reducing conflicts and frustrations. Likewise, families gain awareness of relapse warnings, which enable them to provide timely support and prevention. They can also allow healthy communication, which paves the way for sustained recovery. Through education and support, families have the potential to create a nurturing and warm environment that enhances the recovery of their loved ones who decide to go back to a sober life.

Practices in Drug Screening and Assessment.

A study by Pervanas et al. (2019) aimed to use interprofessional education activities to give healthcare students educational training sessions on Screening, brief intervention, and referral to treatment (SBIRT). It also aimed to evaluate how the training sessions and activities were perceived regarding the students' overall satisfaction with SBIRT instruction and their confidence in using SBIRT in at-risk patients. Three hundred three students in all finished the SBIRT course. Following training, 78% were confident in their ability to conduct a brief intervention (80%), screen for substance misuse, and know when to send someone to treatment (71%). According to 73% of students, the asynchronous online activity enhanced their understanding of the functions and duties of other fields. It allowed them to network with students in different health-related fields. The students who received inter-professional education training from multiple healthcare disciplines felt comfortable performing SBIRT to identify persons at risk for substance misuse in practice.

Additionally, the US Preventive Services Task Force et al. (2020) evaluated the use of a screening tool asking questions about drug use and interventions for unhealthy drug use in adults and adolescents. This resulted from the recommendation to screen adults aged 18 and above by asking questions, provided that accurate diagnosis, effective treatment, and appropriate care are available. This screening does not involve biological testing. While moderate evidence supported its benefits for adults, there was insufficient evidence to determine the risks and benefits for adolescents (12–17). Therefore, no clear recommendation can be made for adolescent screening. This update revised the 2008 guidelines based on new evidence.

Similarly, Rovers and Hagel (2015) aimed to evaluate patients using a 12-item self-evaluation tool to identify those at risk for drug therapy problems (DTPs) and encourage them to seek a consultation with a pharmacist. The study was conducted at senior centers in Florida from April to December 2005, involving 175 respondents. The results indicated that 39.4% accepted the consultation offer. Respondents with higher self-evaluation scores were more likely to accept and had more identified DTPs. The tool effectively predicted interest in consultation and potential medication issues.

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Evaluation of Drug Rehabilitation.

The study by Basu et al. (2019) highlighted that improving patient survival and quality of life in chronic diseases requires prolonged and often lifelong medication intake. Less than half of patients with chronic diseases globally are adherent to their prescribed medications. Medication adherence can be evaluated through both direct and indirect measures. However, the lack of an inexpensive, ubiquitous, universal gold standard for assessing medication adherence emphasizes the need to utilize a combination of measures to differentiate adherent and non-adherent patients. Methods based on the secondary database analysis are mostly ineffectual in low-resource settings, lacking electronic pharmacy and insurance databases and allowing refills without updated, valid prescriptions from private pharmacies. This significantly restricts the choices for evaluating adherence until the digitization of medical data takes root in much of the developing world. Nevertheless, there is ample scope for improving self-report measures of adherence. Effective interview techniques, especially accounting for suboptimal patient health literacy, validation of adherence questionnaires, and avoiding conceptual fallacies in reporting adherence, can improve the evaluation of medication adherence and promote understanding of its causal factors.

Additionally, Petrova et al.'s (2023) study asserted that the overuse or unnecessary use of medication can lead to drug-related problems, non-compliance, poor disease control, and unmet treatment goals. The study evaluated patients' awareness of their medication use and identified potential issues among those taking five or more medications in Bulgaria. The findings revealed a need for Medication Review (MR) services in Bulgarian pharmacies. Implementing MR could enhance pharmacists' roles, reduce drug-related problems, and improve both treatment effectiveness and adherence.

Impact of Drug Rehabilitation.

A study by Mahbuob et al. (2021) aimed to explore the lifestyle practices of people who use drugs undergoing rehabilitation treatment in Lebanon, including dietary intake, physical activity, and sleep, and the perceived benefits and challenges. Findings showed six themes generated from the respondents' narratives: chaotic lifestyle, structured lifestyle, benefits and pitfalls, and suggestions for making rehabilitation a better experience. Further findings revealed the discussions of the respondents on their chaotic lifestyle during addiction with poor food intake, disrupted sleep, and low physical activity, moving to a more disciplined routine that enforced a normal lifestyle with social and professional support. The early phases of treatment result in increased food intake and weight gain.

The early phases of treatment involved increased food intake and weight gain, seen as a health indicator and the only divergence from medication. This gradually shifted towards more structured meals and efforts to lose weight in later stages. Additionally, the study uncovered a lack of variety in physical activity programs due to differences in motivation. It recommended enhancing rehabilitation services, emphasizing healthy eating behaviors and environmental control.

Another study by Unnisa et al. (2019) aimed to know how drug addiction has decreased in Quetta City. The study revealed that the main issues impeding the treatment process include a lack of community support, readily available psychoactive drugs in society, a partial number of drug rehabilitation facilities, a shortage of medications in the rehabs, a shortage of physicians, and more. It was discovered that a range of supportive services were being used to improve the rehabilitation process. These services included job counseling, life skills training, and instruction in skills, including electrical work, shoemaking, and tailoring. Since the state is Islamic, it is standard practice to have religious scholars provide therapy to people with an addiction to help them recognize and prepare to stop using drugs.

In Pakistan, a study by Anwar et al. (2023) determined the capacity and impacts of rehabilitation centers to control drug abuse. There were three groups of respondents, which included administrators, the public, and drug abusers. Results showed that the rehabilitation centers played an essential role in controlling or reducing drug addiction and had significant positive impacts on the drug addicts, their families, and the communities where they belong.

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On the other hand, a study was also conducted in Nepal by Pathak and Saxena (2019), which determined the roles of rehabilitation centers in the reduction of drug addiction. The study employed a mixed method design that analyzed 40 male respondents undergoing drug rehabilitation in Surkhet, Birendranagar Valley of Nepal. The roles and services of the rehabilitation center covered various activities and practices in the rehabilitation center. Counseling, vocational training, realization programs, job opportunities, acceptance, and sympathy were also covered. Findings revealed that the rehabilitation center played different roles in reducing drug abuse. These included recreational services, counseling, meditation, family meetings, input-sharing services, individual counseling, and step workout sessions.

Additionally, sports, inventory programs, distribution of responsibility, guest lecturing, education, work therapy, and art. Likewise, the rehabilitation facility hosts many community and school awareness programs, rallies and campaigns, international drug day celebrations, anti-drug programs, psychiatric treatment, and routine health examinations. When it comes to substance misuse, treatment programs, and rehabilitation institutions have an efficient network and coordination system. Their programs, activities, and services are tremendously beneficial to drug users, their families, communities, society, and country. Rehabilitation centers successfully provide individual counseling services to all drug abusers. The main goal of rehabilitation centers' inventory programs is to transform drug users' lives for a prosperous society.

Level of Satisfaction of Patients in Drug Rehabilitation Centers .

The study by Walag et al. (2024) determined the factors influencing enrollment and completion in community-based drug rehabilitation and aftercare programs in the Philippines, as well as treatment motivation and client satisfaction. Both continuing and finished clients expressed great satisfaction with the program and a high internal motivation for treatment. Client satisfaction identified the areas that need improvement, and they claimed that both internal and external variables affected their completion of the rehabilitation program. In addition to internal and external motivation, other important aspects include the program's overall structure, the skill of the facilitators, community and governmental support, and complementary interventions.

A study by Dhumal (2019) aimed to evaluate the dimension of patient satisfaction relevant to drug abusers' rehabilitation and develop a comprehensive disease-specific instrument to assess satisfaction among patients who abuse drugs. Five major themes emerged from the content analysis of the interview transcripts: (1) programmatic structure (adhering); (2) counselor (skill); (3) skill development (personal responsibility); (4) comparison to other programs; and (5) case management facilitation. In addition to expressing high satisfaction with the counselors' abilities and progress in developing their own, the men's main feedback was that they were happy with the program. The instrument's total dependability was 0.869. There were negative inter-item correlations on the preference scale but moderate to high correlations between items on the counselor, abilities, and program scales.

Challenges in the Drug Treatment at Rehabilitation Centers.

Anjum et al. (2024) conducted a study that identified the challenges of rehabilitating patients with substance use disorders. A phenomenological approach was employed and included interviews with psychiatrists, doctors, psychologists, rehabilitation center owners, lawyers, police officers, anti-narcotics members, educators, policymakers, and researchers. Respondents aged 35 to 50 had 5–10 years of experience. Findings revealed that rehabilitation is a complex process often misunderstood by families who expect quick recovery. Many failed to realize that substance use disorder can be managed, not cured, with proper follow-up and support. Key challenges included easy drug access, lack of resources, weak law enforcement, and government inaction.

Additionally, most rehabilitation centers operate without affiliation, and many are run by former addicts without expert supervision, worsening the situation. A holistic approach involving the government, law enforcement, and health professionals is needed. Solutions include social skills training, awareness programs, conflict resolution strategies, and employment opportunities. These measures can help individuals better manage their condition. The study's findings contribute valuable insights to the scientific literature.

Linkages and Support to Rehabilitation Centers.

The establishment of the Dangerous Drugs Board (DDB) on November 14, 1972, through Republic Act No. 6425, marked the Philippine government's first official step in addressing drug-related issues through a coordinated national policy. The scope of the drug problem and the need for implementation led to the creation of the Philippine Drug Enforcement Agency (PDEA), designated as the DDB's enforcement arm under the Comprehensive Dangerous Drugs Act of 2002 or the RA 9165. Later in 2017, the government expanded its anti-drug infrastructure through Executive Order No. 15, under President Rodrigo Duterte, establishing the Inter-Agency Committee on Anti-Illegal Drugs or the ICAD. Its aim was to streamline coordination among the different government agencies involved in enforcement and rehabilitation. PDEA was assigned as the lead agency, continuing its role in overseeing drug enforcement operations within a broader policy framework (RA No. 9165 of 1972 and RA No. 15 of 2017, The Philippine Government Archive).

The intensified campaign against illegal drugs drew attention not only locally but also from international agencies. Organizations such as the United Nations Office on Drugs and Crime (UNODC), World Health Organization (WHO), Japan International Cooperation Agency (JICA), USAID, and the European Union (EU) engaged with the Philippine government through technical assistance, training, and funding. These efforts supported the development of rehabilitation models, health-based programs, and initiatives aligned with human rights standards.

The Bataan Drug Treatment and Rehabilitation Center (BDTRC) which was established in 2008 through the efforts of former Congressman Albert Garcia, in partnership with the DDB, DOH, and the Provincial Government of Bataan was integrated into the DOH system. The BDTRC provides treatment to both voluntary and court-mandated clients.

In Tarlac, then Congresswoman and later Governor Susan A. Yap initiated the development of the Tarlac Drug Recovery Clinic (TDRC) in 2016, with the goal of strengthening mental health and substance use services at the provincial level. The clinic expanded with support from the European Union which helped in refining the facility's treatment modalities and adopting digital record-keeping.

TDRC serves individuals seeking help for both substance use and mental health conditions, such as anxiety and depression. It also organizes educational classroom talks to promote mental health awareness. With recent infrastructure developments, the clinic is now preparing to offer in-patient services. Its operations are solely funded by the local government of Tarlac.

In addition to its services, TDRC has developed into a learning space for its staff. Its focus on setting-based interventions has opened opportunities for its personnel to receive training both locally and abroad. Through ongoing collaboration with the Department of Health and affiliations with organizations like the Philippine Addiction Specialists Society (PASS), the International Society of Substance Use Prevention and Treatment Professionals (ISSUP), and the International Society of Addiction Medicine (ISAM), staff members are able to stay updated on best practices in drug rehabilitation, treatment and care.

Conceptual Framework.

This study, which evaluated the services of Government - owned Drug Treatment and Rehabilitation Centers, aligns primarily with Sustainable Development Goals. Primarily, this study supports SDG 3, on "Good Health and Well-being," specifically SDG 3.5, regarding the prevention and treatment of drug abuse. By evaluating the effectiveness of the rehabilitation services, the study also contributes to SDG 1 on "No Poverty, recognizing that recovery from addiction is a key to economic reintegration and breaking cycles of deprivation. Moreover, the study supports SDG 8 on "Decent Work and Economic Growth," by promoting the rehabilitation of individuals into productive members of the working group. Lastly, the study aligns with SDG 16 on "Peace, Justice, and Strong Institutions," as effective rehabilitation services play a critical role in fostering safer communities and strengthening institutional responses to substance use disorders (United Nations, n.d.).

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Drug addiction compromises the health of those affected, and preventing its onset in individuals will contribute to achieving "Good Health and Well-being." Furthermore, drug addiction results in mental and psychological issues that impact how abusers concentrate on their responsibilities (e.g., work, school, and other duties). The role of government drug rehabilitation programs is crucial in reintegrating drug abusers into everyday life and fulfilling these SDGs.

The study is further anchored on the concept that evaluating services at rehabilitation centers will lead to findings that could be the empirical basis for enhancing current practices and achieving success in the rehabilitation of drug abusers. Government programs should undergo regular evaluation to provide better services to the Filipinos.

The framework presented in Figure 1 comprises the connection of variables given attention in the study. The figure shows ten (10) fundamental treatment services acquired at the Drug Recovery Clinics. This structure serves as the standard and criterion of the researcher in her study to describe and analyze service delivery of drug abuse treatment and rehabilitation centers. In addition, this also determined the practices among DATRC and proposed recommendations to address and resolve the problem. This also discussed proposed measures or action plans to reintegrate the government approach in government-run DATRC and its implications to public administration.

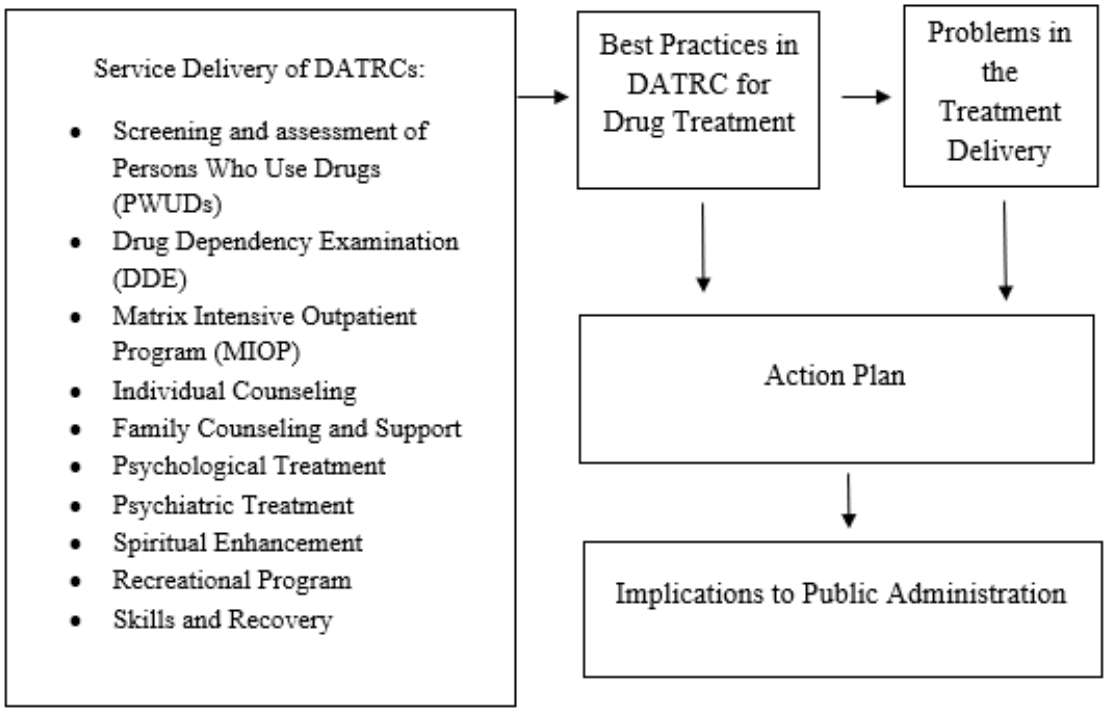

Fig. 1. Paradigm of the Study

The output of the study is the proposed action plan to improve the delivery of treatment services in DOH-accredited government-owned DATRCs in Region III**.** The action plan includes measures to address the challenges encountered in delivering treatment services and the suggestions forwarded by the respondents.

METHODOLOGY

This chapter presents the research design, study locale, sampling design, respondents, research instruments, data gathering procedure, data analysis, and potential ethical issues.

Research Design.

The quantitative descriptive design was used to determine DATRCs' practices in treating and rehabilitating drug abusers. According to Aggarwal and Ranganathan (2019), descriptive research involves characterizing

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one or more variables without considering any causal hypothesis. In this study, the primary focus was to describe the delivery of drug abuse treatment and to identify the best practices in drug abuse treatment.

Locale of the Study.

The study was conducted in two DOH-accredited government-owned drug abuse treatment rehabilitation centers (DATRC) in Region III. The DATRCs are found in two provinces. DATRC 1 and DATRC 2 were used to refer to the two centers in this study.

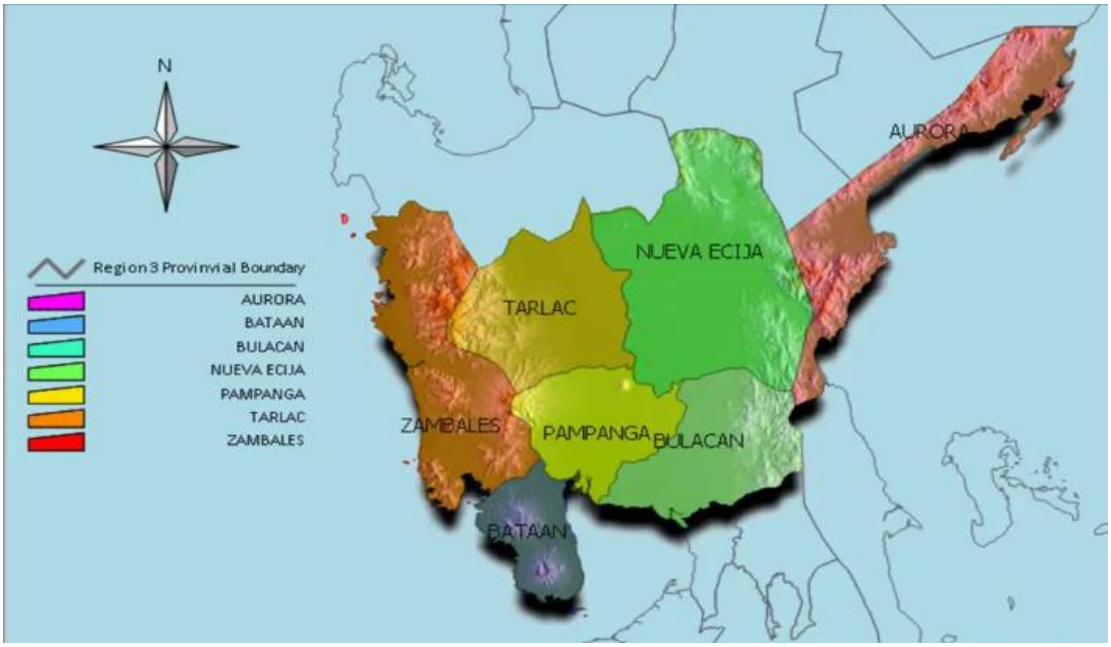

Fig. 2. The Map of Central Luzon

Sampling Design.

The study respondents were selected using purposive sampling. According to Robinson (2014), purposive sampling is the deliberate selection of informants according to their capacity to clarify a particular phenomenon, idea, or theme. In this study, the inclusion criteria are the following:

For patients:

1. Those who have availed of the treatment services from DATRCs are at the final stage of rehabilitation, and those who are recovering are at the time of data collection.
2. Those who are willing to participate in the study voluntarily.

For medical personnel:

1. Those who handled patients from the start of the rehabilitation until the last phase.
2. Those who are eager to participate in the study voluntarily.

Administrative Staff:

1. Those who started working in the DATRC for at least six months.
2. Those who are willing to participate in the study voluntarily.

For patients:

1. Those who are still starting to avail themselves of the treatment services from DATRCs,
2. Those who are not willing to participate in the study voluntarily.

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For medical personnel:

1. Those who just began to handle patients.
2. Those who are not willing to participate in the study voluntarily.

Administrative Staff:

1. Those who started working in the DATRC for less than six months.
2. Those who are not willing to participate in the study voluntarily.

Respondents.

The respondents of the study are shown in Table 1. The respondents were selected through purposive sampling

Table I Respondents

Place	Medical and Administrative Staff	Actual Number of Respondents	Patients	Actual Number of Respondents
DATRC 1	16	16	387	100
DATRC 2	24	24	1,276	150
Total	40	40	1663	250

The total medical and administrative staff in DATRC 1 Drug Abuse Treatment and Rehabilitation Center is 16 (total enumeration) and 100 patients (out of 387 total. At the DATRC 2, the medical and administrative staff comprised 24 (total enumeration) and 150 patients (total patients =1276).

Research Instrument.

The instrument used in this study was a questionnaire composed of three parts for the medical staff and administrative Personnel. Part I elicited data from the respondents on the treatment practices along the eight phases, namely: Screening and Assessment of Persons Who Use Drugs (PWUDs); Drug Dependency Examination (DDE); Matrix Intensive Outpatient Program (MIOP); Individual Counseling; Family Counseling and Support; Psychological Testing and Services; Psychiatric Services; Spiritual Enhancement; Recreational Program; and Skills and Recovery. Part II identified the best practices implemented in DATRCs. Part III identified the problems and challenges that the medical and administrative staff encountered in delivering treatment services. Part IV yielded suggestions to improve the delivery service in DATRCs.

The questionnaires were validated by three experts from a private drug rehabilitation center. There were minor suggestions from the experts. These were incorporated into the final questionnaire and fielded to 20 respondents for a dry run. The data from the dry run was subjected to Cronbach Alpha analysis, and the Index of Reliability was 0.78. This indicates that the questionnaire is reliable. Questionnaires for the patients consisted of the same Part I but were translated into Tagalog. Part II elicited answers on their challenges in availing drug rehabilitation at the center.

The indicators used in the data-gathering instrument were carefully selected to comprehensively evaluate the delivery of services in Drug Abuse Treatment and Rehabilitation Centers (DATRCs) in Region III. These indicators served as the primary variables for measuring the quality, relevance, effectiveness, and responsiveness of each core treatment component offered to persons who use drugs (PWUDs).

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The development of the indicators was grounded in the following:

National Policy Standards:

The indicators were drawn mainly from treatment protocols and service standards set by the Department of Health (DOH) and the Dangerous Drugs Board (DDB) for government-accredited rehabilitation centers in the Philippines. These institutions define the minimum service requirements and performance standards for operating DATRCs, covering intake assessment, therapeutic programs, aftercare, and psychosocial services.

Global Best Practices in Drug Rehabilitation:

References from the World Health Organization (WHO) and models of evidence-based treatment (e.g., Matrix Model, community-based treatment approaches) also informed the instrument's structure. These frameworks emphasize a holistic approach to rehabilitation, incorporating psychological, medical, behavioral, family, spiritual, and social dimensions.

Review of Related Literature:

A comprehensive review of local and international studies on drug rehabilitation services supported the formulation of the indicators. These studies provided validated components that influence rehabilitation success, such as patient engagement, counselor-patient relationship, skill-building, and community reintegration.

The instrument consisted of ten major service areas, each broken down into several performance indicators or service components. Each service area had 3 to 10 indicators reflecting specific actions, outputs, or standards (e.g., “The center conducts drug tests regularly,” “The clinician fosters a positive relationship,” “Patients are encouraged to discuss their addiction openly”).

The indicators were utilized in a Likert-type evaluation tool administered to two main groups:

1. Medical Staff and Administrative Personnel
2. Patients undergoing rehabilitation

This enabled a quantitative assessment of the delivery and perception of each service component, allowing the researcher to:

1. Calculate mean scores per indicator and service area
2. Identify strengths (e.g., high-scoring areas like MIOP and individual counseling)
3. Detect gaps (e.g., family support, skills and recovery, and community-based services)

Moreover, the comparative analysis between the two respondent groups (staff vs. patients) allowed triangulation of findings and revealed insights into how services are delivered versus how they are experienced.

The indicators functioned as key performance metrics for evaluating:

1. Consistency in service implementation across DATRCs
2. Alignment with institutional guidelines and national standards
3. Patient satisfaction and perception of care
4. Gaps requiring policy or operational intervention

The data collected from these indicators directly informed:

1. The identification of best practices
2. The formulation of a proposed action plan
3. The development of recommendations for public administration and policy improvement.

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In addition, although Community-based Screening is not a service directly implemented by the DATRCs, it was included in the evaluation tool to reflect its strategic importance in the rehabilitation continuum. The presence or absence of effective community screening mechanisms directly impacts patient intake, workload, and service sustainability at the DATRC level.

Data Gathering Procedure

Data Gathering commenced upon receipt of the approval to conduct the study from the Region III Director of the Department of Health. The researcher distributed the questionnaire herself with the assistance of the administrative staff in both DATRCs, one at a time. In DATRC 1, the questionnaire distribution commenced in January 2024, and complete retrieval happened a month later. In DATRC 2, the questionnaire was distributed from March 2024 until November 2024. Responses from the questionnaire were tabulated. The data was subjected to statistical analysis.

Data Analysis

The data gathered on the evaluation of the services provided in the DATRCs were analyzed statistically using the mean. The formula is:

$WM = (\sum wf)/N$

Where:

WM = Weighted Mean

w = weight

f = frequency

$\sum wf$ = summation of weight times frequency

N = total number of respondents

Likert Scale for Challenges in the Delivery of Treatment Services

Numerical Rating	Statistical Rating	Descriptive Equivalence	Interpretation
5	4.50-5.00	Outstanding	Demonstrates exceptional care, compassion, and expertise in treatment services for the patients and successfully helps patients achieve very significant progress in recovery from drug addiction.
4	3.50-4.49	Very Satisfactory	Demonstrates high quality care, compassion, and expertise in treatment services for the patients and successfully helps patients achieve significant progress in recovery from drug addiction.
3	2.50 – 3.49	Satisfactory	Demonstrates basic care, compassion, and expertise in treatment services for the patients and successfully helps patients achieve progress in recovery from drug addiction but lacks consistency.
2	1.50 – 2.49	Fair	Medical counsellor struggles to meet the expectations of patients and lack engagement or efficiency.
1	1.00 – 1.49	Poor	Medical counsellor fails to meet the expectations of patients and does not possess the skills required for rehabilitation of patients.

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			problem and may lack information or experience to make a stand.
2	1.50 – 2.49	Disagree	The respondents believe that the problems identified do not significantly impact on the treatment delivery or the problems are manageable.
1	1.00 – 1.49	Highly disagree	The respondents strongly reject the problems identified pose serious impact on the treatment delivery or these do not exist at all.

Numerical Rating	Statistical Rating	Descriptive Equivalence	Interpretation
5	4.50-5.00	Highly agree	The respondents strongly acknowledge that the identified challenges significantly impact the effectiveness and efficiency of the treatment services at the drug rehabilitation center. The challenges are major barriers in the complete rehabilitation of the patients.
4	3.50-4.49	Agree	The respondents recognize that the challenge exists and affect the treatment delivery but do not view this challenge with high impact on treatment as in "highly agree."
3	2.50 – 3.49	Undecided	The respondents are neutral or uncertain about the extent of the

The best practices and suggestions for improving the service delivery at the DATRCS and frequency and percentage were employed.

$$\% = \frac{f}{n} * 100$$

Where:

%= percentage of the respondents;

f= frequency of the respondents; and

n= number of respondents

Potential Ethical Issues

Research ethics were strictly observed in this study. Firstly, the researcher obtained permission from the appropriate authority to conduct the study. Secondly, the researcher adhered to the principles of confidentiality and anonymity regarding the research respondents. The names of the respondents were not disclosed in the study. Thirdly, the respondents signed an informed consent form to indicate their willingness to participate. Before signing, the researcher explained the study's purpose and the potential benefits it could provide. Additionally, the researcher ensured that no harm came to the respondents and that psychologists were available for any situations that might put them at risk.

Presentation, Interpretation, and Analysis of Data

This chapter presents the analysis and interpretation of data on evaluating the treatment services of the DOH-accredited government-owned Drug Abuse Treatment and Rehabilitation Centers in Region III.

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Evaluation of the delivery of services at DATRC

Screening and Assessment of Persons Who Use Drugs (PWUDs)

Table 1 shows the evaluation of screening services offered by DATRC 1 and DATRC 2 based on feedback from medical and administrative staff and patients. The results reveal consistently outstanding performance across all areas, with overall mean ratings ranging from 4.76 to 4.90. These findings indicate that both facilities deliver strong foundational services in the rehabilitation process through professional, ethical, and patient-centered screening practices.

The aspect of identifying patient needs received high ratings from both staff (4.82 to 4.91) and patients (4.89 to 4.91), confirming the centers' ability to implement structured assessment methods, such as the Drug Dependency Examination (DDE). This is supported by the Dangerous Drugs Board (2019), which outlines the DDE as a foundation for treatment planning and rehabilitation program assignment. The World Health Organization (2020) also affirms that "comprehensive assessment at treatment entry is essential to identify the full range of problems that need to be addressed."

Table 1
Screening and Assessment of Persons Who Use Drugs (PWUDs)

Indicators	Medical Staff and Administrative Personnel				Patients			
	DATRC 1		DATRC 2		DATRC 1		DATRC 2	
	M	VD	M	VD	M	VD	M	VD
Patient's needs are properly identified by the Center.	4.82	O	4.91	O	4.89	O	4.91	O
The enter properly categorizes the mode of treatment suited for the patient.	4.59	O	4.68	O	4.88	O	4.92	O
The screening and assessment are made with confidentiality.	4.76	O	4.86	O	4.90	O	4.93	O
The Clinician/Counselor/Health staff motivates patient to share information & feelings that are distressing, personal, and often private.	4.88	O	4.95	O	4.87	O	4.93	O
The Clinician/Counselor/Health staff in the Center who attends to patient is non-judgmental.	4.94	O	5.0	O	4.90	O	4.92	O
Patient is treated with respect during screening and assessment.	4.88	O	4.95	O	4.88	O	4.94	O
Patient is at ease when the screening and assessment are/were conducted.	4.82	O	4.91	O	4.85	O	4.92	O
Patients feel safe and comfortable when screened and assessed in the Center.	4.53	O	4.59	O	4.81	O	4.85	O
The screening and assessment are made by well-trained/professional Clinician/Counselor/Health staff.	4.65	O	4.68	O	4.81	O	4.85	O
There are proper facilities for screening and assessment.	4.76	O	4.68	O	4.84	O	4.85	O
Grand Mean	4.76	O	4.82	O	4.86	O	4.90	O

Legend:
4.50-5.00= Outstanding (O)
3.50-4.49=Very Satisfactory (VS)
2.50 – 3.49=Satisfactory (S)
1.50 – 2.49= Fair (F)
1.00 – 1.49 = Poor (P)

Placement in appropriate treatment programs received high scores, with patients rating it between 4.88 and 4.92, while staff ratings were slightly lower at 4.59 and 4.68. This discrepancy may reflect the staff's understanding of practical limitations, such as facility capacity and resources, which can affect the ideal matching of patient needs with available treatment programs.

The National Institute on Drug Abuse (2020) emphasizes that effective treatment should be individualized, stating that "matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to success. "This supports the individualized approach in providing rehabilitation treatment among the drug addicts submitting themselves to the rehabilitation centers.

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Responses about the confidentiality of the screening process showed strong performance, with staff rating it between 4.76 and 4.86 and patients rating it between 4.90 and 4.93. These findings demonstrate compliance with ethical and legal privacy standards, which align with the DOH Manual of Operations that mandates confidentiality throughout all stages of assessment and care. Additionally, the UNODC-WHO International Standards (2020) emphasize that preserving patient privacy encourages disclosure and fosters long-term engagement in recovery.

Staff and patients also acknowledged the clinicians' and counselors' capacity to promote the sharing of sensitive or distressing information, with ratings ranging from 4.87 to 4.95. These scores indicate a positive therapeutic rapport and a respectful environment, which are vital for uncovering the root causes of drug use and trauma. The WHO (2020) highlights that "treatment services should be delivered in a non-coercive, empathetic, and supportive manner to enhance patient engagement and success." The highest levels of agreement were found concerning staff being non-judgmental, with DATRC 2 staff achieving a perfect score of 5.00 and patients rating this aspect between 4.90 and 4.92. These results indicate a strong culture of respect and dignity, which is critical in minimizing stigma and creating a safe space for clients. The WHO advocates for programs to be "free of discrimination and judgment and to promote dignity and human rights," which aligns well with the current practices in both facilities.

Patients reported feeling respected and at ease during screenings, with scores across groups ranging from 4.82 to 4.95. These findings affirm that the centers are technically competent and provide emotionally safe environments. This level of client comfort reflects the center's commitment to trauma-informed and humanistic approaches to care. However, the evaluation of physical and emotional safety during screenings revealed slightly lower scores from staff (4.53 to 4.59) compared to patients (4.81 to 4.85). While still within the outstanding category, this difference may indicate staff concerns about facility limitations—such as a lack of privacy, cramped assessment areas, or suboptimal furnishings—that may not be readily apparent to clients. According to the DOH Operational Guidelines, the environment for assessments should promote comfort, confidentiality, and psychological safety.

Feedback regarding the professionalism and competence of staff conducting assessments was positive, with ratings ranging from 4.65 to 4.85. This confirms that qualified personnel are performing this key function. As NIDA (2020) highlighted, this is a fundamental requirement under DOH accreditation and a recognized predictor of treatment success.

The adequacy of physical facilities for screening was rated the lowest among the ten items, yet it still received an Outstanding rating (staff: 4.68 to 4.76; patients: 4.84 to 4.85). This indicates a need for continued improvements in infrastructures such as creating more private, soundproof, and comfortable assessment spaces—especially as patient volume increases.

DATRCs in Region III demonstrate effective, ethical, and responsive screening and assessment practices. These practices align with Philippine health standards (DOH, DDB) and international guidelines (WHO, UNODC, NIDA), particularly in maintaining patient dignity, ensuring confidentiality, and using evidence-based assessment to inform treatment.

Although patient satisfaction is exceptionally high, minor gaps identified in facility adequacy and internal categorization procedures indicate areas where operational improvements can be made. Enhancing physical environments and reinforcing triage systems will help maintain quality care and support long-term recovery outcomes.

Community-Based Drug Rehabilitation Program

Although the Statement of the Problem (SOP) of this study primarily examined the delivery of services within DOH-accredited Drug Abuse Treatment and Rehabilitation Centers (DATRCs), the inclusion of the Community-Based Drug Rehabilitation Program (CBDRP) under the domain of screening and assessment provides an essential analytical extension that addresses broader systemic and accessibility concerns in drug rehabilitation service delivery.

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Screening and assessment are critical processes that inform the clinical pathway for persons who use drugs (PWUDs). These determine the appropriate level of care—institutional, outpatient, or community-based—and facilitate timely intervention. The findings presented in Table 2 highlight a significant gap in implementing community-based screening and assessment mechanisms, particularly at the barangay level. The limited presence of CBDRPs across the study sites suggests a structural deficiency that may hinder early detection and localized management of substance use cases. This observation is particularly salient given that CBDRPs are intended to serve as decentralized, accessible, and culturally adaptive intervention modalities that can relieve operational pressures on centralized DATRCs.

Furthermore, Community-Based Programs have the potential to enhance rehabilitation coverage, reduce geographic and financial barriers to care, and promote community participation in the recovery process. Their absence in the current service configuration underscores the need for expanded government investment and intersectoral collaboration to strengthen grassroots-level interventions. Therefore, despite the lack of explicit reference to CBDRP in the SOP, its inclusion in this study is justified by the principle of comprehensiveness in evaluating drug rehabilitation services.

The results presented in Table 2 provide substantial evidence for recommending policy and programmatic enhancements in community-based screening and assessment strategies that align with national drug rehabilitation goals and sustainable public health outcomes. Furthermore, the inclusion of CBDRPs in the domain of screening and assessment aligns with broader international and national frameworks on public health, particularly Sustainable Development Goal (SDG) 3.5, which emphasizes the strengthening of prevention and treatment of substance abuse, including narcotic drug abuse.

From a systems perspective, the World Health Organization and the United Nations Office on Drugs and Crime (UNODC) advocate for integrated, community-based approaches to drug rehabilitation to promote accessibility, cultural responsiveness, and early intervention. Nationally, this approach resonates with the Philippine Anti-Illegal Drugs Strategy (PADS) and the Barangay Drug Clearing Program implemented by the Dangerous Drugs Board (DDB), which highlight the role of community infrastructures in managing low- to moderate-risk PWUDs. By embedding CBDRP considerations in the screening and assessment process, the study provides a grounded and context-specific response to the call for decentralized rehabilitation models, enhancing regional drug rehabilitation efforts' responsiveness, equity, and sustainability. This further reinforces the study's contribution to shaping inclusive public health and administrative interventions that address clinical and structural drug use and recovery determinants.

Table 2 presents an evaluation of the Community-Based Drug Rehabilitation Program (CBDRP) implementation in both DATRC 1 and DATRC 2. The findings indicate that there were no community-based screening services or interventions available in DATRC 1, as reported by the medical and administrative staff as well as the patients. In contrast, DATRC 2 received Fair ratings, with a grand mean score of 2.07 from staff and 1.96 from patients. These scores fall within the 'Fair" category, suggesting the limited reach and effectiveness of the CBDRP in the area covered by DATRC 2.

Table 2
Community-Based Drug Rehabilitation Program

Indicators	Medical Staff and Administrative Personnel				Patients			
	DATRC 1		DATRC 2		DATRC 1		DATRC 2	
	M	VD	M	VD	M	VD	M	VD
Screening services are available at every Barangay or Rural Health Unit.	None	-	1.82	F	None	-	1.81	F
Results of the screening are discussed to the patient by trained Health Care Worker who provided services utilizing the ASSIST-Linked Brief Interventions.	None	-	2.07	F	None	-	1.96	F
Grand Mean	None	-	1.95	F	None	-	1.89	F

Legend:
4.50-5.00= Outstanding (O)
3.50-4.49=Very Satisfactory (VS)
2.50 – 3.49=Satisfactory (S)
1.50 – 2.49= Fair (F)
1.00 – 1.49 = Poor (P)

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Regarding the item, "Screening services are available at every Barangay or Rural Health Unit," both staff and patients at DATRC 2 rated it as Fair (1.82 and 1.81, respectively), indicating inconsistent or inaccessible screening services at the community level. This represents a critical gap, given that the CBDRP is designed to decentralize rehabilitation and enhance service accessibility, particularly for low-risk and early-stage drug users.

The follow-up item, "Results of the screening are discussed with the patient by a trained Health Care Worker using the ASSIST-Linked Brief Interventions," also received fair ratings from both groups (staff: 2.07; patients: 1.96). These findings suggest that even when screening occurs, the feedback and counseling component is weak or inconsistently practiced, reducing the potential for early intervention. The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), developed by WHO, is designed as a brief and structured approach to guide frontline workers in delivering early intervention. Its inconsistent use reflects insufficient training or the deployment of capable personnel.

The lack of a CBDRP in DATRC 1 and the weak implementation in DATRC 2 highlight significant operational gaps. This situation contrasts sharply with the outstanding performance noted in the center-based screening and assessment services, as shown in Table 1. While institutional programs are functioning effectively, community-level extensions remain underdeveloped.

These findings reflect national-level concerns highlighted in a study by University Research Co. (2022), which identified a lack of funding, resources, and trained personnel as ongoing barriers to CBDRP implementation in the Philippines. Their research indicated that Local Government Units (LGUs) allocated only 0.04% to 0.53% of their budgets to CBDRPs, resulting in a reliance on volunteers and temporary staff. Similarly, Hechanova et al. (2022) stressed that the effectiveness of CBDRPs relies heavily on leadership support, infrastructure, health systems, and local capacity. Additionally, contextual factors such as poverty, stigma, and local attitudes toward drug users significantly influence the success or failure of community-based efforts.

The current findings indicate that while national policy requires the implementation of CBDRPs through barangay health units and rural health workers, the actual delivery remains inconsistent. The Department of Health's operational framework highlights the necessity for screening, brief intervention, and referral to treatment (SBIRT) at the community level. However, data from DATRC 2 reveal that these processes are only partially functional and lack standardization.

Considering these challenges, several action points arise: (1) Strengthening local health systems by training barangay-level healthcare workers in the use of tools like ASSIST; (2) Institutionalizing CBDRP processes by incorporating them into LGU plans and ensuring regular budget allocations; (3) Establishing monitoring and evaluation mechanisms to assess the implementation and quality of services provided in the community.

The assessment of CBDRP implementation reveals significant gaps in service delivery at the community level, especially in barangay-based screening and follow-up interventions. Despite solid institutional practices in DATRC facilities, extending services to the grassroots remains weak due to limited funding, workforce shortages, and inconsistent program execution. The contrast between center-based and community-based results highlights the urgent need to strengthen the operationalization of the CBDRP to ensure accessibility, continuity of care, and early intervention in local settings.

Drug Dependency Examination (DDE)

Table 3 presents the Drug Dependency Examination (DDE) process evaluation in DATRC 1 and DATRC 2, as assessed by both medical and administrative personnel and patients. The results indicate that all items received ratings of "Outstanding," with mean scores ranging from 4.53 to 4.94, and grand means of 4.71 (DATRC 1 staff), 4.89 (DATRC 2 staff), 4.87 (DATRC 1 patients), and 4.89 (DATRC 2 patients). These ratings reflect a consistently high-quality implementation of the DDE protocol, grounded in the standards set by the Department of Health (DOH) and the Dangerous Drugs Board (DDB).

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Table 3
Drug Dependency Examination (DDE)

Indicators	Medical Staff and Administrative Personnel				Patients			
	DATRC 1		DATRC 2		DATRC 1		DATRC 2	
	M	VD	M	VD	M	VD	M	VD
The Center can identify the prohibited drugs patient used.	4.90	O	4.90	O	4.94	O	4.90	O
The Center can determine the history of drug use and past medical history of patient.	4.86	O	4.90	O	4.89	O	4.90	O
The Center conducts drug tests regularly, and or when deemed necessary or when the need arises.	4.80	O	4.84	O	4.85	O	4.86	O
The Center conducts immediate evaluation if there are missed appointments and unusual behavior on the part of the patient, and necessary action.	4.74	O	4.90	O	4.87	O	4.90	O
If the result of the drug test is positive, the Clinician/Counselor/Health staff addresses the result by giving an opportunity to explain to the patient.	4.71	O	4.90	O	4.87	O	4.90	O
If the results of the drug test is positive, the Clinician/Counselor/Health staff addresses the result by reinforcing patient's honesty in admitting use.	4.65	O	4.86	O	4.87	O	4.87	O
The drug-test result is only issued to the respective patient and treated with utmost confidentiality.	4.59	O	4.91	O	4.86	O	4.92	O
The drug-test was/are made by DOH accredited personnel.	4.53	O	4.91	O	4.85	O	4.89	O
Additional interventions are provided to patient if deemed necessary	4.59	O	4.91	O	4.84	O	4.89	O
Grand Mean	4.71	O	4.89	O	4.87	O	4.89	O

Legend:
4.50-5.00= Outstanding (O)
3.50-4.49=Very Satisfactory (VS)
2.50 – 3.49=Satisfactory (S)
1.50 – 2.49= Fair (F)
1.00 – 1.49 = Poor (P)

Both staff and patients rated the centers highest for their ability to identify prohibited substances used by patients (DATRC 1: 4.94; DATRC 2: 4.90) and to gather a comprehensive drug use and medical history (ranging from 4.86 to 4.90 across both centers). These components are vital for determining the severity of substance use and creating a tailored rehabilitation plan. The consistent high agreement between personnel and patient ratings demonstrates that this assessment phase is thorough and well-received.

The conduct of regular drug testing, whether scheduled or on an as-needed basis, was also rated positively (DATRC 1: 4.80–4.85; DATRC 2: 4.84–4.86). This indicates strong monitoring of patient progress, a critical component of detoxification and relapse prevention. Additionally, the centers received praise for conducting immediate evaluations in response to missed appointments or unusual behavior, achieving scores as high as 4.90. These follow-up mechanisms are essential for the early detection of non-compliance and for ensuring continued therapeutic engagement.

Notably, the centers received high ratings for how they handled positive drug test results. Both staff and patients reported that clinicians provided patients an opportunity to explain these results (DATRC 1: 4.71–4.87; DATRC 2: 4.90) and encouraged honesty when patients admitted to drug use (DATRC 1: 4.65–4.87; DATRC 2: 4.86–4.87). This reflects a balanced therapeutic approach that values patient openness over punishment, promoting self-reflection and recommitment to treatment.

Confidentiality was another key strength. The management of drug test results received excellent ratings, with patients in DATRC 2 giving the highest score of 4.92. Both staff and patients affirmed that results were disclosed only to the relevant individual and handled with discretion, which is crucial for maintaining trust and compliance throughout the rehabilitation process.

While all items were rated as "Outstanding," the lowest score from the staff was recorded in DATRC 1 regarding the conduct of drug tests by DOH-accredited personnel, which was 4.53. Although this still meets the standard for outstanding performance, it may indicate occasional staffing limitations or procedural inconsistencies. Ensuring that certified personnel consistently administer all tests is essential for DDE results' legal and clinical validity.

The findings indicate that the drug dependency examination protocols are both technically sound and implemented with a high level of professionalism and responsiveness to patient needs. Both DATRCs firmly commit to personalized assessment, confidentiality, and adaptive interventions.

However, while the centers' DDE performance is commendable, broader challenges persist within the national context. According to Dioquino et al. (2022), only seven out of more than 1,000 drug screening laboratories in the Philippines are equipped to conduct confirmatory testing using advanced technologies such as liquid chromatography-mass spectrometry (LC-MS) or gas chromatography-mass spectrometry (GC-MS). These confirmatory methods are critical for validating initial screening results and for detecting emerging psychoactive substances that may not be included in standard drug tests. The study emphasizes the need to modernize testing infrastructure and revise existing cut-off values to align with global drug use and testing trends.

The results of Table 3 confirm that both DATRC 1 and DATRC 2 perform exceptionally well in administering the Drug Dependency Examination. The consistent "Outstanding" ratings across all items reflect the effectiveness of trained staff, adherence to DOH protocols, and the ethical handling of results. While the implementation is strong at the center level, there remains a need to enhance testing capabilities nationally by investing in advanced laboratory technologies, expanding confirmatory testing, and ensuring continuous accreditation of personnel. These improvements will further strengthen the integrity of the assessment process and support the goal of sustained recovery.

Matrix Intensive Outpatient Program (MIOP)

The Matrix Intensive Outpatient Program or MIOP incorporates elements of early recovery techniques, motivational interviews, relapse prevention, contingency management, and cognitive behavioral therapy. Patients take part in a range of individual and group-based activities.

Table 4 presents the evaluation of implementing the Matrix Intensive Outpatient Program (MIOP) at DATRC 1 and DATRC 2. The Matrix Model is a structured, evidence-based treatment approach designed for individuals with substance use disorders, particularly those struggling with stimulant addiction. It integrates elements such as relapse prevention, early recovery skills, family education, and social support groups, which are delivered over a 16-week intensive phase followed by continuing care.

Results indicate consistently high performance, with mean scores ranging from 4.65 to 4.91 and grand means of 4.80 (DATRC 1 staff), 4.85 (DATRC 2 staff), 4.88 (DATRC 1 patients), and 4.89 (DATRC 2 patients). All scores fall within the Outstanding category, confirming that the program is delivered effectively and consistently across both centers.

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Table 4
Matrix Intensive Outpatient Program (MIOP)

Indicators	Medical Staff and Administrative Personnel				Patients			
	DATRC 1		DATRC 2		DATRC 1		DATRC 2	
	M	VD	M	VD	M	VD	M	VD
The Clinician/Counselor/Health staff gives patient a brief overview of the Matrix Intensive Outpatient Program to the patient and/or the family members.	4.82	O	4.86	O	4.88	O	4.89	O
The Clinician/Counselor/Health staff provides a schedule of the Matrix Intensive Outpatient Treatment program.	4.88	O	4.91	O	4.89	O	4.91	O
Intensive Phase Outpatient Treatment sessions are provided for 16 weeks to patients for individual/co-joint family sessions, early recovery skills group sessions, relapse prevention group sessions, family education group sessions, and social support group sessions.	4.82	O	4.86	O	4.87	O	4.88	O
An Intensive Phase Outpatient Treatment session for community support and social reintegration is given for 8 weeks.	4.76	O	4.82	O	4.89	O	4.89	O
The Clinician/Counselor/Health staff provides a service agreement form.	4.82	O	4.86	O	4.88	O	4.87	O
The Clinician/Counselor/Health staff ensures that the patient understands the consequences for not abiding by the agreement.	4.71	O	4.86	O	4.88	O	4.89	O
The Clinician/Counselor/Health staff always allows ample time for questions during and at the end of each session.	4.65	O	4.82	O	4.87	O	4.89	O
Grand Mean	4.80	O	4.85	O	4.88	O	4.89	O

Legend:
4.50-5.00= Outstanding (O)
3.50-4.49=Very Satisfactory (VS)
2.50 – 3.49=Satisfactory (S)
1.50 – 2.49= Fair (F)
1.00 – 1.49 = Poor (P)

The highest-rated item among all groups was the provision of a treatment schedule, with mean scores ranging from 4.88 to 4.91. This indicates that the program is well organized and communicated, enabling patients and their families to prepare for and understand the treatment process. Similarly, providing a program overview to patients and family members also received high ratings (4.82–4.89), reflecting thorough orientation practices.

The delivery of the 16-week intensive phase, which includes individual or joint family sessions, group therapy, relapse prevention, and family education, was also rated Outstanding (4.82–4.88). These components reflect the comprehensive nature of the Matrix Model and are designed to build foundational recovery skills. The 8-week aftercare component for social reintegration was well-implemented, with patient ratings at 4.89 and staff ratings reaching 4.82, supporting continuity of care beyond the intensive phase.

Both DATRCs received high marks for providing and explaining service agreement forms, with scores ranging from 4.82 to 4.88. These documents formalize treatment engagement and clarify patient responsibilities. Additionally, ratings indicate that staff ensures patients understand the consequences of non-compliance with treatment rules (4.71–4.89), emphasizing structured accountability.

The lowest-rated item pertained to allowing sufficient time for patient questions during or after sessions, especially among staff at DATRC 1 (4.65). While still rated Outstanding, this indicates that there may be limitations in time or interaction that could impact patient understanding or satisfaction. Enhancing session dynamics by ensuring that patients have ample time for clarification and feedback may boost engagement and retention.

This observation aligns with Alder's (2025) view, emphasizing that “poor communication between healthcare providers and clients can lead to misunderstandings, decreased adherence, and reduced treatment success.” Strengthening two-way communication enhances patient involvement and ensures alignment between treatment objectives and patient expectations.

Patient ratings were slightly higher than staff scores across most items, suggesting a strong appreciation of services provided and minimal service gaps. The alignment between groups also indicates mutual recognition of program structure and effectiveness.

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Implementing the Matrix Intensive Outpatient Program in DATRC 1 and DATRC 2 is marked by high consistency, patient satisfaction, and adherence to structured therapeutic processes. The centers successfully deliver key components of the Matrix Model, including early recovery interventions, individualized counseling, and continuing care. While results are overwhelmingly positive, enhancing patient interaction through longer Q&A opportunities may improve treatment delivery.

Individual Counseling

Individual therapy sessions allow patients to discuss personal experiences with drug use. They can talk about how their drug addiction has negatively impacted their lives. The clinician/counselor can work with them to identify the triggers and underlying causes of their drug addiction. This enables them to begin developing a strategy to address the issues healthily.

Table 5 shows the data on the evaluation of individual counseling conducted at the DATRC. The grand mean ratings for medical and administrative staff (DATRC 1-4.82; DATRC 2 -4.85) and patients (DATRC 1-4.87; DATRC 2 -4.87) have the verbal equivalence of "outstanding," indicating that individual counseling is being done effectively at the two DATRC.

The highest mean ratings were for fostering positive relationships, as the medical and administrative personnel gave mean scores of 4.94 (DATRC 1) and 4.91 (DATRC 2). The mean scores from patients are 4.90 and 4.91, respectively, in DATRC 1 and DATRC 2. The mean scores show that the staff established strong therapeutic connections with patients.

The clinicians, counselors, and health staff served as outstanding primary treatment agents (Medical and administrative personnel at DATRC 1-4.88 and DATRC 2-4.82; and patients in DATRC 1-4.87, DATRC 2-4.89). As primary agents, they recognized their significant role in rehabilitating clients and patients, and therefore, they strived to meet the expectations associated with their respective roles.

The clinician, counselor, and health staff excelled in their roles as educators and coaches during the sessions (Medical and administrative personnel at DATRC 1-4.82 and DATRC 2-4.86; and patients in DATRC 1-4.87, DATRC 2-4.83). The overall approach of the rehabilitation program for drug dependents is holistic. Therefore, the clinician, counselor, and health staff focused not only on mental health rehabilitation but also on education and coaching, providing direct guidance that patients/clients needed to follow during their rehabilitation journey (Medical and administrative personnel at DATRC 1-4.82 and DATRC 2-4.91; and patients in DATRC 1-4.87, DATRC 2-4.87).

Table 5
Individual Counseling

Indicators	Medical Staff and Administrative Personnel				Patients			
	DATRC 1		DATRC 2		DATRC 1		DATRC 2	
	M	VD	M	VD	M	VD	M	VD
The Center uses Clinician/Counselor/Health staff as primary treatment agent.	4.88	O	4.82	O	4.87	O	4.89	O
The Clinician/Counselor/Health staff function as a teacher and coach during sessions.	4.82	O	4.86	O	4.87	O	4.83	O
The Clinician/Counselor/Health staff fosters a positive/healthy relationship.	4.94	O	4.91	O	4.90	O	4.91	O
The Clinician/Counselor/Health staff is realistic and directs interaction.	4.82	O	4.91	O	4.87	O	4.87	O
The Clinician/Counselor/Health staff ensures continuity of the treatment process.	4.76	O	4.82	O	4.88	O	4.87	O
The Center provides patient an opportunity to establish an individualized connection with the Clinician/Counselor/Health staff and learn about treatment.	4.82	O	4.82	O	4.86	O	4.88	O
The Center allows patients to discuss their addiction openly in a non-judgmental context with the full attention of the Clinician/Counselor/Health staff.	4.76	O	4.86	O	4.85	O	4.87	O
The Center provides a setting where patients and their families can, with the Clinician/Counselor/Health staff's guidance, work out crises, discuss issues, and determine the continuing course of treatment.	4.71	O	4.77	O	4.82	O	4.81	O
Patients understand what is expected of them during treatment.	4.88	O	4.86	O	4.86	O	4.89	O
Grand Mean	4.82	O	4.85	O	4.87	O	4.87	O

Legend:
4.50-5.00= Outstanding (O)
3.50-4.49=Very Satisfactory (VS)
2.50 – 3.49=Satisfactory (S)
1.50 – 2.49= Fair (F)
1.00 – 1.49 = Poor (P)

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The clients/patients were consistently reminded that their success in rehabilitation depended on their adherence to the treatment protocol. The patients/ clients were outstanding in ensuring continuity of the treatment process (Medical and administrative personnel at DATRC 1-4.76 and DATRC 2-4.82; and patients in DATRC 1-4.88, DATRC 2-4.87). The clients/patients were reminded not to quit attending rehabilitation sessions so they would see a positive result.

The centers were outstanding in establishing individualized connections with clinicians/counselors/health staff to learn about treatment (Medical and administrative personnel at DATRC 1-4.82 and DATRC 2-4.82; and patients in DATRC 1-4.86, DATRC 2-4.88). Letting patients understand the treatment programs prescribed for them resulted in increased engagement and cooperation from them.

The centers were outstanding in allowing patients to discuss their addiction openly in a non-judgmental context with the full attention of the clinician/counselor/health staff (Medical and administrative personnel at DATRC 1-4.76 and DATRC 2-4.86; and patients in DATRC 1-4.85, DATRC 2-4.87). The openness of the medical staff encouraged patients' honesty and willingness to share their thoughts and views during the rehabilitation sessions. This opened full cooperation from the patients to the treatment sessions.

The centers were outstanding in creating a setting where patients and their families can work out crises, discuss issues, and determine the continuing course of treatment under the guidance of the medical and administrative personnel (Medical and administrative personnel at DATRC 1-4.71 and DATRC 2-4.77; and patients in DATRC 1-4.82, DATRC 2-4.81). Openness with family members helped a lot in the recovery of the patients. The more the families were involved in the treatment sessions, the more motivated the clients/patients were to complete their rehabilitation program.

The centers excelled at helping patients understand what is expected of them during treatment (Medical and administrative personnel at DATRC 1-4.88 and DATRC 2-4.86; and patients in DATRC 1-4.86, DATRC 2-4.89). According to Toole et al. (2020), patients must grasp their treatment plans to enhance personal care compliance. The indicator for individual counseling, which received the lowest mean score, pertains to providing crisis resolution and family discussions, with mean scores ranging from 4.71 to 4.82. While this is still considered high, it suggests that this area requires improvement among the indicators for individual counseling. There exists an opportunity to improve the provision of a setting where patients and their families can resolve crises, discuss issues, and determine the ongoing course of treatment with guidance from the clinician, counselor, or health staff.

Overall, individual counseling services in both DATRCs are outstanding across all indicators. Continuous improvement could be implemented in family involvement, and crisis intervention could further enhance patient support and recovery results. This is supported by the Drug Addiction Center (2025) in its assertion that holding family members responsible for their actions and establishing incentives for good decisions are examples of healthy roles and behaviors. Family members may participate in the patient's support group. A key component of the family's healing is establishing healthy boundaries.

Family Counseling and Support

Mosel (2025) highlighted that support from family members appears to increase a person's likelihood of quitting drug abuse and staying under the care of a rehabilitation center. Family support was found to enhance communication and abstinence levels in a study of couples.

Table 6 shows that the centers were quite effective in teaching co-dependency and illustrating how families' efforts to help, such as providing financial assistance or concealing issues, might unintentionally complicate matters (Medical and administrative personnel at DATRC 1-4.13 and DATRC 2-4.09; and patients in DATRC 1-4.12, DATRC 2-4.09). This suggests that the center allows families in DATRC 2 to become a source of support for their loved ones undergoing treatment at DATRC 2.

The centers were very effective in helping families communicate more openly about issues such as trust, blame, and fear (Medical and administrative personnel at DATRC 1-4.19 and DATRC 2-4.13; and patients in

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DATRC 1-4.08, DATRC 2-4.11). This reflects the center's success in promoting open dialogue among patients and their families.

The importance of family support and acceptance was very satisfactorily strengthened at the Centers (Medical and administrative personnel at DATRC 1-4.06, DATRC 2-4.04, and patients in DATRC 1-4.06, DATRC 2-4.10). This highlights the crucial role of family in the rehabilitation journey of the clients/patients. Likewise, the centers received a very satisfactory evaluation in their effort to encourage the family to become the patient's support system (Medical and administrative personnel at DATRC 1-4.25 and DATRC 2-4.43; and patients in DATRC 1-4.20, DATRC 2-4.43).

Although all the mean scores are equivalent to the "very satisfactory" range, the lowest mean score (4.0) was given to the indicator "the center helps strengthen the patients' bond with their family" in DATRC 1 and DATRC 2. This suggests the need to explore additional strategies to strengthen family relationships further.

Table 6
Family Counseling and Support

Indicators	Medical Staff and Administrative Personnel				Patients			
	DATRC 1		DATRC 2		DATRC 1		DATRC 2	
	M	VD	M	VD	M	VD	M	VD
The Center teaches about co-dependency and how family's efforts to help, like giving money or covering up problems—might unintentionally make things harder.	4.13	VS	4.09	VS	4.12	VS	4.09	VS
The Center helps family communicate more openly about issues like trust, blame, or fear.	4.19	VS	4.13	VS	4.08	VS	4.11	VS
Importance of family support and acceptance is being strengthened by the Center.	4.06	VS	4.04	VS	4.06	VS	4.10	VS
The Center helps strengthen patient's bond with their family.	4.00	VS	4.00	VS	4.09	VS	4.05	VS
The Center encourages family to become the patient's support system.	4.25	VS	4.43	VS	4.20	VS	4.43	VS
Grand Mean	4.13	VS	4.14	VS	4.11	VS	4.16	VS

Legend:
4.50-5.00= Outstanding (O)
3.50-4.49=Very Satisfactory (VS)
2.50 – 3.49=Satisfactory (S)
1.50 – 2.49= Fair (F)
1.00 – 1.49 = Poor (P)

The grand mean scores for DATRC 1 (Medical and administrative personnel- 4.13; patients- 4.11) and DATRC 2 (medical and administrative personnel -41.14; patients- 4.16) DATRCS reflect a consistent level of satisfaction among the respondents. Although minor differences exist, the mean scores are still within the "very satisfactory" level of satisfaction.

However, family counseling was rated the lowest among the drug rehabilitation treatment protocols. This suggests the need for enhancements in family counseling further to strengthen the role of DATRCs in drug abuse treatment. According to Xia et al. (2022), family support and encouragement are crucial in preventing drug abuse relapses. A healthy family environment not only helps patients feel guilty but also helps them behave less addictively.

Psychological Testing/Services

Psychological approaches are significant supplements to medications and have emerged as a fundamental component of effective clinical intervention against drug abuse. Clinical psychology offers a combination of social and neurobiological concepts for drug addiction intervention (Popescu et al., 2015).

Table 7 shows the data on evaluating medical and administrative personnel and patients in both DATRCs. The mean scores ranged from 4.12 (very satisfactory) to 4.91 (Outstanding), indicating high satisfaction levels.

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Most of the indicators were given mean scores equivalent to "outstanding" except for "psychological testing based on the patient's needs (4.18) and "center properly identifies psychological, emotional, or behavioral issues, and diagnose disorders, using information obtained from interviews, tests, records, and reference materials (4.12)." The low mean scores suggest enhancements in both indicators to offer effective psychological testing services.

The psychological testing is based on the patient's needs (Medica and administrative personnel at DATRC 1-4.18 and DATRC 2-4.50, as well as patients in DATRC 1-4.49 and DATRC 2-4.50). This ensures that psychological rehabilitation is suited to the clients'/patients' psychological condition.

Table 7
Psychological Testing/Services

Indicators	Medical Staff and Administrative Personnel				Patients			
	DATRC 1		DATRC 2		DATRC 1		DATRC 2	
	M	VD	M	VD	M	VD	M	VD
The Psychological Testing is based on the patient's needs.	4.18	VS	4.50	O	4.49	VS	4.50	O
The Center properly identifies psychological, emotional, or behavioral issues, and diagnose disorders, using information obtained from interviews, tests, records, and reference materials.	4.12	VS	4.55	O	4.74	O	4.82	O
The Licensed Psychometrician supervises psychological testing.	4.65	O	4.86	O	4.85	O	4.86	O
The Psychological test results are immediately and properly analyzed and evaluated by the Center.	4.88	O	4.86	O	4.87	O	4.86	O
Psychological assessment is made through careful administration of test and evaluation of patient.	4.75	O	4.91	O	4.88	O	4.82	O
The Center evaluates patient's psychological response to treatment given.	4.76	O	4.91	O	4.86	O	4.82	O
The Center assists drug dependent patients in helping them to cope with their problems, facilitate and/or promote their interpersonal relationship.	4.82	O	4.86	O	4.87	O	4.86	O
The Center facilitates evaluation, diagnoses, and management of drug dependents through psychological testing and evaluation.	4.76	O	4.86	O	4.86	O	4.86	O
The Center has an Intervention/Psychological Evaluation Testing Room.	4.89	O	4.91	O	4.83	O	4.91	O
Grand Mean	4.65	O	4.80	O	4.81	O	4.82	O

Legend:
4.50-5.00= Outstanding (O)
3.50-4.49=Very Satisfactory (VS)
2.50 – 3.49=Satisfactory (S)
1.50 – 2.49= Fair (F)
1.00 – 1.49 = Poor (P)

The centers were very satisfactory in correctly identifying psychological, emotional, or behavioral issues and diagnosing disorders, using information obtained from interviews, tests, records, and reference materials (Medical and administrative personnel at DATRC 1-4.12 and DATRC 2-4.55 and patients in DATRC 1-4.74, DATRC 2-4.82).

The Licensed Psychometricians excelled in supervising psychological testing (medical and administrative personnel at DATRC 1-4.65 and DATRC 2-4.86; and patients in DATRC 1-4.85 and DATRC 2-4.86). The results of psychological tests indicated the extent of therapy provided to individual clients and patients.

The centers evaluated patients' psychological response to treatment (Medical and administrative personnel at DATRC 1-4.76 and DATRC 2-4.91; patients in DATRC 1-4.86, DATRC 2-4.82). The treatment response evaluation results were crucial in evaluating the effectiveness of the whole rehabilitation program.

The centers assisted those dependent on drugs in coping with their problems and promoting their interpersonal relationships (Medical and administrative personnel at DATRC 1-4.82 and DATRC 2-4.86; and patients in DATRC 1-4.87, DATRC 2-4.86). The centers ensured that clients and patients were proactive in their rehabilitation journeys.

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The centers facilitated evaluation, diagnoses, and management of drug dependents through psychological testing and evaluation (Medical and administrative personnel at DATRC 1-4.76 and DATRC 2-4.86; and patients in DATRC 1-4.86, DATRC 2-4.86).

The centers had an Intervention/Psychological Evaluation Testing Room (Medical and administrative personnel at DATRC 1-4.89 and DATRC 2-4.91; and patients in DATRC 1-4.83, DATRC 2-4.91). The testing rooms provided comfort and confidentiality among the clients/patients.

The grand mean scores for medical and administrative personnel and patients across the DATRCs indicate an overall high level of satisfaction with the psychological testing and services provided by the center. However, improvements in psychological testing based on patients' needs, identification of psychological, emotional, or behavioral issues, and diagnosis of disorders using information obtained from interviews, tests, records, and reference materials require further enhancements. According to Insight Northwest Counseling (2025), psychological evaluations are critical in providing treatment for individuals seeking drug abuse treatment.

Psychiatric Services

Substance use has well-documented effects on mental health, often triggering or exacerbating psychological disorders. According to the **Mental Health Foundation (2021),** drug use can lead to long-term mental health issues such as anxiety, depression, psychosis, and other behavioral disorders. These risks underline the importance of integrating **psychiatric services** as a core component of treatment in Drug Abuse Treatment and Rehabilitation Centers (DATRCs).

When left untreated, these psychiatric conditions can hinder treatment engagement, increase the likelihood of relapses, and worsen overall health outcomes. Thus, early psychiatric assessment, proper referral, and continuous psychiatric support are critical in promoting recovery and long-term rehabilitation success.

In Table 8, data show that the mean scores given by patients in both DATRCs were consistently higher than those of the medical and administrative personnel, indicating a generally positive perception of the services they received. The highest mean score was on the center's referral of patients below 18 years old to appropriate authorities for intervention (DATRC 1-4.49, DATRC 2- 4.89). This suggests an increased collaboration with child welfare agencies and psychologists to provide appropriate drug treatment for young patients.

Table 8
Psychiatric Services

Indicators	Medical Staff and Administrative Personnel				Patients			
	DATRC 1		DATRC 2		DATRC 1		DATRC 2	
	M	VD	M	VD	M	VD	M	VD
The Center evaluates patient's behavioral and psychiatric disorders.	4.00	VS	4.64	O	4.48	VS	4.81	O
Patients with primary psychiatric behavior are referred to proper health care facilities.	4.13	VS	4.59	O	4.49	VS	4.80	O
The Center ensures that patients below 18 years of age are referred to appropriate authorities for intervention.	4.19	VS	4.86	O	4.49	VS	4.86	O
Grand Mean	4.10	VS	4.70	O	4.49	VS	4.82	O

Legend:
4.50-5.00= Outstanding (O)
3.50-4.49=Very Satisfactory (VS)
2.50 – 3.49=Satisfactory (S)
1.50 – 2.49= Fair (F)
1.00 – 1.49 = Poor (P)

Additionally, although referrals for primary psychiatric behavior were rated well (Medical and administrative personnel at DATRC 1-4.13 and DATRC 2-4.59 and patients in DATRC 1-4.49, DATRC 2-4.80) ensuring smooth transitions to specialized health care centers could further enhance expected outcomes. This could be made possible by establishing stronger partnerships with psychiatric health facilities and mental health professionals to ensure speedy and more effective patient referrals. However, DATRC 2 was observed to have

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a higher evaluation rating than DATRC 1, suggesting that DATRC1 may ask for best practices in this service delivery area.

The grand mean for DATRC 1 (medical and administrative personnel-4.10, patients-4.49) is lower than that for DATRC 2 (medical and administrative personnel-4.70, patients-4.82). This suggests that DATRC 1 needs to improve its psychiatric services. They may also conduct a needs evaluation survey of the patients, whose findings will be the basis for implementing strategies to enhance their psychiatric services.

Spiritual Enhancement

The role of spiritual enhancement in treating or rehabilitating individuals who abuse drugs is crucial. According to the Orlando Recovery Center (2023), spiritual practices integrating into recovery of addiction, which includes mindfulness and meditation, has been shown to improve treatment outcomes.

Table 9
Spiritual Enhancement

Indicators	Medical Staff and Administrative Personnel				Patients			
	DATRC 1		DATRC 2		DATRC 1		DATRC 2	
	M	VD	M	VD	M	VD	M	VD
Patient's religious and spiritual beliefs is/are respected in every process of treatment.	4.13	VS	4.59	O	4.15	VS	4.79	O
The Center provides opportunity for the patient to decline spiritual or moral support.	4.19	VS	4.64	O	4.11	VS	4.77	O
Patients are reassured that spirituality is not the same as religion, so as to engage patient in spiritual programs.	4.06	VS	4.77	O	4.08	VS	4.78	O
Patients are provided with a proper understanding of what spirituality is and how it affects them.	3.97	VS	4.50	O	4.07	VS	4.65	O
Grand Mean	4.08	VS	4.63	O	4.10	VS	4.75	O

Legend:
4.50-5.00= Outstanding (O)
3.50-4.49=Very Satisfactory (VS)
2.50 – 3.49=Satisfactory (S)
1.50 – 2.49= Fair (F)
1.00 – 1.49 = Poor (P)

The data shown in Table 9 reflect the evaluation of the spiritual enhancement offered by DATRC 1 and DATRC 2. Findings show that in DATRC 1, both sets of respondents gave mean score ratings ranging from 3.97 to 4.19 of 4.07 and 4.15, respectively, for medical and administrative personnel and patients. These mean scores have the verbal equivalence of "very satisfactory." Conversely, respondents from DATRC 2 gave higher mean scores ranging from 4.50 to 4.77 and 4.65 to 4.79 for medical and administrative personnel and patients, indicating an "outstanding" evaluation for spiritual enhancement services at DATRC 2.

Further findings revealed that while both DATRCs prioritize spiritual enhancement for the patients, DATRC 2 demonstrated a strong implementation of spiritual enhancement initiatives as one of the recommended treatment protocols under the DOH for government-owned drug rehabilitation centers. This is supported by a grand mean higher in DATRC 2 (medical and administrative personnel- 4.64; patients-4.75) than in DATRC 1 (medical and administrative personnel-4.08; patients-4.10). The higher ratings in DATRC 2 indicate that patients there felt more reassured and engaged in spiritual programs because of more structured policies or active involvement of the medical and administrative personnel in addressing spiritual needs. The findings in DATRC 1 suggest that there is still room for improvement in the implementation of spirituality as a part of the treatment protocols for drug abusers beyond religious contexts.

These findings are significant for individuals' well-being and holistic healthcare approaches. If spiritual needs are met, patients may experience improved emotional resilience and a more positive perspective on recovery.

Personnel in DATRC 1 may consider adopting the best practices from DATRC 2, such as enhancing communication strategies for integrating spirituality into the treatment program. This would provide more opportunities for spiritual engagement and reinforce policies that ensure respect for diverse religious beliefs.

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Table 10
Recreational Program

Indicators	Medical Staff and Administrative Personnel				Patients			
	DATRC 1		DATRC 2		DATRC 1		DATRC 2	
	M	VD	M	VD	M	VD	M	VD
Patient's religious and spiritual beliefs are taken into consideration in coming up with activities for recreational program.	4.19	VS	4.64	O	4.00	VS	4.84	O
The Center provides sports and recreation to establish peer relationship as an alternative to drug use.	4.31	VS	4.59	O	4.12	VS	4.85	O
The activities provided develop discipline necessary to improve skills and emphasis are directed on gaining respect for good physical health and respect for others as well.	4.38	VS	4.86	O	4.14	VS	4.87	O
The Center has a recreational area.	4.25	VS	4.59	O	4.16	VS	4.83	O
The Center has an Outdoor Activity Area.	4.44	VS	4.56	O	4.16	VS	4.65	O
Grand Mean	4.33	VS	4.63	O	4.12	VS	4.81	O

Legend:
4.50-5.00= Outstanding (O)
3.50-4.49=Very Satisfactory (VS)
2.50 – 3.49=Satisfactory (S)
1.50 – 2.49= Fair (F)
1.00 – 1.49 = Poor (P)

Overall, the findings highlight the importance of spiritual care in rehabilitation treatment to enhance patient satisfaction and holistic healing. This aligns with the study by Galanter et al. (2021) that spirituality improves treatment access, results, and equity for marginalized communities and the medically underserved, such as members of ethnic/racial minority groups and those from lower socioeconomic backgrounds. Another study by Yaghubi et al. (2019) found that religious-spiritual education had positive effects on individuals on drug medication for drug abuse. Patients had enhanced spiritual health and quality of life. The results imply that religious and spiritual education can be regarded as a practical, affordable, affordable, and successful treatment for drug abuse patients.

Recreational Program

The importance of recreation therapy in drug rehabilitation lies in its potential to encourage a healthy lifestyle and to enable people to develop coping mechanisms needed for long-term recovery (Cumberland Heights Foundation, 2024).

Table 10 reflects the evaluation of the recreational program being implemented by the DATRCs. The indicators underscore the significance of integrating recreational activities into the treatment and rehabilitation of patients who are recovering from drug abuse.

For both DATRCs, mean scores generated from the responses of the medical and administrative personnel and patients indicate positive results. Higher mean scores from the respondents coming from the DATRC 2 were observed (all mean scores have verbal equivalence of "outstanding") than those from DATRC 1 (all mean scores have verbal equivalence of "very satisfactory").

The highest mean score among all the indicators was 4.87, on the development of discipline necessary to improve skills and the emphasis directed on gaining respect for good physical health and respect for others. This reflects the strong agreement of the patients from DATRC 2 on the effectiveness of recreational programs in developing good physical health and social values among them. In addition, including religious and spiritual beliefs in recreational activities was highly appreciated in DATRC 2, with a mean score of 4.84 from the patients. This implies a holistic approach to rehabilitation.

The presence of recreational and outdoor activity areas was also perceived to be essential, with a mean score equivalent to "outstanding" from DATRC 2 respondents. However, DATRC 1 lagged behind, with a mean

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score equivalent to "very satisfactory." The variation suggests that DATRC 2 has a better structure and more effective recreational programs than DATRC 1 due to better resources, facilities, or program implementation.

The findings highlight the significance of incorporating well-designed recreational activities in rehabilitation programs. The activities not only serve as an alternative to drug use but also develop patients' discipline, social interaction, and overall well-being. DATRC 1 may revisit its recreational programs and find out which needs improvement.

The benefits of incorporating recreational programs into the rehabilitation or treatment of drug abusers align with the results of the study by Castillo-Viera et al. (2022), where coadjutant treatments (combined behavioral or pharmacological treatments) and physical activity had been proven to strengthen drug-withdrawal treatments. Exercise also lowered the risk of social exclusion and enhanced other physical factors that affected the patients' quality of life, like mood and sleep quality.

Skills and Recovery

Table 11
Skills and Recovery

Indicators	Medical Staff and Administrative Personnel				Patients			
	DATRC 1		DATRC 2		DATRC 1		DATRC 2	
	M	VD	M	VD	M	VD	M	VD
The Center helps patient find ways to earn money independently.	3.06	S	3.14	S	3.16	S	3.07	S
The Center provides essential life skills, such as managing money, communicating effectively, or solving problems.	3.13	S	4.09	VS	3.05	S	4.05	VS
The Center provides technical skills training that can be of help in finding jobs or for employment.	4.88	O	4.05	VS	4.69	O	4.07	VS
The Clinician/Counselor/Health Staff helps patient to discover and enhance their own skills for better opportunities.	3.88	VS	3.09	S	3.99	VS	3.05	S
The Center provides linkages so patients can apply and maximize their skills.	4.88	O	4.09	VS	4.73	O	4.07	VS
Grand Mean	3.96	VS	3.69	VS	3.92	VS	3.66	VS

Legend: 4.50-5.00= Outstanding (O)
3.50-4.49=Very Satisfactory (VS)
2.50 – 3.49=Satisfactory (S)
1.50 – 2.49= Fair (F)
1.00 – 1.49 = Poor (P)

During the final phase of drug rehabilitation, which focuses on skills development and recovery, patients enhance their abilities, particularly in communication, problem-solving, stress management, and technical skills, which may help them earn an income post-rehabilitation. The highest average scores observed were in the center's ability to provide resources, allowing patients to apply and maximize their skills in both DATRC 1 (medical and administrative personnel-4.88; patients-4.73) and DATRC 2 (medical and administrative personnel-4.09; patients-4.07). This indicates that patients who have completed the phases of drug rehabilitation possess skills that enable them to support themselves financially.

The DATRCs gave a satisfactory evaluation of their assistance in developing skills to earn money independently, as attested by mean scores ranging from 3.08 to 31.16. However, these findings suggest the need to improve centers' strategies for empowering patients who are about to be released from the drug rehabilitation centers.

Both centers provide essential life skills (money management, communication, problem-solving skills), but DATRC 2 had higher mean scores equivalent to "very satisfactory," while DATRC 1 had "satisfactory." This implies that life skills training is perceived to be more effective in DATRC 2 than in DATRC 1.

A notable finding is DATRC 2's low mean score on the help offered to help patients discover their skills. Both medical and administrative personnel and patients gave a satisfactory evaluation. For DATRC 1, this indicator gained a very satisfactory rating. This suggests that DATRC 2 has to exert more effort in actively assisting patients in identifying and improving their skills.

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Table 12
Overall Evaluation of the Services in DATRCs

Services	Medical Staff and Administrative Personnel		Patients		Overall	
	DATRC 1	DATRC 2	DATRC 1	DATRC 2	Grand Mean	Adjectival Description
Screening and Assessment of Persons Who Use Drugs (PWUDs)	4.76	4.82	4.86	4.90	4.84	O
Community Based Drug Rehabilitation Program	None	1.95	None	1.89	1.92	F
Drug Dependency Examination (DDE) (Severity of use)	4.71	4.89	4.87	4.89	4.84	O
Matrix Intensive Outpatient Program	4.80	4.85	4.88	4.89	4.86	O
Individual Counseling	4.82	4.85	4.87	4.87	4.85	O
Family Counseling and Support	4.13	4.14	4.11	4.16	4.14	VS
Psychological Testing and Services	4.65	4.80	4.81	4.82	4.77	O
Psychiatric Services	4.10	4.70	4.49	4.82	4.53	O
Spiritual Enhancement	4.08	4.63	4.10	4.75	4.39	VS
Recreational Program	4.33	4.63	4.12	4.81	4.47	VS
Skills and Recovery	3.96	3.69	3.92	3.66	3.81	VS
Over-All Grand Mean	4.03	4.36	4.09	4.41	4.22	VS

Legend:
4.50-5.00= Outstanding (O)
3.50-4.49=Very Satisfactory (VS)
2.50 – 3.49=Satisfactory (S)
1.50 – 2.49= Fair (F)
1.00 – 1.49 = Poor (P)

The two respondents' grand mean scores in both DATRCs are equivalent to a verbal description of "very satisfactory." Hence, the findings imply success in implementing skills and recovery. However, room for improvement is needed in helping patients find ways to earn money independently and provide essential life skills, such as managing money, communicating effectively, or solving problems.

Overall Evaluation of the Services in DATRCs

Table 12 evaluates the treatment and rehabilitation services implemented across two DOH-accredited Drug Abuse Treatment and Rehabilitation Centers (DATRCs) in Region III. The table consolidates responses from two key groups—medical and administrative personnel, and patients—across eleven core service areas. These services align with the standards set by the Department of Health (DOH) and the Dangerous Drugs Board (DDB).

They are recognized as critical in supporting the recovery, reintegration, and sustained well-being of persons who use drugs (PWUDs). The results provide an important lens through which the overall performance, strengths, and areas for improvement in rehabilitation services can be systematically assessed. The **Matrix Intensive Outpatient Program (MIOP)** emerged as the most highly rated service, with an overall mean score of 4.86, which falls under the "Outstanding" category. This indicates that outpatient programs within the DATRCs are not only well-structured but also delivered in a manner consistent with best practices in substance use recovery. The high satisfaction levels among patients and service providers suggest that MIOP is effectively implemented, integrating therapeutic routines, relapse prevention techniques, and follow-up mechanisms supporting client autonomy and sustained recovery. This reinforces the literature emphasizing the utility of evidence-based outpatient programs for individuals requiring continuous but non-residential care (Rawson et al., 2006).

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Following closely is **Individual Counseling**, which also received an "Outstanding" rating, with a mean score of 4.85. This high rating reflects the critical role of one-on-one therapeutic interactions in fostering insight, motivation, and compliance among rehabilitation clients. The evaluation suggests that counselors and clinical staff maintain strong therapeutic alliances and regularly engage clients in goal-directed and client centered conversations that contribute to their progress through the rehabilitation phases. These findings validate the DATRCs' adherence to the DDB's treatment framework, which begins with accurate screening and severity assessment as a prerequisite for assigning appropriate care levels.

Similarly, **Screening and Assessment of Persons Who Use Drugs (PWUDs) and Drug Dependency Examination (DDE)** both recorded an overall mean of 4.84. These foundational services are vital to identifying the severity of substance use and crafting appropriate treatment plans. Their high mean scores reflect the DATRCs' adherence to systematic diagnostic procedures and screening protocols. These processes allow for accurate classification of client risk levels, essential for tailoring interventions based on clinical profiles.

Psychological Testing and Services also received an "Outstanding" rating, with an overall mean of 4.77. This underscores the significant contribution of psychological assessment in identifying comorbidities, tracking behavioral changes, and formulating individualized care plans. It further suggests that the DATRCs employ licensed psychometricians and psychologists who administer, interpret, and utilize test results in a timely and clinically meaningful way. This highlights the need for continued integration of mental health care within substance abuse treatment, a well-established best practice supported by dual diagnosis literature (Drake et al., 2001).

Psychiatric Services, with a mean score of 4.53, though still rated as "Outstanding," emerged as an area requiring more attention. Previous findings indicated that psychiatric referrals, especially for patients with primary psychiatric disorders, were not uniformly streamlined across all centers. This suggests the need for strengthened collaboration with mental health institutions and improved internal protocols for psychiatric care delivery, especially in more resource-constrained DATRCs.

In contrast, **Family Counseling and Support, Spiritual Enhancement, Recreational Program, and Skills and Recovery** were evaluated as "Very Satisfactory," with mean scores of 4.14, 4.39, 4.47, and 3.81, respectively. While these scores indicate general effectiveness, they fall short compared to core clinical and psychological services. Family involvement remains a critical yet underutilized resource in sustaining recovery, and the relatively lower ratings suggest that centers may need to provide more structured and consistent family-based interventions. Similarly, spiritual enhancement and recreational programs promote patient engagement, emotional resilience, and holistic healing, but implementation gaps remain. The lowest score among these services—3.81 in Skills and Recovery—highlights the need for stronger post-treatment economic reintegration strategies. This includes developing sustainable livelihood training, job placement support, and collaboration with local government units and private partners. These domains facilitate long-term behavioral change, reintegration, and resilience post rehabilitation. The lower mean in Skills and Recovery is particularly concerning, given that this domain equips patients with life, communication, and vocational skills crucial to reentering the workforce and supporting themselves independently after treatment. The discrepancy between clinical success and reintegration support suggests that while the

DATRCs are effective at stabilization and behavioral modification, additional support is necessary to sustain recovery in real-world contexts.

The **Community-Based Drug Rehabilitation Program (CBDRP),** although not a direct service under the DATRCs' purview, was included in the evaluation to emphasize the broader structural support needed in the rehabilitation ecosystem. The program received the lowest overall rating (mean score = 1.92, "Fair"), reflecting the absence or inadequacy of decentralized and accessible rehabilitation facilities in community settings. Its inclusion supports expanding services beyond centralized DATRCs and creating sustainable community-based responses to alleviate logistical burdens, reduce treatment dropout, and foster earlier intervention. This CBDRP has far-reaching implications. First, the lack of community-based options forces overcrowding and overdependence on facility-based treatment, placing pressure on already limited DATRC

resources. Second, it limits access to treatment for low-risk or geographically isolated individuals, potentially allowing substance use issues to worsen before intervention is sought. The inclusion of CBDRP in the evaluation, although not initially part of the scope of services directly rendered by DATRCs, strengthens the argument for integrated and layered service delivery models. As supported by WHO (2017), community-based services play a crucial role in expanding the reach of substance abuse treatment and reducing stigma associated with institutional rehabilitation.

The 'Fair' ratings under community-based screening do not reflect DATRC performance but point to system gaps at the community level. These findings support the need for enhanced inter-agency coordination and the expansion of CBDRCs to complement DATRCs. The absence of community-based screening services is not a direct DATRC failure, but its lack contributes to patient overload and delayed access to care. Thus, expanding CBDRP efforts across barangays becomes a vital policy recommendation to decentralize care, improve early detection, and reduce strain on DATRCs.

The evaluations yield an Overalll Grand Mean of **4.22**, categorized as “Very Satisfactory.” This aggregate score affirms that the DOH-accredited Drug Abuse Treatment and Rehabilitation Centers (DATRCs) in Region III generally provide competent, structured, patient-centered services aligned with national treatment standards. However, this overall rating also reveals significant variation across different service domains. While core clinical components—individual counseling, drug dependency assessment, psychological testing, and outpatient treatment programs—consistently achieved “Outstanding” ratings, auxiliary and supportive services such as family involvement, skills development, spiritual enhancement, and community reintegration received relatively lower scores.

This divergence suggests that although the DATRCs possess a strong clinical foundation, recovery from substance use disorders necessitates more than just compliance with treatment protocols. Effective rehabilitation is multidimensional; it must extend beyond therapy rooms to include reintegration into familial, community, and economic life. The high performance in medical and psychological service areas should not obscure the critical gaps in continuity of care and post-treatment recovery, particularly regarding emotional, spiritual, and socio-economic support.

Hence, the Grand Mean presents a paradox: a technically sound and clinically robust treatment delivery framework that remains limited in addressing recovery's broader, long-term dimensions. These findings emphasize the need for a comprehensive enhancement strategy that not only strengthens underperforming service domains but also expands the reach of the rehabilitation program. Institutionalizing aftercare programs, increasing workforce stability, and reinforcing linkages with community-based support systems are necessary to ensure that rehabilitation outcomes are sustainable and inclusive.

Moreover, the inclusion of Community-Based Drug Rehabilitation Program as an identified gap underscores the pressing need for policy innovation and budgetary support to decentralize treatment access. Community-based programs can play a pivotal role in alleviating the burden on existing DATRCs, addressing patient logistical barriers, and facilitating early intervention. As such, while the existing infrastructure performs well within its clinical mandate, evolving toward a more integrated and holistic model of care is imperative for achieving meaningful and lasting recovery for persons who use drugs.

Thus, Table 12 validates the operational effectiveness of the DATRCs. It presents a compelling case for adopting a more integrative and forward-looking rehabilitation framework that values holistic recovery, strengthens post-treatment systems, and expands its reach through community-based options. Future enhancements must thus be guided by clinical performance indicators and the lived experiences of the patients and personnel, ensuring that the rehabilitation journey remains effective, sustainable, and dignified.

Best Practices on Drug Treatment and Rehabilitation as Perceived by Medical Personnel and Administrative Staff in DATRCs

Drug rehabilitation centers should provide the most appropriate treatment programs to achieve success in helping a person restore a healthy and productive life. Table 13 shows the best practices offered by the medical and administrative staff based on their evaluation.

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Results show that a high percentage of medical and administrative staff indicated the five best practices in their delivery service. All medical staff and administrative personnel (100%) stated that the treatment setting is ideal and safe, promoting emotional and mental well-being. Treatment is humane, non-judgmental, non-stigmatizing, and evidence-based. This suggests that the DATRCs have effectively implemented safety protocols, patient-centered care, and a positive workplace culture. Such a setting enhances patient recovery, self-satisfaction, and the overall reputation of the centers. Bank and Roessler (2022) support this assertion in their study, concluding that therapeutic settings with warm surroundings help clients feel relaxed and connected to the community, reduce stigmatization, and facilitate treatment. The authors demonstrate how materials, activities, and sensory processes can create healing spaces and a welcoming environment.

Table 13

Best Practices of the Medical Staff and Administrative Personnel (N=40)

Best Practices	f	%
Treatment setting is ideal and safe promoting emotional and mental well-being.	40	100
Experts tailor treatment based on individual patient needs.	39	97.5
Experts consider the cultural, educational, social, and religious background of the patients in developing treatment modalities.	39	97.5
Implementation of innovative activities and services at the center.	38	95.0
There are linkages available for a more holistic approach.	37	92.5
Management of patients is multi-disciplinary and evidence-based.	37	92.5
DATRCs have available technology to facilitate communication, medical recording, treatment and monitoring.	37	92.5
Compassionate, dedicated, and non-judgmental personnel	37	92.5
Good - conduct of regular home visitation	35	60

Nearly all respondents (n=39, 97.5%) claimed they have carefully tailored treatment based on individual patient needs. This suggests that the rehabilitation treatment plan prioritized patient-centered approaches to ensure treatments are adapted to specific conditions, preferences, and progress. This individualized care is critical in improving patient outcomes, higher satisfaction, and recovery. Maintaining this level of customization requires continuous training, thorough patient evaluation, and adaptive treatment strategies to address evolving patient needs.

The medical and administrative personnel (95%) also claimed that they provided innovative activities and services to facilitate excellent service delivery. Creative services include patient involvement in showcasing their talents and skills (painting, dance, music, culture, landscaping, cooking or baking, and others), the introduction of new programs on family (with the strong involvement of the family as a strong support; and mental health advocacy programs.

Dynamic, engaging, and evolving treatment strategies include therapy workshops, skill-building programs, and recreational activities. These are critical in maintaining patient motivation and promoting long-term recovery. The respondents also claimed they offered a holistic approach to drug rehabilitation (92.5%). Their strategy was establishing partnerships with organizations and sectors, highlighting the importance of a multi-sectoral approach where DATRCs collaborate well with other healthcare team members, community groups, schools, and other government agencies to provide comprehensive care to patients until their final recovery. The holistic approach in drug rehabilitation aligns with the findings of the study by Utomo et al. (2024) that a holistic rehabilitation program improves the quality of life of individuals who are addicted to illegal drugs.

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The respondents stated that they provided evidence-based management (92.5%). The experts' recommendations for everyone's treatment program are based on scientific research and best practices. This aligns with the growing acknowledgment of research-supported treatment methods to improve patient outcomes and ensure that treatment models are effective and current.

The respondents also indicated that they applied multidisciplinary and evidence-based patient management plans (92.5%). These approaches encompass the medical, psychological, and social components of drug rehabilitation. According to Sdrulla and Chen (2015), an interdisciplinary approach benefits most patients and effectively addresses the challenges of drug abuse.

Moreover, DATRCs have available technology to facilitate communication, medical recording, treatment, and monitoring. An existing customized electronic medical record crafted only for DATRC 2 (sponsored by the European Union) enabled speedy information recording and retrieval.

The findings imply that medical staff and administrative personnel highly value patient-centered and evidence-based treatment approaches to rehabilitating drug abusers. The centers' efforts in integrating cultural and social factors, innovative services, strong external linkages, and scientifically tested interventions are critical to the success of rehabilitation programs. The results suggest continuous improvement, interdisciplinary collaboration, and research-based practices for better drug treatment and rehabilitation in DATRC.

1. Problems and Challenges Arise in the Delivery of Services in DATRCs.

Programs aimed at improving health and safety come with challenges. While evaluating the drug rehabilitation program of the two DATRCs in Region III was generally satisfactory, the medical staff and administrative personnel faced and managed various operational and clinical challenges to ensure optimal patient care outcomes. Table 14 reflects these challenges.

Problems and Challenges in the Delivery of Services in DATRCs (Medical and Administrative Staff)

Problems related to the patients were the limited financial capacity of patients to continue and sustain the treatment, limited means of transportation in attending the treatment sessions, and the remote location of patients' residences hindering accessibility to treatment. Although the drug rehabilitation program is free (except for DATRC 1 since they accept voluntary feed from clients/patients who can afford to pay), transportation and food allowance in going to the center were burdensome for some of the patients/clients. Despite financial constraints, most patients complete their rehabilitation program.

Table 14
Problems and Challenges in the Delivery of Services in DATRCs (Medical and Administrative Staff)

Problems Related to Patient	f	%	Rank
Limited financial capacity of patients to continue and sustain the treatment.	40	100	1.5
Limited means of transportation in attending the treatment sessions.	40	100	1.5
Limited access to education and mental health awareness.	39	97.5	3
Impairment of the patient.	38	95.0	4
Patient's residence is located from remote barangays thus hinder accessibility to treatment.	37	92.5	5
Patient's self-destructiveness- is not consistent in following prescribed treatment.	33	82.5	6
Motivational challenges- patients are not ready to quit using drugs.	30	75.0	7
Culture limits patients to facts about mental health.	27	67.5	8

Since DATRC 2 is centrally located in the province, most patients can use various means of transportation (personal car, jeep, tricycle, or any available option). Only a few reside in remote barangays. Therefore, the issue of travel allowance primarily affects those in DATRC 1.

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Other difficulties were the impairment of the patient and limited access to education and mental health awareness. These conditions could significantly hinder the effectiveness of drug rehabilitation programs because they may potentially limit patient's ability to actively participate in therapy, follow procedures, and achieve sustainable recovery. Patients/clients may need more intensive and specialized care in these conditions. Moreover, limited access to education and mental health awareness could lead to misinformation, stigma, and reluctance to seek treatment. This reduces the overall program engagement and long-term success of the drug rehabilitation program.

The patient's self-destructiveness or inconsistency in following prescribed treatment was also identified as a challenge. Non-compliance with treatment plans can lead to relapses, prolonged recovery, and non-successful treatment outcomes. This may also disrupt the continuity of care. The medical staff may need repeated interventions and adjustments in treatment approaches. Patients' self-destructiveness or inconsistency in following prescribed treatment could strain medical staff and resources.

Problems and Challenges in the Delivery of Services in DATRCs (Medical Staff and Administrative Personnel)

The study identified challenges in implementing the drug rehabilitation program in the DATRCs, which suggests the need for solutions to achieve the goals of government-owned rehabilitation centers.

Challenges related to treatment delivery identified the duration of treatment as lengthy and involved numerous sessions as prescribed by law. This may lead to patient fatigue, decreased motivation, and higher dropout rates. On the other hand, lengthy and innumerable sessions could strain rehabilitation resources for the center, increasing the cost of operation and staff workload.

Table 15
Problems and Challenges in the Delivery of Services in DATRCs (Medical Staff and Administrative Personnel)

Problems Related to Treatment	f	%	Rank
Duration of treatment is lengthy and involves numerous sessions as prescribed by law.	40	100	1
Existing jobs of patients/ clients are compromised to comply with the treatment program.	40	100	2
Some patients hardly comprehend protocol sessions.	30	75.0	3
Treatment is compulsory for mandated court cases.	27	67.5	4
Limited facilities for treatment.	19	31.25	47.5
Limited medicines for treatment.	19	31.25	47.5
Other members of the health care team are not cooperative.	17	43.75	42.5
Culture-based treatments are not widely available, only evidence-informed approaches exist.	16	37.50	40.0
No one-size-fits-all solution, as we cater to a diverse group of patients with unique needs	16	37.50	40.0

For problems related to treatment, the centers identified that the duration of therapy is lengthy and involves numerous sessions as prescribed by law (100%). This was attributed to some clients/patients who needed an extension of the programmed schedule since they had to make up for the missed sessions during their absence.

The existing jobs of the clients/patients were usually compromised since they needed to comply with the treatment. This affected their income and added to the mental health issues of some. Other challenges encountered were some patients who hardly understood protocol sessions. Sometimes, this caused prolonged sessions for some individual clients, affecting the next client's time. Also, mandatory treatments were mainly ordered by the court. This leads to forced enrollment in the rehabilitation center for some clients/patients. Most patients who were compelled to subject themselves to rehabilitation were the ones who usually dropped out.

There were also problems with the lack of facilities and medicines for treatment. The specialists augment these deficits by introducing other treatment approaches. This is why most treatment approaches are eclectic or multidisciplinary. However, for severe cases, pharmacological interventions are the ones most needed.

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Problems and Challenges in the Delivery of Services in DATRCs (Medical Staff and Administrative Personnel)

In terms of challenges related to the Department of Health, the central agency being mandated to oversee the establishment and implementation of the drug rehabilitation centers, the respondents claimed to receive inadequate support for the treatment of drug abusers and ineffective policies on salaries and compensation for staff. Most medical staff and administrative personnel had no benefits, especially in DATRC, where most had no Plantilla.

Agencies involved in drug rehabilitation have overlapping roles, which is identified as one of the challenges related to administration. This leads to inefficient resource utilization and fragmented service delivery. This lack of alignment and coordination may lead to confusion among stakeholders and patients, which could eventually lead to decreased efficiency and effectiveness in drug rehabilitation.

Table 16
Problems and Challenges in the Delivery of Services in DATRCs (Medical Staff and Administrative Personnel)

Problems Related to Administration (DOH)	f	%	Rank
Ineffective Policy/ies on salaries and compensation for personnel	32	80.0	2
Unavoidable workplace politics	32	80.0	2
Policies on the implementation of drug rehabilitation centers are not well crafted. Overlapping functions occur among agencies involved in drug rehabilitation.	32	80.0	2
Inadequate training to manage drug abusers.	20	50.0	4
Administrative personnel have a limited background in patient evaluation and treatment.	17	42.5	5.5
Limited understanding of addiction.	17	42.5	5.5

Table 16 presents the administrative challenges encountered in delivering services at government-run DATRCs, as reported by medical and administrative personnel. The findings show that a significant portion of the challenges stem not only from patient-related and operational factors but also from **institutional and policy-related issues**, particularly those within the scope of the Department of Health (DOH) as the supervising agency.

(1) Three indicators were considered as the **Top-Ranked Challenges** identified by **80%** of the respondents, all ranked second, reflecting their equal and high-level concern. (1) Ineffective Policies on Salaries and Compensation for Personnel**.** A primary concern was the inadequacy and inconsistency in the salary structures and compensation packages offered to DATRC employees. Many personnel do not hold regular plantilla positions, leading to job insecurity and exclusion from benefits such as insurance, hazard pay, and retirement contributions. As highlighted in earlier tables, this contributes to low morale, frequent resignations, and high staff turnover. The lack of financial incentives is especially problematic given the demanding nature of rehabilitation work, which involves handling emotionally and psychologically complex situations cases.

(2) Unavoidable Workplace Politics. Another issue raised was the presence of workplace politics, which may influence decisions on staffing, budgeting, and program implementation. Such dynamics often lead to delays, unequal opportunities for professional development, and, in some cases, favoritism or unresolved conflicts. These internal frictions diminish collaboration and may disrupt the efficiency of service delivery in the centers.

(3) Poorly Crafted Policies and Overlapping Agency Functions. The absence of a coherent, well-integrated policy framework has been identified as a significant administrative challenge. Respondents highlighted ambiguity in the roles and responsibilities of various agencies, including the DOH, DSWD, LGUs, PNP, and others. This leads to duplication of services, fragmented resource allocation, and inconsistent

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implementation of rehabilitation protocols. The lack of clear guidelines makes it difficult for center managers to make informed, timely decisions. These three challenges reflect a systemic problem in policy design and governance that goes beyond the rehabilitation centers' confines and points to the need for higher-level policy reform and inter-agency coordination.

For the Mid-level Challenges (42.5% – 50%): **Inadequate Training to Manage Drug Abusers (50%)-** Half of the respondents expressed concern over insufficient or irregular training opportunities. Many personnel feel under-equipped to manage complex cases involving dual diagnoses (e.g., drug use and mental illness), relapse prevention, and trauma-informed care. This gap in knowledge compromises the quality of interventions and the long-term recovery outcomes of patients. Given the evolving trends in drug use and treatment modalities, continuous professional development is critical.

Limited Background in Patient Evaluation and Understanding of Addiction (42.5%). Some administrative personnel lack the foundational knowledge required to understand addiction as a biopsychosocial disorder. This limits their capacity to support clinical decisions, allocate resources appropriately, and engage in meaningful interdisciplinary collaboration. Similarly, staff with no training in patient evaluation may find it challenging to assist in screening, intake processing, or behavioral monitoring—key components of effective rehabilitation.

Problems and Challenges in the Delivery of Services in DATRCs (Medical Staff and Administrative Personnel)

Challenges related to counselors/clinicians/health staff were mainly due to the inadequacy in number, heavy workload, and high cost of specialists. It is important to mention the Dangerous Drugs Board emphasis on a multidisciplinary approach as mandated by Republic Act 9165, also known as The Comprehensive Dangerous Drugs Act of 2002. This requires rehabilitation programs to include a team of professionals such as psychiatrists, psychologists, social workers, occupational therapists, and other related practitioners, working collaboratively with both the drug-dependent individual and their family.

Table 17
Problems and Challenges in the Delivery of Services at the DATRC (Medical Staff and Administrative Personnel)

Problems Related to Staff/Counselor/Health Staff	f	%	Rank
Heavy work responsibilities due to inadequate number or counselors/clinicians	38	95.0	1
Insufficient Employee benefits such as insurance, health hazards, and others.	37	92.5	2
Inadequate training, especially during complicated or severe cases.	30	75.0	3
Mental Health Practitioners are short in supply.	21	52.5	4
Doctors, Psychologists, counselors, clinicians are costly to hire	20	50.0	5
Retention can be challenging, as compensation falls short of matching their expertise and professional demands.	18	45.0	6
No available Plantilla positions for personnel.	17	42.5	7

Unfortunately, in DATRC 2, there is no available Plantilla for most of the personnel needed; hence, there are insufficient employee benefits such as insurance and health hazards. Retention can be challenging, as compensation falls short of matching their expertise and professional demands. These challenges may compromise the quality of care, disrupt treatment continuity, and increase the burden on the staff left to continue the rehabilitation program. Moreover, retraining new staff may add financial costs, potentially exacerbating rehabilitation resources. Skilled professionals who go to the center may have a limitation on the program's ability to implement specialized interventions and maintain adherence to best practices.

While the DATRCs demonstrated outstanding performance across core service areas, the study identified institutional issues—such as limited workforce, inadequate Plantilla positions, and overlapping inter-agency

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roles—as critical internal challenges. These do not reflect poor service quality but operational limitations affecting long-term program sustainability.

Problems and Challenges in the Delivery of Services in DATRCs (Patients)

Some patients' problems include failure to attend rehabilitation sessions regularly because of financial constraints. This is especially true for family clients because they had to provide for their families while attending the rehabilitation sessions.

Table 18
Problems and Challenges in the Delivery of Services at the DATRC (Patients)

Problems	f	%	Rank
Kakulangang pinansyal upang maipagpatuloy and rehabilitasyon (Financial constraints affect regular attendance to rehabilitation sessions.)	238	95.2	1
Kakulangang ng motibasyon na makipagtulungan sa mga medical counselors' para sa aking agarang kagalingan. (Lack of motivation to cooperate with the medical counselors for speedy rehabilitation)	229	91.2	2
Kakulangan ng suportang emosyonal mula sa pamilya. (Lack of emotional support from family).	214	85.6	3
Kawalan ng disiplina sa aking sarili na sundin ang mga sinasabi ng aking medical counselor. (Lack of discipline to follow directions of medical counselor)	208	83.2	4
Kawalan ng pag-asang ako ay gumaling (Loss of hope to get rehabilitated).	207	82.14	5

Those who were forced by the court to go to a rehabilitation program lacked the motivation to cooperate with the medical counselors for speedy rehabilitation. They also lacked the discipline to follow the medical counselor's directions. These challenges led to dropping out of the rehabilitation program.

Some lacked emotional support from family and had lost hope of getting rehabilitated. Although the clients may want to get rehabilitated, their desire was affected by these emotional setbacks.

The findings suggest providing full support from families and communities to individuals willing to undergo recovery sessions to live everyday life again. Singal (2024) states that determining a child's values and conduct entails the familial environment. Parents can establish a solid foundation for preventing drug misuse through encouraging open communication, establishing clear limits, and raising knowledge of the dangers of drugs. Likewise, the study by Bunagan et al. (2019), which examined the effect of family and community involvement in the recovery of drug abusers undergoing rehabilitation, supports the findings that respondents had shown notable improvement in family support and family life quality, along with a reduction in symptoms of drug abuse.

Their relatives also mentioned how the training had changed the respondents on an individual and family level. After completing the intervention, they expressed regret, became more responsible, and improved communication. Additionally, religious rites, family time, and the quality of family life all enhanced. There is a discussion of the implications for community-based drug treatment programs that emphasize family adjustments.

While most treatment services in the two DATRCs were rated as "Outstanding" by staff and patients, these scores reflect the effective implementation of existing protocols within the current capacities. However,

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qualitative data and administrative records revealed systemic and institutional challenges—staffing shortages, lack of Plantilla positions, inadequate support structures, and inter-agency coordination issues—requiring strategic interventions. Thus, high service performance and broader structural limitations must be addressed for long-term sustainability.

As Tickle-Degnen (1998) noted, client satisfaction ratings often reflect relational or experiential aspects of care and may not capture underlying institutional limitations. Hence, program evaluations must include both performance metrics and operational diagnostics.

2. Proposed Action Plan to Reintegrate Evolving Approaches in Government-Run DATRCs based on the Findings

Measures	Objectives	Strategies	Responsible Agency/Person	Expected Outcome/s
Organizing a support group for families.	Enhance Family Counseling and support.	Existing DATRCs may put up family support groups and peer mentoring programs. Implement family therapy programs	Drug Abuse Treatment and Rehabilitation Centers	Family counseling as a critical approach in drug rehabilitation would be strengthened. Improved evaluation of family counseling and support from very satisfactory to outstanding.
Lobbying additional Plantilla positions at drug rehabilitation centers.	Adress inadequate number of medical staff and administrative rehabilitation centers.	The DOH (Central Office) may request additional funding for human resources in drug rehabilitation centers.	Department of Health	Lower turnover of employees leading to higher patient quality management, stability, and less costly operations.
Orienting the whole family about the rehabilitation program for their loved ones and soliciting full support from them.	Encourage patients/clients to attend the prescribed rehabilitation program to achieve recovery /rehabilitation in the targeted time.	The family members of the client/patient may be requested for a meeting to discuss the rehabilitation program that their loved one needs to complete to achieve full recovery. Relatives may be asked to support Clients /patients who need to work for their families so they will not miss any rehabilitation session. The LGUs may also provide financial support or grocery items/rice for clients while on treatment.	Family of Patients/Clients Relatives of Patients/Clients Local Government Units	Attendance to all rehabilitation sessions becomes regular for all clients/patients because of family support. Recovery from Drug addiction will be achieved because of regular attendance to rehabilitation programs. Community gains from decreased drug dependents.

The proposed action plan is based on the findings of the evaluation of the Drug Abuse Treatment and Rehabilitation Center services and the problems and challenges identified in implementing the drug rehabilitation program.

Proposed Action plan

Measures	Objectives	Strategies	Responsible Agency/Person	Expected Outcome/s
Lobbying funds for the establishments of community-based rehabilitation centers (CBDRC) from the national government, LGUs, and NGOs.	Gradually establish community centers Offering Drug Rehabilitation Programs.	The DOH may start to work with policymakers (upper and lower chamber to include budget for at least one CBDRC per municipality per year.	Department of Health	Community-based rehabilitation centers (CBDRC) are available in communities aside from the availability in the province. More centers are available to accommodate drug abusers seeking rehabilitation.
Establishing at least one community per municipality per year and increasing centers in the next year until more CBDRCs are completed.		LGUs may allocate a portion of their budget to support the establishment of CBDRCs in their respective barangays. Securing public and media support. The DOH may conduct public awareness campaigns and dialogues to educate communities on the importance of CBDRC.	Local Government Units	
			Department of Health	The public is made aware of the mandate of the government to establish community-based drug rehabilitation Center (CBDRC). Improved evaluation for CBDRC from fair to satisfactory.

Measures	Objectives	Strategies	Responsible Agency/Person	Expected Outcome/s
Communicating to the DOH and other agencies the actual status of the rehabilitation centers and submitting reports regularly.	Attain consistency in policy implementation from the administration (DOH) and support provision.	The Heads of the rehabilitation centers regularly provide the DOH progress reports and challenges in the rehabilitation. Seeking linkages from non-government organizations whose mission aligns with the rehabilitation centers. Heads of agencies may initiate formal partnerships by reaching out through networking events, proposal letters, and collaboration meetings. The heads may highlight shared goals, patient needs, and potential joint programs (skills training, counseling, or aftercare support). Transparent communication, regular reporting, and accountability will most likely strengthen partnerships for long-term sustainability. Rehabilitation centers gain stability in policy implementation.	Drug Abuse Treatment and Rehabilitation Centers	Gaps in services and resources in the rehabilitation centers will be narrowed.

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One of the challenges that emerged from the responses of the medical staff and administrative personnel is the lack of community centers offering drug rehabilitation programs in some provinces. To address this, the DOH may collaborate with policymakers (both upper and lower chambers) to include a budget for at least one CBDRC per municipality each year. In addition to the national government's funding, respective LGUs could allocate a portion of their budget to support the establishment of CBDRCs in their barangays.

Additionally, establishing at least one community per municipality per year and increasing centers in the next year until more CBDRCs are completed could help expand services at the grassroots levels. The LGUs may allocate a portion of their budget to support the establishment of CBDRCs in their respective barangays. Public and media support may be secured through social media. The DOH may conduct public awareness campaigns and dialogues to educate communities on the importance of CBDRC. By letting the public know about the existence of CBDRC, more government and non-government groups and private individuals may be motivated to support the program implementation.

The presence of Community-Based Drug Rehabilitation Centers (CBDRC) would lead to more facilities that will accommodate drug abusers who are willing to undergo rehabilitation and live everyday life again. In addition, the public would benefit from the government's directive to establish a community-based drug rehabilitation Center (CBDRC).

The ultimate goal of establishing CBDRC is to improve the evaluation of its implementation from fair (based on the present study) to satisfactory. Improved CBDRC services would encourage more clients to seek help with their drug dependency.

Another challenge in implementing the drug rehabilitation program is the lack of family counseling and support. The existing DATRCs may establish family support groups and peer mentoring programs. This would strengthen family counseling as a critical approach in drug rehabilitation.

To address the inadequate number of medical staff and administrative rehabilitation centers, the DOH (Central Office) may request additional funding for human resources in drug rehabilitation centers. This will prevent high employee turnover, leading to higher patient quality management, stability, and less costly operations.

Encouraging patients/clients to attend the prescribed rehabilitation program to achieve recovery in the targeted time may be heightened by orienting the whole family about the rehabilitation program for their loved ones and soliciting full support from them. Attendance to all rehabilitation sessions is possible for the clients/patients because of family support. In effect, recovery from drug addiction will be achieved because of regular attendance of clients/patients to rehabilitation programs. Community gains from decreased drug dependents.

Moreover, lobbying additional Plantilla positions at drug rehabilitation centers will substantially contribute to the effectiveness of the drug rehabilitation table's services. The more stable the employees' status, the more motivated they will be to treat their clients/ patients. The result will be improved service continuity, increased morale, and high patient satisfaction. Regular employees receive better training, benefits, and motivation, fostering a more stable and committed workforce. This leads to a more effective rehabilitation process and better long-term outcomes for recovering individuals.

Another action plan to improve the drug rehabilitation program is to orient the whole family about the rehabilitation program for their loved ones and solicit full support from them. Involving the entire family in the treatment will help the clients/patients stay in the rehabilitation and complete the treatment plan designed for them.

Communicating to the DOH and other agencies the actual status of the rehabilitation centers and submitting reports regularly will ensure a coordinated effort and unified approach among all concerned government agencies (e.g., PNP, DSWD, LGU, DOH, and others). Effective communication will result in effective collaboration, resource optimization, and role clarity to prevent duplication and overlapping of roles.

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To attain consistency in policy implementation from the administration (DOH) and support the provision of proper reporting to the DOH and other agencies regarding the actual status of the rehabilitation centers and submitting reports regularly and strengthen inter-agency task force that clearly defines the roles and responsibilities of each agency. There is a need to ensure a coordinated effort and unified approach among all concerned government agencies (e.g., PNP, DSWD, LGU, DOH, and others) to ensure effective collaboration, resource optimization, and role clarity to prevent duplication and overlapping of roles.

3. Implications of the Study to Public Administration

The findings of the study revealed that drug rehabilitation centers in Region III strive to meet the expectations set by the DOH and DDB in performing their role of assisting and guiding drug abusers toward recovery. This was possible because of structured treatment programs and ensuring quality care for individuals -treating them as humanely as possible.

However, both the medical and administrative staff encounter persistent challenges, including a lack of support for employee benefits, inadequate staffing, and high turnover rates. There is also an absence of regularization, leading to low morale, burnout, and frequent resignations. Should these challenges be addressed, stability of care is achieved, and patient rehabilitation becomes more effective.

In addition, the study respondents felt that there is a tendency to duplicate services from other government agencies. This led to ineffective resource utilization and, at times, confusion among the stakeholders.

The patients' challenges were more related to irregular attendance at scheduled therapy sessions. Some needed to work to provide for their families, others lacked the allowance to visit the center because they lived far away, and few were forced to undergo rehabilitation, so they were not fully abiding by the rehabilitation protocols.

These challenges need to be addressed to ensure the effective implementation and long-term success of the government's national drug rehabilitation program. Without strategic interventions to improve employee welfare, stabilize workforce retention, and provide regular items, the sustainability and overall impact of the rehabilitation initiatives may be compromised.

Strengthening the support mechanisms for rehabilitation personnel is critical to maintaining program effectiveness and efficiency, service continuity, and the achievement of national objectives to fight drug abuse in the country.

The study findings highlight significant implications to public administration, particularly in policy formulation, resource allocation, and governance among drug rehabilitation centers. Regarding policy formulation and workforce stability, the absence of regularization for the rehabilitation center employees leads to job insecurity, low morale, and frequent resignations. Public administration must implement policies that promote job stability through the provision of permanent positions, competitive salaries, and comprehensive benefits. These employment policies will enhance staff retention and ensure continuity of care for rehabilitation patients.

On resource allocation and budget enhancement, public administration should prioritize allocating sufficient financial support to rehabilitation centers to hire and retain qualified personnel, improve facilities, and expand treatment.

On program effectiveness and service delivery, the effectiveness of rehabilitation programs depends on a well-supported workforce. An interagency task force of interagency needs to be stable and motivated to enhance the quality of care provided to drug dependents, improving their chances of recovery. Therefore, integrating administrative reforms supports personnel well-being and directly impacts public health outcomes.

Stronger coordination between public health agencies, social welfare institutions, and local government units can help address the challenges being faced by rehabilitation centers. Implementing standard policies, regular

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performance evaluations, and continuous professional development programs would improve the quality of services delivered.

Addressing the administrative concerns, the government will strengthen the country's rehabilitation system, ensuring that drug dependents receive ample support for reintegration into society.

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

This chapter summarizes the findings, conclusions, and recommendations for evaluating the drug rehabilitation centers of Region III.

Summary of Findings

1. In terms of Screening and Assessment of Persons Who Use Drugs (PWUDs), DATRCs were evaluated to have rendered outstanding screening and assessment services as attested by grand means of 4.76 and 4.82, respectively, for Bataan and Tarlac DATRC. However, the community-based drug rehabilitation program (CBDRP) was 2.07 (fair) from the medical and administrative staff and 1.96 (fair) from the patients in DATRC 2 while non-existent in DATRC 1.
2. For Drug Dependency Examination, the grand mean scores from the medical and administrative (Bataan-4.72, Tarlac-4.87) and patients (Bataan-4.87, Tarlac-4.91) are confirmations that drug dependency examinations in both DATRCs were efficient and well executed. Both DATRCs demonstrate a strong commitment to assessing patients' extent of drug dependence, confidentiality, and the proposed suitable interventions.
3. As to the Matrix Intensive Outpatient Program, the grand mean for the medical and administrative personnel (Bataan-4.78; Tarlac-4.85) and patients (Bataan-4.88; Tarlac-4.89) indicate that the execution of MIOP in both DATRCs is outstanding.
4. For the Individual Counseling service, the mean scores in Bataan and Tarlac DATRC were outstanding across all indicators for both medical and administrative staff and patients. The grand means for medical and administrative staff were 4.80 and 4.85 respectively for DATRC 1 and 2 and 4.88 and 4.89 respectively for patients. However, continuous family involvement and crisis intervention improvement could further enhance patient support and recovery results.
5. As to the Family Counseling and Support service, the grand mean scores for both Bataan (Medical and administrative personnel- 4.13; patients- 4.11) and Tarlac (medical and administrative personnel -41.14; patients- 4.16) DATRC reflected a consistent level of satisfaction among the respondents. Although minor differences exist, the mean scores are still within the "very satisfactory" level of satisfaction.
6. In terms of Psychological Testing and Services, the grand mean scores for Medical, administrative, and Patient personnel across the DATRCs indicate an overall high level of satisfaction with the psychological testing and services provided by the center.
7. For Psychiatric Services, the grand mean for DATRC 1 (medical and administrative personnel -4.10, patients -4.49) is lower than that for DATRC 2 (medical and administrative personnel -4.70, patients -4.82). This suggests that Bataan DATRC needs to improve its psychiatric services.
8. Along Spiritual Enhancement, findings showed that in DATRC 1, both sets of respondents gave mean score ratings ranging from 3.97 to 4.19 of 4.07 and 4.15, respectively, for medical and administrative personnel and patients. These mean scores have the verbal equivalence of "very satisfactory." Conversely, respondents from DATRC 2 gave higher mean scores ranging from 4.50 to 4.77 and 4.65 to 4.79, respectively, for medical and administrative personnel and patients, indicating an "outstanding" assessment for spiritual enhancement services at Tarlac DATRC.
9. Recreational Program services for both DATRCs generated mean scores equivalent to outstanding from the responses of both the medical and administrative personnel and patients indicating positive results. A notable trend was the higher mean scores from the respondents coming from the DATRC 2 (all mean scores have verbal equivalence of "outstanding") than those from DATRC 1 (all mean scores have verbal equivalence of "very satisfactory"). The highest mean score among all the indicators was 4.87, on the development of discipline necessary to improve skills and the emphasis directed on gaining respect for good physical health and respect for others.

10. In terms of Skills and Recovery, The highest mean scores were notable in the centers' provision of linkages so patients can apply and maximize their skills in both DATRC 1 (medical and administrative personnel-3.96; patients-4.92) and DATRC 2 (medical and administrative personnel-3.69; patients-3.66).
11. Best practices in drug treatment and rehabilitation among the DATRCs as perceived by the medical personnel and administrative staff included setting is ideal and safe, promoting emotional and mental well-being; treatment tailored on individual patient needs; consideration of the cultural, educational, social, and religious background of the patients in developing; treatment modalities; innovative activities and services at the center; available linkages for a more holistic approach; management of patients was multi-disciplinary and evidence-based. DATRCs had available technology to facilitate communication, medical recording, treatment, and monitoring; compassionate, dedicated, and non-judgmental personnel; and good – conduct of regular home visitation.
12. Problems and challenges in the implementation of rehabilitation centers included the limited financial capacity of patients to continue and sustain the treatment, limited means of transportation in attending the treatment sessions, and the remote location of patients' residences hindering accessibility to treatment. Other difficulties were severe impairment of the patient, limited access to education and mental health awareness, and the patient's self-destructiveness or inconsistency in following prescribed treatment. Challenges related to treatment delivery identified the therapy duration as lengthy and involved numerous sessions as prescribed by law. Other challenges encountered were some patients who hardly understood protocol sessions. There were also problems with the lack of facilities and medicines for treatment. In terms of challenges related to the Department of Health, the central agency being mandated to oversee the establishment and implementation of the drug rehabilitation centers, the respondents claimed to receive inadequate support for the treatment of drug abusers and ineffective policies on salaries and compensation for staff. Patient problems identified included failure to attend rehabilitation sessions because of financial constraints regularly. This is especially true for family clients because they had to provide for their families while attending the rehabilitation sessions. Those who were forced by the court to go to a rehabilitation program lacked the motivation to cooperate with the medical counselors for speedy rehabilitation. They also lacked the discipline to follow the directions of a medical counselor. These challenges led to dropping out of the rehabilitation program. Some lacked emotional support from family and had lost hope of getting rehabilitated. Although the clients may want to get rehabilitated, their desire was affected by these emotional setbacks.

Conclusions

1. This study set out to evaluate the quality and effectiveness of service delivery in DOH-accredited Drug Abuse Treatment and Rehabilitation Centers (DATRCs) in Region III, guided by ten essential service domains: screening and assessment, drug dependency examination, Matrix Intensive Outpatient Program, individual counseling, family counseling and support, psychological testing and services, psychiatric services, spiritual enhancement, recreational programs, and skills and recovery. The overall results show that DATRCs have achieved very satisfactory to outstanding service levels across these areas, indicating a high degree of adherence to DOH rehabilitation standards and strong delivery of structured, client-focused interventions. Screening and Assessment of Persons Who Use Drugs (PWUDs) have rendered outstanding services, but community-based drug rehabilitation programs (CBDRP) were fair. Drug rehabilitation centers have effective screening and assessment and would be more effectively delivered by improving community programs. Although the evaluation focused on services directly implemented within the DATRCs, the absence of robust community-based screening and rehabilitation pathways contributed to several institutional challenges, such as heavy patient volume, limited MOOE, and staffing issues. These findings support the need to invest in and expand CBS's reach as part of a systemwide improvement strategy. The inclusion of community-based screening allowed the study to identify weak points in the early intervention pipeline. Strengthening barangay-level services will improve early detection, reduce the burden on tertiary facilities, and promote continuity of care.
2. The Drug Dependency Examination was highly effective and well executed. The rehabilitation centers demonstrate a strong commitment to assessing patients' extent of drug dependence, confidentiality, and the proposed suitable interventions.

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3. Matrix Intensive Outpatient Program was delivered well. Treatment for drug dependents was appropriate. The high satisfaction levels among patients and service providers suggest that MIOP is effectively implemented, integrating therapeutic routines, relapse prevention techniques, and follow-up mechanisms supporting client autonomy and sustained recovery.
4. Individual Counseling was outstanding across all indicators. However, continuous improvement in engaging family involvement and crisis intervention could further enhance patient support and recovery results.
5. Family Counseling and Support received a consistent, very satisfactory level of implementation in both DATRCs, indicating success in engaging the family in the recovery journey of the drug dependents.
6. Psychological Testing/Services indicated an overall high level of satisfaction with the psychological testing/services provided by the center. It further suggests that the DATRCs employ licensed psychometricians and psychologists who administer, interpret, and utilize test results in a timely and clinically meaningful way. Drug dependents availed of mental health services that will help them heal mental issues.
7. Psychiatric Services were outstanding, but one DATRC needs improvement to ensure the complete delivery of psychiatric services. This suggests the need for strengthened collaboration with mental health institutions and improved internal protocols for psychiatric care delivery, especially in more resource-constrained DATRCs.
8. Spiritual Enhancement programs were very satisfactory, and this indicates that DATRCs ensured avenues where the drug dependents could increase their commitment to complete the rehabilitation.
9. Recreational Programs were very satisfactory, indicating that there remain some implementation gaps for the clients/patients' holistic rehabilitation.
10. Skills and Recovery services were very satisfactory in its level of implementation, indicating that the drug dependents neeed to acquire more competencies to help them become functional in society.
11. The Medical Staff and Administrative Personnel carried out some best practices that helped with the effective delivery of drug rehabilitation services. The study highlighted innovative practices and regular home visits.
12. Problem and challenges in implementing rehabilitation centers contributed to obstacles requiring solutions for better rehabilitation delivery. Despite the high evaluation ratings, the findings reveal that positive performance indicators do not equate to an absence of institutional or programmatic challenges. Areas such as family involvement, individualized psychological diagnostics, psychiatric referrals, and post-treatment reintegration remain areas for improvement. These gaps point to the need for a more holistic and integrated approach that extends beyond the internal service structure of the DATRCs and considers the broader socio-emotional and institutional support systems surrounding the patient. Patient-related concerns such as financial constraints, limited family support, low motivation, and emotional instability were identified as barriers to sustained engagement in the rehabilitation process. While services are being delivered at a high standard, these external factors significantly affect treatment outcomes and highlight the need for wraparound services, financial support mechanisms, and community-based psychosocial interventions. Medical and administrative personnel reported organizational and staffing issues, including inadequate Plantilla positions, high workload, lack of employee benefits, and low retention, as barriers to long-term program sustainability. Although the current staff implement services effectively, the long-term capacity of DATRCs to maintain quality depends on sufficient human resource support, fair compensation, and stable employment policies. If let unaddressed, these workforce issues may eventually compromise the continuity and quality of service delivery. Inter-agency coordination challenges were also evident, particularly in the overlapping functions of government agencies involved in drug rehabilitation. This lack of role clarity leads to fragmented implementation, inefficient resource use, and limited policy coherence. Stronger coordination mechanisms, clearer guidelines, and a unified inter-agency framework are needed to harmonize services and avoid duplication of efforts. The study highlighted the absence or weak implementation of community-based drug rehabilitation programs (CBDRCs), particularly at the levels of the barangay and rural health unit. While these are not services delivered directly by DATRCs, their absence has downstream effects on center congestion, delayed referrals, and limited early intervention. Including this dimension in the analysis reinforces the idea that drug rehabilitation should be decentralized and community-anchored, allowing for a more accessible preventive framework.

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13. The study concludes that while the DATRCs in Region III are performing commendably in delivering mandated rehabilitation services, long-term success requires aligning service quality with institutional reforms, policy integration, family engagement, and community support. The government needs to address patient problems, including regular failure to attend rehabilitation sessions because of financial constraints.The results support the development of an action plan that bridges service-level delivery with structural enhancements, ensuring sustainability and improved recovery outcomes for drug users.

Recommendations

1. The study found poor evaluation of community-based rehabilitation programs. Since this is provided by law, the DATRCs may advocate stronger legislative support to establish and sustain community-based rehabilitation centers. Rural health units may secure government funding from local government units (LGUs) and non-government organizations (NGOs).
2. The Department of Health, in coordination with LGUs and NGOs, may prioritize the establishment of Community-Based Drug Rehabilitation Centers (CBDRP) and implement regular community screening mechanisms. This decentralization of services would address structural barriers to access, reduce load at tertiary facilities, and promote early intervention for persons who use drugs (PWUDs).
3. The two DATRCs may strengthen rehabilitation approaches, particularly the implementation of spiritual enhancement, recreational programs, and skills development, through the integration of structured activities, trained facilitators, and measurable outcomes.
4. The DATRCs may also tap the assistance of religious groups willing to visit the center to enhance spiritual activities within the allowable bunds. In addition, the centers may offer more recreational opportunities for the patients.
5. Family and community involvement is regarded as crucial in rehabilitating drug users, but it was also found to need improvement. The DATRCs may develop programs that involve the active participation of families and communities in the rehabilitation process. They may offer sports festivals, designate an arts day, or provide any other creative activities.
6. The DATRCs may also ensure that patients gain access to multidisciplinary support, including mental health professionals, social workers, and vocational training experts, as these professionals have the potential to provide a more comprehensive rehabilitation program with positive outcomes.
7. DATRCs' outstanding performance in delivering core services may not overshadow the need for program innovations and systemic reforms. The findings emphasize moving from mere protocol compliance to continuous quality improvement. Integrating feedback systems, professional development, and patient-centered care practices will strengthen service responsiveness and outcomes.
8. An equally important recommendation is that medical personnel and administrative staff continue attending training and development to keep track of emerging trends and best practices in drug rehabilitation. This will facilitate continued high-quality service delivery and high patient satisfaction.
9. Research and evaluation could be valuable for enhanced rehabilitation program delivery. These may include regular evaluation and updating of rehabilitation strategies based on evidence-based practices to ensure interventions remain effective and appropriate to patients' needs.
10. The two DATRCs may sustain their best practices to effectively fulfill their role in drug recovery. They can do this by establishing stronger linkages with health care providers, the Police National Police (PNP), DSWD, educational institutions, employment agencies, and other important government and non-government agencies to facilitate reintegration and post-rehabilitation support for recovering individuals.
11. A strategic and multi-sectoral approach may address the challenges encountered in implementing drug rehabilitation centers. This includes improving employee welfare and retention policies, streamlining inter-agency coordination, and implementing patient-centered support mechanisms. Strengthening these areas will contribute to a more sustainable and impactful drug rehabilitation system in the country.
12. Patient obstacles to attending regular rehabilitation due to financial constraints may be addressed by asking the LGUs for support in terms of transport provision and food allowance.
13. Private- public partnership (PPP) framework may be established to support drug rehabilitation programs of the government. Private sectors may support policies and perform regulatory oversight and funding.
14. All concerned agencies may adopt the action plan developed in this study to address issues related to implementing drug rehabilitation centers in the country.

15. A follow-up study may focus on the gaps in implementing the drug rehabilitation centers identified in the present study.

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