Original Article

Structural Elements of Integrated Treatment System for Alcoholic Patients in Two Rehabilitation Centres in Ghana

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Abstract

In Ghana, much attention has been given to the care and treatment of medical-surgical conditions other than mental health issues and the treatment of drug addiction. The predominant understanding is that alcohol/drug addiction or abuse is a chronic disorder on a par with other chronic conditions such as diabetes and asthma. This research study was conducted on the basis of making additions to existing scientific knowledge on rehabilitation of patients diagnosed with alcohol/drug abuse and how treatment helped in early recovery. It is a qualitative research with exploratory descriptive design. The study selected two (2) major rehabilitation centres in the Kumasi Metropolis namely: Cheshire Rehabilitation Centre and Remar Rehabilitation Centre. A total of twenty-eight (28) participants were selected for the study. sSixteen (16) patients were selected purposively for the study. Thus, eight (8) rehabilitants were chosen from each centre. The study also sampled eight (8) relatives of patients from both homes and two (2) care givers from each centre who also undertook the interview voluntarily using a semi-structured interview guide. Audiotaped interviews were conducted with the participants at the two rehabilitation centres. The data was transcribed and coded using grounded theory and conversation analysis. The data was managed with ATLAS.ti. The study revealed that, though both rehabilitation centres were doing their best, they were under-resourced both in qualified personnel and finances. Unavailability of prescribed medications too caused incessant relapse. The results confirmed the finding of other studies which showed that no rehabilitation physicians are identified in any of the rehabilitation facilities in Ghana.

Keywords:

Rehabilitation; Experiences; Under-resourced; Rehabilitants; Recovery; Ghana.

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Introduction

In the context of integrated rehabilitation, it is hypothesized that factors affecting the rehabilitation process need to be looked at comprehensively in order to achieve patient satisfaction. In the paucity of knowledge on rehabilitation process, it is almost impossible to determine the rehabilitation outcome or treatment modalities that facility users experience. This is the situation in most rehabilitation centres in Ghana over the years.

Perceived alcohol use for pleasure is part of many societies (World Health Organization, 2011). Cultural values have been reported to have a powerful influence over the use of alcohol throughout the world. Africans, in particular, are accustomed to the consumption of fermented beverages which tend to have less alcoholic content than distilled beverages. Alcohol has been part of the social and religious life of Africa since the third century and continues to be an integral part of ceremonies such as child naming, marriage, funerals, judicial processes and legal contracts (Ssebunnya et al., 2020).

Despite scientific evidence suggesting that alcohol is a major source of health and social problems, the earlier studies reported low prevalence and detection of alcohol use disorders at health facilities (Nawaldda et al, 2018, Rathod et al, 2018) alluding to the fact that there is poor appreciation of the health problems associated with heavy alcohol consumption. In Ghana, it is estimated that 40% of the population of over 30 million people are affected by a moderate to mild mental disorder relating to alcoholism. Most of these people are likely to get the quickest results from therapy; yet, the behavioural service gap is 98%. This means that only 2% of those in need of rehabilitation is currently receiving any sort of treatment (Asare et al., 2011).

Treatment non-adherence is one of the major causes of unnecessary suffering, relapse, hospitalization and suicide among alcohol and drug dependants (Ssebunnya et al, 2020). Consequently, the main goals of therapies of all types is to empower the patient and give them some control back over their world and rechart the meaning and purpose of their lives under altered circumstances (Redfied & Kaplan, 2016). The application of rehabilitation approaches and technologies to adults with alcohol related psychiatric disabilities is a relatively new and exciting development in Ghana. The planning process is just the beginning of change. Planned therapies for clients must ensure strategies which enable commitment by taking action. There is some evidence that client commitment change talk is associated with positive Alcohol Use Disorders outcomes (Romano & Peters, 2016).

Research has shown that standardized frameworks provide the basis for structure implementation and outcome measures globally (W.H.O, 2011). However, Adzrago et al. (2018) reaffirm 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. This conception brings to the fore the need to shed more light on the perspectives and expectations of the patient undergoing detoxification and treatment.

Materials and Methods

Design

The study adopted the qualitative exploratory descriptive design to explore the integrated rehabilitation systems for alcohol dependants and the procedures they go through during the processes. Rehabilitants who were recovering successfully and had been at the centre for at least 3 months were subjects of interest.

Setting

This study selected two major rehabilitation centres in the Kumasi Metropolis: Cheshire Rehabilitation Centre and Remar Rehabilitation Centre. These are the main rehabilitation centres in the Northern sector of Ghana, so they are geographically positioned well in accommodating patients with various forms of addiction across the country and have a bed capacity of about fifty (50) each. Their main goal is to accommodate and provide care and treatment for patients who are battling with addiction and are struggling for sobriety and to provide physical, psychological, and moral support. Both homes also serve as referral centres for patients who have been hospitalized and such recommendation is made by a psychiatrist. Each centre has caregivers including non residential, part-time attending psychologists and counsellors etc.

Population and Sampling technique

A total of twenty-eight (28) participants took part voluntarily in the study. Sixteen (16) patients comprising eight patients from each centre were selected purposively for the study. The study also sampled eight (8) relatives of patients from both homes who also undertook the interview voluntarily and two (2) caregivers from each centre using a semi-structured interview guide for Cheshire and Remar Rehabilitation Centres respectively. The sample size was determined by theoretical saturation. Persons who were not related to the patients of the rehabilitation home were excluded. To be recruited, participants satisfied some inclusion criteria such as being on admission for more than three months, being a caregiver and being a relative of a rehabilitant on admission. The aim was to bring into perspective the treatment systems adopted within the roles of caregivers in the rehabilitation process. The study used semi-structured interview guides to generate qualitative data from the following groups: alcohol dependants in Remar Rehabilitation Center as well as Cheshire Rehabilitation Center, Caregivers at both Centers and the family and/or relatives of rehabilitating patients.

Data Collection Procedure

The data collection was done through face-to-face, in-depth interviews by the researcher. A pilot study was conducted at Accra Remar Rehabilitation Center to test the appropriateness of the guiding questions of the interview guide. This pilot study exercise also served as a hands-on examination on exact framing of questions, whether they elicited the right responses, whether the questions were adequate or whether they contained any irrelevant items. In the end, the analysis of the pilot study revealed the need to include additional questions to the survey instrument. When participants who met the inclusion criteria were selected, the researcher then scheduled appointments for a one-on-one, in-depth interview with the participants at their earliest convenience. The interview lasted between sixty (60) and ninety (90) minutes and were audio-taped and recorded with respondents' approval. Field notes were taken during each interview to conclude nonverbal signs. A semi-structured interview guide was used for the interviews and thereafter transcribed, coded and analyzed with the aid of ATLAS. Ti – a qualitative data analysis software for processing varied sets of or multi-objective data. All interviews conducted on the rehabilitants were done in Twi – a local Ghanaian language and English for the caregivers.

Data Analysis

All the recorded interviews were transcribed verbatim. Data analysis was done concurrently with data collection using the process of inductive thematic analysis. Owing to the fact that some of the parents of the patients recruited did not have regular appointments with the rehabilitation caregivers, the researcher had to make use of scheduled phone interviews to administer some survey instruments. Therefore, to check accuracy, the lead author (SFA) initially analyzed the data and the second author/supervisor (EKN) confirmed the findings to ensure that the respondents' realities were truly represented.

Rigor/Trustworthiness of the study

Trustworthiness in a study is achieved through strategies that demonstrate credibility, transferability, dependability and confirmability (Patton, Guba & Lincoln, 2006). By achieving trustworthiness, the researcher demonstrated the quality of the research process. Member checks at the end of each interview were used to fully understand and correctly present the respondents' stories to ensure credibility. For credibility, authors provided a detailed study methodology description which included procedure for recruitment, data collection and data analysis. To ensure confirmability, field notes detailing verbal and non-verbal cues recorded during the interview were used to corroborate the transcripts. The study provided the basis for its applicability in other contexts. Again, the study allowed for external judgments to be made about the consistency of its procedures and the neutrality of its findings (Patton, Guba & Lincoln, 2006; Guba & Lincoln, 1981)

Ethical Consideration

The researchers obtained ethical approval from the Committee on Human Research, Publications and Ethics (CHRPE) of the Kwame Nkrumah University of Science and Technology as well as the study centres. Verbal consent of the eligible study subjects were obtained before recording was done. The study subjects were assured of records confidentiality and the usage of codes to avoid identification. Conse-

quently, codes such as C1, C2, C3 and C4 were used for clients; CG 1, CG2, etc. were the codes used for caregivers, while P1, P2 and P3 were used for parents/ guardians of patients receiving care.

Results

Demographic Characteristics

In this study, a total of twenty-eight (28) participants were included as follows: Eight (8) females and twenty (20) males ranging from the ages of twenty (20) to forty eight (48) years old. Five (5) had separated from their spouses because of the alcohol/drug dependency, seventeen (17) of the rehabilitants were single but all four (4) caregivers were in active marriage. The spouses of two (2) of the guardians or parents were outside the country.

Themes and Subthemes

The study found six (6) emerging themes which included Screening, Admission Comprehensive Assessment; Stabilization, Treatment and Support; Monitoring and review; Supervised withdrawal; Departure Planning and Community-based support program. These were basically the routine procedures adopted by both rehabilitation centers, though each had their own way of treatment procedures but almost followed the same path towards successful recovery of rehabilitants.

Screening, Admission and Comprehensive Assessment

This was the first protocol procedure for both rehabilitation centres. All the caregivers for this study gave account of how patients were admitted into each rehabilitation center. At Remar Center, counselling was firstly done since they did not have any health professional readily available all the time. Patient-turned counsellors gave account of how admission was done.

"The counselling is done at the main office before you are brought here. I just give you some advice and also take you through the rules and all the other activities that go on here. I even use myself as a satisfied client to give them the counselling." (C1)

At Cheshire, the administrator also described the admission procedure in the following words:

"Before they are accepted, we made sure they have self-will to stop the addiction habit. Then they are prepared psychologically to adjust to their environment" (CG1).

The study revealed that mostly, patients who were sent for rehabilitation were not triaged as a result of their worse condition on admission.

"Most of the clients we receive here come in a worst state. Some abscond from the psychiatric hospitals and rejoin their friends for drinking/smoking. Relatives may find them in a hide-out upon a tip-off before they are brought here. With such cases, we have no option than to admit" (CG2).

It was observed that, there was no screening or any assessment tools in both centers. One of the patients who came through a referral system also narrated his admission procedure.

"Before my discharge from the hospital, the psychiatrist called my parents that going for rehab would be the best for me. My parents obliged. So I was brought here 3 months ago. As soon as I entered, here, I was asked if I am willing to change, I said 'yes'. They gave me a form to fill and offered me some form of advice and that's when the procedure started" (C8).

Stabilization, Treatment and Support

The study observed that alcohol dependants usually arrived at the rehabilitation centers in very unstable conditions. The initial stabilization procedure is through prescribed medications.

"Yes, all clients go through the same procedure because it all has to do with mental illness, so, they all have to go through the same treatment. They are all given drugs and they go through the other therapies. E.g. occupational therapy, psychotherapy etc. They are given the same therapy."

"We believe that will be able to prevent relapse. If we follow that, the clients will be able to respond well to their treatment regimen, so they all go through the same treatment." (CG3).

Whilst staff attitude counted, the patients also indicated that the medication served was purposively to stabilize them. One patient recounted his experience:

"The staff are good. I don't have any issue with them. They give me injections sometimes but every day I swallow a drug" (C4).

"They give me oral drugs to swallow too, but I get a reaction from that which I don't like at all. I feel sick when I take the drugs and I have reported to them. They say they will change it for me" (C8).

The study finding suggested that stabilization was usually the foremost step and that was followed by patients' observation to determine what treatment should be administered. Patients in Remar Home were given periodic counselling sessions with "once a while" professional counsellors who visit them at their convenience, while in Cheshire, the counselling process was administered by the caregivers mostly. In both homes, the findings suggested that spiritual counselling from Rev. Ministers was also an accepted practice and some of the patients attested that they found it very helpful in their recovery process. It was also found out in this study that successful patients, after medication and counselling therapy, were taken through occupational therapy to keep them occupied and to rebuild or sharpen their skills in order to earn a living after discharge.

"We have occupational therapy and recreational therapy. These are the two main therapies we take them through to keep their minds active. These are the procedures that we use. We hardly give medications because, to us, it's will-power and nothing else. While the occupational therapy helps them gain skills for their future, recreational therapy helps them to socialize" (CG2).

A 29-year-old male patient – turned counselor at Remar Rehab also stated this: "Eeeeemm, with the counseling, we take on that role ourselves. We counsel them on their condition and encourage them with their medication that will help them to get well."
According to the respondents, most of them came in unsound and did not have insight into their conditions, and others were aggressive. So the first thing was to calm them down, so that they could respond to treatment on time.

"When they are calmed down then we take them through psychiatric interviews to assess their willingness to study. So, we give them medication as the first procedure then we engage them in recreational activities" (C3).

Monitoring and Review

We found that patients were usually under continual observation during their stay at the Centers. At one of the centres, it was noticed that patients were kept under very strict conditions with a well-fenced structure. This was to ensure that patients followed their medication and undertook all the therapeutic exercises and also did not find ways of getting access to alcohol.

"The treatment procedures that rehabilitants go through to rehabilitate these patients are activities, prayers and self-help discussions. The director also has one-on-one discussion with them on Sundays" (CG4).

This, the study found commendable as some patients found it very helpful to their recovery, but others indicated that it was very frustrating and that the conditions were too harsh. Meanwhile, it was observed that rehabilitants at Remar had no fenced wall around their building, and they had no security personnel, thereby leaving them at risk by being attacked by invaders. However, patients who were committed to their course of finding help did not mind. "We don't have a fence wall so our doors are always locked to keep us safe" (C6).
The study also found that the medications usually used for the rehabilitants here were the benzodiazepine family that typically produces a calming effect. Thiamine, which is a vitamin, was sometimes served.

"We give Vitamin B1 because alcohol dependents are at high risk for being deficient in that (Thiamin) and may put them at risk of Wernicke-Korsakoff syndrome" (CG2).

Supervised Withdrawal

Whilst a patient was recovering, it was observed that the patient could be sequentially and medically be withdrawn to less intense treatment methods. At Cheshire, rehabilitants were involved in self-help group activities, periodic counselling, detoxification and occupational therapy. Patients who were at this

stage are usually put in groups and given self-help sessions. The caregivers in both homes indicated that this was the practice.

"… during the admission procedure, we try to find the future plans that they have. They all have different pursuits: some want to work for themselves, others will want to go into formal employment; they all have different future plans. So, as I said, the first is the medical therapy and the last one we look at what you want to do in future, then we train you towards your vocational interest." CG 2.

Departure Planning

This is the stage where caregivers put measures in place to prevent a relapse. The findings indicated that departure planning in both homes leaves a lot to be desired.

"We make guardians and parents aware that their wards would not be institutionalized so definitely they would be discharged home when we see significant improvement"

Departure planning starts on the very day of admission of patients. At Remar, the response indicated that some patients absconded. When departure planning is not made an integral part of the treatment process, patients easily relapse into their previous condition as was the case with a lot of patients at both treatment centers. Most patients might have experienced rehabilitation process more than once. The following is an example to illustrate this point:

"I went to Remar Home in Accra before and now here am I" (C5).

Community- based Support Program

Having explained the meaning of relapse and established the predominance of relapse incidences, the researcher followed up to ask how patients are followed up after discharge.

"After discharge, we call to check on their progress from their parents or the one who brought them here" (CG2).

"Since the family took care of their needs almost all the time, we asked that community or the environment where they were living before the problem set in should be changed if possible. The one who is to monitor you in your new environment would be contacted" (CG3).

A lot can be inferred from the responses to the questions under this theme. First, the study findings indicated that residential support programs were lacking in the rehabilitation process. Rehabilitated patients usually have to rely on their family and friends who are almost always busy enough. In the cases where the community including family, friends, church members and acquaintances all lend their support, the person quickly got well-established and resumed a normal, well-balanced life. As indicated in the following responses, most of these patients belonged to certain social groups before the addiction took place: "My family and the church where I worship are very supportive; they pay me visits and also support me financially" (C8).

The reversal of a patient's condition set in motion when they did not receive the needed support from their community, social groups, family or church members. In certain cases, this lack of support was because the family was simply fed up or that they were simply unaware of the intensity of his condition, or they did not know what kind of support was required of them. This was evidenced in the responses below:

"My family were not supportive, my mother was the one who even called in the police to arrest me, and they later brought me here although they pay for all my medications, I don't feel loved" (C12).

However, one family member of a rehabilitant stated that they chose rehabilitation instead of alternative treatment because they saw it as the best way to get their ward out of addiction. "Friends were suggesting we sent him to a prayer camp because they believed he was under evil attack, but we declined and brought him here. I think it was a good decision we took because here, he is confined, given medication and being monitored too" (C3).

DISCUSSION

In the present research, our aim was to describe the major steps patients are taken through, towards successful recovery process in two major rehabilitation

centers in Ashanti Region. Studies have shown that there is a growing number of alcohol related mental health illnesses (MHIs) in the nation, and there is no standardization of the medical screening examination (MSE) in the emergency department as well as rehabilitation centers (Uhlenbrock et al, 2017). The study found that the first and foremost step to begin the rehabilitation process was screening. However, there was no specific tool for the screening but the caregivers within the centers had their own way of screening and assessing patients for admission. It was found that patients who were sent there in unstable conditions were not triaged but medications were prescribed and administered straight away. However, other studies have proved that a triage tool – specifically, known as Triage Algorithm for Psychiatric Screening (TAPS) for psychiatric chief complaints and cost effective – is needed for the emergency department and rehabilitation centers. (Uhlenbrock et al, 2017). Such a tool could be effective for assessment if it were available in these centers. Assessment was also observed to be done through counselling for patients who were rather stable. The aim was to investigate patients' willingness for the detoxification and their efforts towards their successful recovery. It also aimed at reassuring them of professional assistance.

For stabilization, treatment and support, the study found that self-will played a major role on the part of the patients either to stay for treatment or walk away. As Miller & Rollnick (2013) suggested, self-efficacy is a person's confidence in his or her ability to change a behaviour, such as a behaviour that risks one's health. The researchers totally agree on this emphasis. In line with other studies, we agree with the fact that personal recovery is an individualized process through which people develop a positive identity and live a meaningful life, with symptoms of alcohol related mental illness (Ariss et al, 2019). Another study by Leamy, Bird, Le Boutillier et al, (2011) established the fact that recovery has been described as comprising five processes: connectedness with others; hope – giving a purpose to recovery and enabling the person to achieve it; identity – i.e., being aware that one is not defined by the illness, although it is a small part of one's identity; finding meaning in life; and taking responsibility for recovery. The study also found that counselling given by successfully recovered patients to new or in-coming rehabilitants really served a source of motivation. Another study has emphasized that addressing patients by preferred names and pronouns is one way to help decrease potential psychosocial stress encountered during admission (Alastanos & Mullen, 2017). For prescribed medication, clinical staff indicated that thiamine and Vitamin B1 were normally prescribed for the patients to counteract any withdrawal symptoms. We found that some patients were on maintenance antipsychotic treatment.

Monitoring was observed to be done by clinical staff (caregivers). Various studies have found that psychiatric rehabilitation helps people with serious mental illness to have a better outcome for their daily living, work, learning, and social environments by designing customized, recovery-oriented rehabilitation plans based on their perceived difficulties, resources, needs for care, objectives, and preferred and valued roles. Evaluations in psychiatric rehabilitation are used to design individualized recovery-oriented intervention plans, and to assess their effectiveness on clinical and functional outcomes (Anthony & Farkas, 2012; Franck, Bon, Dekerle, Plasse et al, 2019). We found that patients were on regular monitoring because they were confined. Monitoring of progress of recovery was done in the form of written reports by the caregivers. Responding to needs is one of the key elements of high-quality care that facilitates recovery. Therefore, psychosocial rehabilitation interventions that focus on participants' goals should be more effective than other types of intervention (Green, Perrin , Leo, et al., 2013; Sanches, van Busschbach, Michon, et al., 2018). Rehabilitants usually had to rely on their family and friends who are almost always busy enough, as nurses too were scanty or not available at all to follow-up after care. In addition, evidence showed that clients mandated to treatment tend to engage in a great deal of sustained talk, which is consistent with being in the pre-contemplation stage and predicts negative substance use treatment outcomes (Apodaca et al., 2014; Moyers et al, 2017). Other studies have declared that clinicians who work to help manage acute withdrawal in patients often do not have a large body of literature for research as to the best approaches for detoxification (Pergolizzi Jr et al, 2018). In line with our present findings on rehabilitation centers in Ghana, Adzrago

et al, (2018) reported that no rehabilitation physicians are at post in any rehabilitation centers in Ghana. The authors could attest to this fact. The study findings indicated that more health professionals and residential support programs are lacking in the rehabilitation process.

In supervised withdrawal and for many individuals with substance use disorders, the entry point for addiction treatment can be through withdrawal management (e.g. detoxification) services. Previous studies found that managing withdrawal symptoms is an important element of detoxification, but detoxification itself is not a final treatment for drug dependence, in that patients may relapse after detox (Vipler et al, 2018; Pergolizzi Jr et al, 2019). Occupational therapy, which our study observed to be effective in both rehabilitation centers, was to get patients who were responding to treatment occupied not only to earn a living after discharge from the centres but also served as major diversional therapy. Studies have found that mental health service providers are striving to develop and implement services that are recovery-oriented (Ariss et al, 2019). Additionally, our present results in line with other studies clearly showed that in order to meaningfully improve the social cognitive performance of patients, it is important for them to get involved in community-based clubs (Varga, Endre, Bugya, Tényi and Herold, 2018). Many studies have found that withdrawal is a serious and sometimes life-threatening event in alcohol-dependent individuals. The healthcare profession cannot afford to trivialize the extreme anxiety, fear, aversion, and withdrawal pain, even in those who sincerely and urgently wish to stop taking opioids as well as alcohol (Witt et al, 2020; Pergolizzi Jr et al, 2019). Our study also confirmed with other studies that indicated a small percentage of people who accessed withdrawal management services, which highlights a need to re-examine the current infrastructure of these services (Vipler et al, 2018). Inter-professional collaboration as a practice in discharge planning requires appropriate team communication and organizational structures to ensure successful collaboration. (Schoeb, Staffoni & Keel, 2017). Our study found that departure planning started on the day of admission though some patients had experienced rehabilitation programs more than once. Guidelines of discharge planning include the following principles: (1) early start of discharge planning (at admission), (2) the development of a clinical management plan (e.g. goal setting), (3) team coordination and collaboration, and (4) involvement of patients during the entire discharge planning process (Heath, Sturdy, & Cheesely, 2010). However, both rehabilitation centers were observed to have had their own unique paths of following their discharge planning protocols.

On Community-Based Support program for rehabilitants, research has found that one of the aims of the World Health Organization's Global Disability Action Plan is to strengthen rehabilitation services (Gutenbrunner et al, 2018). The researchers were reliably informed that both rehabilitation centers did not receive any funding and were dependant on benevolent organizations for support. However, other studies have indicated that Community-based Rehabilitation (CBR) guidelines, with sufficient and sustained support, can assist in providing access to rehabilitation services, especially in less resourced settings with low resources for rehabilitation (Gilmore et al, 2017). The environment in which the patient was seeking to re-integrate into has the potential to assist his transition or exacerbate his condition. In the cases where the community, including family, friends, church members and acquaintances all lend their support, the person quickly gets well-established and resumes a normal, well-balanced life and it boosts self-esteem. In their findings about needs and unmet needs on rehabilitation services from eighty six articles, Kamenov, Mills, Chatterji & Cieza (2019) concluded that the main reasons for the unmet needs for rehabilitation were the absence of or unequal geographical distribution of services within a country, lack of transportation, and unaffordability of the services. Our study confirmed that most patients were only able to access rehabilitation programs out of pocket. Moreover, the researchers agree with other authors on the recommendation that information must be collected regarding policies, health, disability, rehabilitation, social security systems, the need for rehabilitation, and the existing rehabilitation services and workforce (Gutenbrunner, Bickenbach, Melvin, Lains & Nugraha, 2018). Our study found that a lot of education to sensitize the public about healthy lifestyles was also lacking as occasional drinking was seen as normal. The researcher therefore agrees with Panebianco et al, (2016) that more extensive so-

cial networks in which individuals with addiction exchange support with one another can help individuals sustain recovery over time.

Implication for Nursing Practice, Education and Policy

The findings indicated the need for more mental health professionals to be stationed at the various rehabilitation centers to provide care for rehabilitants. There is also the need for enough resources to be made available. Also, government and stakeholders of the various institutions like Ministry of Health and Ghana Health Service should make rehabilitation their priority to reduce addiction and ensure proper reintegration back to society for successful rehabilitants. To boost the effort of these rehabilitation centers in Ghana, adequate resources allocation would help to curtail frequent relapse among addicts. Adequate infrastructure too should be provided to ease congestion at the various rehabilitation centers. More nurses should be sponsored, trained and specialized in addiction and rehabilitation nursing at the Ghana College of Nurses and Midwives to give specialized care to patients at these rehabilitation centers to facilitate a successful recovery process. Community and family members should be sensitized and encouraged to seek early help in these centers rather than seeking help in prayer camps or shrines and sending their wards later in deteriorating states.

Conclusion

As far as we know, the present investigation is the first to assess the efficacy of the structural elements of integrated treatments available for rehabilitation of patients and their process of recovery. Inferring from the findings of this study, it is imperative that special attention must be given to the needs of each of the following groups when planning treatment services for rehabilitants in Ghana: Addicts without supportive family; Addicts with supportive family; Addicts recovering from their condition and Addicts who live in environments with easy access to substances. Moreover, the National Health Insurance Scheme should be expanded to cover rehabilitation services in Ghana to relieve families and care providers of financial constraint.

Conflict of Interest

The authors declare no conflict of interest in this study.

Acknowledgement

We are grateful to all patients and caregivers who participated in the study and to all authors whose works were used as references.

Funding

The study was sponsored by the African Union's Nwalimmu Nyerere Scholarship fund for the corresponding author. The A.U had no further role in the study design; in the collection, analysis and interpretation of data; in the writing of the report; or in the decision to submit the paper for publication.

References

Adzrago D., Doku, D. T. & Adu-Gyamfi, A. B. (2018). Experiences of Individuals with Alcohol and Drug Addictions at Rehabilitation Centres in Ghana. *Journal of Addiction Research Theraphy 9*:363. DOI: 10.4172/ 2155-6105.100036.

Apodaca, T. R, Borsari, B., Jackson, K. M., Magill, M., Longabaugh, R. et al, (2014). Sustain talk predicts poorer outcomes among mandated college student drinkers receiving a brief motivational intervention. *Psychology of Addictive Behaviors. 28*(3). 631-638. https://doi.org/10.1037/a0037296.

Ariss, J. J., Gerlach, A., Baker, J., Barry, K., Cooper, L., de Vries, T. L., Laccorix, M. (2019). Community-Based Recreation Therapy and Mental Health Recovery. A Mixed-Media Participatory Action Research Study. *Progress in Community Health Partnerships Research Education and Action 13*(2), 161-170. doi: 101353.cpr.2019.0019.

Babor, T. F., Del Boca, F. D., & Bray, J. W. (2017). Screening, brief intervention and referral to treatment: Implications of SAMHSA's SBIRT initiative for substance abuse policy and practice. *Addiction,* 112, 110–117.

Bassuk, E. L., Hanson, J., Greene, R. N., Richard, M., & Laudet, A. (2016). Peer-delivered recovery support services for addictions in the United States: A systematic review. *Journal of Substance Abuse Treatment, 63*, 1–9. doi:10.1016/j.jsat.2016.01.003

Franch, N., Bon, L., Dekerle, M., Plasse, J., Massoubre, C., Pommier, R., et al,(2019). Satisfaction and needs in serious mental illness and autism spectrum disorder: The REHABase Psychosocial Rehabilitation Project. Psychiatr Serv. https://doi.org/10.1176/appi. ps.201800420

Gilmore, B., MacLachlan, M., McVeigh, J., McClean, C., Carr, S., Duttine, A., Mannan, H., McAuliffe, E., Mji, G., Eide, A. H., Hem, K. G., & Gupta, N. (2017). A study of human resource competencies required to implement community rehabilitation in less resourced settings. *Human Resources for Health, 15* (1), 70. https://doi.org/10.1186/s12960-017-0240-1

Green, C.A., Perrin, N.A., Leo, M.C., et al. (2013). Recovery from serious mental illness: trajectories, characteristics, and the role of mental health care. *Psychiatric Services 64*, 1203–1210

Guba, E. G., Lincoln, Y. S. (1981). Effective evaluation: Improving the usefulness of evaluation results through responsive and naturalistic approaches. San Francisco, CA, US: Jossey-Bass. 423-xxv, 423. (The Jossey-Bass higher and adult education series and the Jossey-Bass social and behavioural science series)

Gutenbrunner, C., Bickenbach, J., Melvin, J., Lains, J., Nugraha, B. (2018). Strengthening health-related rehabilitation services at national levels. *Journal of Rehabil Medicine. 50* (4):317-325. doi:10.2340/ 16501977-2217

Heath, H., Sturdy, D., Cheesely, A. (2010). Discharge planning: A summary of the Department of Health's Guidance Ready to Go? Planning the discharge and transfer of patients from hospital and intermediate care. http://tinyurl.com/ncd2y2g (accessed June 30, 2020)

Kamenov, K., Mills, J. A., Chatterji, S., & Cieza, A. (2019). Needs and unmet needs for rehabilitation services: a scoping review. *Disability and Rehabilitation, 41*(10), 1227–1237. https://doi.org/10.1080/09638288.2017. 1422036

Leamy, M., Bird, V., Le Boutillier, C., et al. (2011). Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry 199*, 445–452

McHugh, R. K., Whitton, S. W., Andrew, D. P., Jeffrey, B. A., Wand, A., Otto, M. W. (2014). Patient preference for psychological vs pharmacologic treatment of psychiatric disorders: A Meta-Analytic Review. doi.org/ 10.4088/JCP.12r07757

Miller, W. R., & Moyers, T. B. (2015). The forest and the trees: Relational and specific factors in addiction treatment. Addiction, 110 (3), 401–413. doi:10.1111/ add.13675

Miller, W. R., & Rollnick, S. (2013). Motivational interviewing: Helping people change (3rd ed.). New York, NY: Guilford Press.

Miller, W. R., Forehimes, A. A., & Zweben, A. (2011). Treating addiction: A guide for professionals. New York, NY: Guilford Press.

Moyers, T. B., Houck, J., Glynn, L. H., Hallgren, K. A., & Manuel, J. K. (2017). A randomized controlled trial to influence client language in substance use disorder treatment. *Drug and Alcohol Dependence, 172*, 43–50. doi:10.1016/j.drugalcdep.2016.11.036

Nalwadda, O., Rathod,S. D., Nakku, J., Lund, C., Prince, M., Kigozi, F. (2018). Alcohol use in a rural district in Uganda: findings from community-based and facility-based cross-sectional studies. *International Journal of Mental Health Systems 12* (1):12.

Pace, B. T., Dembe, A., Soma, C. S., Baldwin, S. A., Atkins, D. C., & Imel, Z. E. (2017). A multivariate meta-analysis of motivational interviewing process and outcome. *Psychology of Addictive Behaviors, 31*(5), 524–533. doi:10.1037/adb0000280

Panebianco, D., Gallupe, O., Carrington, P. J., & Colozzi, I. (2016). Personal support networks, social capital, and risk of relapse among individuals treated for substance use issues. International Journal of Drug Policy, 27, 146–153. doi:10.1016/j.drugpo.2015.09.009

Pergolizzi, *J.V., Annabi, H., Gharibo,* C. et al. (2019). The Role of Lofexidine in Management of Opioid Withdrawal. Pain Ther 8, 67–78 https://doi.org/10.1007/s40122-018-0108-7

Patton, M. Q., Guba, E.G., Lincoln, Y. S. (2006). Effective Evaluation: Improving the usefulness of Evaluation Results through Responsive and naturalistic approaches. *The Journal of Higher Education.*

Peter, E., Nathan, J. W., Zweben, J., & Horvath A. T. (2018). Understanding Alcohol Use Disorders and Their Treatment. The American Psychological Association.

Rathod, S. D., Roberts, T., Medhin, G., Murhar, V., Samudre, S., Luitel NP, Selohilwe, O., Ssebunnya, J., et al. (2018). Detection and treatment initiation for depression and alcohol use disorders: facility-based cross-sectional studies in five low-income and middle-income country districts. BMJ Open.;8: e023421. https://doi.org/10.1136/bmjopen-2018-023421Report on the Second Global Rehabilitation 2030 Meeting. W.H.O. (2019) https://www.who.int/new-room/events/ detail/2019/07/08/default-calender/second global-rehabilitation-2030-meeting. Date accessed 5th May, 2019

Romano, M., & Peters, L. (2016). Understanding the process of motivational interviewing: A review of the relational and technical hypotheses. Psychotherapy Research, 26 (2), 220–240. doi:10.1080/10503307.2014.954154.

Sanches, S.A., van Busschbach, J. T., Michon, H. W. C., et al. (2018). The role of working alliance in attainment of personal goals and improvement in quality of life during psychiatric rehabilitation. Psychiatr Serv 69, 903–909

Schoeb, V., Staffoni, L., Keel, S. (2018). Influence of interactional structure on patient's participation during interprofessional discharge planning meetings in rehabilitation centers. *Journal of Interprofessional Care*. 33. 10.1080/13561820.1538122

Ssebunnya, J., Kituyi, C., Nabanoba, J. et al., (2020). Social acceptance of alcohol use in Uganda. BMC Psychiatry 20, 52. https://doi.org/10.1186/s12888-020-2471-2 Substance Abuse and Mental Health Services Administration, (SAMHSA, 2020). Enhancing Motivation for Change in Substance Use Disorder Treatment. Treatment Improvement Protocol (TIP) Series No. 35.

SAMHSA. Publication No. PEP 19-02-01-003. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Uhlenbrock, J. S., Hudson, J., Prewitt, J., Thompson, A. J., Pereira, A. (2018). Retrospective Chart Review of the Triage Algorithm for Psychiatric Screening (TAPS) for Patients Who Present to Emergency Departments with Psychiatric Chief Complaints. *Journal of Emergency Nursing 44* (5), 459-465. https://doi.org/10.1016/j.jen.2017.12.008

U.S. Department of Health and Human Services, National Institutes of Health, National Institute of Mental Health. (NIMH ,2015). NIMH Strategic Plan for Research (NIH Publication No. 02-2650). Retrieved http://www.nimh.nih.gov/about/strategic-planning-reports/index.shtml 30th May, 2019.

Varga, E., Endre, S., Bugya, T., Tényi, T. & Herold R. (2018). Community-Based psychosocial treatment has an impact on social processing and functional outcome in schizophrenia. Front. Psychiatry 9, 247. doi: 10.3389/fpsyt.2018.00247.

Vipler, S., Hayashi, K., Milloy, M. (2018). Use of withdrawal management services among people who use illicit drugs in Vancouver, Canada. Subst Abuse Treat Prev Policy 13, 27. doi.org/10.1186/s13011-018-0164-3

World Health Organization & World Bank (2011). World report on disability. Geneva.