Kanamori *et al. Substance Abuse Treatment, Prevention, and Policy* (2024) 19:46
https://doi.org/10.1186/s13011-024-00626-6

Substance Abuse Treatment, Prevention, and Policy

RESEARCH

Open Access

Enhancing the drug addiction treatment service by introducing a new residential treatment model in the Philippines: A qualitative study

Shogo Kanamori[1,2*], Tomohiro Shirasaka[3], Ma. Teresa Iñigo[4], Alfonso Villaroman[5], Rosalina Noguera-Caoile[6], Aya Mizusawa[7], Jasmin Peralta[8] and Takayuki Harada[9]

Abstract

Background There is an increased demand for quality treatment and rehabilitation services for people who use drugs (PWUDs) in the Philippines. In response, the Philippines Government's Department of Health (DOH) has established a new residential treatment model, Intensive Treatment and Rehabilitation Program for Residential Treatment and Rehabilitation Centers (INTREPRET), and integrated it into the existing treatment service platform of 21 DOH-owned Treatment and Rehabilitation Centers (TRCs). We conducted a qualitative study to identify the changes engendered by the implementation of this treatment model.

Methods Data were collected through individual face-to-face interviews. We interviewed purposefully selected 29 patients and 35 facilitators of INTREPRET group sessions in seven TRCs. We transcribed the interview records and organized the narrative information into key themes using thematic analysis during the coding process.

Results The changes perceived by the study participants included the attitude and behavior of patients, attitude and competency of facilitators, relationship between facilitators and patients, treatment planning and review process, efficient and standardized treatment services, and monitoring mechanisms of the patient's recovery process. Participants also noted challenges in INTREPRET implementation, including family participation in therapy sessions, lack of facilitators, securing a conducive place for conducting sessions, and reproducing workbooks.

Conclusions The results imply that the introduction of INTREPRET could improve treatment service quality and the effectiveness of treatment, which were primarily associated with behavioral changes in patients, improved relationship between patients and facilitators, and INTREPRET's alignment with key international treatment standards. However, despite the positive changes perceived by the participants, certain challenges pertaining to family participation in therapy sessions and the lack of resources were identified. These criticisms must be addressed by DOH, along with an integration of INTREPRET into its policy and strategic framework, to ensure the effectiveness and sustainability of the new treatment model.

*Correspondence:
Shogo Kanamori
kanamori@post.harvard.edu
Full list of author information is available at the end of the article

© The Author(s) 2024. **Open Access** This article is licensed under a Creative Commons Attribution-NonCommercial-NoDerivatives 4.0 International License, which permits any non-commercial use, sharing, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons licence, and indicate if you modified the licensed material. You do not have permission under this licence to share adapted material derived from this article or parts of it. The images or other third party material in this article are included in the article's Creative Commons licence, unless indicated otherwise in a credit line to the material. If material is not included in the article's Creative Commons licence and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder. To view a copy of this licence, visit http://creativecommons.org/licenses/by-nc-nd/4.0/.

Keywords Cognitive-behavioral therapy, Drug dependence, Relapse prevention model, Residential treatment

Background

Illegal drug use is a significant public health issue in the Philippines. The prevalence rate of illegal drug use in the Philippines was estimated to be 2.3% of individuals between the ages of 10 to 69 years in 2015, that is around 1.8 million people [1]. In 2016, the Government of the Philippines launched *Operation Tokhang* (knocking-the-door operation), a campaign to eliminate illegal drug use. Following this national campaign, over a million people who use drugs (PWUDs) surrendered to the authorities to seek treatment and social support [2]. This unprecedented demand for drug-dependence treatment services highlighted considerable gaps in the knowledge and capacity of the existing treatment and rehabilitation centers (TRCs), which provide (compulsory and voluntary residential) care for PWUDs [3].

In response to the increased demand for quality treatment and rehabilitation services for PWUDs, the Department of Health (DOH), mandated to strengthen the capacity of treatment and rehabilitation services for PWUDs, turned to the Japan International Cooperation Agency (JICA) for technical cooperation. The DOH's request resulted in the formulation of the Project for Introducing Evidence-based Relapse Prevention Programs to Drug Dependence Treatment and Rehabilitation Centers in the Philippines (IntERlaPP). The project was launched in December 2017 with an expected duration of 5 years, which was subsequently extended to 6.5 years owing to the COVID-19 pandemic affecting its implementation.

Under the IntERlaPP, a Technical Working Group (TWG) was formed to facilitate the development of a new residential treatment model. A series of TWG meetings established an evidence-based relapse prevention model, the Intensive Treatment and Rehabilitation Program for Residential Treatment and Rehabilitation Centers (INTREPRET). INTREPRET was formulated based on the Matrix Model, originally developed in the United States as an intensive and comprehensive outpatient relapse prevention treatment approach for stimulant users [4]. However, the INTREPRET used in the Philippines differs from that used in the United States in terms of its target being residential patients, use of the Filipino language, and approach being adapted to Filipino sociocultural norms.

Multiple studies have investigated the efficacy of the Matrix Model and cognitive behavioral therapy (CBT), which serve as the basis of INTREPRET, in various populations of PWUDs. Initially developed in response to the cocaine epidemic of the 1980s in the United States, the Matrix Model has since been applied to methamphetamine users and demonstrated its usefulness and efficacy [4, 5]. A randomized controlled study in a Japanese prison setting indicated that applying the Matrix Model resulted in higher coping skills in the intervention group [6]. CBT interventions have been used for the treatment of substance use disorders [7] and co-occurring mental health disorders [8]. A study of stimulant-dependent individuals in the United States concluded that CBT reduced drug use from the baseline level and produced comparable outcomes for all measures at follow-up [9]. However, evidence is scarce from randomized controlled trial studies on the effectiveness of CBT for methamphetamine use disorders [10], from which 96.1% of patients admitted to residential TRCs in the Philippines suffer [11].

In the Philippines, treatment services for PWUDs are provided at different levels of TRCs, depending on the severity of their dependence. As of December 2023, there are 94 DOH-accredited TRCs located in 14 out of the 17 regions the country is divided into, of which 33 are operated by the DOH or local governments and the rest by private owners. Of the 33 government-run TRCs, six provide only outpatient treatment services while the remaining 27 provide both outpatient and residential services [12]. Based on government guidelines, PWUDs with severe dependence are admitted to one of these 27 residential TRCs [13]. Their admission is either mandated or voluntary. Most patients admitted to TRCs stay in the facility for 6 to 10 months. The Therapeutic Community (TC) modality is predominantly adopted as a platform for residential treatment services [14].

By the end of 2023, INTREPRET had been integrated into the existing TC-based treatment service platform of all 21 DOH-owned TRCs. A quantitative study with a randomized controlled trial design is ongoing under IntERlaPP, aimed at identifying INTREPRET's effectiveness at three TRCs [15]. However, the TWG members of IntERlaPP have proposed a qualitative investigation of the applicability of INTREPRET to a TC-based residential treatment platform.

Qualitative research on drug dependence treatment services has previously been conducted to examine the accessibility of substance use treatment, as perceived by service users in the Netherland [16], substance use service needs of PWUDs in Canada [17], and experiences of PWUDs with opioid substitution treatment in the United Kingdom [18]. These studies used interviews and thematic analyses to gather narrative data. In the Philippines, research has been conducted to identify areas of intervention need in community-based treatment programs for PWUDs, utilizing a mixed-method design with

multiple data sources, such as interviews with PWUDs and focus group discussions with community stakeholders [19]. Additionally, qualitative insights on the use of CBT for substance use disorders have been examined in a few studies. A qualitative study in Pakistan explored the experiences of psychologists delivering CBT in a non-western culture for substance use disorders [20]. Another qualitative study examined the experiences of therapists using internet-based CBT to support people with problematic substance use [21].

However, despite these qualitative studies, there is a lack of knowledge about how introducing a new residential treatment program based on CBT or a relapse prevention model for PWUDs causes changes in treatment service provision, as well as in the attitudes and behaviors of patients and staff members. To address these issues, we conducted a qualitative study with the objective of exploring how the introduction of INTREPRET has changed certain aspects of treatment services in the TRCs.

Methods

INTREPRET

INTREPRET comprises five components designed to improve the psychological and social skills of PWUDs. Based on the Matrix Model, INTREPRET provides more structured treatment sessions and a more user-friendly workbook for patients than the original, as it has not only been translated into Tagalog, but has also been developed in consideration of the socio-cultural aspects of its users. The five program components were conducted across eight sessions per week, each lasting one hour (Table 1).

CBT is the core component of INTREPRET; it was conducted three times a week in group sessions with 10–15 patients using the Patient's Workbook, which comprises 49 topics [22]. Other supplementary programs included Psycho-Education (PE) for Patients and Family Members, a series of interactive lectures conducted once a week with fewer than 50 patients and family members, based on PowerPoint presentation slides on 12 topics [23]; and Social Support, which was conducted twice a week with 10–15 patients based on 40 discussion topics [24]. The Self-Help Group Meeting was conducted once a week with 10–15 patients without TRC staff members. Under INTREPRET, these sessions were incorporated into the TRC's weekly timetables.

Introduction of INTREPRET to TRCs

By the end of 2023, INTREPRET was introduced to 21 DOH-owned residential TRCs through seven batches of training for TRC staff members. The standardized INTREPRET training program, comprising lecture sessions on basic counseling techniques, CBT, the motivational interviewing technique [25], and roleplay exercises on CBT sessions, was delivered over 5–7 days. The staff members who conduct INTREPRET sessions are addressed as "facilitators"; they are typically psychologists, social workers, and nurses. Upon completion of training, facilitators conducted INTREPRET sessions according to the Service Provider's Manual [26], which elaborates on the organizational aspects of INTREPRET implementation and facilitation standards, including standard operating procedures (SOPs) to facilitate group sessions. Some TRCs have applied INTREPRET to all residential patients, whereas others have limited participation to selected patients.

Post-training evaluation sessions were conducted 3 months after the training at each TRC according to the Guidelines for Field Evaluation [27] to ensure the continuity of INTREPRET and adherence to the standards established for its implementation. Selected TWG members who served as trainers visited the TRCs and provided technical feedback after observing the local implementation of INTREPRET.

Sampling study participants

Among the 21 DOH-owned TRCs, data were collected from seven facilities where INTREPRET was well integrated into the existing TC-based treatment service platform, and the TRC heads agreed to make patients

Table 1 Composition of INTREPRET

	Components	Number of sessions/week	Content
1	CBT	3	Group CBT sessions based on the Patient's Workbook comprising 49 different topics. It is divided into three parts: Early Recovery Skill Program, Relapse Prevention Program, and Pre-discharge Program.
2	CBT Review	1	Weekly review of the CBT sessions.
3	Psycho-Education for Patients and Family Members	1	Interactive lectures to provide patients and their family members with accurate information about addiction, recovery, treatment, and the resulting interpersonal dynamics. Based on recurring sessions of 12 topics.
4	Social Support	2	Discussion group to practice resocialization skills. Based on recurring sessions of 40 topics.
5	Self-Help Group Meeting	1	Narcotics Anonymous group meetings facilitated by recovering personnel or patients.
	Total	8	

Note: INTREPRET = Intensive Treatment and Rehabilitation Program for Residential Treatment and Rehabilitation Centers; CBT = Cognitive Behavioral Therapy

and facilitators available for interviews. The participants included in the study were (1) patients admitted to the target TRCs and participating in the INTREPRET sessions and (2) facilitators employed at the target TRCs. Participants were purposefully selected based on the following inclusion criteria for patients and facilitators.

Patients:

1) Male.
2) 18 years of age or older.
3) History of methamphetamine use.
4) Currently participating in INTREPRET sessions.
5) Stayed at the current TRC for over 3 months.
6) Admitted to any TRC twice or more.
7) Capable of communicating in Tagalog or English.
8) Agreed to participate in the study.

Facilitators:

1) Full-time employee of the TRC.
2) Participated in the INTREPRET training.
3) Conducted INTREPRET sessions for over 3 months.
4) Fluent in English.
5) Agreed to participate in the study.

Only male patients were included because five of the seven TRCs accommodated only male patients, and the proportion of female patients in the other two TRCs was significantly low. In addition, patients admitted to TRCs twice or more were selected to elicit perceived differences between their experiences of the previous treatment at TRCs without INTREPRET and the current treatment with it.

We targeted five patients and five facilitators at each TRC to elucidate the changes associated with the introduction of INTREPRET that applied to all seven TRCs, as well as the changes unique to each TRC. At each facility, the head of the psychology department or person designated by the TRC head was asked to nominate patients who satisfied the eligibility criteria. If more than five patients satisfied the criteria, those with a shorter interval between the current and previous admissions to the TRC were prioritized. Similarly, the chief of the hospital in each TRC was requested to nominate facilitators who satisfied the eligibility criteria. If more than five facilitators met the criteria, those who had worked longer at the TRC were prioritized.

Data collection

Data were collected through individual face-to-face interviews with patients and facilitators between July and November 2023. Before the interview sessions, participants were asked to complete a questionnaire to obtain basic information. Based on a semi-structured interview guide, detailed information about interviewees' feelings, perceptions, and opinions was obtained to elicit the perceived changes associated with the introduction of INTREPRET. Particularly, patients were asked to compare their experiences of the previous treatment at the TRC, where INTREPRET was not implemented, with the current treatment with INTREPRET. The interview guide's key questions for patients included perceived changes in (1) the patient's attitude and behavior, (2) other patients' attitudes and behaviors, (3) staff members' attitudes and behaviors, and (4) the TRC's service as a whole. Facilitators were asked to highlight their perceived differences before and after the introduction of INTREPRET. The key questions for facilitators included perceived changes in (1) patients' attitudes and behaviors, (2) staff members' attitudes and behaviors, and (3) the TRC's service as a whole. The facilitators were also asked to share their perceptions of the challenges they faced while implementing INTREPRET. The interview guide was tested with several patients and facilitators at one of the target TRCs to ensure the clarity of questions and gain preliminary insights into a range of potential responses from the interviewees. The lead author of this study, who is not involved in the TRC operations, conducted all the interviews. Each interview lasted for 20–60 min. We interviewed patients who did not understand English via a professional English–Tagalog interpreter. All interviews were digitally recorded.

Data analysis

All recorded interviews were transcribed verbatim. The transcribed texts were subsequently imported into the MAXQDA 2022 software [28] to prepare them for thematic analysis [29]. The lead author read each transcript several times to familiarize himself with the content and coded the texts to categorize the narrative data into themes. Based on the principles of the investigator triangulation, other co-authors reviewed the coded transcriptions and emerging themes to reflect broader views of experts. Disagreements were discussed and coding categories and themes were revised until a consensus was reached. Consequently, 217 codes were selected to categorize 16 key themes of changes associated with the INTREPRET implementation and 56 codes to categorize four types of challenges identified in its implementation. During this coding process, the participants' identities were masked by the researchers.

Ethical considerations

Ethical approval was obtained from the Single Joint Research Ethics Board of the Department of Health, Philippines (Protocol No.: SJREB-2023-46). Study participation was voluntary for both patients and facilitators. Written consent was obtained from each participant, and

they were given the right to refuse to participate in the study. They were also allowed to leave the study and withdraw the consent form they had signed at any time under any condition and without any risk of repercussions. Numbers and codes were used for the recorded interviews and transcripts to guarantee the confidentiality and anonymity of the data.

Results

Twenty-nine patients and 35 facilitators from seven TRCs were interviewed. The characteristics of the study participants included in the analysis are summarized in Table 2.

Participants' narrative responses pertaining to the perceived changes associated with the introduction of INTREPRET were analyzed and classified into a thematic framework that included domains and key themes. Six domains were identified from the analysis: (1) the attitude and behavior of patients, (2) attitude and competency of facilitators, (3) relationship between facilitators and patients, (4) treatment planning and review process, (5) efficient and standardized treatment services, and (6) monitoring mechanisms of patients' recovery process. Key themes were identified in each domain (Table 3). The facilitators' narrative responses regarding the challenges they faced during INTREPRET implementation were also analyzed and categorized.

Attitude and behavior of patients

Most facilitators and several patients described perceived changes in the attitudes and behaviors of patients. A sizable proportion of the facilitators mentioned that they had witnessed patients helping other patients during INTREPRET sessions. In particular, those with higher educational backgrounds committed themselves to helping those with learning difficulties. One facilitator said, "If a patient is having a hard time comprehending that, we can see co-patients helping them. So, they are the ones who really take the initiative by saying, 'Ate [sister], can I help this patient because he doesn't understand that right now'" (Female facilitator, aged 25–29 years old). Another facilitator said, "…what we do, as a facilitator, is that we ask other residents seated next to them to help those, um, illiterate participants to, uh, guide him or her, if there's an activity that needs to be answered…" (Female facilitator, aged 20–25 years old).

Most facilitators stated that patients came to share their thoughts and feelings more frequently during the sessions. They perceived that patients were more motivated and inclined to participate during the INTREPRET sessions. The narratives of facilitators included: "… In the start of the session, they quite felt distant with the facilitator, but as they go along with the sessions, I observed that they are more open, especially in sharing their personal experiences, drugging experiences. Actually, it is very difficult to dig deeper into their addiction and how they took drugs. But in the session, they were able to share" (Female facilitator, aged 55–59 years old). Another facilitator said, "I just observed that in the beginning, the patients are very shy and quiet, and they are reserved. However, when they are exposed to INTREPRET, I can say that they become more open and they express more" (Female facilitator, aged 30–34 years old).

Approximately one-third of the facilitators perceived that the frequency of the violation of cardinal rules by patients decreased. Some described that the patient's knowledge and skills gained through participating in INTREPRET sessions led to this reduction. The narratives of facilitators included: "One [reason] is that they have learned how to control themselves through the INTREPRET session" (Female facilitator, aged 35–39 years old); and "During the CBT session, they realize what they cannot say or what to do… to realize his wrongdoings" (Female facilitator, aged 25–29 years old).

Several patients observed that they were less prone to becoming angry or violent, indicating a shift in their attitudes and behaviors. This phenomenon was also observed by several facilitators. A patient stated, "… Before, ma'am, I was violent back then. I had no patience, ma'am. But now, with the help of CBT and Social Support, I am having restraint or patience in my life" (Patient, aged 20–24 years old). Another patient said, "… before, I did not know the concept of living one day at a time. I had issues with patience… But now, I learned how to be patient" (Patient, aged 20–24 years old).

Attitude and competency of facilitators

Most facilitators and some patients reported a change in the attitude and competencies of facilitators after the introduction of INTREPRET. One-third of the facilitators and a few patients mentioned that the latter were treated with more respect after the introduction of INTREPRET. One patient highlighted the difference between the previous admission and the current one by stating, "… They treat the patients well, with respect, and they value the patients here, unlike in the previous rehab I've been through. They just gave the medication, and then they didn't mingle with the patients" (Patient, aged 45–49 years old). A facilitator described the change in her attitude as, "So before, if we see a patient… [I said] 'Why are you not proper?' So, we scolded them in front of the participants, but now of course, we don't do that because of the [INTREPRET] training. We learned not to do harm, and of course, to also respect the patients because they are also human beings" (Female facilitator, aged 25–29 years old).

One-third of the facilitators recognized that their knowledge and skills in facilitating group sessions had

Table 2 Participant characteristics

	Number	%
Patients (n = 29)		
Age (in years)		
20–24	4	13.8
25–29	5	17.2
30–34	5	17.2
35–39	2	6.9
40–44	6	20.7
45–49	6	20.7
50–54	0	0.0
55–59	0	0.0
60–64	1	3.4
Education		
Did not graduate from elementary school	1	3.4
Elementary school graduate	0	0.0
Did not graduate from high school	2	6.9
High school graduate	18	62.1
Diploma course graduate	1	3.4
College graduate or higher	7	24.1
Number of admissions to TRCs (including the current admission)		
2 times	20	69.0
3 times	3	10.3
4 times	2	6.9
5 times	2	6.9
6 times	1	3.4
7 times	1	3.4
Route of admission		
Voluntary (came to TRC of their own free will)	6	20.7
Voluntary (brought by a family member)	16	55.2
Positive result of drug test conducted at workplace/school/community	1	3.4
Positive drug test result during treatment or aftercare program	2	6.9
Transferred from prison	4	13.8
Facilitators (n = 35)		
Sex		
Male	11	31.4
Female	24	68.6
Age (in years)		
20–24	1	2.9
25–29	11	31.4
30–34	9	25.7
35–39	5	14.3
40–44	3	8.6
45–49	4	11.4
50–54	0	0.0
55–59	2	5.7
Professional title		
Psychologist	6	17.1
Psychometrician	12	34.3
Social worker	10	28.6
Nurse	6	17.1
Radiologic Technologist	1	2.9

Note: TRC = Treatment and Rehabilitation Center

Table 3 Key themes of changes caused by the introduction of INTREPRET

Domains	Key themes
Attitude and behavior of patients	- Patients helping other patients - Patients sharing their thoughts and feelings more during sessions - Patients violating cardinal rules less - Patients not becoming angry or violent easily
Attitude and competency of facilitators	- Patients treated with respect - Better facilitation of group sessions - Applying the motivational interviewing technique to individual counselling
Relationship between facilitators and patients	- Patients finding facilitators more approachable - Facilitators knowing more about patients - Patients sharing concerns with facilitators
Treatment planning and review process	- Patient's concerns shared during sessions relayed to case managers - Common terminologies used during treatment planning
Efficient and standardized treatment services	- Guidance available for facilitators to prepare sessions - SOPs enabling delivery of structured and standardized sessions
Monitoring mechanisms of patient's recovery process	- The patient's attendance logbook enabling better tracking of activities - Feedback from INTREPRET sessions discussed during monthly case conferences

Note: INTREPRET = Intensive Treatment and Rehabilitation Program for Residential Treatment and Rehabilitation Centers; SOP = Standard Operating Procedure

improved. The following statements represent their view: "So, we became better in managing group sessions… we now follow a strict SOP in the group sessions. We are much guided now, and I think it made us better in group facilitation" (Female facilitator, aged 25–29 years old); and "…facilitators in INTREPRET have, I think, become knowledgeable enough and have more insight into what they are doing. And I think it enhances also our skills in giving some information or giving advice to the residents because we also research… also about some other additional information" (Female facilitator, aged 25–29 years old).

Several facilitators mentioned that they had applied the motivational interviewing (MI) technique to individual counseling with patients. They received training on it as part of INTREPRET to help them facilitate group sessions well. However, this counseling technique was used beyond its original expectations. A facilitator said, "…When it comes to the individual counseling of our clients, we are applying what we have learned from the INTREPRET [training] program" (Male facilitator, aged 35–39 years old). Another facilitator said, "In my case, I became more aware of using MI so I think it added more skills for me as a counselor, as a case manager… I became more active in listening… So it, it really improves my listening skills… Now, I'm already applying it with one-on-one counseling" (Female facilitator, aged 30–34 years old).

Relationship between facilitators and patients

A few patients and several facilitators noted changes in the relationship between facilitators and patients. Some indicated that facilitators became more approachable for patients. A patient described: "There are benefits for us; especially when we need something, and we require counseling, they are there. We can approach them more easily" (Patient, aged 30–34 years old). A facilitator highlighted the change: "In Therapeutic Community [without INTREPRET], the authority of the staff was very important. While in INTREPRET, as facilitators or staff, we became approachable, available to patients, and we became more motivating to them and affirmative, which is helpful for their recovery" (Female facilitator, aged 30–34 years old).

A few facilitators indicated that they knew more about patients. A facilitator said, "… It allows us to know more about the residents… because we can see the bigger picture of their problems during the CBT sessions" (Female facilitator, aged 25–29 years old). Another facilitator said, "Since we have fewer patients, compared to other dorms, I think the relationship with the staff is better… Since we know them individually since they are fewer. Unlike in other dorms, they can't memorize their names or what they are, what they are good at or their skills" (Female facilitator, aged 30–34 years old).

A few facilitators also stated that patients shared their concerns more with the facilitators and other staff members. An example statement is: "I can see that the patients now are more open to the staff or to their case manager and the facilitators in expressing what are their thoughts or their feelings since we also develop a bond with them through each [INTREPRET] session that we conduct" (Female facilitator, aged 25–29 years old). Another statement is: "Since they (patients) know every time that they have concerns about themselves, they are reassured that they will be heard" (Male facilitator, aged 25–29 years old).

Treatment planning and review process

Approximately half of the facilitators mentioned that the introduction of INTREPRET facilitated patients' individual treatment planning and review process. Several

facilitators notably indicated that they had relayed the patients' concerns shared during INTREPRET sessions to the case managers in charge of treatment planning and review. A facilitator said: "Even if I am not the social worker in charge, I can help the social worker in making his or her treatment plan by saying that 'These patients during the CBT sessions had problems on this and on that'" (Female facilitator, aged 25–29 years old). Another facilitator said, "We include observations in the INTREPRET program in the treatment plan of the residents…Previously, we didn't have this kind of intervention… [If] I have significant observations from caseloads of my colleagues, I provide feedback to them so that they may be able to… put them in the treatment plan" (Male facilitator, aged 30–34 years old).

A few facilitators stated that INTREPRET enabled them to use common CBT terminologies with patients during the treatment planning and review process. One described, "We are being able to communicate with the same terminologies, for example, triggers, etc. with the patients… So, it is easier for us to explain that this is your treatment plan, this is what we are going to do, this is the problem…" (Female facilitator, aged 25–29 years old). Another said, "Before, they were not familiar or comfortable with the terminologies that we use. We usually did not include the patients when it comes to… treatment planing. But now, since they are familiar, those included in the INTREPRET, we share their treatment plans as they are knowledgeable about those terminologies" (Female facilitator, aged 25–29 years old).

Efficient and standardized treatment services

Half of the facilitators noted that INTREPRET enabled them to provide more efficient and standardized services. Notably, several indicated that the availability of guidance made it easier for facilitators to prepare sessions. A facilitator highlighted the difference following the introduction of INTREPRET by stating, "It helps the facilitators to have a module ahead of time, unlike before, when we did our own research and made our presentations. That depended on the resourcefulness of the facilitators. Here, we have our own structured guide to follow. So, that's very helpful" (Female facilitator, aged 30–34 years old). Another facilitator stated, "Before, the staff were not prepared in doing the sessions. We were given one hour and did whatever we wanted to do with an hour. But right now, since we have the workbook that needs to be taught by the facilitators, we are really doing research and we are also even asking other co-facilitators, 'How did you handle this session? What are your strategies? What are some of the questions raised by the patients?'" (Female facilitator, aged 25–29 years old).

Several facilitators also appreciated the SOPs that helped them deliver structured and standardized sessions. A facilitator shared about the change they experienced: "Before, if you were given a topic, even though you didn't know the details, [you would tell yourself] 'Okay, let's just run it through.' We didn't care about it… just run it through so that we can comply with the requirements. We were very unstructured before. But now, the teaching content has been improved" (Female facilitator, aged 25–29 years old). Another facilitator said, "Because before, we did have modules but we did not have SOP. So, it's not standardized, so it depended much on the facilitators, unlike now that it depends on the modules and the SOP" (. (Female facilitator, aged 30–34 years old).

Monitoring mechanisms of patient's recovery process

One-third of the facilitators indicated that INTREPRET strengthened the monitoring mechanisms of the patients' recovery processes. They perceived that the patient's attendance logbook, introduced as part of INTREPRET, enabled better activity tracking. Their response was represented by the following statements: "We didn't have before the tracking sheet [patient's attendance logbook]. So, it's easier when [name of the chief] asks a report about 'how many patients?' or 'where is a patient in INTREPRET sessions?', we can easily track them because of the monitoring sheet" (Female facilitator, aged 35–39 years old); and "We may monitor how far they have been in the program of INTREPRET, how many sessions they have attended. So it is good to check whether these residents have finished the second round, so we can elevate them into the next program like relapse prevention program and then pre-discharge program" (Male facilitator, aged 30–34 years old).

A few facilitators said that the INTREPRET session feedback was discussed at monthly case conferences. One said: "We conduct monthly case conferences for every resident, and then we provide feedback, including their participation in INTREPRET, their insights, and their sharing" (Female facilitator, aged 30–34 years old). Another stated: "We are doing our monthly case management meetings wherein all of the staff or all of the case managers are gathered and we are having feedbacks [from INTREPRET sessions] regarding different patients who have urgent concerns" (Female facilitator, aged 25–29 years old).

Challenges in INTREPRET implementation

Among the challenges in INTREPRET implementation perceived by facilitators, "engaging family members in PE sessions" was the most frequently mentioned (21 facilitators), followed by "lack of facilitators" (15), "securing a conducive place for conducting sessions" (15), and "reproducing Patient's Workbook for CBT Sessions" (5). Several facilitators indicated that family engagement in

the treatment program was a new initiative that did not exist before the introduction of INTREPRET. Nevertheless, the difficulty in engaging family members was attributed to the following reasons: (a) lack of financial means to cover travel costs, (b) living in geographically distant areas from the TRCs, (c) no Wi-Fi or cellphones to attend virtual sessions, and (d) family members being indifferent to the patients. To address the lack of facilitators, several facilitators proposed providing additional training for TRC staff members.

Discussion

Analysis of the interviews highlighted a range of changes engendered by the introduction of INTREPRET. This newly introduced program is a component of the existing TC-based treatment service platform of TRCs, and other new interventions could also have been made available to patients over the past few years; thus, the changes observed in the study may not be entirely due to the effect of INTREPRET. Nevertheless, based on the responses of the participants, INTREPRET displayed significant impacts on various aspects of treatment services in TRCs.

Changes in patients' attitudes and behaviors

There were significant changes in the patient's attitudes and behaviors after the INREPRET sessions. The causal and quantitative effects of INTREPRET on patients' behavioral changes will be presented in an ongoing randomized controlled trial study [15]. However, at least in the patients' narratives, we observed perceived changes related to INTREPRET participation. For example, many patients did not feel comfortable at an early stage and were reluctant to disclose their opinions and thoughts. It is quite common for such situations to arise in the early stages of treatment. In particular, individuals tend to exhibit resistance to self-disclosure of illegal drug use and related personal issues and often experience shame, anxiety, and other negative emotions [30]. However, as the sessions progressed, they began to reflect on their past, gained self-insight into their problems, and began self-disclosure of their experiences and feelings. In psychotherapy, patients' self-awareness and self-disclosure play a vital role in motivating behavior changes [30, 31].

The behavioral changes that patients exhibited during treatment were not only linked to the motivation to cease illicit drug use but also to a decrease in antisocial behaviors, including violent behavior and rule violations in the TRC, and an increase in prosocial behaviors, such as elevated social support for peers. This is consistent with the ultimate goal of INTREPRET, which is not simply focused on drug abstinence but rather on improving the patient's well-being [32]. Therapists or facilitators now treat patients as equal human beings and with respect. These changes could have helped patients feel safe and develop self-insight during treatment [33, 34]; patients may have realized that their drug-using behavior was only one of their many problems and that their "way of life" itself—including their lifestyle, relationships with family and friends, and the way they spent their leisure time—had several problems. It can be inferred that these transitions in patients' understanding of their problems led them to treat others with respect and change their attitude and behavior within the TRC. Another important factor was that the patients admitted to acquiring anger management and social skills in INTREPRET, which they were able to apply in the TRC.

Anger management, one of the CBT topics of INTREPRET, is shown to be effective in decreasing both anger and aggression and is applicable across different cultures, settings, and individuals with a wide range of problems including substance use [35]. Likewise, a vast amount of research supports the effectiveness of social skills training, showing that it improves treatment outcomes and quality of daily life for people with a variety of problems [36]. While the treatment components of INTREPRET were intended primarily to improve substance use outcomes, the study results suggest that they also had a remarkable effect on improving patients' antisocial behaviors in the TRC and therapeutic relationships.

Enhanced therapeutic relationships between patients and facilitators

Importantly, the changes in the patients' attitudes and behaviors occurred in the context of the enhanced relationship with the facilitators. In INTREPRET, it is emphasized that facilitators always respect patients as persons and respectfully listen to and affirm them. In particular, patients who were former residents of the TRC recounted that facilitators were seen as authority figures in previous therapeutic relationships and that a truly human relationship was not possible.

A prior study indicated that, when patients feel that the therapist is sincere, warm, and trustworthy, the therapeutic alliance with the therapist is facilitated, their reflections deepen, and they are more open during self-disclosure [37]. In addition, a large body of research supports the importance of the therapeutic relationship or alliance and its effects on improving treatment outcomes and preventing dropouts from treatment [33, 34, 38, 39]. Furthermore, the therapeutic alliance has been shown to be equally effective in any treatment approach, disorder, and treatment setting [40]. The narratives of both patients and facilitators indicated that the INTREPRET implementation established the aforementioned therapeutic relationships in psychotherapy and that such a relationship is assumed to produce treatment effectiveness.

The treatment component of INTREPRET includes not only CBT but also MI, with the therapists receiving intensive training on these techniques. In treatment for substance use disorders, patients often lack motivation for treatment or have other legal issues, which is not exceptional in TRCs [11]. In such cases, it is often difficult to create a therapeutic alliance. However, CBT training for therapists has been shown to improve therapist-patient relationships and treatment outcomes [41]. In addition, MI emphasizes the importance of treating patients in a respectful, sincere, and warm manner, as well as having supportive and receptive communication and avoiding negative communication such as rebuttals and blame [42, 43].

Changes associated with international key quality standards

We identified that the changes engendered by INTREPRET were directed toward improvements in personal and interpersonal aspects involving patients and facilitators and toward better management of the TRC's treatment services. Most importantly, some identified changes, represented by the domains and key themes, correspond to key quality standards for drug treatment services established by the United Nations Office on Drugs and Crime [44]. In particular, the changes were associated with improvements or enhancements of the following elements of key quality standards: "patients are treated with respect," "interventions are evidence-based and underpinned by established protocols," and "the service has a patient record system that facilitates treatment and care" [44]. Thus, the introduction of INTREPRET, in addition to achieving its primary aim of preventing relapse, could improve the quality of drug dependence treatment services.

Changes in facilitators' attitudes and competence

The introduction of INTREPRET brought about significant changes in the facilitators. By re-evaluating the facilitator as a person who supports patients' growth and well-being rather than as someone who "manages" the patients, the facilitators became aware of the significance of their existence as therapists and supporters. A therapist's greatest joy is seeing a patient change, which, in turn, leads to professional confidence [45]. This is also crucial for therapists' subsequent motivation to further develop their skills and competence [37].

Challenges in the implementation of INTREPRET

Despite a series of perceived positive changes, facilitators raised several challenges in the implementation of INTREPRET. The foremost challenge was the engagement of family members in PE sessions. Family education is an essential intervention that supports the recovery of PWUDs [46, 47] and was introduced as part of INTREPRET. However, family member participation was hampered by geographical, financial, and psychological barriers. Therefore, it is suggested that TRCs take measures to mitigate these barriers, including providing transport allowances and implementing PE sessions in coordination with local government units accessible to family members. The other challenges pertaining to human resources, therapeutic environments, and financial sustainability are typical issues faced by facilities lacking resources. These can be addressed by conducting additional training for facilitators, constructing new TRCs that are conducive to running several group sessions simultaneously, and securing a budget for the continuous reproduction of the Patient's Workbooks. To ensure the sustainability and effectiveness of INTREPRET, it is recommended that these measures be supported by the DOH's policy framework.

Policy implications

The positive aspects of INTREPRET identified in this study suggest that it is a viable model that can be replicated both domestically and globally. The IntERlaPP has already initiated steps toward adapting INTREPRET to outpatient drug dependence treatment services provided by DOH-owned facilities and those managed by local government units [48]. To facilitate the widespread implementation of INTREPRET in the country and ensure its sustainability, it should be integrated into the DOH's strategic and policy framework on the treatment of PWUDs, particularly after INTREPRET's effectiveness is validated by the ongoing randomized controlled trial study [15]. The treatment model and good practices can also be applied to other countries in the region at a similar level of economic development and with similar treatment service structures for PWUDs, especially to those providing treatment services which are not evidence-based.

Limitations of the study

The study has some limitations. Owing to the qualitative nature of the study, causal relationships between INTREPRET and the resulting changes cannot be identified. Although the research team implemented all possible measures to minimize bias in participants' responses, we could not completely mask the fact that this study was sponsored by the JICA, which also supports the implementation of INTREPRET.

Conclusions

This study highlighted a range of positive changes associated with the integration of INTREPRET into the existing TC-based treatment service platform of TRCs. It presented several aspects of changes in patients' attitudes

and behaviors. In particular, an increase in self-awareness and self-disclosure and a decrease in antisocial conduct facilitated by INTREPRET were important elements of patients' behavioral changes, which play a primary role in the recovery process of PWUDs. In addition, the strengthened relationship between patients and facilitators was observed by the study participants. It is considered an essential element of psychotherapy, particularly for providing effective drug-dependence treatment. Furthermore, some identified changes correspond to key international quality standards for drug treatment services. Thus, the results imply that the introduction of INTREPRET could improve treatment service quality and effectiveness. However, despite the positive changes perceived, certain challenges pertaining to family participation in therapy sessions and the lack of resources were identified. To ensure the effectiveness and sustainability of INTREPRET, these challenges must be properly addressed by the government. In addition, INTREPRET should be integrated into the DOH's strategic and policy framework on the treatment of PWUDs, particularly after INTREPRET's effectiveness is validated by the ongoing quantitative study. Further research may replicate the study with other populations, including female patients, as well as explore INTREPRET's applicability to other countries in the region at a similar level of economic development and with similar treatment service structures for PWUDs.

Abbreviations

CBT	Cognitive Behavioral Therapy
DOH	Department of Health
INTREPRET	Intensive Treatment and Rehabilitation Program for Residential Treatment and Rehabilitation Centers
IntERlaPP	Project for Introducing Evidence-based Relapse Prevention Programs to Drug Dependence Treatment and Rehabilitation Centers in the Philippines
JICA	Japan International Cooperation Agency
PE	Psycho-Education
PWUD	People Who Use Drugs
SOP	Standard Operating Procedure
TC	Therapeutic Community
TRC	Treatment and Rehabilitation Center
TWG	Technical Working Group

Acknowledgements
We appreciate the hospital chiefs and chief psychologists at the seven TRCs for their administrative arrangements to secure venues and assign patients and facilitators for the interviews. We also thank all the patients and facilitators who took the time for the interviews. Special thanks are extended to Ms. Ewygene R. Templonuevo for providing English–Tagalog interpretation services during patient interviews. We thank the Japan International Cooperation Agency for funding this research as part of its technical cooperation project IntERlaPP.

Author contributions
SK conceptualized this study, interviewed study participants, analyzed data, and wrote the main manuscript text. TS provided inputs to improve the study design and the manuscript. MTI, AV, and RNC arranged study participants and provided inputs to improve the manuscript. AM provided logistic support for data collection and inputs to improve the manuscript. JP provided inputs to improve the manuscript. TH provided inputs to improve the study design, assisted in the data analysis, and wrote the main manuscript text. All authors reviewed and approved the final version of the manuscript.

Funding
This research was funded by JICA as part of its technical cooperation project IntERlaPP.

Data availability
Raw data is not available because of the sensitive nature of the qualitative interview data.

Declarations

Ethics approval and consent to participate
The authors have obtained ethics approval from the Single Joint Research Ethics Board of the Department of Health, Philippines (Protocol No.: SJREB-2023-46). Written consent was obtained from each participant.

Consent for publication
Not applicable.

Competing interests
The authors declare no competing interests.

Author details
[1]Department of Global Network and Partnership, Bureau of International Health Cooperation, National Center for Global Health and Medicine, 1-21-1 Toyama, Shinjuku-ku, Tokyo 162-8655, Japan
[2]Department of Community and Global Health, Graduate School of Medicine, The University of Tokyo, 7-3-1 Hongo, Bunkyo-ku, Tokyo 113-0033, Japan
[3]Department of Psychiatry, Teine Keijinkai Medical Center, 1-12 Maeda, Teine-ku, Sapporo 006-8555, Japan
[4]Philippine Institute of Traditional and Alternative Health Care, Matapang St., East Avenue, Barangay Central, Diliman, Quezon City, Philippines
[5]Drug Abuse Treatment and Rehabilitation Center Bicutan, 5th Road, Camp Bagong Diwa, Bicutan, Taguig City, Philippines
[6]Drug Abuse Treatment and Rehabilitation Center Dagupan, Sitio Palatong, Bonuan Binloc, Dagupan City, Philippines
[7]Project for Community-Based Crime Prevention, Supervision, Rehabilitation and Reintegration of Children and Young Persons in Conflict with the Law in Kenya, Probation and Aftercare Services Reinsurance Plaza, 11th Fl., Taifa Rd., Nairobi, Kenya
[8]Drug Abuse Treatment and Rehabilitation Center Cebu, Eversley Compound, Cebu North Road, Jagobiao, Mandaue City, Philippines
[9]School of Human Sciences, University of Tsukuba, 3-29-1 Otsuka, Bunkyo-ku, Tokyo 112-0012, Japan

Received: 8 March 2024 / Accepted: 25 October 2024
Published online: 14 November 2024

References
1. Dangerous Drugs B. 2015 Nationwide Survey on the Nature and Extent of Drug Abuse in the Philippines. Quezon City: Philippines; 2015.
2. Ranada P. More than 1 million drug addicts surrender to gov't. Rappler. 2016.
3. Department of Health. Manual of operations for drug abuse treatment and Rehabilitation. Manila: Republic of the Philippines; 2013.
4. Obert JL, McCann MJ, Marinelli-Casey P, Weiner A, Minsky S, Brethen P, et al. The matrix model of outpatient stimulant abuse treatment: history and description. J Psychoact Drugs. 2000;32(2):157–64. https://doi.org/10.1080/02791072.2000.10400224.
5. Huber A, Ling W, Shoptaw S, Gulati V, Brethen P, Rawson R. Integrating treatments for methamphetamine abuse: a psychosocial perspective. J Addict Dis. 1997;16(4):41–50. https://doi.org/10.1080/10550889709511142.
6. Harada T. Kakuseizai Jukeisha Ni Taisuru Nihonban Matrix Program (J-MAT) no Randam Hikaku Shiken [The randomized controlled trial of the prison-based Japanese Matrix Program (J-MAT) for methamphetamine abusers]. Nihon Arukoru Yakubutsu Igakkai Zasshi. 2012;47(6):298–307.

7. Carroll KM, Kiluk BD. Cognitive behavioral interventions for alcohol and drug use disorders: through the stage model and back again. Psychol Addict Behav. 2017;31(8):847–61. https://doi.org/10.1037/adb0000311.
8. Beck JS. Cognitive behavior therapy: basics and beyond. New York: Guilford; 2020.
9. Rawson RA, McCann MJ, Flammino F, Shoptaw S, Miotto K, Reiber C, et al. A comparison of contingency management and cognitive-behavioral approaches for stimulant-dependent individuals. Addiction. 2006;101(2):267–74. https://doi.org/10.1111/j.1360-0443.2006.01312.x.
10. Harada T, Tsutomi H, Mori R, Wilson DB. Cognitive-behavioural treatment for amphetamine-type stimulants (ATS)-use disorders. Campbell Syst Rev. 2019;15(1–2):e1026. https://doi.org/10.1002/cl2.1026.
11. Harada T, Kanamori S, Baba T, Takano A, Nomura K, Villaroman A, et al. Sociodemographic profiles and determinants of relapse risks among people with substance use disorders in the Philippines: a survey in community and residential care settings. Drug Alcohol Depend. 2023;251:110924. https://doi.org/10.1016/j.drugalcdep.2023.110924.
12. Department of Health. Accredited Drug Abuse Treatment and Rehabilitation Centers as of December 31, 2023. Manila: Philippines. 2023. https://docs.google.com/spreadsheets/u/0/d/e/2PACX-1vRFxdT4eb-IoScXWUfAWnoj2b6FgAMijfwqSwq1P4BacMjFJH-MFsQMe1-hABusiLDCElCX3f9Xe5Xv/pubhtml?pli=1#.
13. Dangerous Drugs Board. Board Regulation No.7 Series of 2019: Consolidated revised rules governing Access to Treatment and Rehabilitation Programs and Services. Quezon City: Philippines; 2019.
14. Bunt GC, Muehlbach B, Moed CO. The Therapeutic Community: an international perspective. Subst Abus. 2008;29(3):81–7. https://doi.org/10.1080/08897070802218844.
15. Harada T, Baba T, Shirasaka T, Kanamori S. Evaluation of the Intensive Treatment and Rehabilitation Program for Residential Treatment and Rehabilitation Centers (INTREPRET) in the Philippines: a study protocol for a randomized controlled trial. Trials. 2021;22(1):909. https://doi.org/10.1186/s13063-021-05882-6.
16. Caris L, Beckers T. Accessibility of substance use treatment: a qualitative study from the non-service users' perspective. J Subst Abuse Treat. 2022;141:108779. https://doi.org/10.1016/j.jsat.2022.108779.
17. Russell C, Ali F, Nafeh F, LeBlanc S, Imtiaz S, Elton-Marshall T, et al. A qualitative examination of substance use service needs among people who use drugs (PWUD) with treatment and service experience in Ontario, Canada. BMC Public Health. 2021;21(1):2021. https://doi.org/10.1186/s12889-021-12104-w.
18. Alves PCG, Stevenson FA, Mylan S, Pires N, Winstock A, Ford C. How do people who use drugs experience treatment? A qualitative analysis of views about opioid substitution treatment in primary care (iCARE study). BMJ Open. 2021;11(2):e042865. https://doi.org/10.1136/bmjopen-2020-042865.
19. Hechanova MRM, Alianan AS, Calleja MT, Melgar IE, Acosta A, Villasanta A, et al. The development of a community-based drug intervention for Filipino Drug users. J Pac Rim Psychol. 2018;12:e12. https://doi.org/10.1017/prp.2017.23.
20. Azad AH, Khan SA, Ali I, Shafi H, Khan NA, Umar SA. Experience of psychologists in the delivery of cognitive behaviour therapy in a non-western culture for treatment of substance abuse: a qualitative study. Int J Ment Health Syst. 2022;16(1):55. https://doi.org/10.1186/s13033-022-00566-3.
21. Ekström V, Johansson M. Sort of a nice distance: a qualitative study of the experiences of therapists working with internet-based treatment of problematic substance use. Addict Sci Clin Pract. 2019;14(1):44. https://doi.org/10.1186/s13722-019-0173-1.
22. Department of Health. INTREPRET Series No. 2a - Patient's Workbook for Cognitive Behavioral Therapy Sessions: Intensive Treatment and Rehabilitation Program for Residential Treatment and Rehabilitation Centers for Drug Dependents (INTREPRET) 1st Edition. Manila: Philippines. 2020. https://www.jica.go.jp/Resource/project/english/philippines/013/materials/c8h0vm0000fd3swf-att/material_02a.pdf
23. Department of Health. INTREPRET Series No. 3b - Presentation Modules (English) for Psycho-Education Sessions: Intensive Treatment and Rehabilitation Program for Residential Treatment and Rehabilitation Centers for Drug Dependents (INTREPRET) 1st Edition. Manila: Philippines. 2020. https://www.jica.go.jp/Resource/project/english/philippines/013/materials/c8h0vm0000fd3swf-att/material_03a.pdf
24. Department of Health. INTREPRET Series No. 4a - Discussion Topics for Social Support Sessions: Intensive Treatment and Rehabilitation Program for Residential Treatment and Rehabilitation Centers for Drug Dependents (INTREPRET) 1st Edition. Manila: Philippines. 2020. https://www.jica.go.jp/Resource/project/english/philippines/013/materials/c8h0vm0000fd3swf-att/material_04a.pdf
25. Miller WR, Rollnick S. Motivational interviewing: helping people change. New York, NY: A Division of Guilford Publications, Inc.; 2013.
26. Department of Health. INTREPRET Series No. 1 - Service Provider's Manual: Intensive Treatment and Rehabilitation Program for Residential Treatment and Rehabilitation Centers for Drug Dependents (INTREPRET) 1st Edition. Manila: Philippines. 2020. https://www.jica.go.jp/Resource/project/english/philippines/013/materials/c8h0vm0000fd3swf-att/material_01.pdf
27. Department of Health. INTREPRET Series No. 6 - Guidelines for Field Evaluation: Intensive Treatment and Rehabilitation Program for Residential Treatment and Rehabilitation Centers for Drug Dependents (INTREPRET) 1st Edition. Manila: Philippines. 2020. https://www.jica.go.jp/Resource/project/english/philippines/013/materials/c8h0vm0000fd3swf-att/material_06.pdf
28. VERDI Software. MAXQDA 2022 [Computer Software]. maxqda.com; 2022.
29. Braun V, Clarke V. Using thematic analysis in psychology. Qual Res Psychol. 2006;3(2):77–101. https://doi.org/10.1191/1478088706qp063oa.
30. Farber BA. Patient self-disclosure: a review of the research. J Clin Psychol. 2003;59(5):589–600. https://doi.org/10.1002/jclp.10161.
31. Farber BA, Berano KC, Capobianco JA. Clients' perceptions of the process and consequences of Self-Disclosure in Psychotherapy. J Couns Psychol. 2004;51(3):340–6. https://doi.org/10.1037/0022-0167.51.3.340.
32. Japan International Cooperation Agency. The Project for Introducing Evidence-based Relapse Prevention Programs to Drug Dependence Treatment and Rehabilitation Centers in the Philippines (IntERlaPP) 2017 [cited 12 February 2024]. https://www.jica.go.jp/Resource/project/english/philippines/013/index.html
33. Norcross JC, Lambert MJ. Psychotherapy relationships that work II. Psychotherapy. 2011;48(1):4–8. https://doi.org/10.1037/a0022180.
34. Del Re AC, Flückiger C, Horvath AO, Symonds D, Wampold BE. Therapist effects in the therapeutic alliance-outcome relationship: a restricted-maximum likelihood meta-analysis. Clin Psychol Rev. 2012;32(7):642–9. https://doi.org/10.1016/j.cpr.2012.07.002.
35. Dewi IDADP, Kyranides MN, Physical, Verbal, Aggression R. The role of anger management strategies. J Aggress Maltreat Trauma. 2022;31(1):65–82. https://doi.org/10.1080/10926771.2021.1994495.
36. Mueser KT, Bellack AS. Social skills training: alive and well? J Mental Health. 2007;16(5):549–52. https://doi.org/10.1080/09638230701494951.
37. Ackerman SJ, Hilsenroth MJ. A review of therapist characteristics and techniques positively impacting the therapeutic alliance. Clin Psychol Rev. 2003;23(1):1–33. https://doi.org/10.1016/s0272-7358(02)00146-0.
38. Asay TP, Lambert MJ. The empirical case for the common factors in therapy: quantitative findings. In: Hubble MA, Duncan BL, Miller SD, editors. The heart and soul of change: what works in therapy. American Psychological Association; 1999. pp. 23–55.
39. Horvath AO, Re AD, Flückiger C, Symonds D. 25Alliance in individual psychotherapy. In: Norcross JC, editor. Psychotherapy relationships that work: evidence-based responsiveness. Oxford University Press; 2011. pp. 25–69. https://doi.org/10.1093/acprof:oso/9780199737208.003.0002.
40. Flückiger C, Del Re AC, Wampold BE, Symonds D, Horvath AO. How central is the alliance in psychotherapy? A multilevel longitudinal meta-analysis. J Couns Psychol. 2012;59(1):10–7. https://doi.org/10.1037/a0025749.
41. Muran JC, Safran JD, Eubanks CF, Gorman BS. The effect of alliance-focused training on a cognitive-behavioral therapy for personality disorders. J Consult Clin Psychol. 2018;86(4):384–97. https://doi.org/10.1037/ccp0000284.
42. Kouimtsidis C, Salazar C, Houghton B, Motivational Interviewing. Behaviour Change in Addiction Treatment. In: el-Guebaly N, Carrà G, Galanter M, Baldacchino AM, editors. Textbook of Addiction Treatment: International perspectives. Cham: Springer International Publishing; 2021. pp. 349–63. https://doi.org/10.1007/978-3-030-36391-8_24.
43. Miller WR, Rollnick S. Motivational Interviewing: Helping People Change and Grow, 4th Edition. New York: Guilford Publications; 2023.
44. UNODC/WHO. Quality assurance in treatment for drug use disorders: key quality standards for service appraisal. Vienna: UNODC; 2021.
45. Beidas RS, Kendall PC. Training therapists in evidence-based practice: a critical review of studies from a systems-Contextual Perspective. Clin Psychol (New York). 2010;17(1):1–30. https://doi.org/10.1111/j.1468-2850.2009.01187.x.
46. Substance Abuse and Mental Health Services Administration. Counselor's Family Education Manual: Matrix Intensive Outpatient Treatment for People With Stimulant Use Disorders. Rockville, MD: SAMHSA. 2006. https://store.samhsa.gov/sites/default/files/sma13-4153.pdf

47. Barnard M. Drug addiction and families. London and Philadelphia: Jessica Kingsley; 2007.
48. Department of Health. ENTREPOSE Series No. 1 - Service Provider's Manual: Enhanced Treatment Program for Outpatient Services for Drug Users (ENTREPOSE) 1st Edition. Manila: Philippines. 2021. https://www.jica.go.jp/Resource/project/english/philippines/013/materials/c8h0vm0000fgmors-att/materials_02_01.pdf

Publisher's note

Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.