

## Experiences of Individuals with Alcohol and Drug Addiction at Rehabilitation Centres in Ghana

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### Abstract

**Background and Objective:** Although rehabilitation helps to restore the physical, social, psychological, and emotional health and wellbeing of individual addicts, their families, and communities, it is often inadequate in many parts of the world, especially in developing nations, despite the high level of alcohol and drug use and addictions. This was a qualitative study and explored the experiences of alcohol and drug addiction patients at two rehabilitation centres in Ghana.

**Methods:** The sample comprised fourteen patients and fourteen service providers at two rehabilitation centres in Cape Coast Metropolis, Ghana. An interview guide was used to conduct tape-recorded in-depth interviews and the data were analysed through content analysis. The study adopted a phenomenological research paradigm to understand the lived experiences of the study participants and to provide a comprehensive understanding of the dynamics of rehab services and patients' experiences.

**Results:** The results indicated that addiction patients argued that recovery from addiction and compliance with rehabilitation service was a challenge as a result of poor and inadequate material and human resources. The patients also expressed their dissatisfaction about negative attitudes of service providers at the centres. The negative attitudes of service providers, among other things, could result in a delay of patients' recovery and in relapse of their conditions.

**Conclusion:** Patients must not be viewed as victims of their circumstances; instead, they must be motivated to speed up their recovering processes. Also, creating an enabling environment for service providers and patients could foster peaceful interaction and co-existence which would facilitate recovery processes. There should be periodic review of rehab services and training for rehab service providers to improve rehab services and to make them more accessible.

**Keywords:** Alcohol and drug addicts; Addiction; Rehabilitation

### Background

The misuse of alcohol and drugs is a challenge faced by numerous nations throughout the globe as illicit drug and alcohol use has serious effects on people's health and livelihood as well as national economies [1]. It is estimated that 200 million people take illicit drugs every year that translates to 1 in 20 people aged 15 to 64 taking an illicit drug, while 25 million are regarded as drug addicts and at least 15.3 million with drug use disorders [2]. Alcohol and drug addiction is a complex illness characterised by intense and, at times, uncontrollable craving, along with compulsive seeking and use that persist even in the face of devastating consequences [3]. Individuals with addiction globally encounter socio-economic and health effects but these experiences are predominant in sub-Saharan Africa including Ghana [4]. Thus, people with addiction for the most part experience family problems, accidents, criminal conduct, violence, homicide and suicide, cardiovascular disease, cirrhosis, and mental disorders as well as death [4]. Nonetheless, alcohol and drug addiction is as yet not perceived as a medical issue in numerous societies including Ghana [5].

Consequently, numerous individuals with addiction are vilified and have limited or no access to treatment and rehabilitation services [5]. Most people become alcohol and drug addicts because of shame, guilt, and stigmatisation owing to family disruption, family violence, loss of employment and financial instability, marital breakdown, physical and psychological abuse as well as continuous advertisement of alcohol and drug products [6]. Rehabilitation, which helps to restore the health, social, psychological, and emotional wellbeing of the individual addicts, their families, and communities, is often limited in many parts of the world especially in developing nations including Ghana despite the high level of alcohol and drug use and addictions [7,8].

Globally, there are limited medical facilities accessible for rehabilitation of alcohol and drug addiction and only 1.7 beds per 100,000 populations are available for rehabilitation of this condition [9]. Just a single in six addicts worldwide receive treatment or rehabilitation every year, and only nine percent of nations have routine screening and brief mediations for alcohol and drug use disorders in primary health care facilities [10]. Even with limited data, it is still evident that low-income and middle-income countries and vulnerable populations bear an increased burden of disease and injury due to

increasing drug and alcohol use and limited or non-existent public health and prevention policies and programmes [11].

Deci and Ryan [12] explain in Self-Determination Theory (SDT) that factors such as rewards, sanctions, use of authority, provision of choice, and level of challenge impact patients' experiences, and in turn their behavioural persistence and outcomes. As a result, a patient's experiences of autonomy, competence, and relatedness are affected by socio-demographic characteristics such as age, sex, religion, marital status, educational status, and among others which consequently influence a patient's ability to comply with rehabilitation services and to recover from his or her condition [12]. Also, a patient's experiences of personal and structural factors such as rehabilitation care organisation and climates, individual differences in personality regarding autonomy, and the intrinsic and extrinsic nature of the patient's aspirations or strivings also impact lifestyle and value priorities and ability to recover [12].

Despite the fact that some studies [7,13-15] have been conducted in Ghana on alcohol and drugs use as well as addiction, there are limited data on rehabilitation of alcohol and drug addicts in Ghana. It is therefore evident that there is a paucity of literature on rehabilitation of alcohol and drug addicts in Ghana [7,14]. This study, therefore, sought to explore experiences of alcohol and drug addicts at rehabilitation centres in the Cape Coast Metropolis of Central Region, Ghana. This is because Central Region has the highest alcohol and drug addiction (15%) far above the national average (6.2%) in Ghana [14].

## Methods

### Participants

The population of this study included alcohol and drug addicts undergoing rehabilitation, former inmates of alcohol and drug addiction rehabilitation, and rehabilitation service providers at two major rehabilitation centres in the Cape Coast Metropolis, Ghana. The service providers were included in the studies to explore their views about the experiences of the addiction patients. Background information of the participants could be found in Tables 1 & 2. The data for this study was derived from 28 In Depth Interviews (IDI) with rehabilitation service providers and alcohol and drug addiction patients at Ankaful and Mercy Rehabilitation Centres in the Cape Coast Metropolis of Central Region, Ghana. Of the 28 participants sampled for the study, five were selected from the Mercy Rehabilitation Centre, owned by a Church and 23 were also from the Ankaful Rehabilitation Centre which is also owned by the Government of Ghana under the management of the Ghana Health Service. The participants consisted of 14 service providers and 12 patients undergoing rehabilitation and two former rehabilitated patients at the two rehabilitation centres. The two rehabilitation centres were selected because they were the only available alcohol and drug addiction rehabilitation centres in the Cape Coast Metropolis of the Central Region, Ghana as of the time of the study.

Respondent's ID	Age	Sex	Academic Qualification	Area of Specialisation	Marital Status	Religion	Number of years of work at the centre	Rehabilitation Centre
A	54	Male	Masters	Counsellor (Chaplain)	Single	Christian	13	Mercy Centre
B	28	Male	Degree	General Nursing	Single	Christian	2	Ankaful Centre
C	30	Female	Diploma	Mental Health Nursing	Cohabiting	Christian	3	Ankaful Centre
D	29	Male	Degree	General Nursing	Single	Christian	5	Ankaful Centre
E	25	Male	Diploma	Mental Health Nursing	Single	Christian	2	Ankaful Centre
F	28	Male	Diploma	Mental Health Nursing	Single	Christian	2	Ankaful Centre
G	24	Female	Diploma	Mental Health Nursing	Single	Christian	4	Ankaful Centre
H	34	Female	Degree	General Nursing	Married	Christian	5	Ankaful Centre
I	29	Female	Diploma	Mental Health Nursing	Cohabiting	Christian	4	Ankaful Centre
J	34	Male	Diploma	Mental Health Nursing	Married	Christian	3	Ankaful Centre
K	26	Female	Diploma	Mental Health Nursing	Married	Muslim	4	Ankaful Centre
L	27	Female	Diploma	Mental Health Nursing	Married	Christian	3	Ankaful Centre

M	26	Male	Diploma	Mental Health Nursing	Single	Christian	2	Ankaful Centre
N	52	Male	Degree	Clinical Psychologist	Married	Christian	5	Ankaful Centre

**Table 1:** Socio-demographic characteristics of service providers.

### Techniques

Purposeful and accidental sampling techniques were adopted for the study. The purposeful sampling technique was used to select the service providers and the two former inmates of rehabilitation while the accidental sampling technique was used to select the addicts undergoing rehabilitation at the centres. The researchers interviewed one male service provider and four addiction patients consisting of one female and three males at the Mercy Rehabilitation Centre while 10 male addiction patients and seven male and six female service providers were also interviewed at the Ankaful Rehabilitation Centre. The intention was to interview an equal number of respondents and to interview an equal number of males and females at both centres. However, this could be not possible because that was the available

number of addiction patients and service provider at the Mercy Rehabilitation Centre. The Ankaful Rehabilitation Centre, there were only 10 addiction patients on admission and all of them were males. More importantly, the service providers at the Ankaful Rehabilitation Centre were also selected based on their availability and readiness to participate in the study having clearly explained the purpose of the study to them. Phenomenology research paradigm was adopted for this qualitative research study in order to comprehensively describe dynamics of the experiences of the study participants [16]. This research paradigm helped to understand and describe the meaning, structure, and essence of the experiences of the individuals with alcohol and drug addiction at rehab centres [16].

Respondent's ID	Age	Sex	Level of Education	Marital Status	Children	Employment Status	Religion	Length of stay at the Centre	Rehabilitation Centre
A	54	Female	Tertiary	Single	None	Lost job	Christian	2 months	Mercy Centre
B	38	Male	Tertiary	Single	1	Lost job	Christian	2 months	Mercy Centre
C	16	Male	Primary	Single	None	Student	Christian	1 month	Mercy Centre
D	30	Male	Secondary school	Married	2	Unemployed	Christian	4 months	Ankaful Centre
E	25	Male	Secondary school	Single	None	Unemployed	Christian	4 months	Ankaful Centre
F	31	Male	Vocational school	Married	3	Lost job	Christian	5 months	Ankaful Centre
G	39	Male	Tertiary	Married	4	Lost job	Christian	3 months	Ankaful Centre
H	27	Male	Vocational school	Single	None	Unemployed	Muslim	2 months	Ankaful Centre
I	42	Male	Vocational school	Married	4	Lost job	Christian	4 months	Ankaful Centre
J	24	Male	Tertiary	Single	None	Unemployed	Christian	3 months	Ankaful Centre
K	35	Male	Primary	Married	6	Lost job	Christian	5 months	Ankaful Centre
L	30	Male	Secondary school	Single	2	Lost job	Christian	4 months	Ankaful Centre
M*	48	Male	Junior High School	Single	3	Lost job	Christian	2 months	Mercy Centre
N*	26	Male	Secondary school	Single	None	Unemployed	Christian	6 months	Ankaful Centre

**Table 2:** Socio-Demographic characteristics of patients (Addicts).

## Procedure

The number of service providers at the Ankaful Rehabilitation Centre was achieved through saturation since they were all giving similar responses. In addition, the two former addicted inmates were contacted and interviewed through the administrators or in-charges of the two centres. The interviews were conducted in English, Fante, Twi, and Ewe based on the language the respondent was comfortable with but most (25) of the respondents spoke English. Prior to the data collection, permission to conduct the interviews at the two centres was sought through letters and personal contact with personnel of the centres. The personnel contacted were heads of the two centres who gave their approval to the study and helped to identify the required respondents. Although permission was granted by the heads, all the respondents' consents were obtained before conducting the actual interview with them. Ethical approval for the studies was given by the Graduate School of the University of Cape Coast. Pseudonyms were therefore used to represent the respondents in the study. Furthermore, none of the respondents declined to partake in the study. The interview on average lasted 45 min for the patients and 60 min for the service providers.

## Data analysis

All interviews were tape-recorded and then transcribed and the interviews conducted in the local languages were translated into English. The meanings in the data were captured and summarised using codes and labels described by Corbin and Strauss [17] in three stages. At the first stage (open coding), codes with similar meanings in the data were clustered into themes and at the second stage (axial coding), major categories of themes were identified with their relatedness to each other. The themes at the final stage (selective coding) were illustrated using quotes and by comparing meanings in the themes.

## Results and Discussion

The results were presented according to themes derived from the interviews and presented together to offer a comprehensive picture of the experiences of alcohol and drug addiction patients. Where necessary, the actual words of respondents were cited to provide a glimpse of their views. The socio-demographic characteristics of the participants interviewed for the study were displayed in Tables 1 and 2 correspondingly.

### Experiences of alcohol and drug addiction patients

The respondents for the study (addiction patients) were interviewed on their personal experiences of alcohol and drug addictions and their general experiences at the rehabilitation centres in order to ascertain how their personal experiences and general experiences at the rehabilitation centres influenced their recovery.

#### Personal experiences of patients with alcohol and drug addiction

The respondents (patients) at both Ankaful and Mercy Rehabilitation Centres were asked about their experiences with alcohol and drug addiction. As such, the patients including the two former inmates attributed the causes of alcohol and drug addiction to a number of circumstances including unemployment, poverty, broken homes, disappointed by a partner, peer influence, loss of a loved one, and failure in an examination as well as barrenness and loss of a job. The respondents were straightforward and stated the factors, which

according to them, led them into drugs and alcohol use and addiction. The following quotes are how some of the respondents stated their case.

*I went for the funeral of friend's father on a weekend which I was not supposed to go to work and when I went to work on Monday, my boss asked me to go home because I went for a funeral without his knowledge. I became disturbed and did not know what to do because that job was what my family depended on. I started drinking and later added marijuana to it to reduce my frustration (M: A 48 yr old single male patient at Mercy Rehabilitation Centre).*

*I completed Senior High School with good grades but I had no one to pay for fees to enable me further my education because my parents did not have money. I became worried and disturbed whenever I saw my Senior High School mates from higher institutions because I was even better than most of them but due to lack of money to pay my fees, they were in school while I was at home. I started using alcohol to clear the shame and the frustration (H: A 27 yr old single male patient at Ankaful Rehabilitation Centre).*

**Socio-economic effects:** it has been observed that drug and alcohol addicted patients face socio-economic challenges [18] as a result, the patients were asked about some socio-economic challenges they experienced with their addiction. Responding, the patients considered their alcohol and drug addiction to be associated with streetism, stealing, loss of properties, rejection by family and friends, exclusion from societal activities, divorce, and loss of a job.

*My friends did not want to associate with me anymore because of my condition. People did not want me close to their houses. I always woke up in people's drinking bars, in front of shops, and unkempt places (K: A 35 yr old married male patient at Ankaful Rehabilitation Centre).*

**Health effects:** Addiction could have some health consequences [19] as well and as such, the patients were asked about some health effects they have experienced with their addiction. The respondents, therefore, explained that they experienced certain health conditions when they started and became alcohol and drug addicts. The patients emphasised these health conditions to be severe headaches, problems with breathing and the heart, sight, hearing and speech problems, coughs, pains in the stomach, loss of weight, and weakened body.

*I always felt pains in my head, eyes, and abdomen whenever I woke up from sleep so I had to use alcohol to reduce those pains. I became very pale and weak before I was brought here (B: A 38 yr old single male patient at Ankaful Rehabilitation Centre).*

Data gathered from both Ankaful and Mercy Rehabilitation Centres show that all the patients were basically alcohol addicts while few of them were also addicts of marijuana, cocaine, pethidine, and hallucinogens. The service providers further reported that most of the patients who were addicted to other drugs (marijuana, cocaine, pethidine, and hallucinogens), were also addicted to alcohol and therefore were both alcohol and other drug addiction patients. It emerged from the study that the level of aggression of a patient at the centres differs from one patient to another based on the substance the patient was addicted to. The service providers also narrated that other drug addiction patients were more aggressive, violent, and have co-occurrence conditions than alcohol-only addiction patients. According to the service providers at the two rehabilitation centres, the patients experienced co-occurrence conditions like liver cirrhosis, problems of

the heart, speech, sight or vision, hearing, and trembling and weakened body.

*Alcohol addiction patients are less aggressive and violent and experience less liver and heart problems, vision and hearing problems compared to other drug addiction patients* (K: A 26 yr old female Mental Health Nursing service provider at Ankaful Rehabilitation Centre).

It was found from the study that socio-economic factors including unemployment, poverty, broken homes, disappointment by a partner, peer influence, loss of a loved one, and failure in an examination as well as barrenness and loss of job predisposed patients to alcohol and drug use and addiction. From the study, it was observed that rehabilitation patients were mostly alcoholics which could be due to the dominance and easy access to alcohol as well as advertisements on alcoholic drinks compared to other drugs. The study further revealed that alcohol and drug addiction patients experience socio-economic and health effects including liver cirrhosis, problems of the heart, speech, sight or vision, hearing, trembling and weakened body, streetism, stealing, loss of properties, rejection by family and friends, exclusion from societal activities, divorce, and loss of job. These findings from the study support what Amoakwa-Fordjour [18] identifies that living in poverty or social isolation, being unemployed or highly stressed in work, bereavement or divorce increases the desire for alcohol and other drug use and subsequently addictions as a coping mechanism. United Nations Office on Drugs and Crime [2] also finds that alcohol is used by most people globally. Similarly, UNICEF [1] indicates that drugs often used and abused include tobacco, alcohol, heroin, cocaine, mandrax, ecstasy, prescription medications, cannabis and hallucinogens due to their easy access and availability. Furthermore, Buckley [19] identifies that alcohol and drug addiction results in raised blood pressure, respiratory failure, heart attacks, panic attacks, depression, schizophrenia, anxiety, irritability, extreme fatigue, and paranoia. Similarly, GSS et al. [14] acknowledge that addiction increases the risk of accidents, violence, cirrhosis, hypertension, psychological illnesses, and congenital malformations as well as unintentional injuries. Consistently, Selby [7] finds that many families in Ghana tend to alienate themselves from their relatives with alcohol and drug addictions due to the amount of resources that have to be spent, level of stigmatisation by the society, loss of suitors, contracts, possessions, and jobs.

#### **Experiences of alcohol and drug addiction patients at the rehabilitation centres**

**Availability of resources:** Williams and colleagues [20] indicate that individuals comply and recover from their poor health conditions when they feel their psychological and social needs such as better mental health, accommodation and sanitation, greater quality of life, and greater intake of food are being supported. The patients including the two former inmates at both Ankaful and Mercy Rehabilitation Centres were asked to narrate their experiences with availability of resources at the centres. The patients indicated that they were provided with pipe borne water for drinking, bathing, and washing; dry lines, electricity, accommodation with single beds, toilet and bathrooms, and fenced centres were provided. They further disclosed that they were provided with games such as ludo and checkers as well as TV sets to entertain them. The patients including the two former inmates at the two centres, however, recounted that they were not provided with playing fields and therefore they did not do exercises to keep themselves fit. They explained that they did not go jogging or play outdoor games and therefore felt bored and sometimes weak.

*We have other facilities but we feel bored and lonely sometimes and would wish to play football or basketball and even go for jogging to entertain and exercise our body but we do not engage in such activities here. It feels sad actually that we do not do these things* (J: A 24 yr old single male patient at Ankaful Rehabilitation Centre).

The current patients and a former inmate at the Mercy Centre also emphasised that they were provided with enough resources because their centre and the rooms were large with good ventilations, and a library. They also disclosed that they had self-contained rooms with toilet and bathrooms, tables and chairs, wardrobes, fans, and fridges. They further recognised that the centre was serene and beautiful and therefore they felt comfortable at the centre.

*To be sincere with you, this centre is far better than my house because the facilities here are more and better than what I have or my parents have. I feel comfortable to be at this centre and therefore I do not think about anything outside this place. It is actually motivating and interesting to be here* (C: A 16 yr old single male patient at Mercy Rehabilitation Centre).

However, it emerged from the study that patients at the Ankaful Rehabilitation Centre were not satisfied with conditions at the centre. The patients indicated that the centre and their rooms were very small leading to overcrowding and poor ventilations which made their rooms always hot, especially when there was electricity power outage (which occurred very often). The patients also reported that there were no wardrobes in their rooms for them to keep their clothes. They also emphasised that the Ankaful Rehabilitation centre, in general, lacked maintenance and has defaced walls, old and broken chairs, tables, doors and windows, fans, and leaking roofs. The patients reported their displeasure that they felt worried and ashamed as well as unsecured sometimes staying at the centre because they felt that the centre was abandoned or not been cared for.

*I feel sad staying at this centre sometimes. How could our guardians pay so much money to these people and this place is like this? The roofs leak anytime it rains and the centre is defaced. We use broken and old facilities like tables, chairs, fans, doors, and windows. The nature of facilities available at this centre discourages me a lot because I feel that the authorities do not care about the centre and us* (F: A 31 yr old married male patient at Ankaful Rehabilitation Centre).

It was therefore evident from the study that there were limited physical and human resources at the rehabilitation centres where some of the available resources were not in good conditions which interfered with the patients' level of comfort and discouraged their level of participation in the rehabilitation services. Also, the findings show that the patients were able to comply with and engage in the rehabilitation services due to the relatively good conditions of some of the limited available resources. Thus, the quantity and quality of resources and facilities available to alcohol and drug addiction patients influenced compliance of patients with rehabilitation services and recovery from addiction. Hence, availability and quality of resources facilitated compliance and recovery, whilst limited and poor resources resulted in non-compliance and slowed recovery from addiction. Again, it was established from the study that some patients had the internal ability (desire to improve personal conditions and recover) to comply and recover from their uncomfortable conditions but were discouraged by the resources available to them. External factors, according to Ajzen and colleagues [21], including an availability of resources affect an individual's behaviour and influence compliance with rehabilitation services and recovery from addiction.

**Attitudes of service providers:** The attitudes of rehabilitation service providers like any other health workers are crucial in rehabilitation services because they have influences on the nature and quality of rehabilitation services offered [22]. The patients interviewed (both current patients and the two former inmates) at both Ankaful and Mercy Rehabilitation Centres were asked to share their experiences with the attitudes of rehabilitation service providers at the centres. As a result, the patients reported that service providers had positive attitudes towards them and therefore they also in return exhibited positive attitudes towards the service providers. The patients elaborated that the service providers were generally friendly and approachable and therefore they (patients) sometimes confided in them for advice on personal issues. The patients further stated that the service providers made sure that every patient at the centres performed his or her duties assigned to him or her. Also, according to the patients, the service providers even used their own telephones to call their (patients') relatives and friends for them to talk to whenever they asked them for such service. They again reported that the service providers escorted them to buy items they needed from shops outside the centres and even played games and chatted with them. With regard to their names they were addressed by the service providers, the patients explained that the service providers respectfully addressed them by their first names; a sign of respect. Furthermore, the patients at the two centres disclosed that the service providers did not discriminate against them because they treated all the patients equally irrespective of age, sex, level of education, marital status, religion, and ethnicity. They quickly added that the attitudes showed them made them happy and felt comfortable at the centre compared to their homes where they were treated with no respect. As indicated by a respondent:

*The service providers are like brothers and sisters to us. They treat us with respect and so we also respect them. They always ask about our health first and are always encouraging us to comply with them so that they can do their best to help us. They call me and any other inmates by our first names and even play ludo and checkers with us at times. They are actually good people to be with* (H: A 27 yr old male patient at Ankaful Rehabilitation Centre).

However, the patients at the Ankaful Rehabilitation Centre disclosed that some of the service providers particularly the female ones were unfriendly because they often spoke to them rudely, insulted, and even addressed them with words such as "hey", "madman", "irresponsible man", "drunkard" or "wee smoker" and some of them (patients) also reacted by insulting or attacking those service providers. The patients further explained that some of these service providers would be making phone calls and texting messages and when they needed their services, these service providers would not attend to them but would rather talk to them (patients) rudely. The respondents also intimated that some of the service providers treated them based on ethnicity, religion, employment, and age. They tended to have more time with patients they (service providers) shared similar background characteristics with than others. A patient had this to say:

*Some of the service providers especially the female ones would always come and look for inmates from their ethnic group first and those who have higher education or good employment before being to the centre. They even call us the young ones "hey" but call the elderly inmates "Sir or Mr." They even call their favourites for individual counselling before us* (D: A 30 yr old married male patient at Ankaful Rehabilitation Centre).

The patients further emphasised that the attitudes of the service providers reminded them of their past conditions that they were trying

hard to recover from and therefore refused the services offered them. The patients also indicated that due to such discriminating acts, they did not approach those service providers because their attitudes discouraged them and made them feel unsecured. This was how a patient at the Ankaful Rehab Centre expressed his feelings:

*Some of the service providers especially the females disrespect and quarrel with us a lot. They like making telephone calls and chatting on their phones and so when you need them to help you, they would not even attend to you. Some would even say "get out of my sight, you drunkard, wee smoker." Some of us get angry and insult them back. When it happens like that, we do not approach such service providers and we even refuse their services because we do not trust them* (N: A 26 yr old single male patient at Ankaful Rehabilitation Centre).

The patients at the Mercy Rehabilitation Centre also explained that their service provider was the only one at the centre and was not always with them because he also worked elsewhere and so did not have much time for them. This, according to the respondents, made them feel worried and unhappy because when they needed him most, he would not be at the centre to attend to them. As indicated by a patient:

*Sometimes when you have something urgent to discuss with him for his advice, he is not available. You only have to wait till he comes back to the centre before he attends to you. At times he gets very tired and asks us not to worry him unless the issue at stake is very urgent. But Sir, what is not urgent here? I feel unsecured here because the counsellor being the only service provider at this centre because something very terrible can happen to any of us while he is away* (B: A 38 yr old single male patient at Mercy Rehabilitation Centre).

It was found out from the study that attitudes of rehabilitation service providers either ensure patients' compliance and recovery or serve as barriers to compliance and recovery from alcohol and drug addiction. Sympathetic and empathetic as well as positive attitudes by service providers towards patients were observed from the study to be factors which ensured compliance with rehabilitation services and at the same time facilitated recovery. This affirms what was found by Kant and Plummer [22] that exhibition of caring attitudes from service providers and freedom and expression of human rights of patients facilitate compliance and recovery. Jeewa and Kasiram [23] also ascertain that rehabilitation processes are successful when patients are treated with dignity, appreciation, motivation, and provision of basic needs. However, unsympathetic and non-empathetic as well as negative attitudes of service providers were reported to be alienating patients and resulted in non-compliance with rehabilitation services and retarded recovery from addiction. Similarly, Deci and Ryan [12] disclose in the Self-Determination Model of Rehabilitation that autonomy, competence, and relatedness, as well as compliance with rehabilitation services and recovery, are influenced by socio-demographic characteristics and structural factors including attitudes of service providers.

Discrimination and favouritism were also narrated in the study to be some of the attitudes exhibited by service providers to patients which resulted in inequality in rehabilitation services provided to the patients and therefore patients were treated based on their socio-demographic backgrounds. Hence, patients with high socio-demographic backgrounds were treated with respect by the service providers whilst patients with low socio-demographic backgrounds were treated with disdainful attitudes. All the rehabilitation centers in Ghana are to follow the policies and regulations provided by the

Government of Ghana but the individual centers and their service providers may have adopted their own choice of practice (available resources) and preferences based on their ethnicity and other reasons. These findings confirm what was revealed by Tang [24] that socio-economic and cultural discrepancies have much influence in rehabilitation of alcohol and drug addicts which results in conflicts and challenges between service providers and addicts as well as with the rehabilitation services in general. Center for Substance Abuse Treatment [25] has also observed that rehabilitation service providers often have good attitudes towards clients with higher socio-economic statuses and same age group, and culture or religion.

## Conclusion

The study exhibited that socio-economic factors influenced access to, use and abuse of alcohol and drugs, and addiction among individuals with alcohol and drug addiction at rehabilitation. Thus, factors such as unemployment, poverty, broken homes, disappointment by a partner, peer influence, loss of a loved one, and failure in an examination as well as barrenness and loss of a job were identified from the study to be socio-economic elements that predisposed the patients to alcohol and drug use and addiction. The study further revealed that alcohol and drug addiction patients experienced socio-economic and health effects. The reported consequences of alcohol and addictions among the patients included liver cirrhosis, problems of the heart, speech, sight or vision, hearing, trembling and weakened body, streetism, stealing, loss of properties, rejection by family and friends, exclusion from societal activities, divorce, and loss of a job. Also, it was established from the study that rehabilitation patients were mostly alcoholics who exhibited less aggressive, violent, and co-occurrence conditions than the patients who are addicted to other drugs (marijuana, cocaine, pethidine, and hallucinogens). In addition, the findings showed that most of the individual patients that were addicted to other drugs, were also addicted to alcohol and therefore experienced more severe co-occurring conditions.

The non-compliance of individuals with alcohol and drug addiction with rehab services, slow recovery, and subsequent relapse were reported in the study to be attributed to the organisation, availability, the nature of resources and facilities, and the general working environment of the rehabilitation centres. Some patients may have the internal motivation or capability to recover from their condition but that ability may be disrupted or thwarted due to non-availability, limited, and poor nature of facilities and the general rehabilitation centres. Also, the study established that the quantity and quality of resources and facilities available to alcohol and drug addiction patients influenced compliance of the patients with rehabilitation services and recovery from addiction. As a result, availability and quality of resources facilitated compliance and recovery, while limited and poor resources result in non-compliance and slow recovery from addiction. Thus, most of the patients felt less comfortable and more discouraged to participate in the rehabilitation services due to limited human resources and poor conditions of the limited available physical resources. Furthermore, the patients were able to comply with and engage in the rehabilitation services due to the relatively good conditions and effective use of some of the limited available resources which helped the patients to feel relatively comfortable, secured, and ready to participate in the rehab services for improved conditions.

Furthermore, various forms of attitudes and behaviours of service providers identified in the study have implications for rehabilitation

services. The study established that positive attitudes ensured compliance and facilitated recovery from addiction and rehabilitation services in general while non-compliance and relapse, as well as poor services, were inevitable with negative attitudes. This suggests that a good relationship between service providers and their patients promotes an enabling environment for rehabilitation services and compliance as well as recovery. Hence, unsympathetic and non-empathetic attitudes, discrimination, and limited and poor service provisions among some of the service providers identified in the study negatively influenced the reactions of the patients toward the service providers and the rehab services. The implication of the findings is that rehabilitation services are challenged by a limited number of an interdisciplinary team of health professionals and hence provision of limited or inadequate services to individuals with alcohol and drug addictions which could subsequently result in patients' relapse and ineffectiveness of rehab services in the Cape Coast Metropolis. Also, rehabilitation services in the Cape Coast Metropolis may not be accessible to every individual with alcohol and drug addictions due to the limited and poor available resources at the rehabilitation centres. In addition, the poor nature of rehabilitation centres and the attitudes of service providers may serve as a barrier to individuals with addictions in accessing rehabilitation services and recovering from addiction in the Cape Coast Metropolis.

It could be recommended based on the findings that policies, guidelines, and programmes developed by Ghana Narcotics Control Board (NACOB), Ministry of Health, Ghana Health Service, NGOs, and other stakeholders should be intensified and enforced to reduce use and abuse of and addiction to alcohol and drugs with their associated consequences. Also, more publication educational programmes should be provided through mass media and other channels on addiction and its consequences. Rehabilitation services should be made accessible to all alcohol and drug addiction patients in order to increase access to rehabilitation services and to ensure patients' recovery from addiction. In addition, the owners of rehabilitation centres should make available, more user-friendly facilities consistent with rehabilitation services and applicable to patients. There should also be regular maintenance and renovation of the facilities available at the centre and the centre in general. Also, a comfortable, friendly, and an enabling environment should be created for both rehabilitation service providers and their patients to ensure peaceful interaction and co-existence. This is because it was recognised from the findings that attitudes serve as motivating factors for or barriers to rehabilitation services as well as compliance and recovery from addiction. Again, owners of rehabilitation centres should provide supervisory roles in order to strengthen and to foster the relationship between service providers and their patients. There should be periodic review of rehab services and training for rehab service providers to improve rehab services and to make them more accessible. Finally, future studies could focus on cohort studies to determine the success rate of rehabilitation services and patients.

## Authors' Contributions

DA: performed the design of the study, executed the data collection, performed the data analysis, and served as the lead author of the manuscript. DTD: contributed to the design of the study, reviewed the manuscript for important scholarly content, and consented for the manuscript to be published. ABAG: participated in the design of the study and contributed to finalization of the manuscript. All authors read and approved the final manuscript.

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