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COLLEGE OF HEALTH AND ALLIED SCIENCES

SCHOOL OF NURSING AND MIDWIFERY

EXPERIENCES OF RESIDENTS IN A THERAPEUTIC COMMUNITY MODEL OF ADDICTION MANAGEMENT AT A PSYCHIATRIC HOSPITAL

KWEKU EWUSIE ORLEANS LINDSAY

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THESIS SUBMITTED TO THE SCHOOL OF NURSING AND MIDWIFERY OF THE COLLEGE OF HEALTH AND ALLIED SCIENCES, UNIVERSITY OF CAPE COAST IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE AWARD OF MASTER OF NURSING DEGREE

OCTOBER, 2022

DECLARATION

Candidate's Declaration

I hereby declare that this project work is the result of my original research and that no part of it has been presented for another degree in this university or elsewhere.

Candidate's Signature……Date: ……

Name: Kweku Ewusie Orleans Lindsay

Supervisor's Declaration

I hereby declare that the preparation and presentation of the project work were supervised under the guidelines on supervision of project work laid down by the University of Cape Coast.

Supervisor's

Signature……..……Date…….

Name: Dr. Susana Aba Abraham

ABSTRACT

Globally, there is a growing concern about the alarming proportions of harmful alcohol use and abuse of illicit drugs. In Ghana, the use of illegal drugs and alcohol is endemic. Therapeutic Community (TC) for Substance Used Disorders (SUDs) has been in existence for about six decades and it was introduced in Ghana about a decade ago in Pantang Mental Hospital and since 2019 at Accra Mental Hospital. However, the effectiveness of this treatment modality for drug addiction in these two institutions has not been scientifically studied; therefore, there is a need for it to be explored. This study sought to explore the experiences of clients or residents enrolled in the Therapeutic Community to unearth their impact on the residents' journey toward recovery from drug addiction. This research adopted a qualitative study design that specifically employed the Explorative-Descriptive method. The target population for this study comprised residents who have been enrolled in the TC programme at the Pantang Mental Hospital with a sample size of 15 participants who were interviewed using a semi-structured interview guide and data analysed using Colizzi's (1978) descriptive phenomenology data analysis process. The study pointed out that residents or participants mainly expressed positive experiences in the programme, including experiencing a sense of belongingness, enhanced self-esteem/self-worth, and most importantly, developing hope of a life free of addiction. The study, however, also found that the programme was structured for all residents and did not offer opportunities for individualized care, which detracted participants from the programme experience. Given the TC programme's impact, it is recommended that out-patient-based sessions should be introduced for residents like pregnant women, breastfeeding mothers, and clients who cannot leave without their families to benefit from the TC programme's effectiveness.

KEYWORDS: Addiction, Experiences, Residents, Recovery, Therapeutic Community (TC)

ACKNOWLEDGEMENT

I want to express my gratitude to the Living God for his abundant mercy, wisdom and favour for bringing me this far in this programme. I would like to express my most profound appreciation and gratitude to my hardworking supervisor, Dr. Susana Aba Abraham, for her professional guidance, support, advice and time that led to the successful completion of this work. I learned a lot from her, and for that, I am incredibly grateful.

Again, I thank all the residents' receiving treatments at Pantang Hospital Therapeutic Community (TC) facility who availed themselves to be interviewed. Additionally, I would like to sincerely acknowledge my colleagues for sharing their academic knowledge and further extend my gratitude to all lecturers in the Department of Nursing, especially Dr. Druye, Dr. Ampofo, and Dr. Ebuenyan, Dr. Doku, Mrs. Patient Doe, not forgetting Dr. Ninnoni.

My final appreciation goes to my supportive and adorable wife for proofreading this work and constantly being on me to finish this research in time.

DEDICATION

To my lovely, beautiful, and supportive wife, Sandra, my angels Felicia, Kate, Mayah, Janice, and Calista, and my caring brothers and sister.

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LIST OF ACRONYMS

AA	Alcoholic Anonymous
CBT	Cognitive Behavioural Therapy
IRB	Institutional Review Board
MDCC	Mosama Disco Christo Church
MTC	Modified Therapeutic Community
NA	Narcotic Anonymous
NACOB	Narcotics Control Board
NTA	National Treatment Agency for Substance Misuse
PWUD	People Who Use Drugs
SDG	Sustainable Development Goals
SUD	Substance Use Disorder
TC	Therapeutic Community

CHAPTER ONE

INTRODUCTION

1.1 Background to the study

According to the World Drug Report (2018), globally, 275 million people, representing about 5.6% of the world's populace aged 15- 64, use illicit drugs. In 2018, an estimated 35 million people experienced drug use problems (World Drug Report, 2019). In 2017, after the drug is abused, Fentanyl, and its analogues, over 47, 000 addicts died in the United States of America and 4, 000 in Canada. The synthetic opioid, tramadol, which has been used for decades as a painkiller, is the most abused in West, Central, and North Africa (Bird, 2019). Other drugs abused include cannabis, karts, cocaine, heroin, and alcohol.

Alcohol use in middle-income nations is the world's third-largest risk factor for sickness and disability (Global Status Report, 2011). Alcohol accounts for almost 4% of all deaths worldwide, more significant than deaths caused by HIV/AIDS, abuse or tuberculosis (World Drug Report, 2019). The World Health Organization (WHO) estimates that excessive alcohol use results in roughly 2.5 million fatalities annually, with a net loss of 2.25 million lives after accounting for the projected protective effects of low alcohol consumption in various population groups on specific diseases.

The use of illicit drugs and alcohol is prevalent in Ghana and current WHO data suggest that the prevalence of alcohol consumption is 23.3%, with an alcohol per capita (APC) of approximately 20ltrs (Bird, 2019). The same can be said of illegal drug usage, as they are less reported despite the documented surge in quantity

being transited through the country (NACOB, 2014).

Illicit drug use is undeniably a social issue because its addiction is a problem that affects the user, family, and friends and has a social impact on the community (Sartor, 1991). Drug abuse is a complex problem in mental health that is frequently linked with problems in different aspects of life such as unemployment, homelessness, relationship disputes, court issues, and medical comorbidity (Brooner, 1999; Storbjörk, 2006). Addiction is widely recognized as a chronic relapsing disorder where recovery is possible. Addiction comprises biological, psychological, and social components requiring multifaceted treatment (Plagenz, 2015).

The problem of illicit drug use has remained an issue of public concern, and its implication for the health systems, community, and family are enormous. Global leaders have also implemented the Sustainable Development Goal (SDG) three (3) objective five (5) aimed at improving the treatment and prevention of drug abuse, including the abuse of narcotics and excessive alcohol consumption.

Like many other countries, Ghana signed its commitment to achieving the SDGs and has therefore instituted measures to curb the menace. Relatively recent developments are programmes to treat substance misuse and addiction/dependence. In the 1960s, substance abuse recovery services began in an organized way because of this significant public health and social crisis in the United States (Institute of Medicine, 1996).

1.1.1 Overview of the Drug Treatment Programmes in Ghana

In Ghana, there are over 70, 000 illicit drug addicts aged between 15-50 years

(NACOB, 2014), and care for addiction centres are just a few in Ghana (Dordoye, 2012). In Ghana, faith healing was the most patronized treatment option for drug addicts before the emergence of residential treatment centres. The majority of clients were treated at churches or prayer camps, or traditional healing centres before attending the Korle Bu Addictive Diseases Unit (Bird, 2019). People who use drugs (PWUD) are viewed as 'cursed' or 'unholy,' leading to the prevalence of pseudo-therapies as a religious treatment that resolves substance-abuse disorders. Therefore, patients of the prayer camp are not permitted to leave at will; their release depends on the permission of the head spiritualist heading the camp. 'Treatment' normally involves fasting, prolonged prayer sessions, and physical suffering, with more severe accounts showing that in the rain or under the boiling sun, patients are whipped or tied to trees (Bird, 2019).

Subsequently, the government, non-governmental organizations (NGOs), and private entities established drug treatment programmes that focused on rehabilitation, which run either in-patient or out-patient services. According to Bird (2019), “three (3) major mental hospitals, which includes Accra Mental Hospital, Ankaful Mental Hospital, and Pantang Menta Hospital, and three (3) Teaching hospitals, namely; Korle-Bu Hospital, Komfo Anokye Hospital, and Tamale Hospital were made available in Ghana in running addiction programmes including community psychotherapy and detoxification clinics”. Bird (2019) found out that they employ the 12-Step Rehab Approach, which leans towards spiritual health where participants have to submit to a higher power, which in the case of Ghana, the Christian God.

Bird (2019) explained that one of the major challenges for addiction treatment in Ghana is the fees charged for receiving treatment both in the governmental and non-governmental rehabilitation institutions seeking treatment. He found that as a consequence, addicts undergoing care in these units reported frequent relapses after detoxification. Also, the stigma associated with entering a psychiatric hospital often discourages many addicts from pursuing care. These challenges are burdens for most addicts seeking treatment.

1.1.2 Establishment of Therapeutic Community in Ghana

Therapeutic Community was established in Ghana by Mrs. Pearl Addison in the year 1973 at Accra Mental Hospital. According to Pantang Mental Hospital's Drug Addiction Rehabilitation Centre, the concept of Therapeutic Community in Drug Addiction management was introduced in Ghana by Nelson Carson from the Philippines in the year 2009, September 9th at Pantang Mental Hospital (Pantang Annual Reports, 2018) as a treatment modality to help addicts recover and live meaningful lives. Pantang uses the hierarchical type of TC model for treating clients with addiction. The approach was initiated as a treatment modality at the Accra Mental Hospital in March 2019. TC in Ghana has taken a clinical perspective and not a public health perspective, even though mental health aims to move from institutionalization to community-based treatment (Roberts, Asare, Mogan, Adjase, & Osei, 2013). In Ghana, TC offers only residential or in-patients services, with a duration ranging from six (6) months to twelve (12) months.

Patients are considered important stakeholders in this healthcare improvement. This is because better patient care experience is correlated with key indicators such as better positive performance of treatment, use of evidence-based treatments, use of healthcare services (Okunrintemi, et al., 2017), lower risk for medical malpractice (Fullam, et al., 2009), adherence to medical advice and treatment plans (Zolnierek & Dimatteo, 2009) and greater employee satisfaction (Rave, Geyer, Reeder, et al., 2003). As a result, the process of enhancing healthcare systems is progressively integrating the patients' perspective. Moreover, the key function of a hospital is patient care (Ghana Health Service, 2010). It is among the criteria used to measure a hospital's effectiveness, which is determined by how effectively it serves its patients. Swamy (2005) argues that the true testimony to the success of hospital management is patient satisfaction.

In Ghana, the Ministry has established that improving patient satisfaction and one of Ghana's health sector reforms' five key goals is to improve the quality of healthcare. Again, Turkson (2009) believes that by focusing more on the patient's perspective, both patient happiness and the quality of care will increase enhancing the skills and abilities of caregivers via better management, the availability of medical supplies, and improving the working environment, staff supplies and motivation (Fekadu, 2011).

1.2 Statement of the Problem

Therapeutic Community (TC) has been linked to various traditions and approaches to promote social and psychological change using interpersonal interactions and activities in a purposely designed social setting or residential environment (Vanderplasschen, et al., 2014). Several studies have shown increasing proof of the efficacy of TC in developing countries (Timms, et al., 1994; Rawlings & Yates, 2001; Perfas 2012, 2014). The TC field has been developed and modified, like other therapies. Substance abuse has become more complex over the last few decades, and the TC movement has responded by becoming more diversified.

Most people who enroll in drug addiction programmes have expectations of recovery and gaining control of their lives following the treatment. However, many studies have reported relapse incidents following discharge from various programmes such as Alcohol Anonymous and 12 steps (Broekaert et al., 2000; De Leon, 2000; National Treatment Agency (NTA), 2006). This necessitated the TC programme's introduction in Ghana about ten (10) years ago (Pantang Annual Reports, 2018). With the many reported successes of the TC programme globally (Van de Ven & Sminia, 2012), it presented another opportunity to provide a treatment intervention to clients who needed to break their addiction to drugs in Ghana.

However, since the inception of the TC programme in Ghana, there is limited insight into the extent to which the programme has impacted recovery from addiction (Rawlings and Yates, 2001; Perfas, 2012, 2014). Published studies on

how the programme is structured to address the needs of patients in the Ghanaian context, the experiences of residents, and the successes chalked have been almost non-existent. This presents a gap in knowledge generation which will help in sharing the impacts of health system quality improvement to enhance the patients' care experiences and outcomes in the Ghanaian context.

Considering that residents are the primary beneficiaries of the programme and have first-hand knowledge, this study sought to explore the experiences of residents enrolled in the Therapeutic Community Model of Drug Addiction Management programme in the Ghanaian setting and unearth the impact of the programme on the residents' journey towards recovery from drug addiction.

1.3 Purpose of the Study

This research aimed to discover clients' or residents' experiences enrolled in the Therapeutic Community Model of Drug Addiction Management programme in the Ghanaian setting. Specifically, the study sought to explore the factors that underscored the residents' experiences in the programme, unearth the residents' perception of the influence of the TC experience on their journey towards recovery from drug addiction and also explore the residents' perception of aspects of the programme that could be improved to enhance the patients care experience.

1.4 Research Objectives

The specific objectives are to:

1. Explore the experiences of clients enrolled in the Therapeutic Community toward recovery from addiction in the Ghanaian setting.
2. Describe the influence of TC programme has on residents' recovery from addiction.
3. Examine the aspects of the programme that could be improved to enhance patients' experience.

1.5 The research questions

This research seeks to address the questions:

1. What are the experiences of clients enrolled in the Therapeutic Community toward recovery from addiction in the Ghanaian setting?
2. How has the TC programme influenced residents' recovery from addiction?
3. Which aspects of the programme could be improved upon to enhance the patients' care experience?

1.6 Significance of the Study

According to the literature, there is a considerable number of research published about the Therapeutic Community (De Leon, 2000; Fees, 1998; Haigh & Lees, 2008; Hinshelwood, 2001; Werbart, 1992). The more significant part of this work has been carried out in the USA, and Europe, and very few have been carried out in Africa. Much of it focuses on Therapeutic Community organized in prisons or correctional institutions. Therefore, this study offers a rich source of information suitable for the African community on Therapeutic Community for substance abuse disorders.

This study provides empirical information on how the TC programme would be structured to influence recovery from addiction in the Ghanaian setting. Therefore, findings from this study offer a useful source of knowledge to potential clients and their families who may be battling with substance abuse and seeking a treatment option as it seeks to highlight the experiences of clients who have enrolled in the programme.

The study also serves as a useful source of feedback for the service providers and the programme regulators. The study explored the areas of improvement from the patients' perspective which when addressed well, will enhance their experiences; hence, it is believed that after post-dissemination, the study will ignite a quality improvement process in the study setting.

The study also contributes to the country's bid to achieve the Sustainable Development Goal (SDG) 3 target 5, which seeks to strengthen substance abuse prevention and harmful alcohol use by shedding light on the countries' effort to

provide the needed therapy for clients. Further to this, it will also inform policy on replicating the therapy sites in other health facilities.

More than half of prisoners fulfill the criteria of substance use disorder (SUD) (DeLeon 2000; Rawlings & Yates, 2001; Perfas 2012, 2014). Also, approximately 4 in 10 inmates have been reported in national prisons around the country with co-occurring drug use and mental problems (Sacks et al., 2012b). The study's findings will ideally assist policymakers and programme implementers in designing evidence-based interventions by incorporating TC treatment with criminal justice to solve the prevalent opioid issues.

1.7 Delimitations

The study was limited to persons diagnosed only as drug addicts who had enrolled in the TC programme. It did not include patients or residents who were enrolled in the programme but had comorbidities (i.e., suffering from other mental health conditions) or patients in the hospital who were not enrolled in TC as the researcher's aim was not to generalize findings. Also, even though two facilities in Ghana provide TC services, the study setting was limited to Pantang Mental Hospital because it has a prolonged experience (10 years) in the provision of TC services and a higher patient population of twenty-four (24) residents as compared to the four clients in residence at Accra Psychiatric Hospital as at the year under study.

1.8 Limitation

Overall, this study had some methodological limitations. Firstly, the researcher recognizes that in using a qualitative explorative, descriptive research design, this study's findings cannot be generalized but may apply to only settings similar to the study area (Polit, & Beck, 2010). Therefore, the researcher ensured that strategies that maintain rigour, such as an adequate audit trail, were firmly instituted throughout the data collection and analysis to ensure trustworthiness in the findings and replicate the study in similar settings.

Secondly, the researcher recognizes that using the nurses and counsellors as gatekeepers to invite and recruit residents into the study could have resulted in potential bias in sample selection as they may have recruited residents who would only give socially desirable responses. Nevertheless, this approach was necessitated because of the Covid-19 restrictions established by the hospital management. As a result, the researcher adopted strategies such as rephrasing, probing, clarifying, and reverse questioning to ensure that the responses were reflections of the participants' opinions about the TC programme and that this potential bias was minimized as much as possible.

Thirdly, the empirical literature on experiences among residents enrolled in the Therapeutic community in Africa and particularly Ghana was very limited. The lack of extensive research on Ghana and Africa's area compelled the researcher to copiously review the global studies available and rely on experience in general health and nursing practice to meet the current study's objectives. The researcher, however, asserts that this situation facilitates and inspires more researchers into

the therapeutic community.

Finally, potential inaccuracies in self-reported data are another constraint that the study encountered. Indeed, it is so hard to independently verify self-reported data, particularly in a qualitative study. Although the researcher needs to take whatever people say in an interview, there is the most significant risk that respondents can exaggerate, embellish, or not completely recall experiences, and both of these may be potential sources of bias that could alter the data's credibility.

1.9 Definitions of terms

Therapeutic Community (TC) is a drug-free community in which individuals with addiction and other psychological health issues live together in a coordinated and structured way to facilitate improvement and make a drug-free life possible outside the community

Substance use: Individuals who use substances associated with addiction. These include alcohol, illicit street drugs, and prescription medications.

Community: Living and working together in a group and encouraging a sense of togetherness. This Community is the primary agent for behavioural change and social learning.

Self-help: When a resident takes the leading role in his treatment and other residents act only as facilitators.

Resident: An addict who enters a TC programme is referred to as a resident instead of a patient or inmate.

Recovery: When an addict becomes a drug-free person and attains sobriety after treatment.

Method: Daily regimen of structured activities and interactions which contribute to the recovery.

1.10 The organization of the study

The study contains five (5) chapters and Chapter one includes the following: the study's background, problem statement, the study's purpose, research questions, study significance, delimitation, limitations, and the definition of terms. The study of similar works of literature is discussed in chapter two. It includes both published and unpublished documents that have valuable information on the subject, such as books, newspapers, and journals. Chapter three discusses the organization of the analysis and the research methods (3). The chapter's topics cover research design, ethical considerations, methods for improving the quality of the study, study settings, population, sampling methods, data gathering tools, data collection procedures, data processing, and data analysis. The presentation of data, analysis, and interpretation of results are highlighted in chapter four. A summary of the findings, the conclusion, and recommendations are included in chapter five.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter's objective is to review various theoretical and empirical studies conducted by different scholars engaged in research. According to Hart (2018), the literature review defines the significance of the research and serves as a tool for learning new information. It also aids in establishing a conceptual and theoretical direction for the research subject. The chapter, therefore, reviews relevant literature using the following search terms; "Therapeutic Community", “Residents In Therapeutic Community “or “Drug Addiction Treatment or management” and “Therapeutic Community in Hospitals” in electronic databases such as; EBSCOhost, CINAHL, Hinari, PubMed and google scholar. The Boolean operators, wild cards, and database vocabulary helped to combine and refine search results. Publications of studies in English within the past ten years both globally and locally on Residents in a Therapeutic Community of Addiction Management were retrieved. However, articles older than 10 years that are still relevant were also taken into account. This investigation also looked for other unpublished grey materials like textbooks and secondary data from the study area.

2.2 Conceptualizing the Therapeutic Community Model of Care

Researchers have argued that TC rehabilitation is based on the principle that drug addiction is the multidimensional condition of a whole person (De Leon et al., 2006), so multidimensional improvements are made in the way of a drug-free lifestyle and a modified personal identity is included in the recovery process (De

Leon, 2010).

2.2.1 Defining the concept of TC in Addiction Management

Harrison and Clarck (1992) indicated that British psychiatrist Tom Main (1946) was the first person to coin the name 'therapeutic community' in a review of the Second World War during the 'Northfield Experiments II' in which soldiers suffered from 'psychological trauma' and 'war neurosis' and used team dynamics therapeutically. Since that time, the phrase has been related to a wide range of therapy modalities and approaches that share the "concept," as well as several treatment traditions. and use all of the residential psychiatric facility's experiences and activities to support the therapeutic purpose (Bridger, 1990, p. 60). In the literature, numerous definitions for TCs were put forward, highlighting work in progress on finding consensus on what should be termed a TC. Therapeutic Community (TC) has been defined by scholars as an environment where a long-term residential therapeutic approach is designed to treat individuals with severe disorders, such as drug addiction, generalized personality disorder, and insanity, as well as disruptive and troubled children (De Leon, 2000; Fees, 1998; Haigh & Lees, 2008; Hinshelwood, 2001; Werbart, 1992).

Another definition of TC by Broekaert states that TC is a drug-free community in which individuals with addiction and other psychological health issues live together in a coordinated and structured way to facilitate improvement and make a drug-free life possible outside the community (Broekaert, 2001). Therefore, to address a person's substance abuse as well as their social and psychological challenges, the therapeutic community uses "community as a method," which is

its basic difference. (De Leon, 1997, p. 269). Despite the different definitions, the pillars of the therapeutic session are self-help and mutual assistance. Residents are primarily responsible for achieving personal development, achieving a more rewarding and responsible life, and ensuring the community's welfare. Ottenberg et al. (1993) pointed out that TC programme is voluntary, and the residents are not kept in the programme through force or against their will.

Vanderplasschen, Vandevelde, and Broekaert (2014) acknowledge that the term Therapeutic Community (TC) has been linked to various traditions and approaches to promote social and psychological change using interpersonal interactions and activities in a purposely designed social setting or residential environment.

According to Maglinger (2011), instead of individuals entering TC programme being called patients or prisoners, they are referred to as clients, tenants, or programme clients. The explanation for this is that all the interactions experienced by the client upon entering therapy are meant to establish a new cognitive orientation that enables the self to be redefined from a negatively isolated person to a more pro-social one (Nielsen & Scarpitti, 1997).

This model was formulated from clinical and research experience found primarily at traditional long-term residential TC. The TC programme's operationalization is organized into three components: Perspective, Model, and Method (Yates, 2012).

2.2.2 Perspectives of the TC model of Care

The perspective addresses the TC understanding of addiction or disease, the

person or the individual, his treatment and what is considered to be right living. This model illustrates how a TC is structured and coordinated, while the approach explains how the group is applied to life in a TC as a self-help method (De Leon, 2000).

The TC's perspective indicates that addiction is not seen as an illness but rather as a 'whole person' problem. Observing that point of view, treatment should focus on the 'person' him or herself rather than treating addiction which has nothing to do with the "drugs" (De Leon, 1997, p. 9). Although drug users mention a variety of reasons (Carulli & De Leon, 1976) and situations as to why they abuse drugs, TCs emphasize how individuals need to consider how they have contributed to the problems they face and establish coping strategies to cope with potential future problems (DeLeon, 2000).

In the TC perspective, the person is considered emotionally weak and immature but can transform positively. Again, drug users often have different cognitive disabilities, such as poor memory, problems in decision-making, and problem-solving skills (DeLeon, 2000). Concerning these cognitive characteristics, drug addicts are often concerned with their self-worth, self-regulation as members of society, and how they communicate with and control emotions.

The expected problems of an individual with fulfilling responsibilities, being held responsible and accountable, and maintaining consistency cause frustration and anxiety, resulting in the avoidance of commitments by using drugs and impeding autonomous functioning. The way drug users deal with the frustration associated with irresponsibility and inconsistency is to lie or selectively forget the details of

commitments. Although the nature of a person's experienced and displayed confidence issues is complicated, they usually cover social and psychological factors such as unstable and dysfunctional family backgrounds, weak parental role models, and poor socialization. The issue is a person's inability to believe others and to trust themselves and their feelings, opinions, and choices (DeLeon, 2000).

In agreement with the TC ideology, residents are expected to strive for 'right living' or a positive lifestyle following the TC philosophy. The right to live in TC requires ideals such as integrity, responsible care, commitment, work ethics, and the fundamental value of learning (De Leon, 2000).

DeLeon (2000) indicated that certain drug users might have social functioning, a supportive culture, and family relationships, but the abrasive properties of substance use ultimately destroyed these resources. For these people, rehabilitation from substance use includes recovery: re-learning or re-establishing their capacity to live a healthy life and regain physical and emotional health.

However, some drug addicts, with their substance use embedded in a broader, more nuanced network of psychological dysfunction and social deficiencies, have never been able to develop functional lifestyles. Recovery for these individuals entails rehabilitation and acquiring the interpersonal skills, behaviours, and values associated with the vision of healthy living for the first time. Considering the varying social and psychological backgrounds that drug users have, the basic purpose of recovery in a TC remains the same; to learn or re-learn how to survive without drugs. TC perspective describes rehabilitation as a continuous or progressive multi-dimensional learning process involving behavioural, cognitive,

and emotional enhancement. Behavioural improvement leads to a decline in asocial and aggressive behaviour and the development of constructive social and interpersonal skills.

2.2.3 The TC Model

George De Leon formulated the treatment Model of TC as theory, model, and method (De Leon, 2000). His formulation presented in this model was conceived to fill this gap in TC. The TC's essential elements have been organized into a theoretical model that can influence clinical practice, research work, and programme development.

The important fundamentals of a generic TC model are the physical environment of the community, the social system, the function as therapeutic and education, TC staff, colleagues, and their roles in the TC, interactions, and programme phases. Each part of the TC framework is an interpretation of the perspective and is used to communicate community principles and facilitate the individual's social and psychological growth (DeLeon, 2000). Even though the TC is focused on self-help, it is operated as an autocracy characterized by ranks in the group and job functions reflective of the level of responsibility of a resident.

Working in a TC is a fundamental social interaction, self-help, healing, and right-living mediation practice (DeLeon, 2000). Because the programme structure is based on need, in the self-help recovery process with the labour required to physically run the programme, it has a deep social and psychological meaning. For drug addicts, working in a TC provides an opportunity to forge personal and interpersonal ties to society., to change their future aspirations, to instill

confidence and a sense of hope, as well as a personal and social identity.

The TC programme usually consists of three phases: an orientation period (1-60 days) intended to include a welcoming, less stressful transition to TC life for new residents; a primary treatment phase (2-12 months) and a re-entry phase (13-24 months) that includes a hierarchically structured community in which residents can learn to express feelings and improve behaviour (Rawlings & Yates, 2001). In some, but not all TCs, these phases are further structurally refined into the following phases: crisis response, ambulatory induction, intake, induction, treatment, and social (re-) integration (Broekaert, 2001). TC residents gain more responsibilities and privileges progressively by moving through the phases. In addition, several phases can be observed concerning the internalization of transition by the citizens, progressing from enforcement over compliance and dedication to integration. Ultimately, this leads to real identity change (De Leon, 1994, 1995, 2000).

The TC is managed regularly, for which it is planned that customers and staff can share meals and coordinate classes, such as group meetings, and conferences (De Leon, 2000). Community meetings were accompanied by events in the morning, lunch, free time, afternoon activities, supper, and some free time till bedtime. The main goal of community gatherings is to promote a sense of belonging and solidarity (De Leon, 2000). Interpersonal interactions are used both within and outside of the program to promote the transformation process. In a healthy environment, residents can learn skills to interact with and relate to other individuals. Family work is seen as an integral component of TCs, and attempts

are made to include family members and prepare clients to meet their relatives (Broekaert, 2001).

Staff members of a TC are recognized as rational authorities. Staff members model trustworthy authority by enforcing their influence and directing instead of punishing and manipulating residents (DeLeon, 2000). For residents who have previously had bad interactions with authorities, this might be a therapeutic experience.

2.2.4 The Method

Though practically all events and relationships lead to healing, strategies are considered the 'daily structure of organized activities. The name 'community as a method' refers to a self-help technique applied in a TC where the community itself causes transformation. Community as a tool includes empowering residents by teaching them how to learn about themselves and bring about personal change to make sensible use of their time. These techniques and programmes put a demand on the residents by asking them to cooperate, act appropriately and comply with the programme's rules. Being a TC member means that each participant is also required to monitor, assess and give feedback on each other's actions, attitudes, and personal changes.

According to TC, "Community as a method is recognized as the key component, with the following critical components: a community setting, with a variety of community activities, and peers as role models; a structured time, peer interaction groups, and an organized day with work as therapy and vocational training (De Leon, 1994, pp. 24-27). Presentations, seminars, encounter meetings, and other

therapeutic activities are scheduled during the day at TC. Everything and anything that takes place in a TC are aimed at improving therapy and education. (DeLeon, 2000). To better understand how the TC can be used to support personal change, the environment, daily activities, residents, and teachings are categorized into nine broad categories: member roles, membership feedback, role model membership status, relationship issues, active learning formats, language and culture structure and systems, effective discussions, and balance groups between people.

2.2.5 Categories of TC

For categorization purposes of TCs, Simpson and Sells (1983) reported that the Drug Abuse Reporting Programme (DARP), the broad US review of the treatment programme, divides TCs into three subcategories: the first category, Conventional TCs, aims at total resocialization with a period of one to three years when treatment including high demands, conflict, and penalties is provided; the second category, Traditional TCs, aims at total resocialization with a duration of one to three years. Short-term TCs aims to provide residents with life skills and promote the re-establishment of family relationships, with standards of practice being moderate to high for a period of three to six months. Such categorizations have led to the division of the TC modality into different forms, although commonly defined as 'traditional' and 'modified.'

Some scholars have emphasized other TC categories such as drug-free, concept-based or hierarchical, and democratic TCs (Glaser, 1981; Haigh & Lees, 2008). These TC categories have become independent in numerous areas around the

world to resolve gaps in current treatment modalities (Glaser, 1981; Haigh & Lees, 2008).

2.2.6 Therapeutic Processes Employed in the TC Rehabilitation programme

Several approaches have been applied in the TC programme to rehabilitate drug addicts globally. De Leon (1989) maintains that TC can be differentiated in two fundamental ways from other major addiction treatment modalities. First, the programme provides a holistic approach to treatment guided by a clear understanding that drug abuse is viewed as a disorder of the entire individual, person or person according to the dimensions of psychological dysfunction and social disabilities, rehabilitation is seen as a development process requiring the integration of particular social and psychological goals and the right to recovery. Secondly, the primary therapist and teacher in the TC is the community itself, which consists of the social environment, peers, and staff who act as counsellors in the recovery process and role models of positive personal growth. Therefore, the culture is both the setting in which transition occurs and the structure for transformation initiation. Using the concept of social therapy, TC employs a coordinated attempt to re-socialize the individual, with the community as an agent of personal transformation. The therapeutic process includes the group (community) on an ongoing basis and includes the patient. When TC uses a social care approach, its members and clinicians do not appear to have a medical history. Hence a wide variety of workers, including ex-addicts, social advocates, and health professionals, are useful in providing the care needed (De Leon, 1988).

According to Magor-Blatch (2009), the therapeutic community emphasized the

biopsychosocial, emotional and moral aspects of drug use, using the environment to treat individuals and encouraging the improvement of habits, attitudes, and values of healthy living. Residents and staff are active in the group's management and activity, leading to a psychological and physical learning atmosphere where appropriate change can occur. The community is a network of friendship and support relationships. All patients [sick] are supposed to be both cooperative and supportive, which is correct for the staff (Hinchelwood 2002).

Carreau-Rizzeto established that TC uses a hierarchical model with phases of care that represent enhanced personal and social roles. Mediated by different group mechanisms, peer influence allows people to integrate social norms and build more productive social skills. Besides, activities are organized throughout the day, aiming at social rehabilitation (Carreau-Rizzeto, 2003).

2.3 Conceptual framework for this study

The conceptual framework for this study was designed by the researcher and is based on an integration of two theoretical models: the Patient Experience framework (Oben, 2020) and the Hierarchy of Needs (Maslow, 1943).

2.3.1 Patient Experience Framework (Oben, 2020)

The patient experience is now internationally documented as an independent dimension of healthcare quality. This framework explains the fundamental patients' human experience as they move from being unique, stable people to a state where an individual experiences both sickness and healthcare services. The sum of all encounters that affect a patient's perceptions along the continuum of care and are moulded by an organization's culture is referred to as the patient's

experience (The Beryl Institute, 2020). The patient's experiences are centered on how they view the hospital services they receive (The Beryl Institute, 2020; Centres for Medicare & Medicade Services, 2020).

Oben (2020), who developed the patient's experience framework, highlighted that before a patient is admitted into the healthcare system, their overall health and experiences with sickness begin. For a thorough understanding of the patient's experience inside the healthcare organization, this holistic experience is essential. The journey a patient experiences consist of three phases or spheres: the person, the patient, the user, or the consumer (Stempniak, 2013).

According to the framework, the role of a person as a user of healthcare services is dynamic. The same person or human with no disease becomes a patient at one point in time when suffering from a disease condition and this same person who is now a patient accesses the health facility to restore his health, recover and is no longer a patient again with many experiences.

The analysis of patient experience is critical because feedback will help identify areas of strengths and deficiencies and plan improvements in quality improvement across the continuum of care so that "patients will receive care" that is healthy, effective, patient-centered, timely, productive, efficient, satisfactory and equitable" (Institute of Medicine, 2019). This is closely linked to the study as the experiences of residents shared will serve as a useful source of feedback for the service providers and the programme regulators,

2.3.2 Theory of Motivation and Hierarchy of Needs

One of the most popular models of human behaviour was Abraham Maslow's hierarchy of needs (Kenrick et al. 2010). Maslow postulates that all human beings are an integrated whole with conscious desires, and they have a higher nature that could be studied and understood through their everyday experience (Zalenski & Raspa, 2006). Maslow's theory has been applied to empirical study in several fields, including education and management (Kiel 1999), social and emotional wellbeing (Gorman 2010), and behavior change concerning health (Freund & Lous 2012; Roychowdhury 2011).

According to Maslow (1943), the model assumes that human needs are organised in a hierarchical order with an upward climb to the next level only attained if the preceding needs at the time are satisfied. The needs at the base of the pyramid are necessary for survival, while the needs at the peak of the pyramid are less basic to survival (Feist & Feist, 2006). The Maslow theory is sometimes depicted as a pyramid, with physiological demands (such as food, shelter, water, and air) at the bottom and wants for safety, belonging, and respect rising to the top (Kenrick et al. 2010). The need for self-actualization, also known as the drive "to become everything that one is capable of becoming," is at the top or peak of Maslow's hierarchy of needs (Maslow 1943).

Physiological needs: These, according to Maslow (1943) are the basic needs. The body craves food, liquid, sleep, oxygen, sex, freedom of movement, and temperature (Feist & Feist, 2006). Maslow explained that these are high-priority needs because until they are met to a greater extent, other needs along the

hierarchy will not emerge to motivate a behaviour or its change (Maslow, 1943). Feist and Feist (2006) postulated that any deficit in the attempt to meet these needs causes distressing tension that is experienced as thirst, hunger, shortness of breath, confinement, sexual frustration, and discomfort.

Safety needs: Following gratification of the physiological needs, Maslow posits that the safety needs of the individual emerge (Maslow, 1943). These needs revolved around the need for security, protection, freedom from fear, dependency, and a need for structure (Feist & Feist, 2006).

Love and belongingness need: These needs include the giving and receiving affection that fills a void of loneliness and rejection (Maslow, 1943). Feist and Feist (2006) explain that the need for love at this stage of the hierarchy does not equate to sex, which is satisfied at the stage of the physiological need. Maslow explained that failure to meet this need for love results in emotional maladjustment (Maslow, 1943).

Esteem needs: According to Maslow (1970), human beings have a desire to be respected as well as have self-respect and the esteem of others. Two levels of esteem needs were outlined by Maslow: self-esteem and reputation.

Self-esteem: When satisfied ensured that the individual feels adequate and confident enough to attempt to become productive in all areas of his or her life (Maslow, 1943). Feist and Feist (2006), as cited in Wicksana and Suwartono (2019), that reputation, on the other hand, refers to the feeling of the prestige and recognition that an individual attains in the eyes of other persons whom he engages with.

Self-actualization needs: This need refers to the individual's desire for self-fulfillment (Maslow, 1943). This self-fulfillment is achieved when the individual actualizes their full potential or aspirations. Feist and Feist (2006) explain that an individual could be self-actualized when he or she fulfills their ambitions at the highest level of potential possible, in whatever endeavors they find themselves. Maslow however, estimated that they constitute one percent or less of the population.

2.3.3 Integration of the two models to develop the conceptual framework for this study

The conceptual framework for this study was developed by the researcher and is based on an integration of the two theoretical models: The Patient Experience Framework (Oben, 2020) and the Theory of Motivation and Hierarchy of Needs (Maslow, 1943).

The researcher proposed that the patient's experiences evolve throughout the stages of their engagement with the health system as they seek health care. Throughout these stages, the individual accessing the health system is described as a "person", "patient" or "consumer" as they evolve through their experiences and the gratification of their needs.

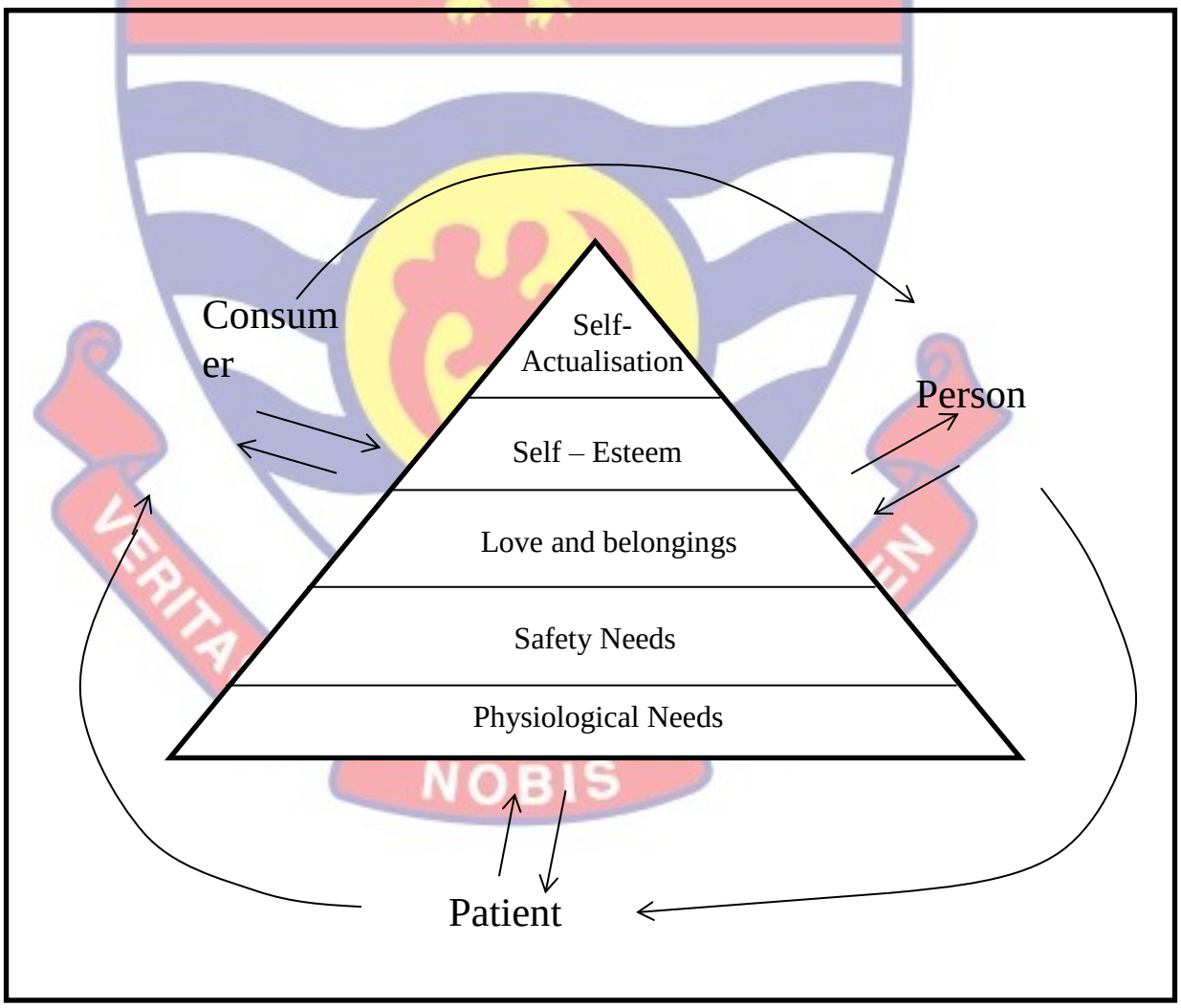
Thus, as a "person", the individual's perception of the health system; in this case, the TC programme is influenced by the pressing need at the time, their previous experiences, reports from friends and families, as well as documented reports. The "person" accepts to enrol in the health system when he or she believes that the physiological needs that bother survival will be met. In this study, it is assumed

that when explored, the person's experiences with the TC programme will be centred on the programme's ability to solve the basic needs that bother on breaking the physiobiological manifestation of drug dependency, food, water, and air, among other things.

The "person's" perception of the health system then evolves into expectations when he or she accesses the health system and becomes a "patient." The researcher proposes that as they interact with the health system, their experiences are shaped by their needs, as described by Maslow's theory. Thus, as the individuals progress along the various phases of the health continuum and their basic or physiological needs (that bother on survival) are met, the patient's experiences are shaped and their needs and expectations progress along the hierarchy to other needs that are not basic to survival; especially safety needs. As the TC programme is residential in nature, the researcher posits that the patient will become aware of their surroundings and therefore assess their safety needs as well as their needs for love and belonging. These gratifications or otherwise of these needs will therefore be the core of the experiences they share when explored. Thereafter, the patient's needs to be respected and to participate fully in the health system will underpin their experience as they recover in the programme and such as a shelter or rehabilitation centre, which is an enabling environment for a positive behaviour change. Drug addicts won't have a great foundation to properly address other issues, including family life or carer, unless their basic needs for safety and security are met in TC, and the facility is contained and safe for social learning (Greenwood et al. 2013). Unmet needs serve as the proximal

goals that drive behaviours since they are goal-oriented and drive people to act. After the primary need is met, the person can climb the hierarchy to pursue objectives and attend to needs at a higher level. The self-discovery process and ongoing human drive are fueled by efforts to meet a person's or addict's needs (Maslow 1970). This is directly related to the idea that healing is a process of optimism and resiliency-filled growth. One of the great things that TC participants experienced was growing (Jacobson & Greenley, 2001; Onken et al., 2007).

Conceptual Framework



Adapted from *Oben (2020) and Maslow (1943)*

2.4 Empirical Review

2.4.1 Experience of patients

In unique periods of crisis, the basic essence of health care includes people taking care of other individuals. Knowing what the patient experience has about required an understanding of the human experience as well (Oben, 2020). The fundamental human experience of patients is acknowledged as an autonomous component of the quality of health care, along with clinical efficacy and patient safety, as patients transition from being distinct, stable people to a state of encountering both illness and healthcare (Dolye, Lennox, Bell, 2013; Manary et al, 2013). Patients' or residents' experiences are a vital component of the quality of healthcare provided at the various facilities, and every patient's perspectives are unique. Patients are properly positioned to assess the treatment and services received in terms of whether their requirements and preferences have been satisfied whenever they are allowed to discuss their initial experiences with each stage of the care process (Fancott, 2014; Baker, 2014). Auras and Geraedts (2010) claimed that the processing of patient information would help organizations make informed decisions about service enhancement. Betts et al. (2016); Charmel and Frampton (2008) argue that improving patient experience should be essential to any healthcare organization's mission and goals because it will lead to a high return on investment, improved productivity, and increased customer loyalty.

Anhang et al., (2014) postulated that patient experiences apply to any patient-observable activity, including subjective experiences (e.g., the pain was controlled), objective experiences, and doctor, nurse, or workers behaviour

observations. Several studies have shown that there is a great deal of interest in measuring the medical care experiences of patients and publicly reporting this information to improve customers selection between hospitals and plans (Farley et al., 2002; Hibbard & Jewett, 1996; Kolstad & Chernew, 2009; Spranca et al., 2000). It also stimulates, guides, and monitors quality enhancement initiatives directed at the experience of patients in treatment (Browne et al., 2010; Davies et al., 2008; Friedberg et al., 2011; Goldstein et al., 2001).

To effectively advocate for change, it is critical to assess patients' impressions of rehabilitation programs and services (DOH, 1997). This is significant because patients' and doctors' perspectives on outcomes and the aftermath of sickness often vary (Hewlett 2003). According to research by Wain, Kneebone, and Billings (2005), patient's perceptions of a rehabilitation facility in a calm setting, kind and understanding staff, and the presence of other patients all contribute to a positive rehabilitation experience. Again, to acquire insight into the viewpoint of adolescent residents, Foster, Nathan, and Ferry (2010) undertook ethnographic research on the adolescent therapeutic group. Twenty-one residents, representing all those accepted into a drug-dependent adolescent program during the study period 15 males and 6 girls, ages 14 to 18 were employed in participant observation. The study's findings of the experiences of the residents showed that Vocational Education and Music Therapy are activities that include residents universally, although disappointment was evident in Journaling (a core programme activity). Group meetings were often used to set up or dismantle social cliques, while complex interpersonal relationships were often beneficial.

De Silva (2013) conducted a Health Foundation Evidence Centre study, a systematic review of 55 primary care and hospital studies, and the researcher identified a consistent significant correlation for a wide range of disease areas, settings, outcome measures, and study designs between patient experience, patient safety, and clinical effectiveness as one of the main pillars of quality in healthcare strengthens the argument for including patient engagement. Adzrago, Doku, and Adu-Gyamfi (2018), also explored the experiences of people with alcohol and substance abuse at Rehabilitation Centres in Ghana. They sampled 14 patients and 14 service providers at two rehabilitation centres. The results of the study showed that a lack of good and sufficient material and human resources made it difficult for people to recover from addiction and adhere to rehabilitation services. Patients were not pleased with the centers' staff members' unfriendly demeanor either. Among other things, the unfavorable attitudes of care providers may cause patients' recoveries to be delayed and their problems to return.

According to Ministerial Council on Drug Strategy (2004) and Muck et al. (2001), drug treatment programmes for adolescents are now more widespread and available than a decade ago, with some successful evidence. Nevertheless, that is not the situation in Ghana and Africa, as few studies have been done, leading to little information and minimal knowledge about the TC programme. This has affected service delivery to the resident and policy development as well; hence the researcher's desire to conduct this study to explore the experiences of residents enrolled in the Therapeutic Community of drug addiction management toward recovery from addiction in the Ghanaian setting.

2.4.2 Factors Influencing Patients' Health Care Experiences

The factors contributing to patients' healthcare experiences are multidimensional (Chen et al. 2016; Adhikary et al., 2018). According to Chen et al. (2016), patients' satisfaction influences their care experience; however, it was stated that multiple factors influenced patient satisfaction.

These factors include patients' variables (demographic features, physical and psychological status and expectations), factors for health institutions (characteristics of health workers, communication between staff and patients, quality of health, care procedures, budgets, hospitals and the atmosphere of health organizations, including the physical setting and food service), and governmental features (social setting, health policy, medical protection, and safety conditions). This indicates that patient satisfaction is a crucial factor in the experience of patient care. Sixma et al. (1998) developed two basic frameworks that described the fundamental factors contributing to satisfactory patient care experience. The first framework presents the patient's characteristics that focus on their socio-demographic characteristics, current health status, attitudes, or behaviour intentions. The second framework discusses the patients' perspectives on the view of the quality of care they receive.

Shale (2013) described three (3) factors influencing patient experience, including physiological illness experiences, customer care, and living experiences. A distinct element of their overall experience is the patient's experience of an illness. The greatest hope of medical treatment is for both the patient and their families and communities to eliminate, minimize or control the multiple psychological,

physical, social, and spiritual experiences of illness.

2.4.2.1 Individual characteristics

Research was conducted on 878 participants by Chen et al. (2016) using a cross-sectional study design to observe in-patient satisfaction and examine possible factors influencing patient satisfaction during hospitalization in China. The study found that 89.75 percent were overall satisfied with the service they received during hospitalization among the respondents, while 0.57 percent reported discontent. For in-patient demographic features such as patient gender, occupation, age, and residence, there were significant satisfaction associations, while monthly income and marital status were not associated with satisfaction. Again, the statistical outcome showed that the attitudes, expenditure, and surroundings of doctors' and nurses' facilities were found to influence the ratings of in-patient satisfaction, with odds ratios of 2.43, 3.19, and 2.72, respectively, affecting the experiences of the patient.

Research done by the Maine Department of Health and Human Services applied the survey method to assess the clients' satisfaction with substance Abuse Treatment facilities. A total of 2,169 patients from 56 facilities were enrolled. The study found that older age (43-67 years) was more likely to have higher satisfaction with services [mean score of 8.7] as compared to adolescents [mean score of 8.3]. Being females [8.7], having a college education [8.7], and being white clients [8.6] were reportedly more satisfied with their experience, but the length of treatment made no difference in the respondents' level of satisfaction with their experience in the facility.

Conversely, in another study conducted in Finland by Kuusisto and Lintonen (2020) to assess factors predicting satisfaction with substance abuse treatment, demographic characteristics such as age, sex, marital status, and employment levels were not predictors of satisfaction with the service. However, the clients' clinical characteristics such as type of substance use [p =.002], positive expectations on treatment outcomes [006], therapist's role in treatment [001], and client's readiness to change [009] were identified at significant predictors of satisfaction with care experience. It is essential to point out that although the instrument's reliability was relatively high (α .85), the participant's attrition rate was relatively high (48.6%). Thus, significant predictors of satisfying experience could have been missed in the final analysis.

In the above studies, these researchers used only a quantitative method to collect their data using questionnaires that limited patients to expressing their satisfaction in their own words. If the researchers had used mixed methods to collect data, the interview would have enabled participants to express themselves better about whether they are satisfied or not using either a semi or open-ended interview guide to ask questions that will reflect their experience in the care provided.

2.4.2.2 Patients perspectives

Dhumal et al. (2020) studied patients' satisfaction dimension with substance use disorder in rehabilitation and interviewed 14 male patients and four staff using semi-structured interview guides. Following a qualitative content analysis, the study found that the availability of a structure of the programme, opportunities for the development of personal responsibility associated with skill development,

comparison to their rehabilitation programme to others, the skill base of the counsellors, and case management facilitation were critical indicators of the positive experience of the clients while in the programme. Despite these insightful findings, the study findings cannot be generalized. Its sample was limited to only male participants and therefore missed out on the opportunity to present a gender-balanced perspective.

On the other hand, Andersson, Otterholt, and Grawe (2017) surveyed to identify aspects of a 3-6-month in-patient substance use treatment in Norway associated with positive outcomes. Of the 188 patients who replied to the survey, three aspects of care that had the highest rating for contributing to the respondents' satisfactory care experience were the admission process (87%), being treated with courtesy and respect (83%), and staff availability when needed (76%). Respondents were, however, satisfied with information flow on the programme routines (44%), treatment not tailored to their individual needs (44%), and availability of staff counselling (38%). It is worth stating that even though the study unearthed important information for service improvement, the findings did not imply causality between these factors and enhanced experience or positive outcomes of the rehabilitation.

2.4.3 Impacts of TC

A Series of research studies have demonstrated improved outcomes in residential rehabilitation for drug misusers (Bennett & Rigby, 1990; Gossop et al., 1999; De Leon and Jainchill, 1982). According to NTA (2006) patients ranked it the best of all treatments. There is little evidence, but it appears that patients with more

severe mental health conditions may have better outcomes from 90-day or more extended rehabilitation stays (Simpson, 1997).

Various experimental studies (not just Randomize Control Trials) and systematic reviews have consistently shown that TCs produce positive impacts among TC graduates (De Leon 2010). De Leon (2000) argued that TCs successfully incorporated innovative and evidence-based methods such as motivational interviewing and relapse prevention techniques to optimize the community as a process approach. Other reports, on the other hand, have claimed that it is almost difficult to prove the effectiveness of a comprehensive and holistic treatment system such as a TC, as is the case with psychology and education as a broad term (Broekaert, Vandevelde & D'Oosterlinck, 2013). Notwithstanding this constraint, thousands of TCs around the world have been constantly seeking to improve the results of care while adhering to the community as a method and implementing creative approaches.

2.4.3.1 TC Treatment Efficacy on Drug use

Numerous studies have reported the effectiveness of TC on substance abuse rehabilitation programmes among adolescents (Carroll & McGinley, 2000; Hser et al., 2001; Jainchill, Hawke, De Leon, & Yagelka, 2000). A study was carried out by Morral, McCaffrey, and Ridgeway (2004) on the Effectiveness of Community-Based treatment for substance-abusing adolescents entering Phoenix Academy conducted at Phoenix Academy, USA, using a quantitative design with 499 participants. The study showed that adolescents confined to a residential TC had superior substance use and psychological coping outcomes later than similar

adolescents in different correctional programmes in 12 months. Similarly, in an observational study, Edelen et al. (2010) conducted a more rigorous assessment using a quantitative design for a residential therapeutic community for adolescents in Los Angeles, California. The study revealed that TC treatment had a positive effect on adolescent drug use and psychological functioning in the first 12 months, although no positive long-term effects were observed. Both researchers collected data for analyses via the self-reports of felonious youths. Self-reports are susceptible to several well-known biases (Morral et al., 2000; Schwarz, 1996). Again, these two studies were limited to only adjudicated youth; hence it affected their generalizability and could not be generalized to youth referred to substance abuse treatment from other sources and other categories of substance abuser users. The success of residential substance addiction treatment, however, appears to be directly connected to the duration of stay in the programme, which is the predominant and most accurate predictor of positive outcomes after treatment (Delany, Broome, Flynn, & Fletcher, 2001; Kasarabada et al., 2002; Messina, Wish, & Nemes, 2000; Soyez, 2006). These positive results include reducing drug use and arrests and increased opportunities relative to those who stay for a shorter time (Hubbard et al., 1989; Simpson, 1993).

To buttress the effectiveness of TC, a study conducted in 2004 from three TC programmes in Israel surveyed 167 addicts for 15 months following their release from treatment. The research examined explicitly the contributions to a good outcome of socio-demographic traits, self-esteem, time in the group, psychopathology and locus of influence. This research found that 90% of those

who completed the TC programmes were drug-free. The research also showed that the longer an individual remained in the TC programme, the more likely they would later be to be drug-free. Another important finding from this study was that substance use was positively correlated with previous criminal behaviour at the 15-month follow-up and negatively associated with living with a partner before completing a TC programme (Dekel et al., 2004).

Historically, patients have stayed in TC for as long as they have had to go through the stages of rehabilitation, usually between 18 and 24 months. In recent years, funding and insurance limitations have reduced the duration of stay to 3, 6, or 12 months of treatment in certain parts of the world (De Leon & Wexler, 2009). The evidence, nevertheless, clearly shows that longer care time correlates with better outcomes (De Leon, 2012). For Ghanaian TC recovery settings, according to the treatment policy of Pantang Hospital and Accra Psychiatric Hospital, the minimum length of stay for the treatment period is six months for a good TC outcome.

However, before positive outcomes are reached, most individuals admitted to TCs abandon treatment. Research has recorded numerous retention predictors, such as the criminal justice system's referral to the programme (De Leon, 1988; Pompi & Resnick, 1987); the understanding of the treatment programme by the client (Walton, Blow, & Booth, 2000); encouragement and preparation for rehabilitation (Green et al., 2002); positive personal improvements in attitude, emotions, and behaviour within the first 30 days in treatment (Edelen et al., 2007); and demographic characteristics, namely age, gender, and prior history of

rehabilitation (Lopez-Goni et at., 2008).

TC is an effective treatment modality for drug addicts and studies have been conducted on this treatment modality and have shown that participants in the therapeutic programme (TC) have shown improvements in substance abuse (Dekel et at., 2004). Criminal behaviour and signs of mental wellbeing are especially important for residents who enrol in treatment with the most severe problems (De Leon, 2010; Vanderplasschen et al., 2013).

In 2010, Wexler and Prendergast documented the efficacy and problems of U.S.A therapeutic communities. Their study found that in the criminal justice system, TCs have been generally recognized and have become the preferred model for treating prison inmates. In addition, the authors said that study has played a significant role in assessing various prison TC systems and has shown a substantial decrease in recidivism. Despite the increasing proof of the efficacy of TC in developing countries (Timms et at., 1994; Rawlings & Yates, 2001; Perfas 2012, 2014), the high-demand strategy is not appropriate for all clients. The TC field has been developed and modified, like other therapies. Substance abuse has become more complex over the last few decades, and the TC movement has responded by becoming more diversified. TC is only a decade old in Ghana, and little research has been conducted in Ghana (Pantang Annual Reports, 2018) to explore the questions which include how and why enrollment in a TC programme can promote the recovery process and how the TC programme has impacted recovery from addiction. Hence, the researcher's quest is to explore residents' experiences in a therapeutic community model of drug addiction management in

Ghana and Africa at large.

2.4.4 TC in Hospital

Hospitals are continually facing challenges in decreasing the gap between patient needs and essential services, according to Fottler et al. (2002). Since the 1990s, hospitals have acknowledged that customer service and provider-patient interactions are important in achieving good results, and they have highlighted the assessment and monitoring of patient satisfaction measures.

Birkelien (2017) said that the delivery of timely and effective treatment creates a compassionate and caring hospital environment that reflects on the quality of care and service experience and is patient centred. The setting of a hospital incorporates the physical and psychosocial environments of the institution through clinical and process interventions. Although clients place the utmost importance on human interactions and quality care outcomes, the physical environment plays a vital role in customer experiences. With the use of modern technology, designated private zones, clean environments, and accessible buildings, hospitals may enhance the patient experience. When a facility offers services like easy parking, Wi-Fi, televisions, comfortable waiting spaces and consultation rooms, nice dining options, decorative sights like windows and a non-sterile interior design, patients recognize the value that is added. The psychosocial environment is the hospital's interpersonal, emotional, and social setting for its clinical treatment and organisational processes. Patient care programmes are a good way for hospitals to show productivity and remove waste. They know that they are cared for by the hospital since patients see a well-

coordinated trip around the hospital and see staff working in teams around departments to improve their recovery. As Radick (2016) pointed out, a good patient experience is fostered by organized and planned staff practices. Patients can receive medical care and healing processes through the emotional comfort obtained from the medical staff and environment. One manager observed that when patients praise his hospital, they make remarks such as, "I felt safe, I felt cared for," instead of "my wound was cleaned, I got my drugs on time" (Lavoie-Tremblay et al., 2016). To concentrate on clinical aspects of treatment, providers must also consider that patients emphasis service quality and protection, concentrating on interpersonal components (Lavoie-Tremblay et al., 2016). The patient-centred care model that prioritizes patient needs, convenience, performance, and overall value is reinforced by positive experiences with workers, quality treatment outcomes, and hospital responsiveness. Increasing the engagement of patients in hospitals is a function of enhancing contact between patients and providers and promoting the availability of information. Patient engagement may be characterized by the access to knowledge of patients, their participation in health care decisions, and their participation in policymaking by health organizations (Carman et al., 2013). Patients who are actively involved must tell healthcare professionals about their health as well as their "views, beliefs, and risk tolerance about care options." Patients are entitled to "timely, comprehensive, and understandable information" from providers (Carman et al., 2013, p. 225). Clinicians play a major role in influencing patient engagement through these positive interactions with patients.

Despite the high rates of alcohol and drug use and addiction, Selby (2011) and Wu (2010) explain that rehabilitation, which aids in restoring the health, social, psychological, and emotional well-being of individual addicts, their families, and communities, is frequently restricted in many parts of the world, particularly in developing countries like Ghana.

WHO (2014) estimated that few recovery facilities are available for alcohol and drug abuse rehabilitation worldwide, and only 1.7 beds per 100,000 population are available to rehabilitate this disease. Each year, only one (1) in six (6) abusers globally undergo rehabilitation, and only 9 % of nations provide regular screening and brief mediation in primary healthcare facilities for alcohol and drug use disorders (United Nations Office on Drugs and Crime, 2014).

This situation has become a reflection in literature, and as a result, most of the studies on TC surprisingly have focused on the prison sectors as against the hospital environment, and that creates a lacuna that needs to be addressed (Cullen, & Woodward 1997, Dietz & Scarpitti, 2003). Currently, many patients are suffering from substance use disorder that needs to be treated or rehabilitated at the hospital, and residential based settings (De Leon, 2012; Vanderplasschen et al., 2013), and this has necessitated the need for the researcher to fill this gap using hospital base setting as a study area.

Although recovery tends to restore the physical, social, psychological and emotional health and well-being of addicts, their families, and community members, it is sometimes ineffective in many parts of the globe, especially in developing countries, considering the high level of alcohol and substance use and

addiction (Adzrago, Doku and Adu-Gyamfi, 2018).

Some studies (Selby, 2011; Binney, 2013; Ghana Statistical Service, Ghana Health Service and ICF Marco, 2009; Ghana demographic and health survey 2008; Langba et at., 2006) have been carried out in Ghana on alcohol and drug use as well as addiction with insufficient evidence on the recovery of alcohol and drug users in Ghana. It is also clear that there is a lack of literature in Ghana on the rehabilitation of alcohol and drug users [Selby, 2011; Ghana Statistical Service, Ghana Health Service and ICF Marco (2009), Ghana demographic and health survey 2008. There is limited or no published research regarding the experiences of residents who have been enrolled in the Therapeutic Community Model of Drug Addiction Management in Ghana. This research, therefore, sought to explore the experiences of clients enrolled in the programme in the Ghanaian setting and unearth its impact on the residents' journey toward recovery from drug addiction.

CHAPTER THREE

RESEARCH METHODS

3.1 Introduction

This chapter discusses the methodology applied in this research to achieve its objectives and understand the phenomenon under study. According to Avoke (2005), as cited in Kusi (2012), a method is a way of producing data. The methodology is the choice of the overall way that data is intended to arrive at conclusions. This includes the research design, study area, description of the population, sample procedure, data collection instruments, as well as the data collection and analysis procedure. In other words, as Leedy (1993) rightly indicates that a clear description of the methodology helps to validate the study.

3.2 Research Design

The "procedures for collecting, analyzing, interpreting, and reporting data in research investigations" are known as "research designs" (Creswell & Plano Clark 2007, p.58). This research adopted a qualitative design that employs the Explorative-Descriptive method (Sandelowski, 2010).

The qualitative design allowed the researcher to systematically explore the subjective experiences (Burns & Grove, 2005) of the residents enrolled in the TC programme and describe their life experiences. This qualitative design allowed the researcher to make meaning of the experiences that the residents have constructed regarding how the residents make sense of their world and the experiences they have in the world (Merriam, 2009). The qualitative approach is the most suitable design as the study sought to understand the personal meaning

of the TC residents' experiences and provide in-depth results (Burns & Grove, 2005) in a manner that cannot be quantified (Queirós et at., 2017).

The study employed an explorative-descriptive design. The descriptive method provides an image of a circumstance, person, or experience or shows how things relate to one another and happen naturally (Blumberg, Cooper & Schindler, 2005). The descriptive approach is useful when the researcher attempts to answer, "What is" or "What was" questions. Descriptive studies, nevertheless, are unable to clarify why an accident occurred and are appropriate for a relatively new or unexplored field of research (Punch, 2013).

The exploratory approach, on the other hand, is useful when sufficient information about a phenomenon and a problem that has not been established is not known (Saunders et al., 2009). It does not seek to provide the final and conclusive answers to the research questions, but merely explores the subject of research with different levels of depth (Brown, 2008). A blend of the two qualitative approaches complemented each other and strengthen the study as it offered to fill up the gaps of each of the approaches (Yoshikawa et at., 2008). One of the fundamental goals of an exploratory, descriptive qualitative design is to carry out an in-depth study of a problem in its context to understand the problem from the perspective of participants where the researcher investigates, recognises, and expresses the participants' experiences and gets close to them through interaction with them in their natural environment to generate data (Mills, Harrison, Franklin & Birks, 2017).

The explorative-descriptive design is suitable for this study because the TC model

is a new treatment model for drug addiction in Ghana. The design allowed for the exploration of clients enrolled in the Therapeutic Community toward recovery from addiction in the Ghanaian setting and described how the TC programme impacted recovery from addiction and how it can be improved to enhance the patient's care experiences.

3.3 Study Area

The study area for this research is Pantang Mental Hospital. The hospital is 20 kilometres outside of Accra's city centre in the Ghanaian community of Pantang, in the Ga East Municipal Assembly of the Greater Accra Region. It was the third of the three mental hospitals in the Republic of Ghana when it was established in 1975. The hospital now has 28 departments open and a bed capacity of 500. There are psychiatric In-Patient, rehabilitation, and medical and psychiatric Out-Patient Departments (OPDs) among the services offered.

The top five reasons for admission were listed as mental disorders related to cannabis use, a mental disorder related to alcohol use, mental disorders related to psychoactive substances, depression and mood disorders, schizophrenia, schizotypal and delusional disorders, according to Pantang Annual Performance Review (2012).

Pantang Hospital Drug Treatment and Rehabilitation Centre was established in 2009. Pantang Hospital Drug Treatment and Rehabilitation Centre, which uses Therapeutic Community Model, organizes two forms of rehabilitation services, a short-term six (6) months minimum and a long-term programme with one (1) year maximum. It provides services for patients with mental disorders due to cannabis

use, mental disorders due to alcohol use, mental disorders due to psychoactive substances, and substance use disorders without mental health problems.

This Drug Treatment and Rehabilitation Centre has treated over 300 residents or patients in the past ten (10) years span at their TC facility, and because the programme is a short and long-term programme so, the TC had choked successes of clients remaining in recovery after discharge. There were instances some clients relapsed and were brought back again for treatment and then recovered. According to the chief TC coordinator, the hospital follows the TC globally success rate of 40%.

The Drug Treatment and Rehabilitation Centre has a bed complement for 32 residents (Male-22 and Female-10), which is managed by staffed mainly by professionals (nurses, psychologists, psychiatrists), and the nurses are about 24 professional nurses and ten (10) auxiliary staff.

The facility has been selected for the study because compared to the Accra Psychiatric Hospital, the TC model has been rolled out as a treatment modality for a more extended time and has more clients with information-rich experiences.

3.4 Study Population

A research population is a comprehensive and well-defined group (universal set) of the elements pertinent to a given research question or hypothesis (Smith, 1975). The target population was all residents who have been diagnosed with substance use disorder or alcohol addiction and who had enrolled in the Therapeutic Community Rehabilitation programme at the Pantang Mental Hospital. Residents should have been admitted into the programme and remained in care. The

researcher presumed participants would have enough TC experience to enable them to reflect on their experiences and share. Again, quality of care is an essential indicator of patients' experiences in health care delivery (Isaac et at., 2010; Price et al., 2014). Hence, a sample of this population was required, which was appropriate to the study's design.

3.4.1 Inclusion criteria

The resident was eligible to participate in the study if he or she had enrolled in the programme for at least two months, in the lucid interval at the time of data collection and could consent to participate in the study. Their records indicated progress in care and the therapist or nurses who provided care signed off that the client could participate in the programme.

3.4.2 Exclusion criteria

Clients who had been enrolled in the programme but had comorbidities (i.e., suffering from other mental health conditions) were not selected to participate in the study.

3.5 Sampling Procedure

According to Lo Biondo-Wood and Haber (2010), a sample is a method of choosing a part of the population to represent the entire population, and it is necessary since the researchers may not be able to use the entire population. The research used homogenous purposive sampling to choose the study respondents (Creswell & Plano Clark, 2011).

Purposive sampling is a type of non-probability sampling that occurs when "the decision of the researcher chooses elements chosen for the sample. Purposive

sampling is a method designed to identify and select information-rich cases for the most efficient use of scarce resources in qualitative research (Patton, 2002). This involves the identification or selection of people or groups of individuals who are extremely knowledgeable about a phenomenon under study (Cresswell & Plano Clark, 2011). Bernard (2002) and Spradley (1979) communicate, in addition to knowledge and experience, the importance of availability and willingness to participate and the ability to link experiences and opinions in an articulate, expressive, and reflective way. Purposeful sampling techniques have been identified as useful for obtaining broad insights and rich information (Neergaard et al., 2009; Sandelowski, 2000), therefore, considering the population characteristics and the objectives of this study, purposive sampling was more appropriate.

The homogenous purposive sampling approach was suitable for the study because the targeted population has similar characteristics; drug addicts enrolled in the TC rehabilitation programme. Additionally, the target population had similar treatment options and similar experiences within the programme as they were all in residence at the Pantang Mental Hospital.

3.5.1 Gaining Access and Recruitment of participants

The study's approval was received from the Institutional Review Board (IRB) of the University of Cape Coast (UCC). Following this, a meeting was held with the Medical Director of the Pantang Mental Hospital to solicit approval to conduct the study at the facility. He was informed of the study, its purpose, and the benefits it will bring to the facility and clients. Approval was offered, but because of the

facility's restrictions due to the Covid-19 pandemic, the facility required the researcher to engage with Research and Ethics officer to agree on how data collection will be conducted while patient safety was ensured.

Meetings were also held with the ward-in-charges to discuss the inclusion and exclusion criteria and determine the number of eligible participants for the study. Twenty-four (24) participants met the eligibility criteria and were eligible for recruitment into the study. A two-step process was then instituted to recruit participants; firstly, the assistant ward-in-charge at the TC resident acted as a gatekeeper to inform the residents about the study and generate a list of those who agreed to participate and others who opted out of the study. He was asked to explain the information sheet to the participants and recruit participants interested in the study because of the Covid-19 situation. Secondly, to avert selection bias where the assistant ward-in-charge will select based on social desirability, the researcher requested to explain the study's purpose to those who opted out during a telephone conversation to ensure that they opted out and were not omitted by the gatekeeper. One resident who had earlier opted out agreed to participate, bringing the total number of those who agreed to participate to 15 out of the 24 eligible participants.

Meetings thereafter were scheduled with the participants for informed consent to be obtained and interviews to be conducted on call because of the Covid-19 pandemic with the assistant ward-in-charge's help through a staff. Due to the Covid-19 pandemic, the researcher encountered some challenges with the hospital management to personally meet the residents or participants on one-on-one basis

for any discussion because of fear that the researcher might infect the residents since the researcher's health status was unknown. They explained that it was their obligation to protect the clients and that it was of utmost importance. The research coordinator suggested staff should interview on the researcher's behalf. However, the researcher refused the brilliant suggestion considering the bias involved because residents will not freely express their negative experiences to hospital staff; hence, the medical director agreed upon a telephone call as the only means to interview the residents for data collection. The participants' informed consent was also obtained on phone calls with the help of ward staff.

3.6 Sample size

Cormack (2013) indicates that a small selective sample is used by qualitative researchers because of the in-depth nature of the study and the needed data analysis. Ayres (2007) also shares a similar view that the small sample size is appropriate in qualitative research due to the richness of information. The sample size selected was 24 participants, and data saturation was reached with the 15th participant; therefore, adding more individuals was not necessary to reach data saturation. When applied to sampling in a qualitative study, saturation is a phase of diminishing returns or the stage at which the gathering of fresh data does not throw any further light on the topics under inquiry (Mason, 2010; Ritchie and Lewis, 2003). (Glaser, & Strauss, 1967). The sample employed was homogenous since participants were chosen following a set standard criterion, and the purpose of the study was to explain a shared experience and behaviour that was generally common to this cohort. Data collection and analysis were conducted concurrently

so that data saturation would be detected. Again, the depth of the information generated, and the volume of data analysed was voluminous since the interview method was in-depth.

3.7 Data Collection Instruments

Data collection is the process of gathering and measuring data about variables of interest in a given systematic manner that enables one to answer stated specific research questions, test hypotheses and evaluate outcomes (Kothari, 2004). The method for collecting the data in this study was a semi-structured interview guide. This interview guide was divided into two sections. Firstly, a background information form comprised questions on the biodata such as the age, educational level, marital status, and the patient's clinical data such as how many years have you been addicted to drugs? How many hospitals or rehabilitation centres have you attended with your addiction? Do you have any family support in your addiction journey? This information was necessary to provide a description of the participants and understand their experiences during the interviews. The second section of the semi-structured interview guide was used to collect information on their TC programme experiences.

The rationale for using a semi-structured interview guide was to enable the researcher to follow a defined set of questions that answered the research questions as well as enabled the researcher to probe into questions asked by asking other questions not included in the defined questions (Patton & Cochran, 2002; Wilkinson & Brimingham 2003). This supported the quest for the richness of data. The semi-structured interview guide was structured into segments

covering questions (Appendix F). The questions were mainly open-ended with follow-up questions that probed to clarify and direct the interview where necessary.

The interview guide was designed to be sensitive and non-threatening, thus encouraging residents to talk freely about the issues they feel pertinent to their recovery experiences. There are two main methods of administering interview guides, which are face-to-face and telephone methods. Face-to-face is the method of administering a data collection instrument where direct or the physical presence of the interviewer and the interviewee is required for data to be collected (Pickard, Roster & Chen, 2016). The telephone method is the direct opposite of the face-to-face method where there is no physical presence of the interviewer and interviewee, and the gap created due to absence or no physical presence is filled using telecommunication devices such as telephone or mobile phone calls to administer data instruments. In this study, because of the unfortunate Covid-19 pandemic, the face-to-face in-depth interview could not be used to collect the data from residents, but rather the telephone method was used to collect data, which was very useful. The residents felt free and communicated freely without the researcher's presence. The interview guide is composed of open-ended questions. Dahlberg et at., (2008) suggested that using open-ended questioning was useful to encourage the narration of experiences naturally and to gain in-depth information about a subject. The researcher encouraged the participants to speak freely, and this assisted in finding rich data. The English language was the medium used to conduct the interview.

The interview guide's pretesting was done using two residents at the Accra Mental Hospital with similar features to the study setting. This was done to help the researcher to identify ambiguities in the questions and identify any differences in interpretation. It also allowed the researcher to practice interviewing skills. After the pre-testing was finished, more reviews were added to the initial interview guide. This was in line with Burns and Grove's (2010) assertion that it is preferable to pre-test instruments on a smaller sample to find and fix faults before using them on the actual sample.

3.8 Data Collection Procedures

According to Hox, the first question that any researcher faces is "Where do I get the necessary information to prove my hypothesis or to answer my questions?" (Hox, 2005).

He distinguishes between primary and secondary data sources. He clarified that all information gathered in a published form by someone other than the researcher is secondary data, whereas the researcher gathers primary data, he notes. Because the researcher collected the data, it was only possible to use primary sources for this study's data. The primary source, as elaborated by Montereau (2013), is the first-hand account of an event, life, or a moment in time and can be said to be in its original form.

A member of the ward staff assisted in obtaining informed written consent from participants after explaining the research procedure, the study's voluntary nature, and their right to discontinue participation at any time to them over the phone. Participants received assurances that their rights to confidentiality and privacy

would be upheld. To ensure privacy and confidentiality respectively, interviews were conducted in the rehabilitation's conference hall using the English language, and the researcher made sure the participants are given privacy being alone in the conference hall after the audiotape is set by the staff who was assisting the researcher in the data collection process. Before starting every interview session, the participants are asked whether the staff had left the hall to speak freely without fear and gain privacy. As much as possible, labels were used to represent participants and no participant was named in any report of this study.

Due to the Covid-19 pandemic, a telephone call interview was conducted with individual participants at their convenient appointed time in the evenings after their day sessions, using a semi-structured interview guide. The background information was collected to maintain the participants' confidentiality, and pseudonyms were assigned to participants to maintain their anonymity. To allow participants to speak freely, open-ended questions were asked. Participants were invited to offer questions for clarification, and the questions were investigated as needed. The responses were then recorded, played out later, and verbatim transcribed. Per participant, interviews lasted between 25 and 40 minutes. All observations made during the data-collecting process, according to Creswell (2007), were recorded in the researcher's field notes during the phone interview. This enabled the researcher to cross-check and confirm the transcripts during the data analysis.

3.9 Data Analysis

Leedy and Ormrod (2005) opined that after data has been collected, a rigorous analysis of the qualitative data commences identifying characteristics that may lead to the categorization or development of themes. According to Flick (2013), qualitative data analysis is subject to the researcher's epistemological forecast, ontological stands, and methodological approach, all done in cognisance of the research questions. After at least three times of repeat listening, the audiotaped recorded, the and interviews were verbatim transcribed. By listening to audio files and contrasting them with field notes, the transcripts were cross-checked, modified, and validated to make sure they matched the participants' specific codes and responses.

A manual analysis of the information collected in this research was carried out using Collaizzi's Phenomenological analysis (Collaizzi, 1978) format as a guide. Beck and Watson (2008) posited that Colaizzi's (1978) analytical method employs Husserlian phenomenology mechanisms highlighting the description of experiences rather than explanation.

Colaizzi's (1978) method of data analysis comprises seven phases, which are as follows:

Phase 1: The transcripts are read in-depth to get a feel for the data and its fundamental meaning.

Phase 2: Significant statements or phrases are extracted.

Phase 3: Each significant statement is framed into a formulated meaning.

Phase 4: An organization of the formulated meanings into clusters of themes

reveals patterns in the data. During this time, the original transcripts are reviewed and compared to ensure validation.

Phase 5: Integrating the findings of the study into a detailed description of the phenomenon under study.

Phase 6: Describing the fundamental structure of the phenomenon.

Phase 7: In this last phase, the research participants' validation is sought to compare the researcher's detailed results with their experiences.

The researcher analysed the data as follows:

Phase I:

To get a sense of the full content, the investigator reads each transcript many times. During this process, any views, feelings, and thoughts emerging from the researcher were added to the field notes. The procedure is aimed to reduce perceptions and preconceptions or biases to gain the phenomenon as the residents experienced them.

Phase 2:

At this phase of the analysis, the researcher identified and extracted significant statements and phrases or expressions about residents' experiences of enrolments towards recovery, the TC programme's influence over residents' recovery from addiction, and the aspects of the programme improved from each transcript. Transcripts were reviewed, and the statements which were related to the phenomenon were highlighted. These statements were written on separate sheets and coded based on their "transcript, page, and line numbers." After analysing data from all fifteen (15) in-depth interviews, there was extraction of 435

significant statements.

Example of an extracted significant statement on experiences of residents in a TC.

> *"It is like you are rebuilding yourself again and there are procedures, steps which you have to go through almost every day. You go to seminars, read recovery books, learn from experiences of some past addicts and how they recovered. You are taught how to manage your anger, how to deal with your self-esteem…"* **R007.**

Appendix G presents the extracted significant statements from the interviews.

Phase 3:

Meanings were extracted from each of the significant statements during this third level. Each underlying meaning was coded into one category by the primary researcher as it represents a detailed explanation and process verified by the research supervisor. Minimal differences found were resolved through dialogue. A total of four hundred and thirty-five formulated meanings emerged from four hundred and thirty-five significant statements. The researcher organized each significant statement on the left-hand column of a table in the word document against a column on the right, indicating the formulated meanings. After that, the full statements and their meanings were verified by the supervisor, who identified the correct and consistent meanings. Appendix G provides a table of significant statements and formulated meanings extracted.

An example of significant meaning in phase 2 above, the meaning formulated is:

> *"Client's perception about TC is that it is pa lace for therapeutic treatment for behaviour change. He also thinks that TC is a structured*

programme with structured daily activities such as seminars, reading from recovery books, learning from experiences of some past addicts, attending anger management and self-esteem classes."

Phase 4:

The researcher grouped all the formulated meanings into groups (sub-cluster themes), clusters of themes and themes during this fourth phase of the analysis using colour coding of three different colours representing each theme that emerged. After, each cluster of themes was subsequently coded to include all the formulated meanings associated with that category of meanings. After that, in other to form a distinctive theme, groups of clusters of themes that depicted a fundamental issue of the concept were integrated. Each category label reflected the cluster of themes that emerged from the formulated meanings under each category. Every formulated meaning belongs to only one category. Example. The sub-theme clusters: helplessness, willingness to receive treatment, family**,** self-motivation**,** hope to change behaviour**,** explore the programme**,** and recovery were all grouped under the theme cluster, "The Push to Enroll."

A total of eleven (11) theme clusters emerged, further grouped into three (3) emergent themes giving rise to the final thematic map. Table 3 shows how the emergent themes and cluster themes were grouped from the formulated meaning. The researcher, together with the supervisor, checked for the accuracy of the final thematic map.

Phase 5:

Colaizzi (1978) suggests writing summaries for each of the clustered themes at this point of the fifth phase of analysis. A detailed overview was used to describe all the emerging trends. The complete structure of the phenomenon “experiences residents a Therapeutic Community" was extracted after integrating all the study themes. Subsequently, in order to provide a sufficient definition and ensure that the comprehensive description represents the experiences of residents in a therapeutic setting, the researcher found an expert researcher who revised the results in terms of richness and completeness. Finally, the research supervisor confirmed the validation of the comprehensive summary.

Phase 6: This is the final phase, which is similar to phase 5; however, no exhaustive meanings were sought. A reduction of findings was made in which redundant, misused, or overrated descriptions were eliminated from the overall structure. This effort was initiated to highlight the fundamental framework. Many modifications were applied to generate clear clarification between theme clusters and their extracted themes, such as eliminating contradictory concepts that undermine the whole description.

Phase 7:

Colaizzi (1978) proposed a final validating phase of the study results using the "member checking" method that could be accomplished by returning to each participant in an interview setting to ask their opinion of the findings. Due to the Covid-19 pandemic era, the researcher could not return to the participants setting but got advanced approval, and participants views on the study findings were

obtained directly via phone calls to validate the findings. All participants confirmed that the results were a true reflection of their experiences in the Therapeutic Community on their road to recovery.

3.10 Rigor of the study

In qualitative studies, it is paramount for researchers to ensure trustworthiness in the findings. While reliability and validity are characteristics of quantitative research, rigor and trustworthiness are of qualitative research (Creswell, 2009; Lincoln & Guba, 1985; Shenton, 2004). A criterion for obtaining quality in a qualitative study is ensuring rigor and reliability by minimizing biases and subjectivity. This section explains trustworthiness by Lincoln and Guba (1985) proposed four criteria for determining credibility, transferability, dependability, and confirmability in qualitative research.

Credibility: seeks to ensure congruence between the research findings and reality (Holloway & Wheeler, 2002; Macnee & McCabe, 2008). Credibility was maintained through prolonged engagement. The researcher ensured early familiarity with the TC programme at the Pantang Hospital before data collection began and a minimum of one month of data collection to ensure rapport was established and familiarity was also achieved. Member checking was done throughout data collection and analysis, and this allowed the participants to provide feedback on the researcher's representation of their discussions.

Transferability: refers to the degree to which the findings of a qualitative study with other respondents may be applied to other contexts and is the interpretive equivalent of generalizability (Bitsch, 2005; Tobin & Begley, 2004).

However, there are apparent restrictions on generalizing the findings because qualitative approaches examine the experiences and views of a smaller number of people in a specific situation. To meet the transferability criteria, the researcher provided comprehensive information about the context and environment in which the study was conducted. The individual interviews were audio-recorded, and descriptions of participants' experiences were well documented, allowing for comparisons and transferability to be made (Denzin & Lincoln, 2013; Shenton, 2004; Whittaker, 2012). Similarly, studies were also considered in the literature review that employed similar study techniques in comparable and distinct settings.

Dependability: requires the assessment of the outcomes, interpretation, and recommendations of the research by participants so that both are informed by the data obtained from study participants (Lincoln & Guba, 1985). In the current study, by developing an audit trail, transparency was ensured in the data collection and analysis. With this, the researcher identified the processes, methods, and techniques used in the study transparently. This included written documentation of any changes in the context within which the study took place and the methodology and the rationale and how the decision influenced how the data collection was managed.

Confirmability: is associated with determining that the interpretations and results of the researcher are derived from the information, requiring the researcher to show how interpretations and conclusions have been reached (Tobin & Begley, 2004). To ensure congruence between the data and findings in this study, a second

person who had a master's degree and was familiar with qualitative research and the thematic analysis process coded the data recorded alongside the researcher, which ensured inter-coder reliability. An audit trail and accurate description of the context were maintained. The research supervisor and researcher also had access to electronic data and hard copies throughout the study to re-visit the data during the research process.

3.11 Ethical consideration

In qualitative studies, ethics are of significance and describe the acceptable practices researchers must adhere to throughout the entire research process (Kvale & Brinkmann, 2009; Dowling, 2000). Importantly, all research involving human subjects should be approved for research ethics after the publication of the Nuremberg Code and the Helsinki Declaration, and research ethics approvals remain a vital requirement (World Medical Association, 2013). The researcher understands the value of ethics in science and has received ethical approval before data collection from the Institutional Review Board of the University of Cape Coast (UCC-IRB). This study's topic was first approved by the Department of Adult Health, School of Nursing of the University of Cape Coast. To be compatible with all ethical principles needed to perform research, the following ethical guidelines were followed. Firstly, because the study area was at the hospital facility, copies of the research proposal were sent to the Institutional Review Board of the University of Cape Coast (UCC-IRB) for evaluation and approval and the Ghana Health Service. During the study, the ethical considerations outlined in the Helsinki Scientific Research Declaration (World

Medical Association, 2013) concerning human subjects were adhered to. Again, the respondents were briefed about the study's intent to ensure free, informed consent and involvement in the recruitment processes. Before the interview started, the respondent who could read and write in English were given a written consent form to read and freely decide to participate in the study by signing to confirm autonomy. To emphasize the importance of beneficence, the purpose of the research was explained to the respondents or residents. Individuals or residents invited to participate in research understood the study's purpose and decided to participate after weighing the benefits and risks.

Nonetheless, for those who could not read the informed consent form, the researcher and the research assistant (ward staff) read it and interpret it to the best of their understanding before participation. Those who could not write and agreed to participate in the study would have been asked to thumbprint on the consent form, but all the participants were educated and signed the consent form themselves. In addition, before any interview was tape-recorded, approval was obtained from the respondents. The recorded voice and the field notes were securely stored after every interview to adhere to the ethics of confidentiality. Any data that appeared to expose or identify the respondent was also not included in the study report to ensure confidentiality. Participants were informed that they were permitted to withdraw from the research at any time and that the treatment they received would not be affected by this.

3.12 Chapter Summary

This chapter introduced the methods used to gather and analyse data collected for the study. Using the qualitative approach rationalized the reasons for the choices made in this chapter. The various procedures used to consist of the research design, population, study area, sampling procedure, data collection instruments, data collection procedure and data processing and analysis, ethical consideration, and strategies used to enhance the study's quality.

CHAPTER FOUR

RESULT AND DISCUSSION

4.1 Introduction

This chapter describes the key findings of the study as well as the analysis and discussion of the results. This research sought to examine the experiences of clients or residents enrolled in the Therapeutic Community Model of Drug Addiction Management programme in the Ghanaian setting and unearth its impact on the residents' journey towards recovery from drug addiction. The researcher interviewed fifteen residents of addicts at Therapeutic Community Centre (Rehabilitation Centre), Pantang Hospital. The study used the explorative, descriptive qualitative study design. Data were analysed using Colaizzi's (1978) descriptive phenomenology data analysis process.

The chapter presents the demographic and clinical characteristics of participants or residents and the final thematic map. Three main themes based on the study's objectives emerged from the analysis: what are the experiences of clients enrolled in the Therapeutic Community towards recovery from addiction in the Ghanaian setting, how has the TC programme influenced residents' recovery from addiction, and which aspects of the programme could be improved to enhance the patients care experience. Quotes of participant's voices are used to support the results. The chapter provides a description of study participants followed by a detailed presentation of the findings that emerged from this research.

4.2 Results

A total of 15 residents were interviewed and of this number, 13 were males. The youngest of the participants was 22 years, while the oldest was 58 years. Eleven participants had studied at the tertiary level and most of them (10) were either self-employed or formally employed. Except for two Muslims, all the other participants reported being Christians. Of the 15 participants, eight were single, while the other seven were married. Almost all the residents were Ghanaians except only two participants, who were Liberian and Togolese, respectively. The demographic of the participants are presented in table 1 below

Table 1: Demographic characteristics of participants

Participant ID	Age (in years)	Sex	Educational background	Marital status	Occupation	Religion	Nationality
R001	47	M	Tertiary	Married	Teaching	Christian	Ghanaian
R002	22	M	Secondary	Single	Student	Christian	Ghanaian
R003	58	M	Tertiary	Married	Farmer	Christian	Ghanaian
R004	46	M	Tertiary	Married	Graphic designer	Christian	Ghanaian
R005	25	M	Tertiary	Single	Student	Christian	Liberian
R006	35	M	Tertiary	Single	Student	Christian	Togolese
R007	33	M	Secondary	Married	Soldier	Muslim	Ghanaian
R008	23	M	Tertiary	Single	Mechanical Engineering	Christian	Ghanaian
R009	40	M	Secondary	Single	Straighter	Christian	Ghanaian

R010	36	F	Tertiary	Married	Midwife	Christian	Ghanaian
R011	24	M	Tertiary	Single	Student	Muslim	Ghanaian
R012	30	M	Tertiary	Married	Businessman	Christian	Ghanaian
R013	25	M	Tertiary	Single	Student	Christian	Ghanaian
R014	36	F	Tertiary	Married	Nurse	Christian	Ghanaian
R015	28	M	Secondary	Single	Sales Assistance	Christian	Ghanaian

4.3 Participants' Clinical History

The number of years clients were addicted to drugs ranges between two to thirty-five years, with the average years of addiction being ten years. Out of the fifteen residents, only three residents had experience attending a different rehabilitation centre before enrolling in the TC programme. The cause of the resident's addiction ranges from lack of confidence, anger, inferiority complex, stress, accident, curiosity, and peer pressure. All the residents had family support throughout their addiction journey. This also shows the number of months each resident had spent in the Rehabilitation centre, ranging from three (3) months to six (6) months.

Table 2 below presents the participants' clinical characteristics

Table 2: Residents' Clinical characteristics

ID	Years of addiction	Rehab centres attended	Months on the TC programme	Causes of addiction	Family support
R001	25	1		Curiosity	Yes
R002	11	1		Lack of confidence	Yes
R003	35	1		Peer pressure	Yes
R004	25	1		Peer pressure	Yes
R005	5	2		Curiosity and Peer pressure	Yes
R006	6	1		Peer pressure	Yes
R007	17	1		Anger	Yes
R008	9	1		Inferiority complex, Stress, Peer pressure	Yes
R009	25	4		Peer pressure	Yes
R010	3			Stress	Yes
R011	10	1		Peer pressure	Yes
R012	2	1		Peer pressure	Yes
R013	8	1		Peer pressure	Yes
R014	7	1		Accident	Yes
R015	8	2		Curiosity	Yes

4.4 Emerging Themes

The themes addressed the participants' experiences while enrolled in the TC programme, the impact of the programme on the participants' recovery, as well as the aspects of the programme that the clients felt needed to be improved to enhance the residents' care. Three main themes emerged from the data:

- **"Why I stayed"**
- **"All things are new"**
- **"Pointing out the Lacuna"**

The themes and sub-themes are presented in table 3 below

Table 3: Final Thematic Map

Theme One: "Why I stayed" **MOTIVATION**	**Theme Two: "All Things Are New"** **Life transformation**
1. The Push to Enrol a) Helplessness b) Self-Motivation c) Willing to receive treatment d) Family e) To explore the programme f) Recovery g) To gain financial freedom h) Be responsible again	**1. Gaining Insight** a) Self-Awareness b) Empowerment c) Increase self-worth or self esteem d) Behaviour modification e) Life's Reflections f) Abstinence from Addiction

2. Why I stayed because a) Confinement or restrictive nature of the environment b) Physical environment is structured to be homey c) Structured programme activities d) Therapeutic programmes e) Impact of the TC programme f) Insightful programme g) Environment as a community oriented h) Positive social interactive skill / positive socialization i) Relevant topics discussed **3. Beholding the possible future** a) Hope for recovery b) Role modelling c) Communal nature encourages mutual help d) TC programme enhances self-esteem	2. **Taking back the reins of life** a) Personal Hygiene maintenance b) Recovery from laziness c) Time Consciousness d) Physical health Improvement e) Changes in physical appearance 3. **Becoming emotionally matured** a) Anger control b) Showing Regret about lost times in Life c) Feeling happy about behaviour modification 4. **Social changes** a) Gaining social skills b) Social confidence 5. **Spiritual changes** c) Exploring spiritual issues d) Embracing religion

Theme Three: "Pointing out the Lacuna"
1. The structure of the programme a) Stressful programme b) Lengthy programme duration c) Restrictive nature of the programme d) Challenging environment (confinement) e) No patient engagement **2. Unconducive environment** a) Poor physical environment b) Unhygienic environment c) Lack of physical comfort **3. Dreary Programme Activities** a) Repetitive and unstimulating programme activities b) Uninteresting daily programme activities c) Inadequate recreational activities d) No occupational therapy e) TC should recognize the

socio-cultural aspect of the programme

4.4.1 THEME ONE: "Why I stayed": Motivation

The theme presents the residents motivation for enrolling, remaining and fully participating in the Therapeutic Community programme. Three sub-themes emerged from the narratives: The push to enroll (4.2.1.1); I stayed because… (4.2.1.2); and Beholding the possible future (4.2.1.3).

4`.4.1.1 The Push to Enroll

The study revealed that most of the participants had battled with the addiction over many years and had tried to personally overcome the addiction without success. The residents reported many factors underscoring their decision to enroll in the study. From the narratives, most of the participants recounted a feeling of helplessness as the main reason for enrolling in the programme. This feeling overcame them when they failed to break the addiction despite the efforts, they committed to it. The feeling of helplessness often preceded an episode of relapse into addiction. R003, a 54-year-old married man explained that:

> *"I couldn't do it all by myself, I have tried before and it was the same result, just a week or probably less than that and I will be back to the same position [relapse]. So, I thought I needed help, maybe some help will get me further than before."* **R003**

For this participant, therefore, enrolling in the care was self-initiated and done willingly.

"I came here willingly to treat my addiction." **R012**

However, for other participants, their enrolment in the TC programme was initiated by family members who watched them struggle with the addiction and made efforts to assist the participants in accessing the help. A participant recounted that:

"My family was supporting me, they gathered hope and brought me here." **R009**

It was evident from the narratives that despite who initiated the participants' enrollment in the TC programme, most residents had high expectations and showed commitment when they signed on. The reasons cited for showing commitment included eagerness to recover, gaining financial freedom, and being responsible for their families. This is evident in some participants' narratives:

"Recovery first… It's the first reason why I'm here.". **R002**

"I'm ready to take every step for the recovery. I'm ready to do every work with all the activities at this place so that my life will be manageable." **R009**

Some residents stated that they enrolled in the Therapeutic Community programme because they wanted to gain financial freedom from their addiction which was costing them and affecting their families. A resident noted that:

"It [narcotics] has too much expenses. I have kids, I am married so I have to cut the expenses on drugs [narcotics] in order to finance my family well." **R007**

A few of the participants were however skeptical of the ability of the TC

programme to help break their addiction and this was because they had not been successful in other programmes they had accessed in previous years or had failed when they tried to break the addiction on their own. A participant recounted:

> *..... in Duncan Williams rehabilitation centre at Douwenya, it is like they say that its faith based. It's like just faith and they are trying to force you to believe in God, that's it, they don't do counselling and stuff like that so I failed to break my addiction. I decided to try a different place (TC) and see if it could help me solve my addiction problem. But here in TC, they have a lot of books that deals with addiction and they have a lot of counselors to talk to us and to educate us on how to prevent relapse. Here they deal with the mind and to help you change your mindset and stuff like that!* **R015**

But whether or not they succeeded or failed, the few doubtful participants showed the eagerness to commit to the programme.

4.4.1.2 "I stayed because…"

This sub-theme describes the positive experiences that underscored the resident's reasons to remain in the TC programme and learn to overcome their addiction to drugs. The factors mainly emerging from the narratives included a conducive environment for care, the structure of the programme, and relationships built among residents.

For some participants, the residential nature of the programme was useful as this diminished access to the external world as well as to their source for the drugs. R004 indicated that:

> *"The place is locked out from getting your choice of drugs."* **R004**

Another participant further explained that:

> *"The confinement alone is good for me, because I tried so many times in the house, I couldn't stop, I had some [drugs] in the house and because I had access to it [drugs], I stop a little then I go back. But here [TC residence], because of the confinement, there is no way you will get it.* **R014**

Another consideration was that, although the programme was residential, the physical environment was structured to be homey and welcoming and did not give the impression of confinement. One of the participants reported that:

> *"In the TC, we have nice rooms, there are ones we share 2 in a room, very comfortable ones and we have 5 in a room"* ***R007***

Another participant said:

> *"... Everyone gets his own things with wardrobe. We have five cubicles for showering so we don't normally get crowded in the bath house. The learning environment is very serene. Very quiet and you get to learn. Often, you hear cars passing around but the environment is good."* **R008**

Another feature that enhanced the participants experience in the programme was the structure of the programme itself. For most of the participants, the various activities undertaken in the programme accentuated the structured nature of the programme and was suited to promoting recovery. This is expressed by a participant in the following narrative:

> *"It is like you are rebuilding yourself again and there are procedures, steps which you have to go through almost every day. You go for*

seminars, read from recovery books, learn from experiences of some past addicts and how they recovered. You are taught how to manage your anger, how to deal with your self-esteem…" **R007**

From the narrative by R006:

"I think the programme has some things like classes, meetings, departmental work, sports time and also have a session of teaching self-esteem and anger management." **R 006**

Thus, for R008, a 23-year-old man who succumbed to drug use because of Inferiority complex:

"That's why there is no dull moment. We're always doing something". **R008**

For some others, the therapeutic focus of the programme was insightful and impactful and a different experience from other programmes that were faith- or medication- based. A resident explained that:

"I was thinking that since here is… a hospital, I was expecting… medications being given to you and that stuff but later I got to also understand that... it's therapeutic…that is helping me helping you… programme… so I actually embraced it." **R001**

Except from another participant's narrative revealed:

*"In the [other] programme…. it's like they are trying to force you to believe in God, that's it***.**" **R015**

Hence, although structured, the programme was community-oriented and gave a sense of partnership.

"We live as family and we do everything as a family because we take care of ourselves so everybody has someone to take care of. So, we build that relationship to help ourselves." **R003**

From the narratives, the opportunity to interact with other persons who have similar challenges and to have frank discussions about their weaknesses without feeling criticized was another aspect of the programme that most participants found useful. A participant said:

"When you saw us under the tree, we were discussing the negative things we [had] seen in our peers in the week. So, you point out the person's negatives and if it's me everybody takes turn telling me what they saw negative about me. Later in the afternoon, we come back and talk about the positives that we saw in the same person and the next week we expect that you have change from the negative's behaviour the week before and you work on them." **R003**

A different participant also said that:

"Day by day, I learn from the residents who teach me and I have a big brother [another resident] here who teach me how to do the right thing, how to live here." **R006**

For other participants also, the topics for discussion were relatable and impactful on their daily living.

"Some people come here and they do not know how to iron, wash and do certain things, arrange things in their locker. So, it is just about teaching them how to be neat and learn how to arrange their stuffs, dressing their

bed all the time." **R007**

Another resident said:

"The way they teach you to live in this house, you are always on your toes, always keeping your hygiene, dressing your bed, cleaning your room and department. It's like you are in the house and at the same time in your office." **R004**

4.4.1.3 Beholding the possible future

A concept that emerged throughout the narratives was hope. The participants reported observing other residents who outside the programme struggled with addiction, successfully exhibiting signs of recovery. Hence, for R005, whose cause of addiction was curiosity and peer pressure, observing others succeed boosted his confidence in the programme and gave him a ray of hope for his own recovery. He said:

"I came to meet some of my friends I knew from outside [the TC programme] and they are actually doing well now. Outside of the TC environment [we were] very close from doing everything together and he got his recovery after leaving the TC programme. Even though recovery is a life time work, he is actually doing well and that also motivates me" **R005**

This hope garnered from observing others succeed motivated some of the participants to commit fully to the programme and explore the available options.

"It has really influenced my recovery because the community has taught me… how to get recovery so they [those who have recovered] are the

backbone of my recovery." **R007**

Some participants elucidated that being assigned a senior resident who was succeeding as a brother/ sister enhanced ability to also succeed through role modelling.

When you get in… you are assigned with a sister who oriented you on the dos and don'ts so they serve as role model. We look up to them." **R004**

The communal nature of the programme which allowed for the residents with some strengths to assist those who were struggling enhanced their self-esteem and was highlighted in many participants' narratives.

Where you are lacking in something, I can just help… we are encouraged to do that. **R003**

We also learn from each other because we believe everybody have something great in them." **R013**

Thus, the transformation was evident even to the residents.

"… I have this kind of inner peace and that assurance even though I don't want to feel like. I have arrived at my destination; I've learned a whole lot." **R005**

Summary

Three sub-themes emerged; Pushed to enroll, I stayed because and Beholding the possible future were identified as the factors that motivated enroll, remain and fully participate in the TC programme as clients shared their experiences. It was observed that participants or residents expected some needs of which they could not be met in their lives hence led to enrollment into the TC programme to fill that gap expecting their needs to be fully met in the programme. Some of the findings revealed that the majority of the residents or clients experienced happiness about how the TC programme transformed their lives. The basis for this happiness was "hope" to recover from their addictive behaviour and attain sobriety. This hope motivated them to stay and actively participate in all the programme activities after enrollment with the aim to live a drug free life.

After enrolling to explore the programme, most of the participants needs were met from basic needs to love and belonging. These needs enhanced participants experiences which made them witnessed that the nature of the environment was conducive for behaviour modification and social interactions.

4.4.2 THEME TWO: "All Things Are New"

This theme presents the changes residents witnessed or observed in their lives while enrolled in the Therapeutic Community programme. Five sub-themes emerged from the narratives and these are presented as Gaining insight (4.3.1.1), Taking back the reins of life (4.3.1.2), becoming emotionally matured (4.3.1.3), social changes (4.3.1.4), and spiritual changes (4.3.1.5).

4.4.2.1 Gaining Insight

This sub-theme presents the psychological transformations experienced by residents while on the TC programme. It was evident from the narratives that participants expressed becoming enlightened, resulting in behaviour modifications and personal reflections.

For some participants, their involvement in the TC programme has brought them an awareness of the impact of illicit drug use on their lives and livelihood. This awareness included the physiological implications of illicit drug use. An excerpt of the participants' narratives explains this perception:

> *"I have learnt that when I take the drug it affects things in my brain like neurons… and I don't have control over myself and my actions"* **R015**
>
> *"We have learnt... it [drug addiction] is a disease that changes the brain so you can go mad"* **R012**

For most of the participants, this awareness resulted in the nurturing of empowerment among the programme residents. Through their involvement in the programme, the participants identified their innate capacity and will power to resist the urge for illicit drug use. A participant, R014, explained that:

> *"I now know the power I carry [within me] to overcome the drug. Also, it has given me a certain tool to reuse my life again."* **R014**

Further to this, the analysis revealed that most participants had gained some sense of self-worth that empowered them through the programme. For several of the participants felt good and deserved to be treated with respect. One of the participants stated that:

"Yes, now I can live without drugs, I can do everything anyone else out there can do and I am not a useless person, am actually a good and talented person." **R015**

R001 also acknowledged that transformation in his feeling of self-worth and esteem.

"My self-esteem increased... Because way back [while] in addiction, I felt shy to say I am a teacher. That kind of lifestyle that I was living was not good". **R001**

The narratives revealed that, this psychological transformation resulted in behaviour change for most of the participants. This change in behaviour was a significant sign of recovery.

"Everything has changed… My way of thinking was very negative. I am improving in a positive way." **R009**

These changes experienced by the participants reportedly prompted them to reflect on their lives before enrolling in the programme and the transformation they witness. These reflections enabled them to plan for the future and to work; towards building a life outside the programme. R007 said that:

"Now I have to further my education too because now I have the opportunity to do that… I have the chance to reflect on my life and [I have] seen my mistakes, cutting off friends and other stuffs is what I want to do." ***R007***

The behaviour changes also translated to developing resilience necessary to break the addiction. R012, a 30-year-old man who abused drugs for two years as a

result of peer pressure stated that:

"I've learned to stay away from drugs." **R012**

4.4.2.2 Taking back the reins of life

This sub-theme presents the attitudinal changes that participants felt had occurred while on the programme. The change included maintaining personal hygiene and developing a sense of duty and punctuality. This gave the participants a sense of control over their lives.

The study showed that almost all the participants had issues maintaining their personal hygiene while battling addiction. But the structure of the TC programme afforded them the opportunity to develop a routine that made basic activities such as bathing a part of their daily lives. R007, a 40-year-old man, who has been addicted to drugs for 25 years recounted:

"The previous time [before enrolling into TC], I can even wake up from bed and don't even bath then I go outside and do whatever. It will take me 2 days where I have not even put water on me. Here, I bath two times a day. Here, we bath morning and evening. It can even take me about three days whereby I've not put chewing stick in my mouth but here I paste two times a day, morning and evening". **R009**

For many participants also, who otherwise described themselves to be lazy, being in the programme nurtured in them a sense of responsibility towards work. This is evident in a participant's narratives:

"Before I wasn't here, I was lazy. But here, in TC, it's not a bed of roses, it entails hard work. So, if you are a very lazy person, you are always

going to be very active, working harder and as you stay here for some time, you will get adjusted to it naturally, then it becomes part of you. So, laziness is out." **R012**

A few of the participants explained that the TC programme had transformed their lives by teaching them to respect time, which gives them a sense of purpose. This sense of purpose they believed will prevent relapse when they exited the programme. Some participants said:

"*They are helping me to be time conscious so that I will not be able to go back to drugs again."* **R011**

"Punctuality is now part of my life." **R015**

For other participants, taking back control of their lives also impacted their physical health as they were able to access health care while in the programme.

"Out there, I didn't know I had problems with my liver. When I came here [TC programme], I was tested and realized that I was having problems with my liver. Now everything is okay." **R014**

A participant explained that these changes experienced in their programme even reflected in their physical appearance.

"There has been a dramatic change. When I came in first, I took a photograph. And now if I look at myself and compare the photograph, you realise that I'm now a new person. My body size has actually increased, and, I'm doing well. I look I mean I look so good." **R014**

4.4.2.3 Becoming emotionally matured

From the narratives, several of the clients developed positive ways to express their emotions. The programme offered several anger management sessions, which were deemed very useful by most residents who reportedly battled with anger issues, violent behaviours, and verbal aggression when they enrolled in the programme. These participants developed self-control and learned to express their anger in a more acceptable and mature way. Thus, for R007, a 33-year-old military man, whose cause of addiction was attributed to anger problems, he explained that:

> *"For me I have problem with anger, so I'm doing anger management at the moment and they have taught me a lot that it is ok to get angry, but it shouldn't lead to aggression. So, as of now, when I get angry, I take my time to go through the issue and all of that so I don't burst out and I don't keep things within me because I've learnt that the more you keep on piling emotions one day you might just burst out over a trivial issue."* **R007**

Others also reported becoming more considerate of others and learning to find amusement in situations that could otherwise have turn sore.

> *"I was easily angered but now things have changed. Someone even offended me and I didn't mind him, I only laughed and walked away, I was even surprised at myself."* **R010**

A resident explained that:

> *"I've realized that since I've entered here, I've also been able to understand people. You know, those here are coming from different*

backgrounds." **R001**

While many participants expressed developing positive emotions, few of them also expressed regrets for the time wasted in drug addiction, especially time lost with family. R007, recounted:

> *"I realized I lost a lot of time I should have spent with my family in the ghetto; people who were supposed to respect me. I have to get my respect back."* **R007**

The study revealed that majority of the participants were happy and content for the behaviour change in various aspects of their lives. This culminated in a sense of accomplishment. R008, a participant whose cause of addiction was inferiority complex reported that:

> *"When I lay my bed, I feel very proud of myself... Am feeling proud of myself."* **R008**

4.4.2.4 Social changes

This sub-theme describes the social changes and interpersonal relationships that were fostered among residents. From the narratives, many participants who struggled to relate with other people before enrolling in the programme had gained social skills that enabled them to relate better with different people. R001, a 47-year-old teacher, recounted that:

> *"I've been able to actually socialize. Back in addiction, I was somebody who was actually anti-social you know… because our genre of choice, was not actually permitting us to socialize."* **R007**

Other participants elucidated that the social learning activities, especially the

social meetings, have given them a platform to boost their morale and gained the confidence to be assertive and communicate well among people. An excerpt from participant R005 narrative revealed:

> ***"****I was a shy person but since I came here, the group meetings have built me up like I can stand in front of people and talk with confidence***," R005**

4.4.2.5 Spiritual changes.

This sub-theme emerged with two main concepts: participants embracing religion. The TC programme offered the participants to explore spiritual issues and embraced all religions. A participant reported that:

> *"They are always teaching you about the word of God … to make sure that anything you do; you have to consult God first."* **R012**

From the narrative, participants who explored the religious component of the programme developed religious habits that gave them purpose and hope. R009, a 25-year-old student revealed:

> *"Even now I can wake up and pray. I was not the type of person who pray every morning. Now, what am experiencing, I also thank God. I know once he has started, He will put me to a better end. Everything spiritual that goes on here, I like it."* **R009**

Except from another participant:

> "*I will stay far away from drugs and I will go to church to pray."* **R006**

Summary for theme 2

This second emergent theme, "All Things are New" indicates the findings that brought the changes residents or participants witnessed in the lives during their stay in the TC programme. Five sub-themes emerged from the narratives, which reflected their transformation experiences. These were gaining insight, taking back the reins of life, becoming emotionally matured, social changes and spiritual changes.

The results revealed the residents' transformational experiences revolved around the determinants of health, which was physical, psychological, emotional, social, and spiritual. These changes were made possible or enhanced when resident's needs (Example basic needs, safety need, self-esteem needs and love and belonging) were met through the TCS's positive environmental influence, the structure of the TC programme activities, such as role modelling and addiction classes (AA/NA), behaviour modification activities, and other blends of activities such as knowledge generation, religious and socializing activities which were effective in bringing transformation and impacting the lives of these residents.

4.4.3 THEME THREE: "Pointing out the Lacuna"

This theme discusses the residents' perception of deficits in the TC programme that had to be addressed to enhance residents' experiences and outcomes. Sub-themes that emerged include the structure of the programme, an unconducive environment, and dreary programme activities.

4.4.3.1 The structure of the programme

This sub-theme presents the factors that participants explained detracted from the TC experience. From the narratives, it was evident that some participants felt the structure of the programme caused some stress.

"It is a very good programme but the way it is structured makes it quite stressful." **R015**

This was attributed to packed activities, leaving little time for rest and recuperation of energy.

R007 reported that:

*"My only problem is there's a lot of stress. From morning to around four we're on our feet going up and down. Like we don't have an idle moment. Either we're having library or seminar which they talk to us about our addiction. We only use an hour for siesta around one. From six am to four pm***." R007**

"*Mmmm, the waking up early is too early for us to wake up at that time; 6:00am."* **R013**

Other participants also disclosed that the length of the programme, being a six-month residential programme, affected other aspects of their lives.

"The duration is a bother to me because I have 3 children and who will take care of them for me?" **R014**

"I think they can include an out-patient attachment to it, so that when someone wants to be going home and coming for meetings and lessons that one depends on the person. I will prefer it [non-residential], because I

have kids at home, I miss them a lot…" **R010**

Another participant suggested parole as a strategy to break the effect of the long residential programme.

I see someone who has been in treatment long here, he should be given the chance to do trigger walks. **R007**

Further to this, some participants reiterated that the programme was restrictive and did not allow engagement with the outside world.

"You cannot use phone. You cannot talk to your family when you want to do something…" **R002**

The residential nature was also a challenge for a few participants.

"Because it is a confinement, that's the challenging thing there is nothing wrong with the programme but it is because you are stuck here and it is demanding, it takes a lot to sit at one place, you know see the same thing all over again, every day for two months is even a lot and six months is kind of you know…" **R004**

It was evident from the narratives that the residents felt they were not engaged as active participants in the programme but rather as passive recipients.

*"It looks like most us are handled as if we came with an empty head, everything will be decided and you will be controlled but a lot of people are well educated***." R014**

"I will say that it's a bit difficult because you cannot prove your point…sometimes you just have to listen even when they address your fumbles… you don't have to give any feedback." **R004**

4.4.3.2 Unconducive environment

The study revealed that most of the participants felt that, the physical environment within which the residents were housed detracted from the TC programme.

> *"Some of the shutters are not in place, some of the nets are torn, you have to seal the net with handkerchief. Our safety is not 100% guaranteed."* **R 010**

Another participant supported this assertion:

> *"The environment, seriously it is 0%.***" R014**

Others also pointed to the unhygienic environment within which they were made to reside.

> *"The environment is very poor; it is VERY poor. Sometimes when you sleep there are mouse moving in the rooms, you know."* **R010**

Another issue raised about the physical environment was the lack of physical comfort.

> *"Like our fan got spoilt for 6month. It's a point of discouragement."* **R006**

For many of the participants, some maintenance of the physical environment would improve the overall programme experience.

> *If the whole place is renovated, it will be a nice place.* **" R014**

4.4.3.3 Dreary Programme Activities

It was evident from the narratives that some participants felt the existing TC programme activities were repetitive and lacked the needed stimulation to keep the participants interested after a period of time. A participant said:

> *To be honest, the [activities] are one-way… boring activities. Am five*

months now. ***R008***

For other participants they describe most of the TC daily activities as monotonous, uninteresting, and sometimes unreasonable:

"We have a lot of life skills on the timetable which actually to some of us it doesn't make sense, mopping one place without using the place about three times a day. We actually see it to be quite unreasonable because, how can you be mopping a place which is not used three times." **R001**

Several participants also reported the lack of recreational and occupational therapy that could enhance their experience while in residence:

"*… To me they need a lot of recreational activities***." R004**

I like TC but I don't like this particular TC because there is no basketball court, you cannot use your phone… there is no music therapy there is no art therapy..." **R002**

"Every rehab centre should have occupational therapy but we don't have it here. And some of the residents here actually enrolled with the intention to learn some vocation." ***R001***

Few participants were also concerned about some of the programme activities. R001 revealed that:

"I've been brought up in a typical Ghanaian village. Some of the activities here. I'm finding it a bit tough… Like a man of my own, I have a wife and four children, coming all the way here to scrub toilet and then you know… being like a robot … telling me what to do, you know that stuff." **R001**

Participant R003 suggested that some variety in programme activities could be

more stimulating and enhance the TC experience.

> *"People should do different activities every day. Instead of bible studies every morning we can change and do newspaper review or poem."* **R003**

Except from another participant, R012, a 30 years business man's narrative who was grateful and appreciated the positive impact the TC programme has created in his life also revealed:

> *"We do a lot of programmes, a lot of things here that keeps you reminded that what you've been doing out there was destroying our future, was destroying a good life in us so we are blessed to be here and we are grateful because it, this thing has really created an impact in our lives, me personally uh huh."* **R012**

Summary of theme 3

This emergent theme, "Pointing out the lacuna" discussed participant's perceptions of the shortfalls they experience with the TC programme, which, if addressed, will promote participants' experiences. This theme emerged with three sub-themes: the structure of the programme, the unconducive environment and dreary programme activities.

This theme's findings revealed that the programme had some limitations such as non-involvement of residents in some decision-making, programme structure limiting the individualized care and absence of some relevant programmes that would have enhanced residents' experiences and sped up their journey to recovery from addiction. This shows that some residents expected a standard basic need from the programme's environment (shelter, food) and also safety (complain of a

dilapidated building and not 100% safe environment) and love and belonging (some residents complaining of their opinion not being respected by some staff).

4.5 Discussion of Results

This section of the chapter discussed the study's findings with previous research and this study's theoretical framework.

4.5.1 Theme one: Participants' Motivation

Today, the patient experience is widely recognised as an independent component of the quality of health care. In unique periods of crisis, the basic essence of health care includes people taking care of other individuals. Understanding the humanity of patients is the essential basis upon which all good patient-centred experience initiatives should be developed, according to the patient experience framework by Oben (2020). Oben (2020) further argued that "patient" begins in the centre, indicating that the person is not always a patient (not an addict) and becomes one with the onset of illness (becomes an addict). The "User" means that with their first contact with the health-care system, the person who has a disease just becomes a user of healthcare services and builds rich memories of either negative or positive over time depending on the quality of care they receive. The residents expressed their experiences as motivational factors that encouraged them to stay and participate actively in the TC programme. Miller and Moyers, (2015) posited that motivation is multidimensional. It involves the internal preferences, wishes, and values of clients. It also includes external (positive and negative) stresses, requests and reinforcers that affect clients and their perceptions about the risks and benefits of engaging in drug use behaviours.

Flannery (2017) asserted that motivation is a critical element of behaviours change that predicts client abstinence and reduced substance use (DiClemente et al., 2017). The majority of the participants described positive experiences that motivated their reasons to remain in the TC programme and overcome their addiction to drugs. The factors mainly were; a conducive environment for care, the structure of the programme, and relationships built among residents in the programme. Motivation is a part of the human experience, and nobody is unmotivated (Miller & Rollnick, 2013). According to Miller and Rollnick (2013), motivation is available and can be changed at several points in the phase of transition. Hence, this explains the positive experiences residents described as the reasons to remain in treatment and fully participate in the programme, since the TC influences addicts to engage in a positive change process.

The study reveals that the conducive environment for care, the structure of the programme, and the relationships built among residents in the programme motivated the participant to access hope, which triggered them to change willingly and gain recovery. The sense of motivation birthed hope in the lives of many participants. The study, hope succeeded in motivating many of the participants to commit fully to the programme and explore the options available to recover. Wiles et al. (2008) explained that hope increases the outcomes of treatments for many health conditions, including mental health issues (Werner, 2012, Stickley & Wright, 2011). In the treatment of addiction, hope encourages patients to move from the stage of hesitation to the stage of decision-making, which leads to a positive change and thus leads to recovery. From the results, it

was also found that some residents observed others succeed in their recovery, which gave them a glimpse of hope. Shaver (2012) asserted that participation in self-help organizations like TC makes residents feel useful, strengthens their confidence, and positively affects their network of social relationships when they experience hope.

From the findings, although some participants-initiated enrolment, family support was an important component for others. Roozen et at., (2010), reported that family members could play an important role in the understanding of the issue and acceptance of care by the abusers if they have adequate education and treatment for themselves. Community Encouragement and Family Training (CRAFT) evidence-based family treatment has shown its efficacy in increasing the frequency at which addicts undergo treatment. Many researchers have emphasized the importance of the social dimension engaging the patient and their families and communities, enhancing patient care experiences (Institute of Medicine, 2013; Commission, 2020; Clay & Parsh, 2016). Any conflict in the dynamics of the family has been shown to raise the risk of relapse. Issues such as family boundary problems, communication problems, lack of cohesion, role disorders, and behavioural problems can contribute to recurrence, and effective treatment of such problems can lead to recovery. (Turner et al., 1993; Flora & Stalikas, 2013). This shows that irrespective of the domestic problems families encounter with addicts in Ghana, families still support and motivate them in their journey to recovery.

The study revealed that most of the participants had battled with the addiction over many years and had tried to personally overcome the addiction without success. According to National Coalition for the Homeless (2009), breaking an addiction is difficult for anyone, especially for homeless substance abusers. To begin with, motivation to stop using substances may be low. Miller and Rollnick (2013) reported that motivation helps individuals overcome their ambivalence about making difficult changes to their lifestyles. Helping clients affirm their motivation increases the chance that they will stick to a particular strategy for behavioural improvement. The residents reported many factors underscoring their decision to enroll in the study. Most of the participants recounted a feeling of helplessness as the main reason for enrolling in the programme. Motivation and desire to change are consistently correlated with increased help-seeking, treatment. This finding is also consistent with DeLeon (2000), who indicated in the TC perspective that an addicted person is considered emotionally frail and immature, but with the potential to change positively. After their (addicts) basic needs are fulfilled, the person (Oben, 2020) no longer feels the need to use alcohol or drugs to survive, breaking the addiction. This suggests addicts are motivated to go beyond physiological norms and step up the hierarchy. The individual is no longer engaged in an operation that endangers their health and personal safety, so they can now enjoy a real sense of security. The person can become involved in the sober TC programme during early recovery, which can further contribute to the feeling that they are healthy.

For other participants, the physical environment was structured to be homey. The

TC learning environment has been made just homemade or homelike and it is very conducive for all activities like socialization, sports, and entertainment. The TC learning environment is confined and everything you will need in your daily activities can all be found there, and monitoring is high. Birkelien (2017) said that delivering timely and attentive treatment produces a compassionate and caring hospital atmosphere that reflects and is patient-centred on the quality of service and service experience. A hospital environment should be a combination of the institution's physical and psychosocial conditions through medical and administrative interventions. Because the effect of social interaction and quality care is of utmost importance to customers, the physical facility plays an important role in customer impressions. Rehabilitation centres can enhance patients' experience with clean facilities, create privacy zones, and use available modern technology. Patients see the added value when they have services such as easy parking, accessible Wi-Fi, TVs, comfortable waiting areas and exam rooms, quality dining options, and aesthetic appeals such as windows and a warm, non-sterile interior design.

In this study, the TC programme was residential in nature. This was useful as this diminished access to the external world and their source for the drugs. Drug treatment programmes in Ghana are operated through rehabilitation. It can either be on an in-patient or out-patient basis. Pantang TC rehabilitation centre's residential nature is only on a residential basis having a bed capacity of 32 occupants. Residents and staff or counsellors live in the facility for 24 hours, 7 days a week. The centre is confined to residents moving out of the facility. The

residential nature of the programme has created a conducive environment for problem-solving. The residents seek help either from the counsellors or supporting each other or self-help themselves in the programme, which helps address behavioural, emotional, and attitudinal change. According to DeLeon (2000), the basic elements of a generic TC model are factors such as the physical environment of the community, social structure, function such as counselling and education, TC members of staff, colleagues and their roles in the TC, interactions, and programme stages. An interpretation of the perspective is expressed in each aspect of the TC model and is used to communicate community teachings and promote the individual's social and psychological development. The physical environment of TC represents continuity and predictability, adding to the process of transition for residents. In every TC programme, the basic rules guarantee an atmosphere of confidence and safety: no substance or alcohol, no abuse and no sexual relations.

Being a residential programme also allows the therapist to observe the clients and identify their peculiar needs to make the programme as individualized as possible. DeLeon (2000) supports this assertion and avers that a description can be drawn up of the behaviours and attitudes of residents that need to be addressed and established by observations and that the reason why residents are not allowed out of the TC environment. Birkelien (2017) further pointed out that it could also encourage therapists to offer prompt and sensitive treatment that produces a patient-centred hospital environment that reflects the quality of service and service experience.

The study also found that the TC programme was structured with very organized activities that kept the residents engaged. Considering other drug treatment approaches like 12-Step programmes according to National Treatment Agency for Substance Misuse (2006) is a model which was developed by Alcoholics Anonymous and is the spiritual foundation for personal recovery from the effects of alcoholism, not only for the alcoholics but also for their friends and family. The model also views addiction as a disease. The philosophy or models underpinning 12-Step operations are different from the Therapeutic community because, based on the spiritual nature of the 12-Step programme, clients are supposed to surrender to a supernatural being, which is God. In contrast, according to NTA (2006), the Therapeutic community enables workers or counsellors and residents to participate together as members of a social and learning community.

It was evident from this study that the TC programme's daily activities are structured to ensure that the client's life is organized to bring a reflection in shaping residents' behaviour and develop new attitudes that could be useful after they exited the programme. This result corroborates the study by DeLeon (2000) that anything that takes place in a TC programme is intended or structured to enhance improvements in therapy and education. Although the work arrangement focuses on necessity, in the process of self-help transformation, it has a profound social and psychological meaning, with labour required to operate the programme physically. The TC work experience gives drug addicts the chance to build personal and social participation in mainstream society, change their future aspirations, instil hope and a sense of opportunity, and social as well as personal

identity (DeLeon, 2000). The study established that forming partnerships and a communal sense of living was a useful strategy to enhance recovery through encouragement and role modelling. The first psychologist to theorize motivation, Alfred Adler (1956), found encouragement to be a central aspect of human growth and any psychotherapeutic care. Adler claimed that human beings are inherently based on social interests, a desire to belong to others and society and interact with them. Hence, the programme breaks the habits of loneliness through forming partnerships and a communal sense of living. Sweeney (2009), as cited in Adler (1956), explained that "to encourage is to inspire or help others, particularly toward a conviction that they can work on finding solutions and that they can cope with any predicament" (Adler, (1956), p. 90). Again, the role modelling and communal living made the senior residents succeed that budded hope in the newcomers. This hope motivated participants, which allowed for better cooperation and motivated newcomer residents to undergo long-term treatment.

Perfas and Spross (2007) argue that residents who have made strides in improving their attitudes and behaviours serve as "right-living" role models and support those in earlier stages of rehabilitation. Both behaviours and interpersonal and social experiences in the TC are considered valuable opportunities to promote personal transformation. This supports De Leon's research (2000; 2015) that living in a TC with others interested in self and mutual support is seen as a mechanism to modify their total lifestyle and identity. Evidently, in this study, the researcher found that the TC created a learning environment for peers' teachings where senior residents teach junior residents activities that were necessary for

daily living like ironing and grooming. Bandura (1977) cited in McLeod (2011) confirms that behaviour is learned through observational learning. Bandura asserts that behaviourism alone could not explain all there is about learning. He believed that behaviour and the environment affected each other.

From the study, the TC programme presented residents with the opportunity to interact with other persons who have similar challenges and to have candid discussions about their weaknesses without feeling criticized, which most participants found useful. The findings re-echo the claim of Rapoport (1960) that TC essentially implies that all members of the community should accept each other from a wide variety of activities that may seem deviant from standard norms. This will lead to socialization, which can lead to improvement. This social interaction would nurture a sense of belongingness (Paget & Woodward, (2017), which further buds a sense of shared responsibility for one another, makes collective decisions that affect the community's functioning, and considers and discusses their attitudes feelings towards each other.

Rapoport (1960) argued that living together in the group would contribute to social situations in which the person encounters problems outside the TC parallel with his or her daily difficulties. The Theory of Social Learning emphasises this claim by suggesting that we learn in a social environment from our interactions with others by observing the behaviours of others, assimilating, and imitating that behaviour, particularly if their observational experiences are successful or include rewards (Nabavi, 2014).

It was evident in the study that most participants experienced some form of basic needs, safety needs, self-esteem, love and belonging, and few others were expecting these needs in their experience during the programme. Some residents or participants in their narratives expressed that "they do not get healed completely," which indicates that it is residents 'hope' to self-actualize (complete recovery) and that is what they all yearn for during enrolment to make their experiences complete. Conversely, self-actualisation does not happen in the TC programme but until after discharge, when residents have been reintegrated back into the community when they are no longer the consumers of the programme. To buttress this, in the narratives, one of the residents revealed, "*I came to meet some of my friends I knew from outside [the TC programme] and they are actually doing well now. Outside of the TC environment [we were] very close from doing everything together and he got his recovery after leaving the TC programme. Even though recovery is a life time work, he is actually doing well and that also motivates me"* **R005.**

Another resident said, *"Recovery first… It's the first reason why I'm here.".* **R002**

This shows that what participants needed the most throughout their experiences was self-actualisation and that is what was found to motivate them to stay in the programme and participate actively, of which most of them do not attain it in the programme.

4.5.2 Theme Two: Participants' transformational process

TC has been established to be an effective treatment modality for drug addicts globally (Deleon, 2000). The findings show that TC impacts participants' lives as they witnessed or observed significant transformations physically, psychologically, emotionally, socially, and spiritually. The study's findings are in congruence with other studies that reported on this treatment modality.

Selby (2011) and Wu (2010) found that the programme brought a restoration of health, and physical, social, psychological, and emotional wellbeing to the drug addicts, their families, and their communities.

Dekel, Benbenishty, and Amram (2004) also affirm that participants enrolled in the TC show remarkable progresses in drug abuse, criminal activity, and mental health symptoms. De Leon (2010) and Vanderplasschen et al. (2013) further assert that the transformation was particularly true of residents enrolling in treatment with the most severe problems.

From the study, the participants' transformation was possible through activities that allowed for knowledge sharing on drug addiction and the road to recovery. Primarily, the philosophy of knowledge sharing is a method designed to acquire information from others. Pulakos et at. (2003) maintained that knowledge sharing pertains to preparing clear information, know-how to interact with others to promote people, problem-solving, and developing new ideas. This knowledge gained enlightened residents to develop coping strategies that help them manage potential future problems in their addiction journey, modify their behaviour, and lead to behaviour change or recovery in the form of living a sober life. Salisbury

(1996) explained that the role of health education in modifying patient behaviour increases in the body of knowledge of the client and contributes to improved adherence, encouragement and happiness when co-opted into a treatment regime relevant to therapeutic health.

De Leon (1997) mentioned that the development of skills necessary to manage and communicate feelings was an important measure of sustaining recovery. From this study, the majority of the clients learned to manage their anger and relate with others. These life skills are essential for sustaining their gains against addiction. In this study, many participants gained their freedom through social learning activities, especially during social meetings. This gave them a platform to develop good interpersonal relationships, gained social confidence to be assertive and communicated well among people.

Some also observed a tremendous transformation in their lives in the form of improvements in their self-esteem. Increased self-esteem promotes self-efficacy and self-efficacy leads to relapse prevention. Self-efficacy is a measure to which, in a particular situational sense, a person feels competent and able to perform a specific behaviour. Nurhazlina and Azlinda (2009) stated in their research that two out of eight respondents fell back after completing drug treatment because they lack the strength and self-confidence that they live without drugs or face a self-esteem issue. Ibrahim (2009) reported that to overcome the challenges that lie ahead, most addicts have low self-esteem; it is easy to give up and not be able to solve a problem with an optimistic and intelligent approach and because of these factors, so they are easily influenced by things that contribute to the relapse

problem. Cheung et al. (2003) found that 9 individuals out of 21 drug addicts studied succeeded in abstaining from using the drug because they had high self-confidence due to work satisfaction and stable income in their lives. Self-efficacy thus helps customers or addicts learn some successful coping strategies or responses that avoid or decrease the risk of relapse of customers. Their self-confidence due to work satisfaction leads to success and increases their self-esteem over time (Gorman, 2010).

The study also identified a religious dimension of transformation. The study revealed that many residents established some form of religious routine that was attributed to faith through the influence of the programme activities. Although this was not a regular practice in TC programmes, the Ghanaian socio-cultural environment may have necessitated its incorporation in the activities in this study setting. Having said that, the programme could be said to have addressed the biopsychosocial-spiritual needs of the participants who enrolled.

4.5.3 Pointing out the gaps in the TC programme

Department of Health (DOH) (1997) reports that seeking participants' perceptions regarding rehabilitation programmes and services is significant for advocating change. In line with this, the study sought to identify gaps in the programme that needed to be addressed. It was evident in the findings that some of the participants were not satisfied with some aspects of the programme and the caregivers' attitudes that affected their quality of care and identified the gaps.

Clients' satisfaction plays a vital role in sustaining interactions between patients and health workers (Marquis, Ross & Ware, 1983). Patient satisfaction has been

used as a tool to assess whether the available supply of healthcare services meets the health needs and desires of patients. This tool is commonly used across the globe in the field of health care. Patient satisfaction is a valuable predictor of the quality and efficiency of health care and also affects patient recovery (Sun et at., 2001; Sahin, Yilmaz, & Lee, 2007, Zendjidjian, & Baumstarck, 2014). According to Chen, li, Wang et al. (2016), patients have become more informed about health care in recent decades. As a result, they have begun to demand higher expectations of medical efficiency, health-staff services, and expenditure; health care providers and regulatory bodies can better observe overall patient satisfaction, meet patient needs, and discover deficits in medical service results by using information gained from patient satisfaction surveys, all of which can be useful for enhancing quality health care. The study found that programme activities were packed and gave little room for rest. Sleep is an important feature that helps your body and mind to recharge (Berger et at., 2020), leaving you refreshed and alert when you wake up. Healthy sleep also allows the body to stay healthy and avoid illnesses. The brain cannot function properly without enough sleep. This can affect their ability to focus, think clearly, and process memories (National Institutes of Health, 2019). The majority of the participants complained about the stressful and demanding nature of the programme. A stressor is an event that exceeds an individual's perceived ability to cope (Lazarus and Folkman 1984) and can have lasting effects on the brain and behaviour. Tse et at. (2010) stated that, stress may be either external to environmental sources or caused by internal perceptions of the individual.

The latter form can generate anxiety or other negative emotions and feelings such as strain, pain, and depression. Whenever stress goes further than the optimal level, individuals ranging from physical health have several issues. This correlation is expressed both in transient health issues such as common recurrent infections and in chronic health problems such as cardiovascular diseases (CVDs), diabetes, musculoskeletal pain, poor self-rated health, sleep problems, accelerated biological aging rates, and eventually in early mortality (Shirom, 2010; Melamed et al., 2006; Ahola & Hakanen, 2014). According to Fottler, Ford, and Heaton (2002), hospitals face a continuing challenge to reduce the gap between consumers' expectations and the actual services.

The study found that all the participants lamented about the programme's duration, which is six months to one year. However, research supports the length of stay as it is proven that the effectiveness of residential substance abuse treatment appears to be closely related to the length of stay in the programme (Kasarabada et at., 2002; Soyez, 2004). Nevertheless, in recent years, funding and insurance restrictions have reduced the length of stay in certain parts of the world to treatment durations of 3, 6, or 12 months (De Leon & Wexler, 2009).

It was evident in this study that the residents felt they were passive participants and needed to be actively engaged. Carman (2013) supports this observation by reiterating that access to information for patients, their involvement in health care decisions, and their participation in policymaking for healthcare organizations could strengthen programme enhancement. Engaged patients, as well as their values, beliefs, and risk tolerance about care choices, should express their health

status to providers." Research now shows that counsellors can help consumers recognize and discuss their desire, willingness, motives, and need to change the conduct of drug use; this initiative increases motivation and encourages progress towards change (Miller & Rollnick, 2013). These findings contradict the research conducted by Andersson, Otterholt, and Gra˚we (2017), who examined the correlations between the satisfaction of patients with various domains of care for inpatient drug use and their perceived outcome of treatment. Patient-experienced improvements have been shown to be related to confidence in staff competence and patient engagement. This means that the interactions of residents in the TC programme can be strengthened by a positive and collaborative partnership between patients and counsellors. The sober person or addict will be able to develop purposeful and lasting relationships with other individuals (Fukui, 2011). They no longer get involved with a group of unreliable addicts working to keep each other down. As the person rebuilds their life in the treatment centre, they gain friends and family (Clay & Parsh, 2016).

Most of the participants expressed displeasure about the unconducive nature of the residence that negatively impacted learning. Some participants also complained about the physical environment (facility structure), which looks very dilapidated, unattractive, needs renovations and painting. Birkelien (2017) stated that a hospital's environment is a combination of the organization's physical and psychosocial settings through clinical and process measures (basic needs not up to standard). It is important to note that, while consumers place the greatest importance on human interaction and the results in quality care, the physical

facility does play an important role in customers' impressions. Seemingly, the TC facility or environment used for this study is noted by residents to be old, and lack many amenities and modern technology.

In this study, participants reported monotonous and uninteresting activities as well as a lack of recreational, occupational and vocational activities. These activities are regularly included in rehabilitative programmes because they have improved the participants' chances of recovery and re-integration (Foster, Nathan & Ferry, 2010). For them, recovery involves rehabilitation, meaning re-learning or re-establishing healthy functioning and skills (NIDA, 2002).

Interestingly, the study identified the participant's perception of TC's activities concerning their experiences from their sociocultural contexts. In the Ghanaian socio-cultural context, age, sex and marital status are noted as significant determinant of authority and power in the home environment. The aged male participants found it difficult to adjust to taking up the stereotypical females' roles such as sweeping, mopping floors and scrubbing toilets. This perception is reflected in their expectations of activities assigned to them and the care dynamics. According to Foucault, as cited in Balan (2010), power relations exist between spouses, parents and children, employers and employees, and members of society and political institutions. The power relations in Ghana's social and cultural structures provide a critical analysis of the intersecting factors of the inequalities resulting from inherent gender roles. These inequalities result from the lack of decision-making power, the lack of freedom of choice, the restricted mobility of girls, poverty and cultural beliefs (Opare, 2015 as cited in Ngulube,

2018).

It is important to note that the work structure in the TC programme is grounded in the necessity, with labour required to operate the programme physically and it invariably has profound social and psychological meaning in the self-help recovery process (De Leon 2000).

Summary

Consequently, this study found that the participants had positive experiences in the TC programme, which motivated them to enroll, stay, and participate fully and also encourage the resident to learn to transform their lives, live in sobriety, develop new attitudes and behaviours, which manifested physically, psychologically, emotionally, socially and spiritually. However, the study identified some gaps in the TC programme that, when improved upon, will make it a wholesome programme and enhance the experiences of residents in the community.

Residents or participants experiences in the TC programme are iterative and most of them revolves around Maslow's first four hierarchy of needs which are the basic needs, safety needs, self-esteem, love and belonging, excluding self-actualization which they need the most to make a full recovery. However, residents or participants do not self-actualize when they are consuming the programme, but after discharge, when they are living in their various community outside TC, they desire it and it is not everyone who gets self-actualized in the community (full recovery or healing) and those who get self-actualization do not return to the TC programme but others who are unable to self-actualized relapsed

and brought back to the programme to continue treatment.

CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Introduction

The Chapter is divided into four sections. The first section highlighted the summary of the main findings of the study. The second section discussed the overall study conclusions and implications of the study findings. Section three discussed the recommendations, and finally, section four discussed the contributions of the study to knowledge and further research that can be conducted on the TC programme.

5.2 Summary

This study sought to explore the experiences of clients or residents enrolled in the Therapeutic Community Model of Drug Addiction Management programme in the Ghanaian setting and to unearth its impact on the residents' journey toward recovery from drug addiction. The study used the explorative, descriptive qualitative study design. Three main research questions guided the study: 1) What are clients' experiences enrolled in the Therapeutic Community toward recovery from addiction in the Ghanaian setting? 2) How has the TC programme impacted recovery from addiction? and 3) Which aspects of the programme could be improved to enhance the patient's care experience?

Purposive sampling was employed to recruit fifteen participants enrolled in the TC Rehabilitation Centre at Pantang Psychiatric Hospital, Accra. A telephone call interview was conducted using a semi-structured interview guide. Data were analysed using Colaizzi's (1978) descriptive phenomenology data analysis

process.

5.3 Summary of Main Findings

5.3.1 Experiences of clients enrolled in the Therapeutic Community towards recovery from addiction

1. It was found that most of the residents enrolled into the programme with an expected needs which could not be met in their various communities and majority of their needs were met in the TC programme except self-actualization need which was revealed to be met after resident live outside the TC programme.
2. The study revealed that the majority of the residents felt very happy about how the TC programme transformed their lives.
3. The clients mainly expressed positive experiences in the programme, including experiencing a sense of belongingness, enhanced self-esteem/self-worth, and most importantly, developing hope of a life free of addiction.
4. It was also evident that the participants' sociocultural background also influenced the generality of their experience as conflicting social roles such as married men assigned house chores detracted from the positive experiences of some participants.
5. The monotonous nature and the length of the programme were cited as contributing to the programme's negative experiences.

5.3.2 Impacts of TC programme on recovery from addiction

1. The residential nature of the TC programme was found to have differing impacts on the residents' experiences as newer residents found it a useful approach to preventing their access to the drugs, while residents who had stayed longer found it restrictive and tedious.
2. The aspects of the TC programme that enhanced the participants' experiences and aided their recovery included the conducive environment for TC care, the structure of the programme, which included opportunities for role modelling, behaviour modification and learning of life skills that were necessary for living a meaningful life free of addiction outside the TC programme. Developing a network of relationships with caregivers and residents who had gone through similar challenges but were recovering from the addiction was also identified as an important motivation.
3. The blend of activities that included knowledge generation, religiosity and life skills was found to be useful as the programme was found to meet the biopsychosocial-spiritual needs of the residents on the road to recovery from addiction.
4. The TC programme has attempted successfully to integrate innovative and evidence-based interventions like motivational interviewing and relapse prevention techniques to optimize the community as a method approach

5.3.3 Aspects of the programme that needs improvement to enhance the patients care experience

1. It was evident that the programme limitations included inadequate opportunities for client inclusion in decision making as they stayed longer in the programme and gained competencies that indicated recovery.
2. The programme was structured for all residents and did not offer opportunities for individualized care, especially as patients became more perspective and were on the road to recovery. This evidently detracted from the programme experience.
3. The absence of certain programmes that could engage the patient example, occupational, recreational and music therapy and the absence of certain facilities clients felt were essentials for recovery programmes were also identified as areas that could be addressed to enhance the care experience.

5.4 Conclusion

The following conclusions could be drawn based on the findings emanating from the study:

The study findings conclude that residents enrolled in the TC programme generally had positive experiences and were confident of the ability of the programme to ensure their recovery. Participants said that the relaxed environment, friendly and understanding staff, and the presence of other patients contribute to a positive TC experience. Additionally, this study also concluded that the positive experiences of residents in the TC programme motivated them to stay, and participate fully and also encouraged the residents to transform their

lives, live in sobriety, and develop new attitudes and behaviours of which the impact of the TC programme manifested physically, psychologically, emotionally, socially and spiritually. Conversely, the study again identified some gaps in the TC programme, such as the stressful nature of the programme, negative environmental influences, monotonous TC programme activities, and unmet residents' expectations. When these problems are adequately addressed or restructured well, it will make the programme wholesome, thereby enhancing better experiences of residents in the therapeutic community.

Significantly, the study discovered the novelty which was lacking in the literature is the sociocultural impact of clients' backgrounds that influenced the generality of their experience as conflicting social roles such as married men assigned house chores detracted from the positive experiences. Gender issues where women experiences were also different as they complained about poor food preparation and the environment untidiness of the facility as their negative experiences considering their background as women.

Another discovery made by the study was on clients' perception of easing restrictions as they progressed toward recovery. It was discovered that when new client enrolls in the programme, their experience is that they are highly motivated to stay in their newly found restrictive or confined environment, which they described as conducive because it helps them to dissociate themselves from the drug and attain a drug-free life. However, after adjusting to the environment and attaining a sober life, they began to experience the environment's restrictiveness and wished to be released from their confinement. Again, this study filled the

literature gap by capturing the experiences of both gender and not only men or women, thereby revealing a gender balance perspective of patient experiences.

Another unique aspect of this study that will contribute to the paucity of knowledge about TC in Ghana and Africa at large and fill the gap in the literature is the aspect of the TC programme that needs improvement. This aspect revealed the gaps or deficits in the TC programme, which did not enhance clients' experiences.

5.5 Recommendations

In the light of the findings discussed above and the conclusions drawn, the following recommendations have been made considering Pantang Hospital, policymaking and education:

Start from Addiction recovery practice, Education, policy

- **Policymaking**
  - ✓ The TC programme should be introduced in Ankaful Psychiatric Hospital and all the teaching hospitals across the nation to relieve the burden on the two facilities, making Ghanaians benefit from its impact or transformative effects and prevent traveling from long distances example, the northern region to the south for treatment.
  - ✓ I recommend the government subsidize the cost of the programme and give the opportunity to many drug addicts to benefit from the programme's effectiveness.
  - ✓ Due to the programme's transformative effect or significant impact, I recommend the programme to be introduced in various prison

facilities across the country. This because research has found that about 60% of inmates are addicts and addiction cause criminal behaviour resulting in their imprisonment. So, the programme will heal their addiction, give them a sense of purpose in life to start afresh in life, help them relate better with people, and reintegrate them back into society, thereby reducing the nation's crime rate.

- **Nursing Education**
  - ✓ I will recommend that patient who has gone through the programme successfully and is now living a drug-free or sober life should be used as ambassadors to encourage and educate addicts in the country via electronic media who feel ashamed to be treated with many misconceptions to embrace their condition and willingly come out for treatment.
  - ✓ Addiction experts should educate citizens about addiction to reduce drug addiction rates, especially among our youth in the country.
- **Nursing/Clinical practice**
  - ➢ TC programme should introduce out-patient-based sessions for residents like pregnant women, breastfeeding mothers, and clients who cannot leave without their family to benefit from the TC programme's effectiveness.

- **Pantang TC programme**

  I. Management should develop a progressive programme structure that allows for increasing levels of autonomy and participation of clients.

  II. The programme should create a conducive physical learning environment for residents to learn.

  III. I recommend the hospital to revamp the facility, add more amenities and use modern technology to make staying and learning enjoyable for residents.

5.6 Suggestions for Further Studies

- A study should explore the recognition of culture in the TC programme in the African context.
- Another study should be done to determine the experiences of residents' life after TC, their challenges, and successes.

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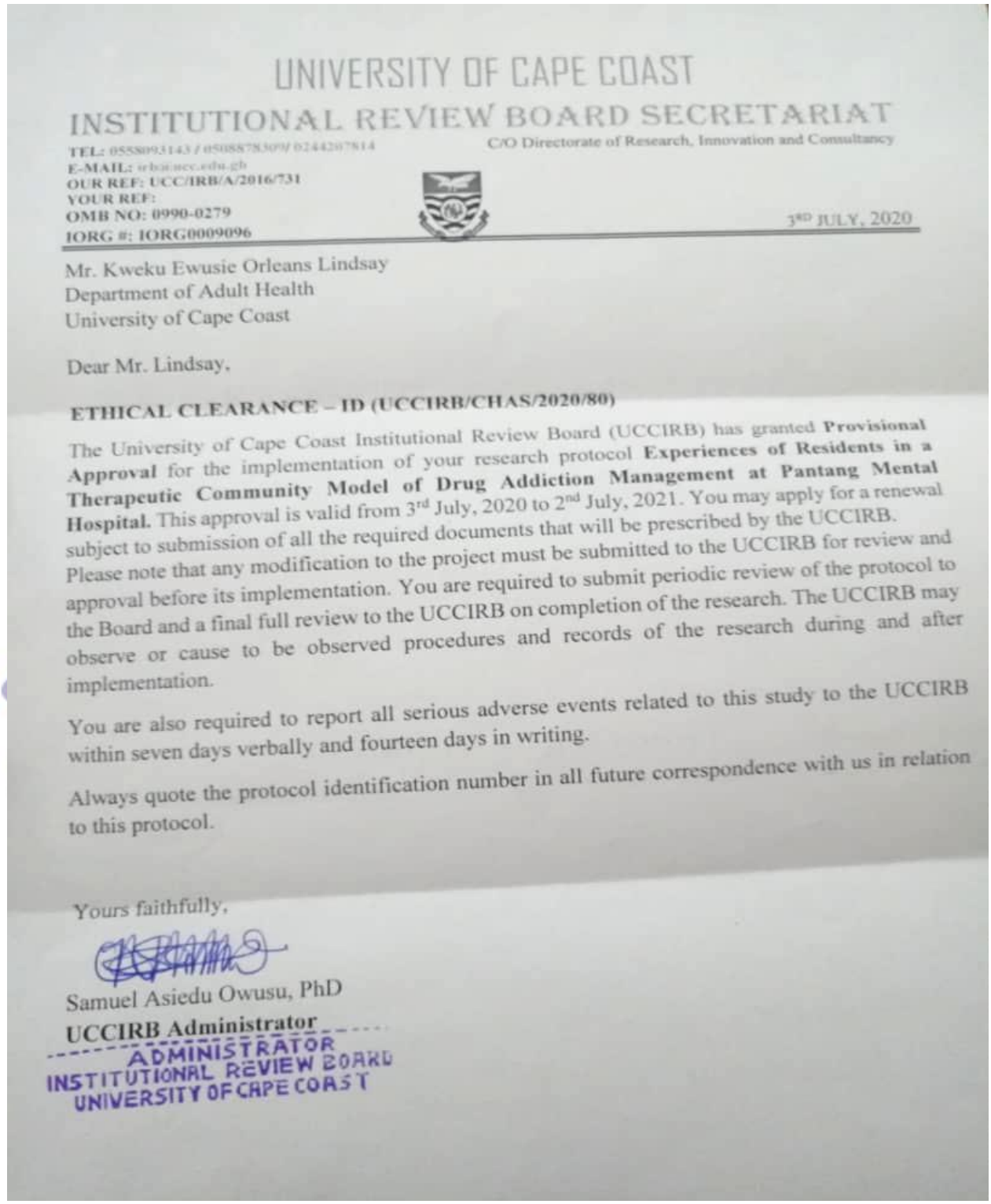
APPENDICES

Appendix A - Ethical clearance IRB



UNIVERSITY OF CAPE COAST

INSTITUTIONAL REVIEW BOARD SECRETARIAT

TEL: 0558093143 / 0508878309/ 0244207814
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YOUR REF:
OMB NO: 0990-0279
IORG #: IORG0009096

C/O Directorate of Research, Innovation and Consultancy

3RD JULY, 2020

Mr. Kweku Ewusie Orleans Lindsay
Department of Adult Health
University of Cape Coast

Dear Mr. Lindsay,

ETHICAL CLEARANCE – ID (UCCIRB/CHAS/2020/80)

The University of Cape Coast Institutional Review Board (UCCIRB) has granted **Provisional Approval** for the implementation of your research protocol **Experiences of Residents in a Therapeutic Community Model of Drug Addiction Management at Pantang Mental Hospital.** This approval is valid from 3rd July, 2020 to 2nd July, 2021. You may apply for a renewal subject to submission of all the required documents that will be prescribed by the UCCIRB. Please note that any modification to the project must be submitted to the UCCIRB for review and approval before its implementation. You are required to submit periodic review of the protocol to the Board and a final full review to the UCCIRB on completion of the research. The UCCIRB may observe or cause to be observed procedures and records of the research during and after implementation.

You are also required to report all serious adverse events related to this study to the UCCIRB within seven days verbally and fourteen days in writing.

Always quote the protocol identification number in all future correspondence with us in relation to this protocol.

Yours faithfully,

Samuel Asiedu Owusu, PhD
UCCIRB Administrator

ADMINISTRATOR
INSTITUTIONAL REVIEW BOARD
UNIVERSITY OF CAPE COAST

Appendix B-Permission from Pantang Hospital

PANTANG HOSPITAL

OUR CORE VALUES:-
* Recognition of diversity
* Equal treatment
* Confidentiality
* Professionalism
* Compassion
* Teamwork

Address:P.O Box LG-81 LEGON-ACCRA
website: www.pantanghospital.gov.gh
Email: Info@pantanghospital.gov.gh
Tel: +233 (0) 30 3972 321
+233 (0) 30 3972 322

My Ref. No: MHA/PH/GF.10/20/22
Your Ref. No: .....

18TH JUNE, 2020

MR. KWEKU EWUSIE ORLEANS LINDSAY
DEPARTMENT OF ADULT HEALTH
UNIVERSITY OF CAPE COAST

RE: REQUEST FOR PERMISSION TO CONDUCT RESEACRH AT PANTANG HOSPITAL

We acknowledge receipt of your letter and its content thereof and I have the instructions of management to tell you that your permission has been granted to conduct your research work at Pantang Hospital.

We hope you will adhere to all the protocols and rules and we wish you well as you embark on your research.

Thank you.

Yours faithfully,

DR. LEVEANA GYIMAH
CLINICAL COORDINATOR

DR. LEVEANA GYIMAH
AG. CLINICAL COORDINATOR
PANTANG HOSPITAL

Appendix C- Cover letter from school of nursing

UNIVERSITY OF CAPE COAST
COLLEGE OF HEALTH AND ALLIED SCIENCES
SCHOOL OF NURSING AND MIDWIFERY
DEAN'S OFFICE

Telephone: 233-3321-33342/33372
Telegrams & Cables: University, Cape Coast
Email: nursing@ucc.edu.gh

UNIVERSITY POST OFFICE
CAPE COAST, GHANA.

Our Ref: SNM/I/4/VoL.1/83
Your Ref:

25th February, 2020

The Chairman
Institutional Review Board
University of Cape Coast
Cape Coast

Dear Sir,

APPLICATION FOR IRB CLEARANCE: KWEKU EWUSIE ORLEANS LINDSAY

We forward herewith the attached application for ethical clearance from the above-named level 850 Master of Nursing student with registration number **SN/MNS/18/0008** of the School of Nursing and Midwifery for your consideration, please.

Thank you.

Yours faithfully,

Dr. Dorcas Obiri-Yeboah
DEAN

Appendix G- Extracted Significant statements and formulated meanings

Significant Statements	Formulated Meanings	Transcript No.	Page No	Line No
I couldn't do it all by myself, I have tried before and it was the same result, just a week or probably less than that and I will be back to the same position [relapse]. So, I thought I needed help, maybe some help will get me further than before	Client tried all avenues to stop his addiction but still felt helpless because his personal effort could not help him and that motivated him enroll into the programme to get treatment and see the outcome	R003	2	41-43
I came here willingly to treat my addiction	Client enrolled into the TC programme willingly	R0012	3	9
My family was supporting me, they gathered hope and brought me here	Client was supported by his family to enroll and with the hope to recover from addiction	R009	3	44-48
recovery first, because it's the first reason why I'm here	Clients prioritize his recovery over everything because it is very beneficial	R002	5	123-124
I'm ready to take every step for the recovery. I'm ready to do every work with all the activities at this place so that my life will be manageable	Client Enrolled into the programme with determination and Motivation to stay. He was eager to learn and Wants to win life back at all cost	R009	3	38-40
It [narcotics] has too much expenses. I have kids, I am married so I have to cut the expenses on drugs [narcotics] in order to finance my family well.	Client was Motivated and determined to learn and change his behaviour because of because of the welfare of his family and also to gain his financial freedom	R007	2	25-26
The confinement alone is good for me, because I	Clients expresses how programme's	R014	36	5-6

tried so many times in the house, I couldn't stop, I had some [drugs] in the house and because I had access to it [drugs], I stop a little then I go back. But here [TC residence], because of the confinement, there is no way you will get it	environment influenced his life positively to be free from drugs by Confining nature and thinks the confinement is good. He also thinks the environment is a good place that Create an atmosphere for reflection about their lives			
Everyone gets his own things with wardrobe. We have five cubicles for showering so we don't normally get crowded in the bath house. The learning environment is very serene. Very quiet and you get to learn. Often, you here cars passing around but the environment is good.	**Client sees the** Learning environment as nice and meets expectations	R008	5	83-86
"It is like you are rebuilding yourself again and there are procedures, steps which you have to go through almost every day. You go for seminars, read from recovery books, learn from experiences of some past addicts and how they recovered. You are taught how to manage your anger, how to deal with your self-esteem	The programme uses seminars, Reading of recovery books, Learning from experiences as a therapeutic strategy to teach residents anger management	R007	6	100-104
That's why there is no dull moment. We're always doing something	Client is displeased about the fact that the nature of the programme is stressful even though it is a good and complains that the daily activity is compact and they don't have their free time at all and always on	R008	2	30-33

	their toes learning all the time.			
I was thinking that since here is… a hospital, I was expecting… medications being given to you and that stuff but later I got to also understand that... it's therapeutic…that is helping me helping you… programme… so I actually embraced it	**Client had an** Initial misconception about the therapeutic nature but later got understand and made him stay to learn	R001	5	100-104
We live as family and we do everything as a family because we take care of ourselves so everybody has someone to take care of. So, we build that relationship to help ourselves	Client narrates that the nature of Socialization in the facility makes the live as family, as one people, Caring for each other and building a mutual relationship to help each other recover.	R003	3	74-77
The way they teach you to live in this house you always on your toes, always keeping your hygiene, dressing your bed, cleaning your room and department. It's like you in the house and at the same time in your office	Client expresses how TC the programme *teach*es and encourages residents how to develop new behaviours and attitudes	R004	5	22-24
I came to meet some of my friends I knew from outside [the TC programme] and they are actually doing well now. Outside of the TC environment [we were] very close from doing everything together and he got his recovery. Even though recovery is a life time work, he is actually doing well and that also motivates me	Client recounts how the environment has influenced him greatly through role modelling. Other residents' recovery has also giving client internal motivation to learn hard. TC graduates have giving client encouragement and hope.	R005	9	173-178

	Client is confident that the things he has learned is good enough to give him inner peace and positive assurance to arrive at his destination