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Community-Based Drug Rehabilitation Clients' Motivation, Satisfaction and the Factors Affecting their Completion of the Rehabilitation and Aftercare Program: A Convergent Mixed Methods Study

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Abstract

This study examined treatment motivation, clientele satisfaction, and the factors affecting enrollment and completion in community-based drug rehabilitation and aftercare programs in the Philippines. A convergent mixed methods research design was employed using a survey and qualitative focus group discussions. Both on-going and completed clients had high level of internal motivation towards treatment and were highly satisfied with the program. Clients reported internal and external factors influenced their completion of the rehabilitation program while their satisfaction determined the areas that require necessary improvements. Aside from internal and external motivation, the general structure of the program, competence of facilitators, government and community support, and complementary intervention serve as influential factors.

Keywords: clientele satisfaction, community-based interventions, drug recovery, drug rehabilitation, family support, treatment motivation

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Introduction

The United Nations Office of Drugs and Crime (UNODC) (2014) describes illicit drug use as a complex health problem that has social, psychological, and biological dimensions. Instead of addressing illicit drug use from a purely criminal justice perspective, UNODC (2014) advocates the use of a holistic perspective, treating it as a health problem, and employing community-based treatment programs as an alternative to incarceration when possible. This shift came from compelling evidence of its economic, medical, community, and ethical benefits (Merzel & D'Afflitti, 2003). Several studies have shown that those who underwent community-based treatment had lower relapse and recidivism rates, and had higher motivation from admission to discharge, compared to those who underwent inpatient treatment (Tabor, 2019).

Community-Based Drug Rehabilitation (CBDR) is an integrated model for helping persons who use drugs (PWUDs) with low to mild use severity. The model includes screening, treatment, recovery and family support, aftercare, and reintegration. Another goal of CBDR is to promote social integration and increase the accessibility of rehabilitation programs in the community (UNODC, 2014).

However, one challenge of community-based treatment is completion. In a study, community-based programs had a completion rate of 45% with court-ordered offenders 10 times more likely to complete treatment compared to voluntary clients (Coviello et al., 2013). For substances, such as heroin where there is pharmacological treatment, the addition of pharmacotherapy appears to make a difference. A study on heroin users enrolled in community-based program reports a 24% completion rate but the cohort offered Naltrexone in addition to the treatment as usual had a completion rate of 76% (Chan, 1996).

Beyond the nature of treatment, an important factor in determining enrollment, completion, and success of any drug rehabilitation is the client's motivation (De Leon et al., 2000). The Transtheoretical Model of Change (Prochaska & DiClemente, 1982) suggests that the cessation of unhealthy behaviors to the adoption of healthy behaviors involves five stages (precontemplation, contemplation, preparation, action, maintenance). Pre-Contemplation is the stage where a person is unmotivated to change unhealthy behavior. Those in the contemplation stage recognize there is a problem but are ambivalent. The preparation stage is where individuals are motivated to change behaviors and begin the steps to change them. The action stage is one where individuals begin to practice successful behavior changes. The maintenance phase is the continuance of new behaviors and prevention of relapse (Prochaska & DiClemente, 1982).

This body of literature suggests the important role played by motivation in determining and predicting success of drug rehabilitation programs. Motivation has been found to predict entry into treatment programs (De Leon et al., 2000) and motivation enhancing rehabilitation procedures also increase retention in the program (De Leon et al., 2000; Dees et al., 1997)

Beyond motivation, another important factor in determining the success of a drug rehabilitation is client satisfaction. Treatment satisfaction and treatment motivation has been found to be significantly associated with treatment progress and success (Yang et al., 2019). In addition, studies have found that satisfaction with the access and effectiveness to rehabilitation services is significantly associated to abstinence from substance use (Carlson & Gabriel, 2001).

Much of the literature on motivation and client satisfaction comes from developed economies and there is a dearth of literature from non-Western and low- and middle-income countries. This study seeks to fill this gap by examining client motivation and satisfaction among Filipino community-based drug rehabilitation clients.

Community-Based Drug Rehabilitation in the Philippines

In the Philippines, the widespread implementation of CBDR began in 2016 as an offshoot of the government's "war on drugs." Aggressive case finding by law enforcement led to over 1.3M surrenderees, the majority of whom were low and moderate risk and could be treated in communities (Hechanova et al., 2023). However, the drug rehabilitation landscape in the Philippines has been described as a forced treatment rather than voluntary (Lasco & Yarcia, 2022).

Nevertheless, some benefits have been reported. Studies on the impact of community-based drug rehabilitation have reported improved well-being, social and financial protection for the clients, access to services, and an overall decrease in drug use and occurrence of crimes in the community (Hechanova et al, 2023). Similarly, another study noted healthier family relationships among clients who completed CBDR in Lingayen and Mountain Province, Philippines (Kiblasan et al., 2020). However, there were many challenges reported by local government units including the lack of resources, tools, and capacities to deliver CBDR. These led to delays in service provision, over-prescription of treatment, low uptake, and stigma and discrimination (Hechanova et al., 2023).

This present study aims to add to the literature by exploring the client motivation and satisfaction level towards community-based drug rehabilitation program and unravel the factors that influence enrollment and completion of aftercare program. This study aims to address the gap our understanding of how motivation and satisfaction levels influence enrollment and completion in the aftercare program using a mixed methods research design.

Research Objectives

The main goal of this research is to determine the motivation, satisfaction, and the factors that influence entry and retention in CBDR. Specifically, we ask:

1. What are the motivations of clients in participating in the CBDR?
2. What is the level of satisfaction of CBDR clients from screening to aftercare?
3. What are the factors that influence enrollment, completion in CBDR and aftercare?
4. What are the areas in CBDR that clients believe needs to be improved?

Methodology

Research Design

The research utilized a convergent mixed methods research design. A convergent mixed methods research design aims to obtain different but complementary data on the same topic to best understand the research problem (Creswell & Plano, 2017). Particularly, the study utilized the parallel-databases variant where two parallel strands of data are collected and analyzed independently and are only brought together during interpretation. The quantitative component determined the motivation of clients availing the CBDR program and their level of satisfaction. The qualitative component explored the factors that influence client's enrollment, completion of the aftercare program. The general procedures of the research are summarized graphically in Figure 1.

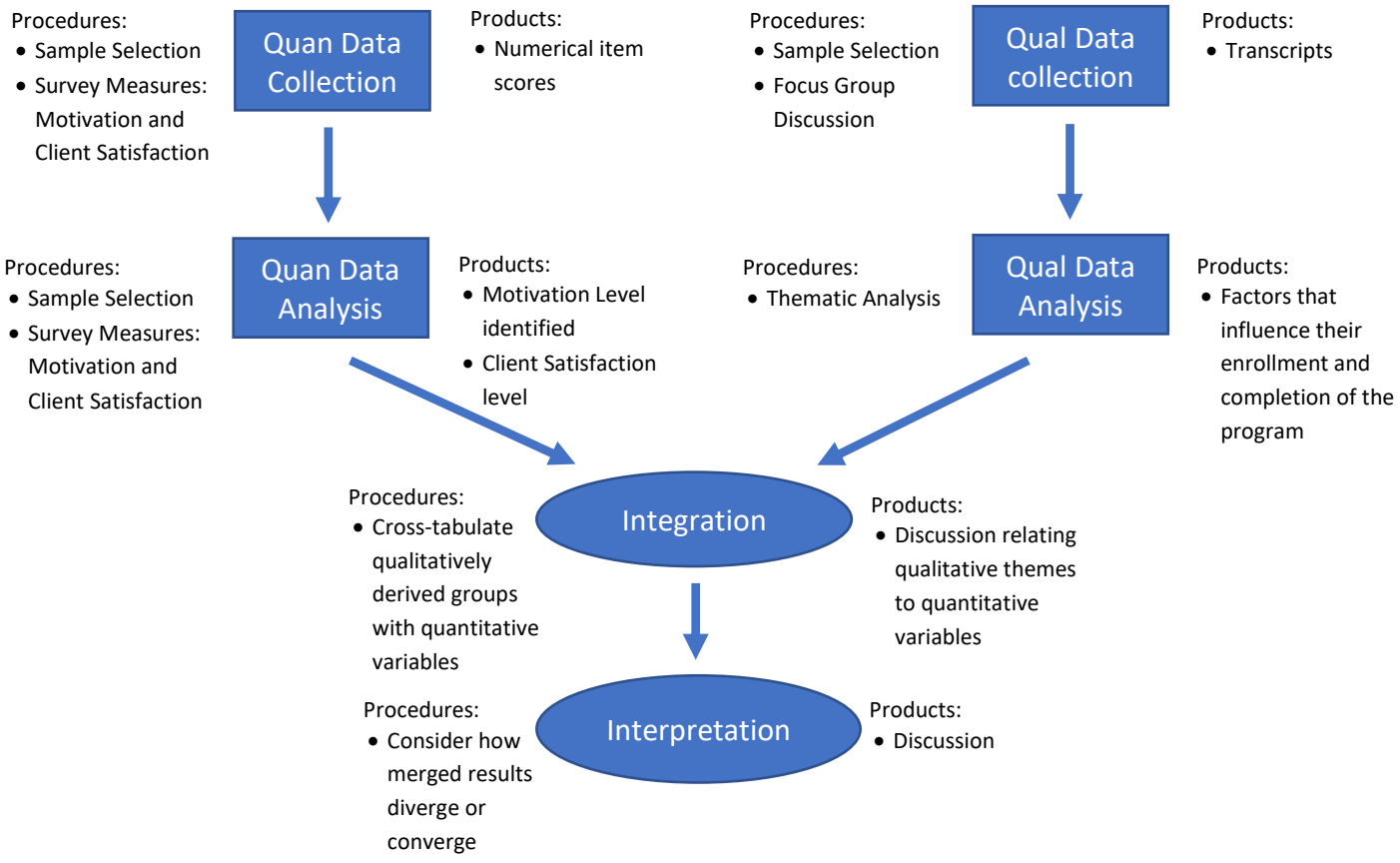

Figure 1. Schematic diagram showing the flow of the study

Context

This study was conducted in the City Government of Cagayan de Oro, a highly urbanized city in Mindanao, Philippines. In 2016, there were 7,020 surrendering drug users in the city. As of 2021, 39% of clients (=2,727) PWUDs have been screened. Of those who have been screened, 58% (n=1,586) enrolled in the CBDRP and of those enrolled 72% (n=1,137) have completed the program. Among completers of CBDRP, 76% (n=860) were endorsed to the Aftercare Program although only half (n=429) completed the aftercare.

Participants

The quantitative component utilized a complete enumeration sampling due to the limited number of potential participants. The respondents for this component are the clients who are ongoing clients and those completed the CBDR regardless of if they availed of the aftercare program or not. The second phase utilized a purposive sampling technique. The respondents were selected based on the following criteria: a) clients who have completed the aftercare program not more than 3 months; b) clients who have enrolled in the aftercare program but was not able to complete it; c) clients who did not enroll in the aftercare program after finishing the CBDR in not more than 3 months; or d) Clients who either did not proceed to treatment after screening or who dropped during treatment. Their demographics are summarized in Table 1.

Table 1: Sociodemographic and Clinical Characteristics of Clients (n = 60)

	Frequency	Percent		Frequency	Percent
Sex			Age of onset		
Male	49	81.66	10-17 years old	11	18.33
Female	11	18.33	18-25 years old	29	48.33
Marital Status			26-33 years old	12	29.00
Single	27	45.00	34-41 years old	6	10.00
Married	20	33.33	42-49 years old	1	1.67
Separated	1	1.67	50-57 years old	1	1.67
Widowed	2	3.33	Past Frequency of Drug Use		
Occupation			Daily	6	10.00
Factory Worker	4	6.67	Twice a week	3	5.00
Government worker	1	1.67	Weekly	8	13.33
Barber	1	1.67	Once a month	4	6.67
Construction Worker	10	16.67	Twice a month	3	5.00
Driver	12	20.00	Thrice a month	2	3.33
Fish Vendor	4	6.67	Occasional	8	13.33
Laborer	9	15.00	Primary Reason for use		
Janitor	5	8.33	Peer-pressure/influence	41	68.33
Marketing	1	1.67	Work/Work-related stress	4	6.67
Waiter	1	1.67	Personal/family problem	4	6.67
Unemployed	12	20	Screening Result		
Completion of CBDR			Low-risk	6	10.00
Completed	29	48.33	Moderate-Risk	48	80.00
On-going	31	51.67	High-Risk	1	1.67
Vices other than meth/THC			Programs Attended		

Alcohol	31	51.67	General Intervention for Health and Well-Being Awareness (GINHAWA)	5	8.33
Cigarette	30	50.00			
Gambling	7	11.67			
Others:			*Preventive Education and Self-Help*	9	15.00
Computer games	3	5.00	*Counselling*	9	15.00
Aromatic solvents/adhesives	1	1.67	*Community-Based Drug Rehabilitation Program*	48	80.00

Research Instruments

Motivation. The motivation to join the CBDR was evaluated using the Treatment Motivation Questionnaire (TMQ) (Ryan et al., 1995). The instrument was utilized to examine the participant's reasons for entering a treatment program and their feelings about treatment. Using a 7-point scale, the TMQ assesses both the internal and external motivation for treatment as well as the confidence in the treatment. Content validation index (CVI) was also calculated for the revised questionnaire based on the methods mentioned above and yielded a CVI of 0.86 for 7 experts. The instrument was translated and back-translated to the first language of the respondents and yielded an Cronbach alpha of 0.76.

Level of Satisfaction. The satisfaction of the CBDR services provided was assessed using the Verona Services Satisfaction Scale (VSSS) (Ruggeri et al., 2007) but modified to fit the objectives of the study. The instrument consists of 54 items covering seven dimensions: overall satisfaction, professionals' skills and behavior, information, access, efficacy, types of intervention, and relative's involvement. Sociologists and experts in drug rehabilitation were also invited to validate the instruments based on face and content validity. Content validation index (CVI) was also calculated for the revised questionnaire based on the methods mentioned above and yielded a CVI of 0.82 for 7 experts. The instrument was translated and back-translated to the first language of the respondents and yielded a Cronbach alpha of 0.97.

Focus Group Discussion. The Focus Group Discussion aimed to ascertain the factors that influence the aftercare enrollment, completion of CBDR graduates.

For those who enrolled in the aftercare program

1. How do you evaluate your CBDR experience?
    a. Please describe your experiences further
    b. Would you say that you have a positive or negative experience with CBDR?

c. Can you tell us more about that experience?

2. What do you think are the factors that encouraged you to enroll in the aftercare program?

    a. Aside from those you mentioned, what else have you experienced?

3. Do you think that your CBDR experience had an effect on your decision to enroll in CBDR?

    a. Why do you think that this experience influenced your decision to enroll?

4. What were the significant experience you had in CBDR that contributed significantly in your decision?

    a. Please describe your experiences further

5. What did you expect to gain or experience from the aftercare program before joining?

    a. Did you gain or experience what you expected? Why or why not?

    b. How can this be improved?

    c. Did this affect your decision to complete or not complete the program?

6. Overall, do you find the aftercare program an essential component in your rehabilitation? (for completed)

    a. Can you cite some examples of how important it was in your rehabilitation?

For those who did not enroll in the aftercare program

1. How do you evaluate your CBDR experience?

    a. Please describe your experiences further

    b. Would you say that you have a positive or negative experience with CBDR?

    c. Can you tell us more about that experience?

2. Do you think that your CBDR experience had an effect on your decision not to enroll CBDR?

    a. Why do you think that this experience influenced your decision to enroll?

3. What do you think are the factors that discouraged you from enrolling in the aftercare program? Can you describe them?
    a. Aside from those you mentioned, what else have you experienced?
4. If you can change one thing in your CBDR experience to hopefully motivate you to enroll in the aftercare program, what would it be?
    a. Aside from those you mentioned, what else would you like to change?

Procedures

Procedures were compliant on the University of Science and Technology of Southern Philippines Research Ethics Review Committee Manual of Standard Operating Procedures. Informed consent was obtained from participants. Coding was utilized to ensure anonymity and confidentiality.

Data Analysis

The quantitative component of the research was reported using descriptive statistics. Independent t-test was conducted to compare the motivation of completers and on-going CBDR clients. The qualitative data was recorded and transcribed verbatim. The transcripts were first read as a whole to identify initial codes. The transcripts were then analyzed using the initial codes. The codes were then sorted out into potential themes to identify trends and patterns in the data. Some themes can be converted into subthemes. The themes were then compared and reviewed against the literature and were revised as needed.

Results

Treatment Motivation

This study examined based on their internal and external motivation, their interpersonal help-seeking motivation, and their confidence in treatment (as shown in Table 2). Results reveal that clients currently engaged in CBDR reported the highest motivation in interpersonal help-

seeking factor or the motivation to share problems and relate to others during the treatment course. Meanwhile, CBDR completers had highest in the internal motivation factor, which reflects both a personal commitment to change and a desire to change based on guilt and anxiety concerning one's addiction. In the present study, external motivation, which refers to clients' perceived lack of choice in seeking treatment and the experience of external pressure to remain in treatment, had the lowest score for both on-going and completers of the CBDR.

Table 2: Treatment Motivation of Community-based Drug Rehabilitation On-going and Completer Clients

Treatment Motivation Factor	On-going (n=31) Mean ± SD	Completer (n=29) Mean ± SD	p-value*
Internal Motivation	6.15 ± 0.95	5.94 ± 1.01	0.39^{NS}
External Motivation	4.52 ± 1.44	4.72 ± 1.47	0.59^{NS}
Interpersonal Help-seeking	6.20 ± 0.97	5.98 ± 1.02	0.39^{NS}
Confidence in Treatment	5.74 ± 1.53	5.39 ± 1.37	0.37^{NS}

*significant at 0.05 level, ^{NS}not significant

Motivation to Participate in CBDR

Factors that encouraged clients to participate in the CBDR were also explored and the results are summarized in Table 3. As shown, majority of the clients reported that they engaged in the treatment because they want to become better. This result is also consistent with the high internal motivation of the clients as reported in Table 2.

Another factor that encouraged clients to participate was their engagement with program facilitators. This highlights the importance of therapeutic alliance in engaging participants in treatment. Clients cited the structure of CBDR as a motivator to their participation to the program.

Table 3: Factors in CBDR that Encourages Clients to Participate (n=60)

Factors considered important by the clients	Completer (n=29)		On-going (n=31)	
	Frequency	Percent	Frequency	Percent
I want to become better	27	93.10	29	93.55
Engagement with program facilitators	20	68.97	21	67.74

I get structured program	18	62.07	25	80.65
I can learn new things	18	62.07	22	70.96
I think it is fun	14	48.28	17	54.84
I can socialize with others	12	41.38	17	54.84
Session hours	12	41.37	12	38.71
Number of session days	8	27.59	12	28.71
I earn some money	4	13.79	7	22.58

The qualitative data revealed both extrinsic and intrinsic factors that influences a person to complete the CBDR. An intrinsic motivator was the sense of pride and self-efficacy. A completer proudly shared, “Now, I am very proud to walk around our community. Before, people will talk negatively about me every time I passed by. Now, they will say instead that “hey, he has a nice job.” Just like that.” Others were motivated by the desire to improving their image, “Instead of just by-standing, we need to show that we are changing, that we are working. There is self-motivation.”

Beyond intrinsic factors, participants mentioned several extrinsic motivators. Family was a commonly mentioned as what motivated clients throughout their journey. The support from family accounts for a huge chunk in the participants’ motivation as evident in these sample responses, “Yes, family is the number one reason. Every time I need them, they are always there to support me” and “My family, since they know that I attended the program, they always give advice to me until I joined, they give their support, they supported me. Their support to me is invaluable, if there is no support from the family, after attending the program they will say that instead of joining they should prioritize their responsibilities at home, their work, so that they have something to feed their family. If my family did not support, you will never complete, it is one of the reasons to stop because of their hurtful words.” Aside from their family, program facilitators’ willingness to help also contribute to the motivation of the PWUDs.

Beyond family, fear of being punished was an important motivator to enroll in the program. As a participant shared, “People say you will be in a watchlist. You will be monitored. The government will know, you will no longer be safe.” This was validated by another, “If I did not stop maybe I will suffer from heart attack. I will be stressed. I can’t sleep thinking that maybe one of us will be shot or caught.”

The food subsidy was another motivator to continuously attend. As shared by a participant, “It is really a big help, even it’s just one kilo of rice, you can bring this to your family each time, and then there are canned goods too. It is what our family really needs. They have a family and one reason they don’t attend because they will prioritize their work.” *Another client shared that*

the incentives may help entice them to join the program when they said, "It will entice the clients when their neighbors see them that they have something to bring for their family, they will say 'hey, what, I will also join'." Participants also cited transportation assistance from the barangay as a motivator, "We are brought to the center. That is what is nice with our barangay. We are supported. Even now it is near and we are still fetched."

Finally, a participant cited having a supportive employer as an enabler, "There are times that my work will fall on shut down, or there are guests and rush work but when we ask permission to attend session and since our employers/management understand, they will allow us and give some consideration. They will say that you can be scheduled the next day so that we can support you and your community."

Motivations to Complete the Aftercare

Once participants finished CBDR, some continued simply because it was a requirement, "It was requirement to complete the program." However, for others, their motivations seemed to shift from fear or wanting to prove themselves to their family and community to wanting a better life*, "*For example you have a plan to start a business, they will prepare you and give ideas. The module is really helpful." Others were motivated by in continuing to learn, "The module topics include family, community, and surroundings. The aftercare provides great motivation to finish it" and "There are things that I need to adopt, to enhance. So, additional knowledge, skill development, actually, there was a briefing provided which helped prepared me. It is one of the reasons to motivate me. That pushed me, so I strived."

One participant cited spirituality as a motivator, "The secret is always think of God. Every time we have a meeting. Last time, we were lost. God was the one who guided me... I always have faith in the Lord. I have been lost for a long time. The mind is peaceful when you talk to the Lord. Anytime you can reach Him. It's very peaceful after sessions end. When you arrive at home, my family welcomes me. Before, they will not open the doors because they are not sure where I wandered. It's like that, we are welcomed by our family if there is God."

Other participants were motivated by their family and the better life they were experiencing, "My family is one of the reasons. Another reason is the improvement and changes that I see in my life." However, others joined the aftercare program because recognized that the process to recovery takes time, "If you took the program seriously, six months would not be enough for the learning. Especially for those who have been sober for long. You are clearing your thoughts, cleaning yourself. It's like foundation, it's not enough, knowledge is not enough. It is one of the reasons that boosted me participate in the aftercare because that's where I will see my personal development."

Reasons for not Completing the Aftercare

Unfortunately, out of more than a hundred who initially registered for CBDR, only 12 completed their aftercare program. A common reason cited for drop-out was conflict in program

schedules and work, "The reason why I stopped in … because, our scheduled session is in timing when there is a league [basketball competition]. During leagues, I serve as an umpire, I will always choose being an umpire since I will earn money, I will prioritize where I will get money so I can buy rice and milk for my children." This is echoed by another, "I was not able to complete because when I serve in the committee [work], I can earn money compared to attending [aftercare]. I have nothing to bring to my family."

Others were de-motivated because of program suspension and delays, "For me sir, CBDR is okay, but the problem ours took a long time to finish. For the other groups, it was quick while for us it's not. That is one of the advantages when the program finished early compared to what we had. Instead, we started first and they started later. The program started before the Covid pandemic, since 2019. Until now, it's not yet finished. We are still in aftercare. Other batches have already finished. It is unfair that they are already completed even if they started later."

Others feared the drug-testing that were a part of the program, "Some are already afraid to join the aftercare since they aren't sure what will happen. Most of them are afraid maybe there are surprise monitoring. That is where they will know whether we are still using or not."

Some participants shared that inconsistencies in the implementation of program policies was a deterrent, "For some who joined the aftercare and complete it, their names are still in the government watchlist. So they don't see the need to join." Another suggested, the change in government was a factor, "Since we already have a different president. Since the program is Duterte's and we have a new president, we are no longer afraid because it's not Duterte anymore."

Client Satisfaction

Treatment satisfaction is a major consideration in design of any treatment regimen. Overall, clients are highly satisfied with the services provided by CBDR. The dimension clients, both ongoing and completers, reported to be least satisfied is the type of intervention. Both ongoing and completers, reported to be least satisfied is the availability of recreational activities outside of the treatment and rehabilitation and the opportunity to find employment (see Table 3). Clients also differ in their level of satisfaction in terms of the type of intervention provided.

Table 3: Client Services Satisfaction Level

	Completer		On going		p-value
	Mean ± SD	Dissatisfied (%)	Mean	Dissatisfied (%)	
Overall Satisfaction	4.54 ± 0.94	5.00	4.75 ± 0.48	0.00	0.28 ^{NS}
Efficacy	4.69 ± 0.69	1.67	4.82 ± 0.36	0.00	0.37 ^{NS}
Relative's involvement	4.41 ± 0.89	3.33	4.53 ± 0.73	5.00	0.58 ^{NS}
Information	4.33 ± 1.03	6.67	4.53 ± 0.71	1.67	0.39 ^{NS}

Professionals' Skills and behavior	4.29 ± 0.90	5.00	4.55 ± 0.53	0.00	0.17 NS
Access	4.22 ± 1.29	10.00	4.71 ± 0.64	3.33	0.07 NS
Recreational Activities	4.18 ± 1.02	10.00	4.35 ± 0.78	10.00	0.46 NS
Type of Intervention	3.80 ± 0.81	10.00	4.32 ± 0.74	8.33	0.02*

*significant at 0.05 level, NSnot significant

Client's Suggestions to Improve the CBDR and Aftercare

Suggestions on how to improve delivery of CBDR and aftercare were also solicited from the clients and are summarized in Table 4. Clients reported that they need more fun things do during their rehabilitation. They believe sports, physical exercises, games and other teambuilding activities need to be integrated in their program, "There were games before, but now, no more. It was every Friday that we have sports festival. Like basketball or the different sports of the participant's liking. It motivates the participants to join. It is fun and we can see other participants."

Table 4: Factors in CBDR that Clients Think need to be Changed (n=60)

Factors that clients believe needs to be changed	Completer (n=29)		On-going (n=31)	
	Frequency	Percent	Frequency	Percent
I would like to learn new things	12	41.38	16	51.61
CBDR should help me become better (as completed by clients):				
improve myself	12	41.38	12	38.71
stop using illegal drugs	3	10.34	1	3.22
in providing information to family members	1	3.45	1	3.22
in finishing my studies	1	3.45	-	-
The CBDR should provide better structure	8	27.59	11	35.48
I would like to socialize more with other	7	24.14	8	25.81

More engagement with program facilitators	7	24.14	12	38.71
Provision of food packs	5	17.24	8	25.81
I would like to earn more money	4	13.79	7	22.58
Increase number of session days	4	13.79	5	16.13
Lesser session hours	2	6.90	4	12.90
There should be more fun things to do such as (as completed by clients):				
Games/basketball/Sports/Exercise	8	27.59	7	22.58
Teambuilding activities	-	-	1	3.22
Learning activities	1	3.45	-	-
Livelihood activities	-	-	1	3.22

Others wanted additional livelihood training course that are suitable to them would be much appreciated., "The trainings offered are not fit to us, like last time they offered TESDA Training but what they offered is housekeeping, those who are masculine clients won't take it. That's why no one enrolled in it. So I suggest that more courses should be added. They can add courses on wielding, electrical, mechanic, plumbing, and others, like automotive. This will entice other clients to really join and attend especially that their neighbors will see that they will bring home skills."

The financial support that was promised to be given to them when they finish the aftercare is also much appreciated, "It should be continued sir, like the giving of subsidy. Subsidies like goods that the clients can bring like rice, food consumption, and food. It is the greatest factor that motivates us to join." Others suggest that subsidies could be used for livelihood, "The financial subsidy that will be given should be continued, it can be used as starting capital for small business selling fried banana, grilled banana, and the likes."

However, others lamented the lack of equity, "when it was selection time for livelihood opportunities, only few were chosen. Some needed it most and were deserving but they were not selected. I guess it's just that slots are limited or they lack some endorsement or were not close to some officials. I just saw some who were given subsidy even they own a store, they have good jobs, while those who have nothing should be given, at least they can start at something."

There were also those who wanted consistency in implementation and felt the program was too loose, "The program has lenient rules, it's not too tight to the participants. Some participants

are complacent and do not attend. Some do not complete since the rules are not strictly implemented. During the first batch, it was very strict for us, all of us attend. For the succeeding batches, only few completed."

Discussion

Motivation is crucial in the rehabilitation process as studies have reported that motivated clients have significantly better treatment outcomes than those who are not motivated (Longshore & Teruya, 2006). Our findings reveal that participants are motivated intrinsically by a sense of self-efficacy, a need to prove themselves and a personal desire to be sober. This is consistent with studies that show that participants are motivated to quit using drugs because they recognize the benefits of staying sober (Chan et al., 2019).

Aside from their intrinsic motivation, family was an important extrinsic motivator in the initiation and continuation of treatment. PWUDs are motivated to participate in the treatment because they appreciate the positive changes in their lives especially in their familial relationships. This is consistent with a study of Filipino PWUDs undergoing CBDR that family members are important actors both on before and after CBDR (Hechanova, Manaois, et al., 2019). This highlights the important role of families and community members in the rehabilitation journey of PWUDs under CBDR and is consistent with literature that a family provides to a patient's recovery from addiction is essential to that patient's success (Adejoh et al., 2018). Family support is a strong predictor of recovery and life skills of PWUDs undergoing CBDR (Hechanova et al., 2023) and as such may reduce relapse. The presence of significant people serve as an adaptive social bonds that reduces their engagement in delinquent behavior (Chan et al., 2019).

The qualitative comment suggest that fear motivated some participants to participate in the rehabilitation program. This is understandable given the aggressive case finding and reported killings of more than 7,000 lives (Simangan, 2018) that instilled fear for their safety among persons who use drugs. As Lasco and Yarcia (2022) noted that the "war on drugs" of the Duterte administration created a rehabilitation landscape in the Philippines that is forced and not voluntary (Lasco & Yarcia, 2022). Legal coercion has been used by many countries however, three decades of research on coerced treatment yield mixed and inconclusive results. There are those who report that mandated clients are more likely to complete treatment compared to voluntary clients (Coviello et al, 2013). However, there is also evidence that coercion is not useful in helping someone to stop taking drugs (Chan et al., 2019) and voluntary clients have better treatment outcomes (Klag et al., 2005).

This is a notable finding since treatment motivation, particularly treatment readiness, has been found to mediate treatment retention (Stevens et al., 2015). This internal motivation may also be due to the fact that CBDR becomes a protective factor because recovering users are given a chance for treatment and reform and only reported to the police if they fail to cooperate (Allado et al., 2019).

Another factor that encouraged clients to participate is their engagement with program facilitators. This is noteworthy as effectiveness of treatment relies on the extent to which facilitators can relate to and keep clients interested (Sparer, 1975). When clients feel efficacious

in quitting drugs and receive empathetic understanding, they are more likely toll enjoy a higher sense of well-being and become more intrinsically motivated towards healthy behavior like quitting drugs (Chan et al., 2019). A study of CBDR facilitators in the Philippines revealed that they view themselves as journeying with the participants rather than as teachers or experts. Perhaps because these CBDR facilitators are paraprofessionals or volunteers, they take on the role of advisers and personal mentors to clients struggling with some issues even outside the context of rehabilitation. This highlights the positive effect of a therapeutic alliance in enabling support and motivation.

Overall, clients are highly satisfied with all dimensions of services particularly the efficacy of the program. There is a growing body of literature have highlighted its effects on the success of treatment and rehabilitation programs (Yang et al., 2019). For example, in a peer support group recovery program, clients were found to be satisfied with their treatment and had significantly reduced drug use (Tracy et al., 2012). The CBDR program provided has modules on life skills, which focuses on managing their emotions and thoughts, recognizing their strengths, relating to others, rebuilding relationships, solving problems, and making meaning of the past and finding hope in the future (Hechanova et al., 2018). The results validate previous studies that suggest that the CBDR program resulted in improved recovery, life skills, and wellbeing (Teng-Calleja et al., 2020). This also highlights the importance of culturally nuanced and need-based design of rehabilitation programs to ensure that the content, language, methodologies, and materials are appropriate for the target clients (Hechanova, 2019)

Although clients report that they are highly encouraged to engaged in CBDR, they also reported unmet needs. The dimension clients, both ongoing and completers, reported to be least satisfied is the type of intervention. Both ongoing and completers, reported to be least satisfied is the availability of recreational activities outside of the treatment and rehabilitation. Clients also reported that they wanted more fun things do during their rehabilitation such as sports, physical exercises, games and other teambuilding activities especially with families. This is not surprising as growing body of evidence has reported the importance of sports in rehabilitation, relapse prevention (Fenech, 2017), the quality of life and recovery process of drug-dependent patients (Giménez-Meseguer et al., 2015), treating drug addiction (Robertson et al., 2016).

Clients also cited the lack of appropriate livelihood training and employment opportunities. On the one hand, this is understandable because these are covered in the aftercare program and not in the CBDR. However, this also suggests the need to review the protocols for provision of wrap-around services. Many LGUs appear to provide livelihood/employment after treatment. However, especially for those with mild dependence this stepwise approach may not be necessary. A study suggests that learning new skills and participating in physical and recreational activities are helpful factors in in the remission of drug addiction (Petrova et al., 2015). This reinforces the findings of Hechanova et al. (2019) that complementary interventions are useful to recovery.

Aside from the motivation derived from the feeling of being well and from seeing the positive impacts in their life as a result of the program, participants also find religion or their connectedness to God to be a driving force towards quitting drugs. These results are also consistent with studies that report recovering users undergoing treatment and rehabilitation practice religious coping by looking for strength from or connection with God (Johnson & Jang, 2011). Similarly, religious

involvement and commitment have been found to decrease delinquency in part due to its likelihood to increase the fear in punishment, social bonds, and self-control while decreasing strained-related negative emotions (Kelly et al., 2015).

The study elicited a number of tarriers to completion – the most common of which is accessibility. Programs are run on weekdays that conflict with work. It should be noted that participants are informally employed and their income is based on a per day/work basis. Being absent from work has a significant effect to their family. Program schedules as barriers has also been reported in other studies on CBDR in the Philippines. However, even as local government and the program implementers recognize this concern, they grapple with a scarcity of facilitators available on weekends (Hechanova et. al 2019).

Clients cited subsidy and food incentives as a motivating factor. However, they also cited the lack of consistency and sustainability. There is robust evidence for contingency management or using incentives to encourage sobriety and retention works in substance use treatment (Petry, 2000). A study on CBDR in the Philippines reveal that other LGUs also sought to provide food or subsidy to compensate participants for their opportunity or income loss. However, the lack of funds for CBDR endanger the sustainability of such incentives (Hechanova, 2019).

Another barrier to implementation identified by the participants is the delay in the program implementation, inconsistent program policies, and the perception that the provision of program subsidy is biased. These are all symptoms of a much deeper challenge in the implementation of the CBDR. These are lack of funding, lack of skilled personnel, heavy workload, inadequate resources, which are also cited in other countries (Belizan et al., 2019; Long et al., 2018). What seems to be unique in the Philippines is the emergence of concern regarding result of drug test after completion of the program that serves as a barrier to aftercare. This fear that emanates from the implementation of *Oplan Tokhang* – which echoes the safety and security concerns identified by a number of studies (Lasco & Yarcia, 2022; Hechanova et al. 2023, Hechanova et al, 2019).

Implications

While this paper provides important insights with regards the influence of motivation and satisfaction towards completion of rehabilitation program, caution must be taken in the interpretation of the findings due to some methodological limitations. Firstly, the sample size for both quantitative and qualitative phases were limited to the clients currently accommodated at different community-based drug rehabilitation in the city. Future researches may wish to explore motivations of clients who are not yet in treatment. Longitudinal studies may also be useful to examine whether motivations change over time. Secondly, the participants of the qualitative phase did not include clients who opt out in the aftercare and CBDR and thus the reasons they provided is based on their perception and their discussion with other members of their cohort. Future studies on those who never enter treatment or drop-out are also warranted.

While the study had some limitations, it still provided meaningful and practical implications towards the improvement of community-based drug rehabilitations as it is currently implemented. Because the enrollment and completion of rehabilitation and aftercare programs are influenced by both internal and external motivations, efforts must be addressed to strengthen these.

The program may be expanded to include modules and activities geared towards improving self-confidence, self-image, etc. Issues of equity, transparency and sustainability of support services also need to be addressed. Given the change in government, the use of coercion and fear need to be replaced with more evidence-based approaches. Another important improvement is ensuring that program schedules are accessible as well as implemented continuously to avoid drop-outs in the program.

Conclusion

Treatment motivation and clientele satisfaction has been drawing attention of drug rehabilitation practitioners due to its immense effect on treatment outcomes. This study explored treatment motivation, clientele satisfaction, and the factors affecting enrollment and completion in community-based drug rehabilitation and aftercare programs. The results revealed high interpersonal help-seeking motivation and internal motivation towards treatment which are also confirmed in the qualitative findings. Clients found the changes that happened in their life as a result of the rehabilitation program to be a major determinant in their completion of the program. Similarly, the support from their family, significant others, and the local government motivates the clients to finish the program. Fear and coercion to participate and complete the program also resonated in the participants due to the generally punitive approach of drug use in the country. Aside from internal and external motivation, the general structure of the program, competence of facilitators, government and community support, and complementary intervention serve as influential factors in the enrollment and completion of the rehabilitation and aftercare program. Completion of the CBDR and aftercare are primarily influenced by client's motivation and their satisfaction of the services provided.

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