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Experiences of Rehabilitation Service Providers at Rehabilitation Centres in Ghana

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Abstract

Background and Objective: The benefits of rehabilitation of alcohol and drug addiction far outweigh the economic costs of providing rehabilitation services. However, there is a gap in rehabilitation service provision globally, especially in developing nations and a majority of people worldwide are still living with alcohol and drug use disorders or addictions. This paper explored the experiences of rehabilitation service providers at two rehabilitation centres in Ghana.

Methods: This was a qualitative study which adopted purposive sampling approach to recruit the study participants. The sample involved fourteen service providers at two rehabilitation centres in Cape Coast Metropolis of the Central Region in Ghana. An interview guide was used to conduct in-depth interviews and the data were analysed through content analysis.

Results: The service providers were of the view that provision of rehabilitation services was a challenge as a result of negative attitudes of some patients and their guardians as well as some staff members and management. The service providers also expressed their dissatisfaction with inadequate and poor available facilities, limited interdisciplinary personnel, salaries, and remunerations. The findings also indicated that relationships between and among staff members, patients, and management foster or serve as barriers to the provision of rehabilitation services.

Conclusion: Service providers should, therefore, not be neglected but motivated and provided with the needed support to improve their conditions of service and commitment in order to facilitate the provision of rehabilitation services. Providing more user-friendly facilities consistent with rehabilitation services and applicable to patients could ensure effective and efficient provision of rehabilitation services. Furthermore, good working conditions and environment foster work satisfaction, commitment, and relationships which positively influence the provision of rehabilitation services.

Keywords: Alcohol and drug addiction patients; Addiction; Rehabilitation; Rehabilitation service providers

Background

Rehabilitation involves the process of helping addicts to recover from addiction [1]. According to United Nations Office on Drugs and Crime [2], alcohol and drug use and addiction are on the rise, and initiation of use is occurring at younger ages such as 15 years globally. Alcohol and drug use problems are among the major contributors to the global burden of disease in the 21st Century, which includes disability and mortality. A situation which leads to family disintegration and causing misery to millions of other people which undermine economic and social development and also contribute to crime, instability, and insecurity [2-4].

The benefits of rehabilitation of alcohol and drug addiction far outweigh the economic costs [1]. However, a majority of people worldwide are still living with alcohol and drug use disorders or addictions due to inadequate availability of rehabilitation services, limited knowledge on rehabilitation services, and barriers to and unmet need for evidence-based rehabilitation. Such situations are widespread particularly in developing countries including Ghana, even though alcohol and drug use disorders are preventable and modifiable [2,5,6]. Also, there is an infrequent practice of rehabilitation services due to sociocultural practices and limited human and financial resources and infrastructure for rehabilitation services and monitoring of drug-related deaths and disabilities in developing countries including Ghana [5,6]. Although provision of rehabilitation services involves an interdisciplinary team of healthcare professionals such as physicians, therapists, nurses, psychologists, nutritionists, and chaplains, it is often a major challenge in developing nations including Ghana [7] to have a team made up of different related professionals providing rehabilitation services at any rehabilitation centre.

Alcohol and drug addiction, according to United Nations Office on Drugs and Crime [8], remains stable between 16 million to 39 million people worldwide. However, there continues to be a gap in rehabilitation service provision such that only 9% of countries have routine screening and brief interventions for alcohol and drug use

disorders in primary health care. Rehabilitation involves the process of helping addicts to recover from addiction [1]. Positive experiences with profession or job are associated with shared positive experiences with co-workers, clients or patients, conditions of service, minimal differential treatments, provision of basic needs, and some level of freedom and expression of human rights [9]. Experiences of service providers, rehabilitation service supports, and barriers within the rehabilitation system and the nature of the organization influence provision and effectiveness of rehabilitation services [9-11]. Thus, the quality and quantity of rehabilitation facilities and materials, remunerations, professional training, and service coordination and management impact rehab services.

Self-Determination Theory (SDT) explains that human motivation, personality, and optimal functioning as well as socio-demographic characteristics, and structural factors influence experiences [12]. Thus, factors such as rewards, sanctions, use of authority, provision of choice, and level of challenge impact experiences and behaviour of individuals including service providers. Psychological needs such as competence, relations, and autonomy are considered as universal necessities, influence professionalism and service delivery. As a result, a basic need whether physiological or psychological is an energizing state that, if satisfied, conduces toward positive experiences, but, if not satisfied, contributes to negative experiences [12].

In Ghana, 1.25 million people were known to be alcohol and drug addicts in 2012 [13] and the data on the regional variations show that the highest use of alcohol and drugs is in the Central Region (15%) [14]. However, there are limited rehabilitation services with limited literature on rehabilitation in Central Region and Ghana as a whole [14-16]. There is, therefore, the need to examine the experience of rehabilitation service provider from their own perspective to be able to help policy makers and managers of these centres to fashion out programmes and policies to improve the provision of rehabilitation services for individuals with drug and alcohol addictions. As a result, this study sought to explore experiences of rehabilitation service providers at rehabilitation centres in the Cape Coast Metropolis of the Central Region, Ghana.

Methods

The study participants comprised rehabilitation service providers at the two rehabilitation centres in the Cape Coast Metropolis, Ghana. Background information about the participants could be found in Table 1. The data for this study was purposefully derived from 14 in-depth interviews (IDI) with only persons who provide rehabilitation services at Ankaful and Mercy Rehabilitation Centres in the Cape Coast Metropolis of Central Region. These centres were the only alcohol and drug addiction rehabilitation centres in the Central Region as of the time the study took place. Of the 14 participants sampled purposefully for the study, one was selected from the Mercy Rehabilitation Centre, which is a privately-owned facility while the remaining 13 were selected from the Ankaful Rehabilitation Centre which is also owned by the Government of Ghana.

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	Cohabitating	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	Cohabitating	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 provider.

One male service provider at the Mercy Rehabilitation Centre was interviewed and seven male and six female service providers at the Ankaful Rehabilitation Centre were also interviewed. The unequal number of the respondents was not premeditated but due to the limited availability of the rehabilitation service providers at both centres. Respondents from the Ankaful Rehabilitation Centre were selected based on their availability and readiness to participate in the study after the purpose of the study had been clearly explained to them. Also, the concept of saturation was used to achieve the number of service providers at the Ankaful Rehabilitation Centre. The interview ended when no new information were given by the respondents. All the respondents were interviewed in English since they all expressed a high level of comfortability of the English language.

Permission to conduct the interviews at the two rehabilitation centres was obtained through letters and personal contacts with the heads of the centres prior to the data collection. Also, all the respondents gave their consents before the interview was conducted with them. Ethical approval for the study was given by the Department of Population and Health and the Graduate School of the University of Cape Coast and none of the respondents declined to participate in the study. In order to ensure anonymity of the respondents, pseudonyms were used to represent their identities in the findings. The interviews on the average lasted 60 min with each participant.

To ensure effective data analysis, all interviews conducted were transcribed and the meanings in the data were captured and summarised using codes and labels described by Corbin and Strauss [17] in three stages of data coding. 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

Themes were used to present the results as they were derived from the interviews to demonstrate coherent picture of the experiences of drug and alcohol rehabilitation service providers. Actual words of the study participants are appropriately cited to provide a glimpse of their responses. The socio-demographic characteristics of the participants interviewed for the study are displayed in Table 1.

Experiences of service providers with rehabilitation of alcohol and drug addicts

The service providers were asked to narrate their experiences at the rehabilitation centre and to also describe their experiences with the patients in order to ascertain the experiences they go through while providing rehabilitation services to patients at the rehabilitation centres. The shared experiences of the service providers, which were of interest to the study, include the roles of the service providers, availability of resources, and attitudes of the patients at the centres.

Roles of service providers in providing rehabilitation services

The role of health professionals including rehabilitation service providers in providing health services to patients is very paramount in patients' recovery and health care delivery [7]. As a result, the service providers were interviewed on their roles in rehabilitation services at the centres. Thus, the respondents (service providers) including the clinical psychologist interviewed at the Ankaful Rehabilitation Centre explained that rehabilitation services are mainly provided by nurses at the centre despite the fact that most of them are holders of Diploma in mental health nursing; while few of them are degree holders in general nursing. They elaborated that all service providers do counselling, administration of medicines, teaching the 12 Steps of Alcoholics Anonymous, and monitoring the patients. They also reported that their diploma in mental health nursing and degree in general nursing training included rehabilitation of addiction, self-care, and dynamics of patients' cases and safety management. The respondents further indicated that supervision of the rehabilitation centre and roles of the service providers are conducted by the rehabilitation centre administrator who is also a nurse. Again, the respondents narrated that because they perform the same roles and functions at the centre, some of their colleagues would most often show lukewarm attitudes toward work and patients because they would be expecting co-workers or colleagues to perform such duties. Hence, according to the respondents, they experience conflicts with co-workers and patients sometimes due to apathy, lateness, and absences of expected service providers on duty. Furthermore, the respondents indicated that they are often unable to provide some medical services to patients with some co-occurring health problems (cirrhosis, heart, vision, and hearing problems) because they (service providers) they do not have such professionals readily available at the centre to provide such services. Consequently, the respondents elaborated that they become confused and stranded when such co-occurring medical problems occur (which often occur). In addition, according to the narrations of the respondents, processing of patients with co-occurring health problems to be taken to hospitals for treatment involves a long administrative bureaucratic process usually 3 h or more. The respondents elucidated that they usually call the guardians of the patients with co-occurring health problems for financial processing before those patients are taken to a hospital.

"*We are all nurses at this centre and we do everything the same ways because there are no physicians or psychiatrists at the centre. Therefore, all aspects of the rehabilitation services are handled by any nurse at the centre*" (M:A 26-year-old male Mental Health Nursing service provider at Ankaful Rehabilitation Centre).

"*Sometimes we quarrel at the centre because some of our colleagues would not stick to their schedules and would want other colleagues to work for them*" (G:A 24-year-old female Mental Health Nursing service provider at Ankaful Rehabilitation Centre).

On his roles, the sole service provider at the Mercy Rehabilitation Centre reported providing counselling services, teaching of the 12 Steps of Alcoholics Anonymous, and monitoring of the patients. He,

however, said he does not administer medicines to patients since he is not licensed to do so and therefore do referral to other health care facilities whenever a patient needs medical attention, as indicated in the statement:

"*I am a counsellor so I do counselling, teach the 12 Steps of Alcoholics Anonymous, and monitor the patients, but I do not give them medicines unless it is prescribed by a doctor because I am not qualified to do that*" (A:The 54 yr old Counselling service provider at Mercy Rehabilitation Centre).

It was observed from the study that rehabilitation services are provided by service providers with similar functions at the two rehabilitation centres and hence the services do not include diverse health professionals to ensure a holistic approach to rehabilitation of alcohol and drug addicts at the centres. As a result, the service providers are often stuck and confused when there are some patients with co-occurring health problems and medical emergencies which require a physician-assisted treatment modality. Also, there is an often lukewarm attitude toward work and patients among some of the service providers because those service providers feel their colleagues could perform their roles if they are late to work or absent. Consequently, such apathy, lateness, and absenteeism often result in conflicts among some of the service providers and between them and their patients as well. The findings also showed that referrals are used by the services providers to aid the limited medical services at the centres but often faced administrative bureaucratic processes and frustrations such as long awaiting approval times or days. Thus, according to the respondents, alcohol and drug addiction patients have associated health problems which are at times beyond the professional and the facility levels of service providers and hence referrals to other health facilities. Contrary to these findings, Martin [18] found that involving a numerous, diverse and interdisciplinary team of health professionals in rehabilitation services promote effective treatment and facilitate recovery because addiction involves multidimensional processes. Diverse health professionals provide evidence-based solutions and medicines to patients based on their (health professionals') areas of expertise which help patients go through rehabilitation services without much difficulty.

Availability of resources

Resources available to health service providers including rehabilitation service providers have influences on rehabilitation services and patients' recovery from their health conditions. As such, the study was interested to enquire from the service providers their experiences with the availability of resources to ensure efficiency and higher work output. Respondents were, therefore, interviewed on the nature of resources available to them at the centres. The service providers at the Ankaful Rehabilitation Centre recognised that they have limited resources and facilities which limit their work efficiency and result in burnouts. They indicated that although most of them are mental health or general nurses who are trained in rehabilitation of addiction, they do not receive further or periodic training to equip them with new and additional skills. They have nineteen service providers comprising eleven males and eight females but they are all nurses and as such are challenged with a limited interdisciplinary team of related health professionals. This, according to them, makes the ratio of two service providers to a patient because the patients are only nine. However, the respondents at the Ankaful Rehabilitation Centre explained that they have a shift system where more than half of them work during the day and the rest work during the evening and therefore the ratio is one service provider to a patient. This shift system, according to the respondents, is done due to the small nature of the centre to accommodate all the service providers at the same time and to allow them to rest well because rehabilitation of these patients requires a lot of energy to monitor and to attend to them. Similarly, the clinical psychologist at the Ankaful Rehabilitation Centre reported that the nurses run a shift system because of limited facilities at the centre like tables, chairs, and offices.

"*This centre is very small to accommodate all of us at the same time because the place would be overcrowded resulting in limited ventilations if we should all come to work at the same time. That is why we have a shift system to allow more space for the patients and to allow us to rest too where some of the nurses come during the day and the rest come during the evening*" (G:A 24 yr old female Mental Health Nursing service provider at Ankaful Rehabilitation Centre).

The respondents complained that there are not enough rooms at the Ankaful Rehabilitation Centre for the in-patients. The respondents indicated that there are only two rooms available for the male in-patients, while the female patients used to sleep at the female ward in the Ankaful General Hospital and come for services during the day with the escort of the service providers. However, there was no female patient on admission at the centre during the time of the data collection. The respondents also added that there is a room for the administrator, an ICT room without a computer, and a junior common room for both the service providers and the patients. Also, they indicated that they have one small common room for dressing, resting, and storing drugs. The service providers further recognised that there are toilet and bathrooms for patients as well as toilet facilities available to the service providers.

The respondents at the Ankaful Rehabilitation Centre again explained that there are games such as ludo and checkers that they play with the patients as a form of entertainment for the patients in order to reduce or minimise boredom. In addition, respondents reported that they have a common television in the junior common room which they watch together with the patients for news and entertainments such as movies and music. The respondents further emphasised that the centre is fenced to ensure security by preventing the patients from going out or an outside attack which makes them (service providers) feel safely comfortable, in that regard, to work at the centre.

"*We have a junior common room for ourselves and the patients where we all watch TV, group therapy, and interact with each the patients and among ourselves. We also have games like ludo and checkers that we all play anytime anybody feels like playing it to entertain ourselves*" (L:A 27 yr old female Mental Health Nursing service provider at Ankaful Rehabilitation Centre).

The respondents at Ankaful Rehabilitation Centre further disclosed that the centre looks old and tattered as well as abandoned with defaced walls, broken chairs and tables, malfunctioning fans, leaking roofs, and limited offices and vehicles at the centre making service provision at times challenging. This is because, as explained by the respondents, they feel worried and discouraged and have the belief that they are not properly cared for when people visit the facility and talk about the bad conditions in which they are living.

"*Working at this centre sometimes is discouraging and worrying because the centre lacks maintenance and renovation. When I go and visit some of my colleagues with the same qualification at their workplaces, I become ashamed and sad because their workplaces look new with computers and air conditioners. I feel worried and shy*

whenever I see health workers from other health care facility at this centre because such people always tease us over the poor working condition here at the centre" (K:A 26 yr old female Mental Health Nursing service provider at Ankaful Rehabilitation Centre).

In contrast, the respondent (sole service provider) at the Mercy Rehabilitation Centre indicated that he has more than enough facilities at the centre which encourage him to work and make him happy apart from limited human resources which make him experience burnouts because he is the only service provider at the centre. He mentioned that there are four different rooms for the patients; two for females and two for male in-patients. He quickly added that there are only a female and two male patients at the centre as at the time of data collection because the rest had recovered and been discharged. Furthermore, the respondent added that each room for the patients has toilet and bathrooms, wardrobes, two bunk beds, fridge, and a ceiling fan. In addition, the service provider disclosed that he has a junior common room for all the patients with TV, table and chairs, fans, and dining hall where they eat their meals prepared for them by the cook at the centre.

The respondent at the Mercy Rehabilitation Centre also explained that there is a room with tables and chairs and marker board for group therapy where all the patients are counselled together and are taught about the 12 Steps of Alcoholics Anonymous. There is, again, an office for individual counselling where the patient is able to express personal feelings and challenges. He, in addition, stated that there is a library and the centre, in general, is fenced to provide security and to avoid escape by the patients and to prevent intruders. He disclosed that he has a self-contain apartment at the centre where he stays which has a sitting room, a bedroom, toilet and bathroom as well as a kitchen. He made it known that he feels comfortable and motivated working at this centre because the centre is better than other rehabilitation centres that he visited.

The respondent at the Mercy Rehabilitation Centre also added that he is provided with food and accommodation which motivates him to work more at the centre. Again, he stated that he is also one of the Reverend Fathers of the Church that owns the centre and therefore he is highly supported by the Church which encourages him to work and feels responsible for the development and growth of the centre.

"*I feel happy and comfortable working at this centre because I have more facilities than I need but the only challenge I have is that I am the only service provider here who does everything and therefore over stress myself because I go to preach at the church and to teach at the seminary too*" (A:A 54 yr old male Counselling service provider at Mercy Rehabilitation Centre).

On the contrary, the respondents at the Ankaful Rehabilitation Centre reported that the centre is owned by the state (Government of Ghana) but they are not treated well. They are paid the same amount that other nurses at general hospitals and other healthcare facilities are paid but, according to them, their (service providers) work is more dangerous and intense than their colleagues at other health facilities. This, said respondents, is because working at a drug and alcohol addicted rehabilitation centre demands total attention and strict monitoring due to the fact that the patients are not psychologically fit and sometimes attack them and try to escape. They feel, as stated by the respondents, that they are not being supported because they do not receive any other supports apart from their salaries.

The respondents at the Ankaful Rehabilitation Centre further disclosed that most of them live far away from the rehabilitation centre and pay transportation fares every day before arriving at the centre. This, according to them, leads to high level of tiredness and frustration because they end up spending all their salaries on rents and transportation without any savings and therefore are discouraged working at the centre.

"*Rehabilitation of alcohol and drug addicts involves close monitoring and counselling because addicts are not psychologically sound and therefore could misbehave or become aggressive at any time. This requires more motivations and confidence to be with these patients every day. However, we receive meagre salaries and use the same salaries for renting and paying utility bills at our residences and therefore there is nothing left to be saved*" (B:A 28 yr old male General Nursing service provider at Ankaful Rehabilitation Centre).

The rehabilitation service providers at the two rehabilitation centres in the Cape Coast Metropolis clearly articulated that the organisation, availability, and the nature of resources and facilities, and the general working environment encourage or discourage the provision of rehabilitation services. It was revealed from the study that availability of diverse human resources such as physicians, counsellors, psychologists, psychiatrists, and nurses are very important as they influence rehabilitation services because addiction affects the whole being of the individual; psychological, behavioural, and physical aspect of the individual. However, as evident in the study, there are limited diverse rehabilitation service providers. Most of them are mental health or general nurses who are trained in rehabilitation of addiction but they do not receive further or periodic training to equip them with new and additional skills to facilitate patients' recovery. It was also observed from the study that there are limited resources and facilities available at Ankaful Rehabilitation Centre and limited supports from employers were challenges to the provision of rehabilitation services at the centre by the service providers. Accordingly, these rehab centers are limited in providing medical emergency services to the patients. Consistent with these findings, United Nations [5] and World Health Organisation [6] identified that in Africa, there is limited human and financial resources and infrastructure for rehabilitation services.

Similarly, Jeewa and Kasiram [11] found that rehabilitation process is successful when service providers are treated with dignity, appreciation, motivation, provision of basic needs, cleanliness and good condition of the rehabilitation centre. Kant and Plummer [9] identified that provision of basic needs and supports for rehabilitation services positively influences health professionals' behaviour and rehabilitation services. Also, it was evident from the study that the nature and quality of facilities available to the service providers either facilitate the rehabilitation services or serve as barriers to rehabilitation services. Thus, the service providers at Ankaful Rehab centre expressed their dissatisfaction with poor condition and quality of the centre and its facilities which impede efficiency of service provision at the centre. These findings also confirm what Babor and Poznyak [19] identified that resources, tasks, and linking elements of rehabilitation services for the coordination of resources as well as equity and efficiency affect the provision of alcohol and drug addiction or disorder services. In addition, Jeewa and Kasiram [11] found out that failures, barriers, and factors preventing recovery are attributed to negative experiences faced by service providers.

Experiences with addiction patients and their relatives

Patients and Family Therapy: Sussman et al. [20] recognised that addiction does not affect just the individual addict in isolation. This is because family members or relatives are often affected by their loved

one's addiction and therefore family involvement in rehabilitation processes serves as an important component of the recovery process for that addict. The service providers at both centres were asked about their experiences with family involvement in rehabilitation services. The respondents explained that addiction patients are mostly brought to the centres by their relatives and friends. The relatives and friends, according to them, who bring patients to the centres are encouraged to visit the patients because that forms part of the rehabilitation programme called "family therapy".

"*Relatives and friends are important in one's life and therefore patients need their relatives and friends' support either economically, socially, or emotionally to aid the patients' recovery process. They would make the patients feel that their relatives still care for them and therefore they are not neglected with their condition*" (A:A 54 yr old male counselling service provider at Mercy Rehabilitation Centre).

It was also disclosed by the respondents at both centres that family therapy helps to motivate the patients and to ensure a sense of family belongingness and maintenance of recovery because some patients always feel sad and get more depressed when their guardians do not visit them whilst those that are visited comply and recover faster. The respondents reported that patients whose guardians do not visit them at all or do not visit them frequently, feel that they have been abandoned at the centres due to their conditions and therefore refuse the services at times and try to escape or commit suicides.

"*Patients whose guardians do not visit them at all or do not visit them frequently are always sad and do not attend counselling sessions. Such patients often do not attend dining and may not want to talk to anybody. They sometimes want to escape unless they are convinced for some number of hours. However, patients who are visited frequently are always happy and respectful and therefore always attend counselling sessions and eat on time. When you compare these two groups of patients, the frequently visited ones recover faster than the non-visited and not frequently visited ones*" (D:A 29 yr old male General Nursing service provider at Ankaful Rehabilitation Centre).

It became evident from the study that family therapy or family involvement in rehabilitation processes is very crucial in rehabilitation services and recovery because relatives and friends give support which motivates the patient for compliance and recovery at the centres. The support relatives and friends offer includes emotional, psychological, financial, and social support during and after rehabilitation services and recovery. As a result, patients whose relatives show commitment towards their rehabilitation programme comply with rehabilitation service providers and recover faster than patients whose guardians show less commitment towards them. In addition, patients were mainly sent to the rehabilitation centres by their relatives and friends to undergo rehabilitation. Similarly, Flora and Stalikas [10] stated that support from families and friends in terms of visitations, financial assistance, food, and clothing motivate patients to feel a sense of belonging and to comply with rehabilitation services and to recover from their conditions. Consistently, National Institute on Drug Abuse [21] established that family and friends in addition to socio-economic status have varied influences on the individual. Kant and Plummer [9] explained that family support to addiction patients influences the patients' behaviour and as such, patients' non-compliance is also associated with no or less familial support and visitation. National Institute on Drug Abuse [22] also found that some addicts are compelled to go to a rehabilitation centre by the court system and family or friends to help the addicts recover.

Attitudes of Patients: Factors such as patients' characteristics including attitudes and culturally conditioned patterns of alcohol and drug use and addiction affect the provision of alcohol and drug addiction or disorder services [19]. The service providers at both Ankaful and Mercy Rehabilitation Centres were interviewed about attitudes of their patients. The respondents, therefore, considered their patients generally to have positive attitudes which make them recover on time and make them (service providers) satisfied. The respondents explained that the patients make less noise, do not insult, fight or quarrel with each other and with the service providers. The respondents further indicated that some patients also come voluntarily to discuss their personal issues with the service providers for assistance or counselling.

"*These patients are very intelligent because most of them are great people but their conditions have made them like this and therefore they restrain themselves and respect us a lot*" (E:A 25 yr old male Mental Health Nursing service provider at Ankaful Rehabilitation Centre).

"*Some of the patients are always ready to be helped and therefore are ready to share their personal issues and ask for help. You could see that they are always on time for any activity or meeting organised for them at the centre*" (I:A 29 yr old female Mental Health Nursing service provider at Ankaful Rehabilitation Centre).

However, it emerged that some of the patients occasionally exhibit negative attitudes which interrupt and discourage service provision to those patients and working at the centres in general. The negative attitudes generally exhibited, according to the respondents, include refusing to eat, not wanting to attend counselling sessions, throwing things around in their rooms and at the centre, making noise, insulting and fighting with each other and with the service providers, trying to escape and to commit suicide. This, as explained by the respondents, happens with some of the patients unconsciously because they do hallucinate sometimes while some also feel lonely and sad in the sense that they feel that their families have abandoned them that is why they do not visit them, as indicated in the statement:

"*Some patients get angry and insult or fight because they hallucinate and therefore apologise when they become calm. Some also show bad attitudes like refusal to eat, noise making, absconding, and trying to commit suicide because of loneliness, guilt, and intimidation by colleague inmates*" (F:A 28 yr old male Mental Health Nursing service provider at Ankaful Rehabilitation Centre).

Attitudes of alcohol and drug addiction patients were found from the study to have influences on rehabilitation services positively or negatively at the rehabilitation centres. Hence, positive attitudes of patients ensure compliance and facilitate recovery whilst non-compliance and relapse are inevitable with negative attitudes. These findings also affirm what Jeewa and Kasiram [11] identified that positive attitudes of patients ensure improvement in health condition and recovery from addiction. The findings further corroborate what Alcoholics Anonymous [23] explained in their 12 Steps that recovering from addiction behooves the patient's compliance with rehabilitation services and providers to assist that patient; a client recovers if that client accepts to be helped and willing to take certain steps. Flora and Stalikas [10] also found out that negative emotions and attitudes of patients affect compliance with rehabilitation services and recovery whilst patients with less dominant negative emotions and attitudes have higher chances of complying and recovering from their conditions.

Conclusion

Provision of rehabilitation services was found to be associated with the availability of facilities, personnel, salaries and remunerations, and attitudes of patients, authorities, and staff members. Limited diverse health professionals, logistics, poor conditions of facilities, personal and management expectations, and management support negatively influenced the provision of rehabilitation services. It emerged from the study that rehabilitation services were basically provided by nurses who also performed similar roles at the rehabilitation centres. Thus, the service providers indicated limited interprofessional provision of coherent services and limited recovery by alcohol and drug addiction patients due to the fact that the same limited health professional(s) were treating different aspects of the patients that required the interdisciplinary team of health workers. More surprisingly about the inadequacy of the rehab facilities, although most of service providers are mental health or general nurses who are trained in rehabilitation of addiction, they do not receive further or periodic training to equip them with new and additional skills.

The findings also indicated that relationships between and among staff members, patients, and management foster or serve as barriers to the provision of rehabilitation services. Negative attitudes such as non-cooperation, insults, attacks, absconding, and attempting suicide by some of the patients in addition to limited support from their guardians were some negative experiences articulated by the service providers which were found to be undesirably affecting the provision of rehabilitation services to patients and their recovery. However, they also expressed satisfaction with the attitudes of some patients for their cooperation and respect in addition to positive support from their guardians which encourage service providers and facilitate provision of rehabilitation services.

The study concludes that inadequate and faded rehabilitation facilities (such as tables and chairs, roofs, and offices), limited supports (example, low salary, lack of provision of accommodation, and lack of remuneration) were some expressed negative experiences by some of the service providers which were indicated to have negatively influenced motivation for provision of rehabilitation services and professional development. Accordingly, the service providers feel worried and discouraged working at the centres because they feel abandoned and uncared for by their employers and managements. Also, good working conditions and environment foster work satisfaction, commitment, and relationships among service providers and between them and their patients which significantly influence the provision of rehabilitation services.

Consequently, provision of effective rehabilitation services in the Cape Coast Metropolis could be limited due to inadequate interprofessional rehabilitation service providers which could affect interprofessional learning and development and provision of timely and appropriate services to patients. Also, poor and dilapidated rehabilitation facilitates and environment due to irregular maintenance and renovation could discourage service providers and their patients who might result in ineffective service delivery and slow patients' recovery, repulsion and non-utilization of rehabilitation services. Thus, service providers and patients could feel that the rehab centres might not be properly equipped to ensure their service delivery, personal comfortability and development, and to properly address patients' needs and problems. Also, rehabilitation services may be ineffective and inefficient due to poor working conditions of service providers in addition to attitudes of management and patients and their guardians which have the potential to affect the utilization of rehabilitation services by patients. It could, therefore, be recommended that service providers should not be neglected but motivated and provided with the needed support to improve their conditions of service and commitment in order to facilitate rehabilitation services. Also, there should be a provision of more user-friendly facilities consistent with rehabilitation services and applicable to patient's needs and conditions to ensure an effective and efficient provision of rehabilitation services.

Authors' Contributions

DA:performed the design of the study, conducted 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 the completion of the manuscript. All authors read and approved the final manuscript.

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