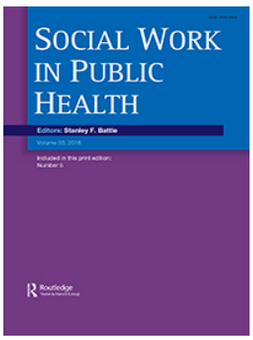

Social Work in Public Health

ISSN: 1937-1918 (Print) 1937-190X (Online) Journal homepage: http://www.tandfonline.com/loi/whsp20

Rehabilitation of drug abusers: the roles of perceptions, relationships and family supports

Samuel Ojima Adejoh, Olusegun M. Temilola & Funmilayo F. Adejuwon

To cite this article: Samuel Ojima Adejoh, Olusegun M. Temilola & Funmilayo F. Adejuwon (2018) Rehabilitation of drug abusers: the roles of perceptions, relationships and family supports, Social Work in Public Health, 33:5, 289-298, DOI: 10.1080/19371918.2018.1469063

To link to this article: https://doi.org/10.1080/19371918.2018.1469063

SOCIAL WORK IN PUBLIC HEALTH
2018, VOL. 33, NO. 5, 289–298
https://doi.org/10.1080/19371918.2018.1469063

Routledge
Taylor & Francis Group

Rehabilitation of drug abusers: the roles of perceptions, relationships and family supports

Samuel Ojima Adejoh[a], Olusegun M. Temilola[a], and Funmilayo F. Adejuwon[b]

[a]Department of Sociology (Social Work Unit), University of Lagos, Nigeria, Lagos, Nigeria; [b]Neuropsychiatric Hospital, Yaba, Lagos, Nigeria

ABSTRACT

The increase in the use, abuse and misuse of psychoactive substances is not just of concern to national government of different countries but poses a big problem to the international community as well as of a global public health challenge. The study explored the perceived influence of perceptions, relationships and family support on rehabilitation of drug abusers undergoing rehabilitation in a rehabilitation centre. The non-experimental study design was used. The study population was that of drug abuse patients undergoing rehabilitation in the Neuropsychiatric Hospital in Lagos. Purposive sampling technique was used to select the respondents. Forty drug abusers who were met the criteria of not being a psychotic, had undergone detoxification, in the last stages of rehabilitation and consented to voluntarily participate were interviewed using In-depth Interview Guide to collect qualitative data based on the objectives of the study. The data were manually content analysed. The drug abusers viewed their condition as a mental disorder, an illness, a bad and dangerous habit that can be treated. They viewed their relationship with their rehabilitation officers as professional and cordial, which is essential for the rehabilitation process. Financial, material and moral supports given by the family were identified as important catalysts for quick rehabilitation. Rehabilitation officers and policy makers should consider on improving on the role of professional relationships and family support in the rehabilitation process of drug abusers undergoing rehabilitation.

KEYWORDS

Mental disorder; rehabilitation; professional relationship; family support

Introduction

The 20th World Drug Report revealed that globally in 2015 about a quarter billion people used drugs. Of these, about 29.5 million people or 0% to 6% of the global adult population were engaged in problematic use disorders, including dependence. Opioids were the most harmful drug type and accounted for 70% of the negative health impact associated with drug use disorders worldwide (United Nations Office on Drugs and Crime, 2017). According to National Drug Law Enforcement Agency (NDLEA; 2013 as cited in UNODC, 2017), drug trafficking remain a thriving business and a serious issue in Nigeria and that strong efforts are needed to control its trade. Report revealed that Nigeria has the highest one-year prevalence rate of cannabis use (14.3%) in Africa and ranked third in Africa with respect to the one-year prevalence rates of cocaine (0.7%) and opioids use (0.7%) (UNODC, 2011).

Between January and December 2015, 1,044 patients entered for treatment in Nigeria in the 11 treatment centers. The drug declared the most frequently used by the patient entering treatment are

CONTACT Samuel Ojima Adejoh samuelojima@yahoo.com Department of Sociology (Social Work Unit), University of Lagos, Nigeria.

cannabis (36.2%) followed by opiates (28.3%) and alcohol (17.1%), whereas cigarettes/tobacco (79%) were classified as "others". The opiates used are mainly prescription medicines: tramadol (71% of opiates), codeine (15.1%), and pentazocine (9.9%). Heroin and morphine represent only 3.3% of the opiates declared (NENDU, 2015).

Some Nigerian adolescents, youths, and even adults use one form of drug or the other for various reasons including peer pressure, loneliness, and depression; anxiety; social deprivation such as unemployment; and homelessness. Such drugs used include tobacco, indian hemp, cocaine, morphine, heroine, alcohol, ephedrine, madras, caffeine, glue, barbiturates, and amphetamines. Oshodi, Aina and Onajole (2010) in a study on perception of drug abuse among Nigerian undergraduates identified dependence and addiction as two of the major consequences of drug abuse, characterized by compulsive drug-craving seeking behaviors even in the face of negative consequences.

In Nigeria, the estimated lifetime consumption of cannabis among the population is 10.8%, followed by psychotropic substances like benzodiapines and amphetamine-type stimulants 10.6%, heroin 1.6%, and cocaine 1.4%, in urban and rural areas. Drug abuse appears to be common among males with 94.2% than females 5.8%, and the age of first use is 10 to 29 years. The use of volatile organic solvents is 0.53%, and widely spread among the street children, in school youth and women. Multiple drug use happens nationwide with 7.88% to varying degree (UNODC, 2011). Oshodi, Aina, and Onajole (2010) reported that 12% of pupils age 11 to 15 had used drugs, amphetamine was commonly used among students, and barbiturate was used by adolescents with suicidal tendencies rather than for addictive purpose. Adamson and Malomo (1991) and Obaeri and Odejide (1993) found cannabis, alcohol, and amphetamines as the most prevalent drugs of abused in northern Nigeria, whereas cannabis, heroin, and cocaine were the most prevalent drugs of abuse in southern Nigeria.

Adamson, Onifade, and Ogunwale (2010) evaluated the trend in two 5-year periods, 1992to1997 and 2002 to 2007, of alcohol and substance use disorder and associated variables in patients admitted to a drug abuse treatments facility and found the importance of continuous evaluation of the drug abuse patient population in treatment which may help drive changes in treatment inputs. Onifade et al. (2011) investigated the types, spread, and characteristics of the substance abuse treatment centres in Nigeria and found a dearth of substance treatment units, where available, units were not networked and lacked a directory or an evaluation framework.

The negative health consequences of illicit drug use on members of the society have been identified. About US $200 billion to 250 billion (0.3%–0.4% of the global gross domestic product [GDP]) will be needed to cover all costs related to drug treatment worldwide. Only one in five persons who need such treatment actually received it. Illicit drug use also affects negatively a society's productivity—in monetary terms—as losses are equivalent to 0.3% to 0.%of GDP (UNODC 2012).

Literature search showed that no study has examined the factors that are likely to influence rehabilitation of drug abusers undergoing rehabilitation in rehabilitation centers. Therefore, this study addressed the following questions: What is the role of perception of drug abusers about rehabilitation officers' perception of their drug habit in the rehabilitation process? What kind of relationship exists between rehabilitation officers and drug abusers undergoing rehabilitation? Finally what is the role of the family in the rehabilitation process?

Literature review

Drug rehabilitation

Drug rehabilitation, which is also referred to as "drug rehab," is a complex set of therapeutic measures designed to assist an individual to get rid of his or her drug dependency. Asuni (1988) asserts that the purpose is not just developing strategies to alleviate psychological and physical types of dependency on various psychoactive drugs, but also to assist the individual avoid numerous negative consequences of substance misuse. Rehabilitation is, therefore, the means through which an individual is assisted to adjust to the weakness of his or her disability. The nature of disability

determines or dictates the particular form of rehabilitation. For successful drug rehabilitation, there is the need to apply various therapeutic measures to cope with physical dependency on the agent, which are known under the term *drug detoxification* or *drug detox* (Obot, 1993). Patients are encouraged to learn how to interact with their own world without resorting to drugs and how to change their habits, social circle, and, sometimes, their entire lifestyles to make it drug free. Gureje and Olley (1993) noted that the psychological aspect of drug rehabilitation is absolutely crucial if the person wants to quit using addictive substances for good. It has been noted that without any form of intervention, compulsive alcohol and drug users are usually unable to stop their use for more than a few days at a time.

The roles of perception and relationship

Patterson (1994) argued that the relationship between the health providers and the drug abuse patients can stand against effective rehabilitation of the patients. Extant studies showed that professional groups connected with rehabilitation had negative perceptions of their clients who used drugs (Romney Jenkins & Bynner 1992; Knox, 1976; Chappel, Veach, & Krug, 1985; Cohen et al., 1992). Church (1992) pointed out that nurses have historically humanized health care, yet they dehumanize that same care for the client who used illicit drugs. In the same manner, Goffman (1963) reported that client who used illicit drugs were stigmatized by professionals and were viewed as tainted, blemished, and polluted people. The negative and demeaning perception of professionals were not directed at the 'illness' but the very essence of the illicit drug-user and his or her personality (Greenwood, 1992). However, this could leave a negative on the client to be rehabilitated and hamper the process of rehabilitation. The need to identify the type of relationships that exist between rehabilitation officers and drug abusers is necessary considering the cultural differences between regions.

Family support

Obot (1993) opined that patients seek substance abuse treatment because of positive family involvement and intervention. Thornicroft (2006) argued that the type of positive family involvement can also help lead the rest of the family toward a journey of recovery and self-discovering. The support that a family provides to a patient's recovery from addiction is essential to that patient's success, and rehabilitation centers allow visitation and encourages family into educational substance abuse treatment program, such as supportive and dynamic recovery workshops and sessions for family involvement (Gureje, Olley, & Lola, 2006). There is the need for the family members, who are providing supports to be included in the rehabilitation program, so as to give the drug abuser a sense of being loved and hence enlist the abuser support in return.

The process of rehabilitation

All patients brought to the Federal Neuro-Psychiatric Hospital, Yaba, pass through emergency unit—the first point of call/contact. Patients are registered at this unit and, thereafter, examined by the doctors. The patients undergo laboratory investigation—urine toxicology to reveal any psychoactive substance. Any patient with positive result of any psychoactive substance is known as substance use abuser. The rehabilitation unit of the hospital is divided into two sections: Adeoye Lambo Ward and Tolani Asuni Ward. Lambo Ward accommodates patients with psychotic features like grandiose delusion and hallucination. Tolani Asuni Ward houses those that are motivated and treated of their psychosis. Those in this section had realized the damage the use of psychoactive substances has done to their lives and are ready to be helped.

Rehabilitation is tailored in relation to the need of every patient. Each patient is assessed to know the particular needs of that patient by the social worker of the hospital. The rehabilitation program is broadly divided—social psychotherapy, occupational, and residential therapy. Under the social

psychotherapy, there are the small- and large-group psychotherapies, social counseling, behavioral assessment, social case work-up/psychoeducation for the patients and their relatives. The occupational therapy handles patients' occupations dealing with vocational training, fashion design, shoemaking, hair dressing, tie and dye, soap making, among others. The programs are planned with the substance use abusers relations and the rehabilitation team. These vocations are meant for those abusers who dropped out of school and could not proceed, whereas the educated ones are engaged in reading books in the library and learning computer application usage.

The last stage of rehabilitation involves the patient being allowed to go home on every Friday and return on Monday accompanied by a relative or guardian with report on the client's behavior for a certain period of time. After undergoing certain activities at the centre, if the reports showed a positive behavior, then the individual will be given the final nod to be discharged and finally rejoined to his or her home. The rehabilitation continues with the client visiting the center from time to time depending on the appointment given by the center until the individual totally let go of the substance abuse.

Methods

The study used a nonexperimental research design and was carried out among drug abusers undergoing rehabilitation at the Federal Neuro-psychiatric Hospital, Yaba, Lagos. Qualitative method of data collection was used as it enables us to have a better understanding of why and how the respondents perceived the issues under investigation. In addition, it allows the researcher and the respondents to have a form of conversation, which enables both the researcher and the respondent claries issues, when such issue looks vague.

Forty respondents who met the selection criteria consented to participate. Three refused participation citing various reasons such as not interested in the study, shying away from discussing past experiences and also considering such experiences as a private affair that need not be discussed with an "outsider."

The respondents were purposively selected because they must meet the selection criteria to participate in the study. The criteria were that the respondent must not be psychotic and must have undergone detoxification and other forms of treatment that may have been prescribed. They were selected as they come in for appointments and consultation with their doctors on clinic days.

The study used in-depth interview guide (IDI), and the respondents were all individually interviewed. The interviews were conducted after the respondent has had his or her consultation with the doctor. Before the interviews, the objectives of the study were clearly explained to the respondent and his or her consent sought before the commencement of the interviews. The interviews were conducted on face-to-face basis. One of the authors with two trained field assistants conducted the interviews. An average of 25 to 30 minutes was spent with each respondent.

Data on sociodemographic characteristics were first collected before the main research questions were asked. Questions such as type(s) of drug abused, reasons for taking such drugs and who introduced you to such drugs were asked, tell me the kind of relationship that exists between you and the rehabilitation officers? How would you describe the attitude of your rehabilitation officers toward you? Tell me how the relationship between you and your rehabilitation officer has assisted you in the rehabilitation process? Since your admission into this rehabilitation center, in what ways has your family supported you? Can you tell me the specific supports received? Questions asked were not limited to these questions, but further questions were asked based on the responses from the respondents. All the interviews were audio-taped and conducted in English language, "pigin" English and in Yoruba language. Two respondents were identified as giving socially desirable responses on some of the questions as their responses contradicted earlier answers to some of the questions that they were asked. Such responses were excluded from the final analysis.

Data analysis was based on the same method (qualitative data) as reported elsewhere in another study by Adejoh, Olorunlana, and Olaosebikan (2017). All the information was transcribed verbatim and those conducted in "pigin" English and Yoruba language were translated into English language. Statements with similar interpretation were grouped into categories. Similar categories were grouped

Table 1. Demographic characteristics of users of psycho-active drugs.

Characteristics	Frequency (%)
Age	
11–25	10 (25)
26–50	26 (65)
51 and older	4 (10)
Sex	
Male	29 (72.5)
Female	11 (27.5)
Marital status	27 (67.5)
Single	
Married	7 (17.5)
Divorced	1 (2.5)
Separated	5 (12.5)
Educational Attainment	
Primary	1 (2.5)
Secondary	15 (37.5)
Tertiary	24 (60)
Occupation	
Students	5 (12.5)
Artisan	4 (10)
Trading	2 (5)
Civil servants	3 (7.5)
Unemployed	12 (30)
Self-employed	14 (35)
Type of substance abuse	
Alcohol	4 (10)
Marijuana	7 (17.5)
Multiple use (those who used more than one substances at a time)	29 (72.5)
Introduction to substance use	
Friends	33 (82.5)
Self	6 (15)
Boss	1 (2.5)
Reasons for use	
Curiosity	18(45)
For calmness	10(25)
To feel high	4(10)
For pleasure	3(7.5)
For sleep	4(10)
To enhance reasoning	1(2.5)

into themes and subthemes. Direct quotes from the data were used in data presentation. Coding was performed using "sensitizing concepts" (Blumer, 1969). The analysis used two types of phases of coding, initial and selective or focused coding (Charmaz, 2002). These methods allowed for free associations of thematic issues and adoption of frequently reappearing initial codes in sorting and synthesising a large amount of data.

The ethical committee of the hospital reviewed the research instrument and gave ethical approval before the study was conducted.

Results

Table 1 showed that the majority of the respondents were male. More than one half of the respondents were in the age range of 26 to 50 (65%). The age range in this study is supported by earlier studies such as Lambo (1961), Anumonye (1980), Ebie and Pela (1981), and Nevadomsky (1981).

Drug abusers' perceptions of rehabilitation officers' views of their habit

The data revealed that successful rehabilitation of substance abusers partly depends on the perception by the drug abusers on the state of their condition. These deal with issues operating within individuals, including individuals' thinking, belief, feeling and behavior. Some of the substance abusers in rehabilitation perceived their conditions as mental illness, bad and dangerous habit that requires treatment because they were told by the rehabilitation officers. They also considered as helpful their rehabilitation officers' perception of their condition as an illness. This they believed would facilitate success in the rehabilitation process, because such behavior can be corrected. Respondents noted that this perception gives them the hope that their conditions can be treated just like other forms of illnesses. These were illustrated in some of the statements of the respondents. A female respondent stated that:

> My rehabilitation officers perceived my smoking habit as a mental disorder caused by the wrong application of drug which is detrimental to my life but the rehabilitation officers assured me that I can still be well again if I stop the smoking habit; that is why I have a cordial relationship with them. The rehabilitation team is made up of all the professionals concerned with the treatment of my self-inflicted illness. (Female 31)

A respondent stated a similar view, "My rehabilitation officers perceive my substance abuse problem as a mental illness caused by wrong use of psychoactive drugs. They feel that my condition can be treated if I am motivated" (Male 28). A respondent expressed the views of the rehabilitation officers thus:

> They feel it is not a good habit and should stop. They feel it is a habit that if not checked and stopped, it could destroy my future, but they believed that if I am motivated, the health care professional will help me get over this habit. (Male, 25)

Another respondent stated, "They perceived it as a dangerous habit which can make me to be useless if not treated" (Male, 31). In the words of another respondent, "They perceived it as a bad and dangerous habit which can destroy our careers" (Male, 46). A respondent believed that it can lead to mental illness, "It is a dangerous habit that makes people to break down with mental illness" (Male 32). Another respondent expressed the views of the rehabilitation officers thus, "They perceived it as a mental disorder caused by the negative use of drugs which is detrimental to me" (Male 20). A respondent who believed in the role of professional management stated thus, "They believed it's a bad habit but with professional management I could be independent of drugs" (Male 29).

The responses of the drug abusers clearly showed that the drug abusers considered their conditions as a mental disorder and as a bad habit that must be stopped. They are equally of the view that the habit can be stopped if they are well motivated and managed professionally.

Rehabilitation officers–drug abusers relationships

The data from the respondents showed that the relationships between the rehabilitation officers and their client were cordial, professional and healthy. Such relationship is needed for quick rehabilitation.

A respondent noted that:

> A professional relationship exists between my rehabilitation officers and me and this gives me confidence because the health team is multidisciplinary and each of them draws up programmes to assist me in my rehabilitation. One of the programmes is: Group Therapy where I sat on the "HOT SAT" to give the details about my drug use experience, how l spent all my salaries on drugs l even sold some of my belongings to aid my habit. But my rehabilitation officers assured me that if l can make the best use of the programme for rehabilitation l will still function as a useful personality in the society. (Male 30)

Most of the respondents were of the opinion that mutual perceptions of their condition build good relationship and ensure successful rehabilitation. One of the respondents asserted that:

> If I maintained a good relationship with them, they would give me my medications on time and my name will appear in all the rehabilitation programmes on the ward. i.e. group therapy, psycho-education, vocational training and all these would aid my rehabilitation process. (Male 25)

This is similar to what another respondent said during the interview:

> If the relationship is cordial, the nurse administers drugs with a smile on her face, which is indirectly telling you that she cares for you and there will be a kind of relief, unlike a nurse frowning her face. Even the drugs she administers will not work because, in your mind, you do not like such a nurse. Cordial relationship heals me from inside. (Male 28)

The clients believed that if there is no close and cordial relationship between the rehabilitation officers and clients, the rehabilitation process will be hampered. The views of the respondents presented below capture this, "If we are not in cordial relationship, it can work against my treatment because all the psycho-education they are giving me will not go well with me and it will work against my rehabilitation process" (Male 21). Another respondent has this to say, "They are all understanding and professionals. This relationship will help me in my treatment of drug use and even during my follow up clinic" (Male 46). In the view of another respondent, "An official relationship which will help me stop drug use and even help me after discharge in the area of what I can start doing at home as a means of livelihood" (Male 19). It is important to observe that these sorts of views allow good relationship to develop between the clients and the rehabilitation officers. Thus, the sharing of the same view between the patient and the rehabilitation officer about the substance-abuse condition is an important factor when considering successful rehabilitation of drug abusers.

The role of family supports

The data revealed that family supports received from members of the family included financial, material, and moral supports. Family members do pay visits, take food to them, and, sometimes render advice on what will and should be done during and after rehabilitation program. The response of a male respondent captures this vividly:

> They have been excellent; they do not want me to lack anything here. This then would make me think straight and never think of going back to my old habit when I am discharged. They provide moral, financial and material support. In fact, they have made provision for all my needs .This is my first time of being admitted into this centre and it will be the last time because l could not believe that what l thought l was enjoying can land me to be sleeping with mad people. When my family members saw this sober reflection on me, they have decided to support me. So I am going back to school as every facility required has been made available. (Male 24)

One of the respondents also stated that:

> My family made treatment available for me at this centre. They pay my bills, visit me during visiting time and we discuss what I will do after discharge. They assure me that if l can turn a new leaf, l will go back to school to finish my academics and become a graduate of Economics like my other siblings. (Male 22)

A female respondent has this to say:

> My mum has been supportive by paying my admission fee and medical fee and she also brings food and provisions for me. But my dad, because he has so many children does not bother about my life though l know that l have made a mistake by going into smoking but l can still be useful with the help of God and with the rehabilitation programmes l am going through in this centre. (Female 23)

Another respondent explained the attitude of his family member thus:

> My family members are not happy with me, as this is not my first or second time of coming to this centre. So they are tired of me that l am embarrassing them because, each time I relapse, I destroy things at home and become a public nuisance. Whenever I am brought for admission, they would not bother to visit me but this time around I can see their love and affection which shows that I am still part of the family .This also made me to decide not to go back to the drug habit again. I have made up my mind to go back to school and be of good behaviour because I have to reciprocate their good behaviour towards me. (Male 26)

A male respondent, who said he went into smoking because of the attitude of his parents, claimed that:

> My parents are nice and caring but they have their own shortcomings because we[the children] are loose, no proper monitoring from both of them, but now that they have decided to take up their responsibility, it gives a sense of belonging any time that I am not with them l feel nostalgic for them. Inasmuch they still have my interest in their hearts, it will help me to comply with my medications, so as not to relapse and go back to my bad habit which will prevent the effectiveness of my rehabilitation. (Male 30)

It is clear from the data that for any rehabilitation to take place, the family must be involved since the family provides the financial supports for such rehabilitation to take place.

Discussion

The study examined the roles of perceptions, relationships between drug abusers and rehabilitation officers, and family supports among drug abusers undergoing rehabilitation in a rehabilitation center. The study found that the views or perception held by the drug abusers was what the rehabilitation officer told them. Despite the perception of drug abusers' condition as mental illness, a bad and dangerous habit by rehabilitation officers, the drug abusers still cooperate with the rehabilitation officers because of the realization that their condition can be improved if they are well motivated. The perception of their condition as a mental illness, bad and dangerous habit means that just like any treatable illness, their condition can be treated. Also, this perception has the manifest function of reassurance of recovering from the rehabilitation officers that if they agree to follow the programs of rehabilitation, they will quickly recover and leave the center on time. This line of thinking is in line with Finney and Moos' (1984) view that positive perceptions of treatment were associated with improvement in retention rates and outcomes among patients with substance addiction. It was argued that perceptions among the patients should be taken into account because it is desirable to carry out treatment that is relevant and well adjusted to the specific needs of the patients.

Unlike McLaughlin, McKenna, & Leslie (2000), McLaughlin, McKenna, Lesley, Robinson, & Moore (2006) that found professional health care workers as unable or unwilling to empathise with the person who used illicit drugs, this study found rehabilitation officers to be caring and empathizing with their clients. Cordial relationship was also identified as one critical element in the rehabilitation process by the drug abusers, as they claimed that "it heals from the inside." Although the relationship between rehabilitation officers and drug abusers were described in various ways, all were aimed at quick rehabilitation, as confirmed by earlier studies, where treatment perception was how patients evaluated the quality of their relations to treatment by staff. Interpersonal relations and levels of self-esteem were considered important for recovery (Lovejoy et al., 1995; Bacchus et al., 1999; Cooper-Pattick et al., 2002; Nordfjaern, Rundmo, & Hole, 2010).

The professional relationship that existed between rehabilitation officers and drug abusers, as emphasized by drug abusers, will go a long way in aiding quick rehabilitation. This relationship brought about motivation and encouragement for the drug abusers. The implication is that there is the need to continually reemphasize the need to maintain cordial relationship between the rehabilitation officers and drug abusers as this is a crucial factor in the rehabilitation process.

The data revealed that family support had a great influence on effective rehabilitation of drug abusers. The findings showed that the family members of drug abusers were very supportive and responsive in the process of rehabilitation of drug abusers, as exemplified in their involvement through financial, material, and moral support. Respondents were passionate about the role of their respective families in their rehabilitation process. Most of the drug abusers identified their mothers as the pillar in their rehabilitation process. This finding supports the views of Klimenko (1968) on the need to have group therapy sessions for members of addicts' families. However, despite the supportive role of the family in the rehabilitation process, many of the drug abusers blamed their condition on their parents, especially their fathers, neglect and deprivation. The implication of this finding is that the rehabilitation center must work with significant others in the lives of drug abusers

as identified by the drug abusers themselves. This is important as some of the drug abusers were not in good relationships with their parents. However, the center can take a step further to see that such broken relationships between drug abusers and parents are mended. Also, the kind of neglect and deprivation complained by the drug abusers must be investigated so that they will not leave the center back into such neglect and deprivation.

Finally, the cordial relationship between drug abusers and rehabilitation officers could be described as the foundation for a successful rehabilitation. The perception of drug abusers' condition by rehabilitation officers could have a lasting impression on how motivated the drug abusers will be to accept rehabilitation programs. Without family support, the rehabilitation process could be slowed down. Further study is needed to investigate the processes and mechanisms and kind of neglect and deprivation suffered at homes by drug abusers as this may continues to pose a major problem for the drug abusers either undergoing rehabilitation or not.

Limitation

The main limitation of the study is the fact two drug abusers were ready to participate in the study with the hope that their participation will hasten their discharge from the rehabilitation center. The purpose of the study was explained to them, and it was stressed that it has no connection with their discharge from the center. This had implication for few of the responses, as they gave some socially desirable responses. However, such responses were identified through filter questions and were not included in the final analysis.

References

Adamson, T. A., & Malomo, I. O. (1991). Psychosocial profile of some armed robbers in Bendel State, Nigeria. *Nigeria Medical Journal*, *21*, 41–44.

Adamson, T. A., Onifade, P. O., & Ogunwale, A. (2010). Trends in sociodemographic and drug abuse variables in patients with alcohol and drug use disorder in a Nigerian treatment facility. *West African Journal of Medicine*, *29*(1), 12–18. doi:10.4314/wajm.v29i1.55947

Adejoh, S. O., Olorunlana, A., & Olaosebikan, O. (2017). Maternal health: A qualitative study of male partners' participation in Lagos, Nigeria. *International Journal of Behavioral Medicine*. doi:10.1007/S12529-017-9659-y

Anumonye, A. (1980). Drug use among young people in lagos, Nigeria. *Bulletin on Narcotics*, *32*(4), 39–45.

Asuni, T. (1988). Sociocultural and economic determinants of rehabilitation. *International Journal of Mental Health*, *17*(2), 8–14. doi:10.1080/00207411.1988.11449088

Bacchus, L., Marsden, J., Griffiths, P., Gossop, M., Farrell, M., Clarke, K., & Strang, J., (1999). Client perceptions of impatient treatment: A qualitative account with implications for service delivery. *Drugs Education, Prevention and Policy*, *6*, 87–97. doi:10.1080/09687639997313

Blumer, H. (1969). *Symbolic interactionism: Perspective and method*. Berkeley: University of California Press.

Chappel, J. N., Veach, T. L., & Krug, R. S. (1985). The substance abuse attitude survey: An instrument for measuring attitudes. *Journal of Studies on Alcohol*, *46*(1), 48–52. doi:10.15288/jsa.1985.46.48

Charmaz, K. (2002). Qualitative interviewing and grounded theory analysis. In J. Gubrium & J. Holstein (Eds), *Handbook of interview research: Context and method* (pp. 675–694). Thousand Oaks: Sage.

Church, O. M. (1992). Owning up to our differences: Historical perspective on nursing's role in substance abuse issues. *Addictions Nursing Network*, *4*(2), 30–32. doi:10.3109/10884609209023722

Cohen, J., Schamroth, A., Nazareth, L., Johnson, M., Graham, S., & Thomson, D. (1992). Problem drug use in a central London general practice. *British Medical Journal*, *304*, 1158–1160. doi:10.1136/bmj.304.6835.1158

Cooper-Pattick, L., Powe, N. R., Jenckes, M. W., Gonzales, J. J., Levine, D. M., & Ford, D. E., (2002). Identifaction of patient attitudes and preferences regarding treatment of depression. *Journal of General Internal Medicine*, *12*, 431–438. doi:10.1046/j.1525-1497.1997.00075.x

Ebie, J. C., & Pela, O. A. (1981). Some socio-cultural aspect of the problem of drug abuse in Nigeria. *Drug and Alcohol Dependence(Lausanne)*, *8*, 301–306. doi:10.1016/0376-8716(81)90039-9

Finney, J. W., & Moos, R. H. (1984). Environmental assessment and evaluation research: Examples from mental health and substance abuse programs. *Evaluation and Program Planning*, *7*, 151–167. doi:10.1016/0149-7189(84)90041-7

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity (Paperback)*. New Jersey: Prentice Hall.

Greenwood, J. (1992). Unpopular patients: GPs' attitudes to drug users. *Druglink*, *7*(JuVAug), 8–10.

Gureje, B., Olley, O., & Lola, K. (2006). Do beliefs about causation influence attitudes to mental illness?. *A Journal of World Psychiatry, 5*, 104–107

Gureje, O., & Olley, D. (1993). Alcohol and drug abuse in Nigeria: A review of the literature. *Contemporary Drug Problems*, *19*, 491–504.

Klimenko, A. (1968). Multifamily therapy in the rehabilitation of drug addicts. *Perspective in Psychiatric Care*, *IV*, 5.

Knox, W. J. (1976). Attitudes of psychologists towards drug abusers. *Journal of Clinical Psychology*, *32*(1), 179–188. doi:10.1002/1097-4679(197601)32:1<179::AID-JCLP2270320145>3.0.CO;2-G

Lambo, T. A. (1961). Schizophrenic-like psychoses associated with amphetamine intoxication in African students. *Dokita (Ibadan)*, *2*, 33–37.

Lovejoy, M., Rosenblum, A., Magura, S., Foote, J., Handelsman, L., & Stimmel, B., (1995). Patients perspective on the process of change in substance abuse treatment. *Journal of Substance Abuse Treatment*, *12*, 269–282. doi:10.1016/0740-5472(95)00027-3

McLaughlin, D., McKenna, H., Lesley, J., Robinson, J., & Moore, K. (2006). Illicit drugs user in Northern Ireland: Perceptions and experiences of health and social care professionals. *Journal of Psychiatric and Mental Health Nursing*, *13*, 682–686. doi:10.1111/j.1365-2850.2006.01015.x

McLaughling, D. F., McKenna, H., & Leslie, J. C. (2000). The perceptions and aspirations Illicit drug user hold towards healthcare staff and the care they Receive. *Journal of Psychiatric and Mental Health Nursing*, *7*, 435–441. doi:10.1046/j.1365-2850.2000.00329.x

Nevadomsky, J. (1981). Patterns of self reported drug use among secondary school students in Bendel State. *Nigeria Bulleting in Narcotics*, *33*(1), 9–19.

Nigerian Epidemiological Network on Drug Use (NENDU). (2015). *Drug treatment information system in Nigeria: Data analysis of 2015 data, Dominique Lopez*. UNODC.

Nordfjaern, T., Rundmo, T., & Hole, R. (2010). Treatment and recovery as perceived by patients with substance addiction". *Journal of Psychiatric and Mental Health Nursing*, *17*, 46–64. doi:10.1111/j.1365-2850.2009.01477.x

Obaeri, J. U., & Odejide, O. A. (1993). Admission for drug and alcohol related problems in Nigeria psychiatric care facilities in one year. *Drug Alcohol Dependence*, *3*, 101–109.

Obot, I. S. (ed.). (1993). *Epidemiology and control of substance abuse in Nigeria*. Jos, Nigeria: Centre for Research and Information on Substance Abuse (CRISA).

Onifade, P. O., Somoye, E. B., Ogunwobi, O. O., Ogunwale, A., Akinhanmi, A. O., & Adamson, T. A. (2011). A descriptive Survey of types, spread and characteristics of substance abuse treatment centre in Nigeria. *Substance Abuse Treatment, Prevention and Policy*, *6*, 25. doi:10.1186/1747-597X-6-25

Oshodi, O. Y., Aina, O. F., & Onajole, A. T. (2010). Substance use among secondary school students in an urban setting in Nigeria: Prevalence and associated factors. *African Journal of Psychiatry*, *13*(1), 52–57. doi:10.4314/ajpsy.v13i1.53430

Patterson, D. (1994, July 4–5). Dealing with drug misuse in Northern Ireland (Drug Prevention News).

Romney, D. M., Jenkins, C.D., & Bynner, J.M. (1992). A structural analysis of health-related quality of life dimensions. *Human Relations*, *45*, 165–176.

Thornicroft, G. (2006). *Perceptions by service users of healthcare staff*. Retrieved from http://www.mentalhealthcare.org.uk/

United Nations Office on Drugs and Crime. (2011). World drug report. New York.

United Nations Office on Drugs and Crime. (2012). World Drug Report. New York.

UNODC. (2017). World Drug Report 2017: 29.5 million people globally suffer from drug use disorders, opioids the most harmful. Retrieved from www.unodc.org/unodc/en/frontpage/2017/june/world-drug-report