Perceptions on quality of life among persons recovering from alcohol use in Kirinyaga County, Kenya.

*Esther Gachara**

Department of Psychology, Kenyatta University, Kenya

***Corresponding Author:**

Esther Gachara

Email Address: gachara.esther@ku.ac.ke

Submitted: 12th October 2020

Published: 31st December 2020

Abstract

Drugs and alcohol abuse impairs an individual's ability to live a normal life. These problems relate to all spheres of life; physical and mental health, social and economic. With rehabilitation it is expected that these aspects of quality of life will improve. However, majority of the studies have largely focused on abstinence as the rehabilitation outcome. This study aimed at establishing the perceptions of quality of life among persons recovering from alcoholism after presidential crackdown and subsequent rehabilitation in Kirinyaga County. The study utilized a descriptive survey. The study population was drawn from persons attending community support groups established after presidential crackdown on illicit brew and subsequent rehabilitation. A multi-stage purposive sampling method was utilized to get eleven (11) support groups and one hundred and forty-one (141) respondents. A Questionnaire and a focus group discussions were utilized to collect data. Abstinence was measured using Recovering Addicts Adherence Scale (RAAS) which was adapted from Alcoholics Anonymous Affiliation Scale. Perceptions of quality of life outcomes were measured using Recovering Addict's Quality of Life Scale (RAQOLS) which was adapted from the World Health Organization Quality of Life instrument (WHOQOL-BREF). Data collected was coded and analysed using Statistical Package for Social Sciences (SPSS) version 23 and analysed using descriptive statistics. The study findings revealed favourable perceptions of quality of life in all the four domains. Physical health was rated moderate while social health was rated highly. This can be attributed to the support groups which emphasized on empowerment of the recovering persons and abstinence. Favourable rates of abstinence can also be attributed to improved quality of life. The implication to treatment is that domains of quality of life need to be emphasized during treatment process for the ultimate goal of rehabilitation to be achieved.

Keywords: *Community support groups, quality of life, abstinence, rehabilitation, recovering persons and alcoholism.*

Introduction

Many rehabilitation centres, government and private, inpatient and outpatient and after- care support groups have been set up in Kenya to assist persons recovering from drugs and alcohol addiction change their addictive behaviours. This is aimed at helping them achieve a lasting abstinence and improve the quality of their current life. In essence they return to their normal life functioning. However, majority of studies have mainly focused on abstinence and rates of relapse

Although over the years the goal of substance use treatment and rehabilitation has been achievement of abstinence and prevention of relapse, a key question that arises is whether abstinence is the only expected rehabilitation outcome and predictor of successful treatment. Substance use affects individual's physical and mental

social functioning. Apparently these are the domains of quality of life emphasized by World Health Organization (World Health Organization ,1997). Substance use affects these domains of quality of life and dissatisfaction experienced can lead to more indulgence in substances to avoid the unpleasant impacts and emotions.

According to Borges, Ketsela, Munodawafa & Alisalad, (2013) alcohol use results in permanent health damage, neuropsychiatric disorders, and social problems such as unemployment, violence, trauma and death. This results in poor perceptions of quality of life of the affected persons. American Psychiatric Association (2013) also correlates drugs and alcohol use with deterioration of quality of life. They associate use of drugs and alcohol with impairment on an individual's functioning. The normal functioning is thus replaced with a persistent need which results to recurrent use of drugs and alcohol. This calls for demand for more money and time to satisfy the cravings. Less time is left for attending to family, occupational duties, responsibilities, to nurture meaningful relationships and attend to leisure activities.

Studies have shown that persons with substance use disorders experience poor quality of life. Muller, Skurtyet and Clausen (2016) studied quality of life indicators amongst drugs and alcohol addicts on admission to a Norwegian treatment program. They discovered that among both males and females, majority of them (75 percent) reported either poor or very poor quality of life on admission. Further, the author's states that persons with drugs and alcohol addiction report substantial poor quality of life comparable to those suffering from serious psychiatric disorders. Majority of respondents (75%) reported low levels of quality of life ranging between poor and very poor for both genders.

Vederhus, Prip and Clausen (2016) also observed that patients with drugs and alcohol in a detoxification general hospital in Norway had significant low quality of life on physical, psychological, social and existential domains. Abdu-Raheen (2013) studied sociological factors and effects of drug abuse in Nigeria and reported that health, social, psychological, physical, cultural and moral consequences of alcohol use result in poverty, disability, maladjustment, death and poor academic performance among students. These studies have shown that persons dependent on drugs and alcohol have poor quality of life on various domains. Treatment and rehabilitation should aim at improving these domains of quality of life affected by alcohol addiction. Improvement on these areas then reflect an effective rehabilitation process. Assessment of perceptions of quality of life domains is therefore important at all stages of substance use treatment and rehabilitation to discern the progress of the effort and programs.

Improvement in quality of life outcomes is depicted in the reduction of the major drug used and improvement on an individual's life functioning domains. The concept of quality of life embraces the central notion that health is not restricted to the absence of a disease (to Faller, da Rocha, Benzano, Lima & Stolf ,2015). It also includes a state of social, mental, and physical well-being (Office of Disease Prevention and Health Promotion,2020). This signifies that an assessment of quality of life domains captures the full impact of addiction on the individual. Quality of life involve assessment of how drug-dependent individuals experience their daily lives (Zubaran, Emerson, Sud, Zolfaghari & Forest, 2012). Assessment after rehabilitation captures how an individual experiences life functioning after treatment. This permits a holistic focus on the far-reaching objective of rehabilitation which is achievement of abstinence and prevention of relapse as well

as improving the addict's quality of life.

Qualitative studies have shown that the desire to amend the negative effects of substance abuse on a patient's life and improve the domains of quality of life is a more explicit goal of treatment among patients than reducing substance use itself. Muller Skurtveit & Clausen (2016) adds that poor quality of life may also be a predictor of treatment readiness. Persons using substances seek help in quitting drugs and alcohol as a way of escaping destructive impacts of addiction and to acquire better life (Laudet, 2011).

Improvement in quality of life outcomes is depicted in the reduction of the drug of choice and improvement on an individual's life functioning domains. Domains of quality of life improve with abstinence then deteriorates with relapse. It also improves with both short term and long term abstinence among individuals' dependent on alcohol following treatment. (Srivastava, Bhatia, Rajender & Angad ,2009). Abstinence therefore is a contributing factor to quality of life. Quality of life also help in sustaining abstinence. In Norway, Vederhus, Prip & Clausen (2016) observed modest improvements in various domains of quality of life after six months follow-up. Reduction in alcoholism increased prosocial behaviour which were inferred from decreased number of arrests, improvements in quality of life and community involvement. Srivastava & Bhatia (2013) observed that quality of life improved significantly through the three months of treatment in four domains of quality of life in India. These were, physical, psychological, social and environmental domains. Laudet (2011) found that higher quality of life at treatment discharge predicted abstinence better than traditional substance use disorder characteristics. Therefore, quality of life plays an important role in recovery from substance use disorders.

However, despite their importance as rehabilitation outcomes and in promoting abstinence, quality of life indicators has scarcely been included in the studies of drugs and alcohol addiction. (Dawson, Li,Chou, & Grant, 2009; Preau et.al.2007 as cited in Laudet, 2011). Laudet, (2011) add that quality of life in relation to addiction is an emerging issue. Muller, Skurtyet & Clausen (2016) emphasized that the immediate goal of reducing alcohol and drug use is necessary but rarely sufficient for the achievement of the longer-term goals of improved personal health and social function and reduced threats to public health and safety—i.e., recovery. This implies that improvement in the domains of quality of life after treatment and rehabilitation reflect effective rehabilitation. A focus on these aspects of life functioning gives an all-inclusive picture of the success of rehabilitation process. Therefore, quality of life is critical to the goal of recovery.

Quality of life require to be incorporated in assessment, treatment and in after care programs. According to Muller, Skurtyet & Clausen (2016) quality of life measures help in determining factors that could lead to relapse after treatment. Determining whether their employment status, health, and family contact, for example, are satisfactory or not help clinicians recognize problems other than the specifics of the disorder hence make better treatment decisions and priorities and help determine where to focus treatment services. Knowing the variables that influence recovering person's' well-being can help focus treatment toward person-centred needs and goals. This can result in improvement on treatment engagement, retention and success.

Improvements in key domains of quality of life should be included among the goals of treatment. Assessing quality of life at intake can be an opportunity to learn about patient vulnerabilities. Continued measurement of

assessment can help guide further treatment plans. It is also an outcome measure of treatment, which for a chronic condition must be monitored and addressed during the course of the disorder at various phases during treatment. If treatment's goal of recovery and improved well-being is to be achieved, services must be offered on multiple levels and empower patients to improve numerous areas of their lives without focusing only on abstinence outcomes. Majority of studies however in alcohol use have mainly focused on abstinence. This study therefore focused on domains of quality of life as an important outcome of rehabilitation which eventually enhances abstinence.

The study was done in Kirinyaga County as one of the counties which previously formed Central Province of Kenya. These counties had experienced serious impacts of alcohol use including illicit liquor which necessitated a crackdown order by the President in 2016 (War on Illicit Brew is still on, 2015). A Baseline Survey on Alcohol and Drug Abuse in Central Province, carried out by NACADA in 2010 indicated that Kirinyaga County scored a high of 75.4%. Following the crackdown was subsequent establishment of community rehabilitation centres. Kirinyaga County further established support groups immediately for continuum of care under the Department of Social Services. In Kirinyaga County, the support groups were an extension of the rehabilitation programs geared towards sustaining abstinence and empowerment through various economic projects such as poultry, farming and table banking. Due to scarcity of documented studies on support groups and domains of quality of life, this study purposed to establish the perceptions of quality of life among persons recovering from alcoholism in Kirinyaga County.

Theoretical Framework

The study was based on Marllat's Cognitive-Behavioral Model of Relapse proposed by Marllat and Gordon in 1985. Basic assumption is that relapse is preceded by a high risk situation, outcome expectancies and covert antecedents such as lifestyles, urges and cravings. It is based on cognitive behavioural models which attribute relapse to contextual factors and cognitive processes (Handershot, Witkiewitz, George & Marlatt, 2011). In this study, this model is used to explain how relapse occurrence is related to perceptions of quality of life domains.

The model proposes that a person feels in control when he or she maintains abstinence or complies with the rules that govern a given behaviour. The perceived control persists until the person encounters a situation that has a high potential for relapse. The danger of relapse threatens the sense of control achieved and eventually increases potential of relapse. The situations that poses the highest risk of relapse are undesirable emotional statuses, relational skirmishes and social influence. Apparently these are some of the aspects of quality of life that are affected by addiction and are expected to improve with achievement of abstinence. This theory informs this study that the risk of relapse will increase if domains of quality of life do not improve. Initial lapse is precipitated by an inability to deal effectively with these situations (undesirable emotional statuses, relational skirmishes and social influence). These then exposes the recovering persons to the greatest risk of relapse.

Objectives of the study

The specific objective was to establish the perceptions of quality of life among persons recovering from alcohol addiction in Kirinyaga County.

Research Methodology

The study used a descriptive research design to describe the perceptions of quality of

life and generate both quantitative and qualitative data. The design was utilized to Hence confining the study to the nature of perceptions of quality of life. The study was conducted in Kirinyaga County among persons attending community based support groups. The target population included both males and females recovering from alcohol addiction. The support groups were chosen to enable the study perceptions of quality of life as reflected in the experiences of recovering person's daily lives outside the confinements of a rehabilitation centre.

The study used multi-stage sampling technique in order to get a representative sample. The sample size of support groups was determined by adopting a formula by Kathuri and Pals (1993) for estimating sample size (n) from a known population size (N).

$$n = \frac{\chi^2 NP(1-P)}{\chi^2 (N-1) + \chi^2 P(1-P)}$$

Where n= required sample size N= the given population size of potential adults 12 support groups and 439 members.

P= population proportion assumed to be 0.50
χ^2= degree of accuracy whose value is 0.05
χ^2= table value of chi-square for one degree of freedom which is 3.841

Substituting these values in the equation, estimated sample size (n) for support groups would be

$$n = \frac{3.841 \times 12 \times 0.50\ (1-0.5)}{(0.05)^2\ (12-1) + 3.841 \times 0.5\ (1-0.5)}$$

verbose

n= 11

The eleven groups were randomly selected by eliminating the group picked from a pool of folded papers with the group names. Purposive sampling based on the willingness of the participants present at the period of study to participate enabled recruitment of 141 participants. Dattalo (2008) states that purposive sampling can be applied to select participants based on their willingness to participate. Two focus groups comprised of 16 participants who were randomly selected from the research participants.

Table 1

Distribution of Participants among Community Based Support Groups

Support Group	Sample Size
Kiamwenja	11
Kakanga	15
Kagumo	12
Kaitheri	18
Kerugoya	20
Sunrise	8
Difsthas	7
Wamumu	10
Mumbui	15
Kiamuthambi	16
Jitegemee	9
Total	**141**

A pilot study was carried out at the Clinic of Substance Abuse Treatment (CSAT) in Mathari hospital centre in Nairobi County. The pilot study utilized clients who had gone through rehabilitation, inpatient or outpatient. Results of the pilot study were used to improve on the validity and reliability of the instruments. Results of Cronbach's Coefficient Alpha analysis implied a reliability of the instrument with a reliability coefficient of 0.968.

This study was undertaken between November and December 2017. A questionnaire and a focus group discussion guide were utilized in data collection. The first section of the

questionnaire was used to collect data on demographics characteristics while Recovering Addicts Quality of life Scale was utilized to collect data on perceptions on quality of life. Recovering Addicts Quality of Life Scale (RAQOLS) was adapted from the World Health Organization Quality of Life instrument (WHOQOL-BREF).

According to WHO (2018), WHOQOL-BREF has good discriminant validity, content validity and test-retest reliability. Domain scores produced by the WHOQOL-BREF correlate at around 0.9 with the WHOQOL-100 domain scores. It was used to assess patient's perception of how they were functioning on four domains: physical health, Psychological health, Social relationships and environment. Physical health comprised of 7 items: Psychological health 6 items, Social relationships 3 items and environmental had 8 items. The responses in all the four domains were rated using a Likert scale of 1 to 5 (1-Not at all, 2-A little, 3-Moderate amount, 4-Very much, and 5-An extreme amount). The last section was used to collect data on the respondents' perceptions on interventions that can be applied to enhance various domains of quality of life.

Data Analysis Procedures

Data from the questionnaire was analysed descriptively while data from the focus group discussions was analysed using content analysis by deriving themes based on respondent's perceptions of their quality of life. The scores from Recovering Addicts Quality of Life Scale (RAQOLS) were analysed based on the four domains of quality of life as follows: Physical Health, Psychological Health, Social Relationships and Environment Quality of Life. The scores were then divided into three levels representing low perceptions, moderate perceptions and high perceptions on various domains quality of life.

Demographic Characteristics of the Respondents

A total of 141 respondents participated in the study. Sixteen of them participated in the focus group discussion. Majority of the respondents were males (57.4%), compared to 41.8% females. Respondents that were aged between 26 to 35 years were 27.0% while 36.2% ranged between 36 to 50 years. The respondents that were married were 56.7% while 31.9% indicated that they had been divorced. Forty-one percent (41.1%) of the respondents had been able to abstain from alcohol for a period of 1 to 3 years, while 17% had abstained for about 6 months. Since majority of the respondents were a cohort thus left rehabilitation during the same period, this indicates that the rate of abstinence in relation to the period of abstinence increased with time.

The total number of 67.4% respondents indicated that they were in a community rehabilitation program before joining the support groups while 14.2% had not gone through rehabilitation program at all. Those who had been in rehabilitation for the first time were 85.8%. This could be attributed to the fact that majority of respondents were rehabilitated after the President ordered a crackdown on illicit brew in the counties that formerly formed the Central Province of Kenya. Scarcity of public rehabilitation centres in the rural areas and high cost of private in-patient rehabilitation centres could have prevented many persons struggling with addiction from seeking treatment before the crackdown.

On the type of addiction, 57.8% were addicted to alcohol, while 26.7% used both alcohol and other drugs. The type of alcohol mostly abused was second generation alcohol and beer indicated by 61.1% and 38.9% respectively. This correlate with findings observed in other areas for example, alcohol was also found to be more prevalent in Rwanda with 34%

followed by tobacco with 8.5% and cannabis with 2.7% (Kanyoni, Gishoma & Ndahindwa, 2015). Second generation types of alcohol may be the most abused due to the fact that they are cheaper and affordable than other types of alcohol for low income earners in the rural areas.

On attendance to support groups, 70.9% of respondents in Kirinyaga County began attending support group meetings immediately, 36.9% of the respondents indicated that they attended support group meetings very often while 26.2 % attended often and 26.2% sometimes respectively. The favourable attendance could be due to the unique nature of support programs, the support groups were an extension of the rehabilitation programs geared towards sustaining abstinence and empowerment through various economic projects such as poultry, farming and table banking.

The empowerment programs may have been the motivation behind the attendance of the meetings. This is by improving their lives and enhancing their quality of life positively. This was supported by the focus group discussions. "We save kshs. 50 per person, then share where I get about a thousand and I'm able to buy food for my cows, and improve my life." Another respondent said "I'm able to invest in chicken project where I get money for my family after selling the eggs." The reason may due to their social status since majority of them depend on casual labour to earn a living and thus when such an opportunity arises they give it the first priority. This was noted also during the focus group discussions 'One respondent reported "Sometimes I do not come for meetings because I have to go to work at the construction or else I lose the opportunity to someone else, that is where I also get money for table banking"

Though economic activities are important in improving quality of life, involvement and participation in the activities is equally important. Active involvement provides more opportunities to members to learn from peers during and after the meetings. Tracy and Wallace (2016), suggest that active engagement in peer support groups is a key predictor of recovery and also sustain recovery. Findings from focus group discussions support this view where respondents said that from the support group meetings they were able to support each other, get advice from others, get new ideas and continue to be sober.

The implications is that there is need to provide information on recovery resources after treatment to ensure the respondents attend support groups after rehabilitation for continuum of care. According to Donovan, Ingalsbe, Benbow and Daley (2013) although early and frequent attendance / involvement (e.g., three or more meetings per week) is associated with better substance use outcomes, even small amounts of participation are helpful in increasing abstinence. However, higher amounts of adherence are needed to increase abstinence and reduce the risk of relapse. The support groups need to incorporate activities that are geared towards improving quality of life in addition to sustaining sobriety. These activities are a motivation in themselves to continue attending support group and also help in improving quality of life.

Results of the Study

Perceptions on Quality of Life domains among Persons Recovering from Alcohol Addiction

Quality of life was assessed in terms of satisfaction with their physical health, psychological health, social relationships and their living environment. The findings are as shown in the following sub-sections.

Physical Health

Results on perceptions of physical health are presented in table 2 and table 3

Table 2

Frequencies of Perceptions on Physical Health

Quality of Life	Frequency	Percent
Low quality of life	15	10.6
Moderate quality of life	68	48.2
High quality of life	58	41.1
Total	**141**	**100.0**

From table 2 majority of the respondents (48.2%) had a moderate perception on quality of life. Descriptive statistics of the same are presented in Table 3.

Table 3

Descriptive Statistics of Perceptions on Physical Health

County		N	Minimum	Maximum	Mean	Std. Deviation
Kirinyaga	Physical health	141	11	35	23.18	3.752
	Valid N (listwise)	141				

Table 3, indicates that the lowest score attained by the respondents was 11 while the highest score attained was 35. The mean score was 23.18 (SD=3.752) which indicates that the perceptions on quality of life in terms of physical health was on the moderate level (19-24). Favourable perceptions on physical quality of life in the current study were further supported by the reports in the focus group discussions. A respondents reported that "I am able to eat well, sleep and even maintain hygiene after rehabilitation."

Psychological Health

Respondents were required to assess their satisfaction on the quality of their psychological health in a Likert scale of 1 to 5 Summary of the findings were presented in Tables 4 and 5

Table 4

Frequencies of Perceptions on Psychological Health

Psychological health	Frequency	Percent
Low quality of life	9	6.4
Moderate quality of life	33	23.4
High quality of life	99	70.2
Total	**141**	**100.0**

From Table 4, majority of the respondents (70.2%) had a high perception on psychological health. The data was further computed descriptively and presented in Table 5

Table 5

Descriptive Statistics of Perceptions on Psychological Health

	N	Minimum	Maximum	Mean	Std. Deviation
Psychological	141	7	30	22.80	4.213
Valid N (listwise)	141				

From Table 5 results indicate that the lowest score attained by the respondents was 7 while the highest score was 30. The mean score was 22.80 (SD=4.213) which indicates that the perceptions on quality of life in terms of psychological health was on the high level.

Social Relationships

Respondents were required to assess quality of their social relationships. Summary of the findings are presented in Table 6 and 7.

Table 6

Frequencies on Social Relationships Quality of Life

	Frequency	Percent
Low quality of life	9	6.4
Moderate quality of life	27	19.1
High quality of life	105	74.5
Total	**141**	**100.0**

As shown in Table 6, majority of the respondents (74.5%) had a high perception on social relationships quality of life. This indicate that many respondents had better social relationships. Further analysis was done on this and the descriptive results are presented in the Table 7 below.

Table 7

Descriptive Statistics of Perception on Social Relationships

	N	Minimum	Maximum	Mean	Std. Deviation
Social	141	4	15	11.52	2.238
Valid N (listwise)	141				

From Table 7, results indicate that the lowest score attained by the respondents was 4 while the highest score was 15. The mean score was 11.52 (SD=2.238) which indicate that the average quality of life in terms of social relationships was on the high level.

Environment

Respondents were required to assess quality of their life in terms of their satisfaction with their environment. The findings are presented in Table 8 and 9.

Table 8

Frequencies on Perceptions of Environment Quality of Life

Environment	Frequency	Percent
Low quality of life	15	10.6
Moderate quality of life	61	43.3
High quality of life	65	46.1
Total	**141**	**100.0**

As shown in Table 8, majority of the respondents (46.1 %%) had a high perception of quality of life followed by 43.3% who had moderate quality of life. The data was then analyzed descriptively and the findings are presented in the Table 9 below.

Table 9

Descriptive Statistics of Perceptions on Environment

	N	Minimum	Maximum	Mean	Std. Deviation
Environment	141	14	40	27.45	5.133
Valid N (listwise)	141				

From Table 9, results indicate that the lowest score attained by the respondents was 14 while the highest score was 40. The mean score was 27.45 (SD=5.133) which indicate that the average quality of life in terms of environment was on the moderate level.

Overall Perception on their Quality of Life and Health

Respondents were further asked to rate the quality of their life generally and the satisfaction with their health in a Likert scale of 1 to 5. The findings are shown in figure 1 and 2.

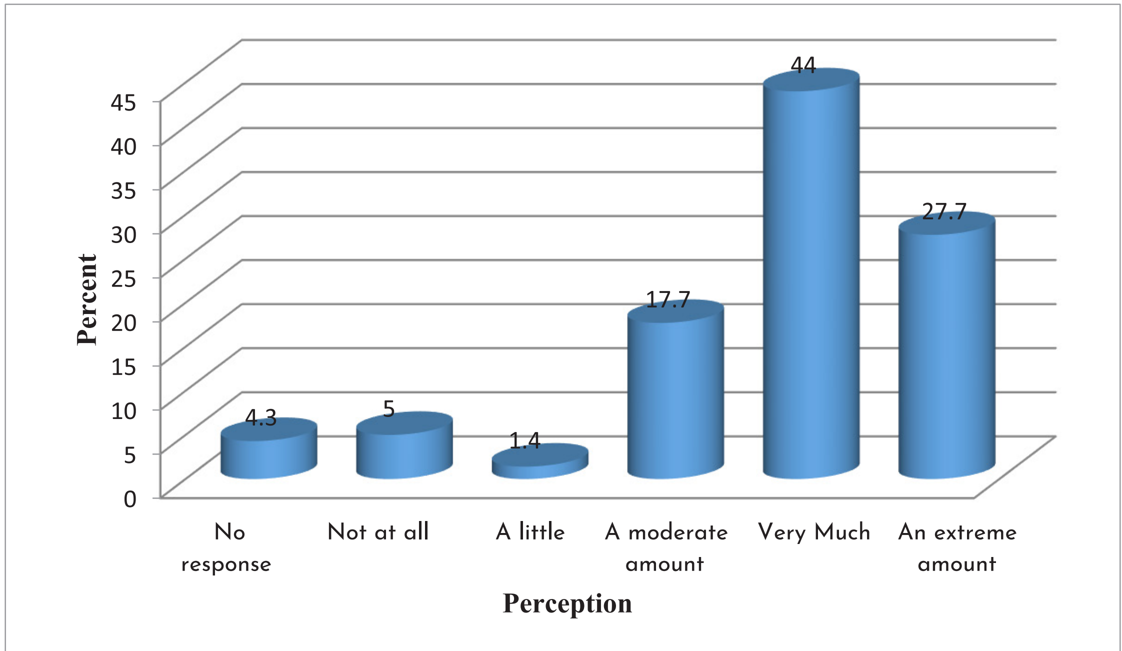
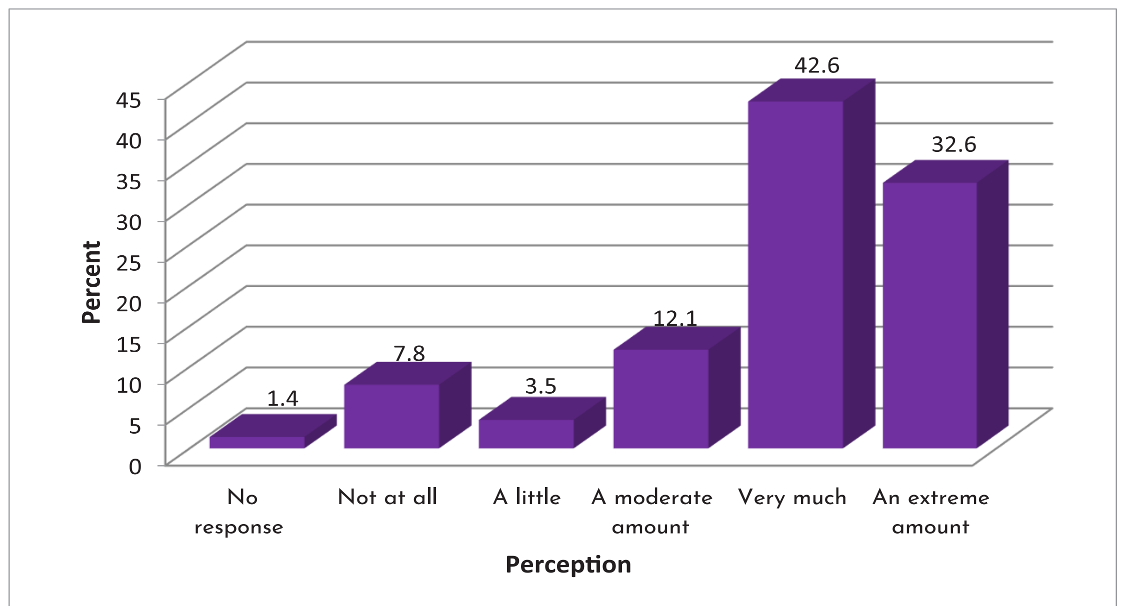


Figure 1 Perceptions of Respondents on the Quality of their Life.

As shown in figure 1, 44% of the respondents were very much satisfied with the quality of their life.

Overall Perception on their Quality of Health.

The overall perception on quality of health is presented in figure 2 belows



As shown in figure 2, majority of the respondents were very much satisfied with the quality of their health representing 42.6%.

The results were supported by data from focus group discussions. The respondents reported satisfaction with changes in their life as follows. They reported satisfaction with their ability to carry out their daily activities such as farming and feeding their cows, bodily appearance and on their physical strength, being able to eat, take a bath ,work, get home early and have time for my family, family members were happy and showed more love. A respondent said "I am even expecting a new born with my wife". Another one said "People have now started respecting me". These results agree with the goal of treatment according to NIDA (2012) which is to return people to productive function in the family, workplace and community.

Discussions of the Results

Better perceptions on physical health observed in the study could be attributed to two factors. First one is abstinence. These results compare with those in the literature. For instance, Srivastava and Bhatia (2013) found that physical health among other domains of quality of life improved significantly among 56 patients of alcohol dependence aged 18-45 years over a three months' study period in India. This was associated with complete abstinence and effective control of withdrawal symptoms. The second one is empowerment through community support groups.

Favorable satisfaction was expressed on psychological health among the respondents in this study. This can be associated with activities related to attendance to the community programs hence reducing chances of relapse. According to Faller, da Rocha, Benzano, Lima & Stolf (2015) the presence and absence of alcohol use disorders are strongly associated with changes in mental and psychological functioning. Srivastava and Bhatia (2013) associated improved psychological functioning to complete abstinence and effective control of withdrawal symptoms. The reductions in drugs and alcohol use result in decrease in problems associated with the abuse which eventually affects positively the psychological functioning.

The results also showed that respondents had good social relationship outcomes. An inconsistency is evident in existing literature. For instance, past primary studies searched in Web of Knowledge and analyzed by Poudel, Sharma, Gautam and Poudel (2016) found that social and family functioning improved over time while others found no differences at all. Current results can be explained by attendance to support groups which gives them empowerment economically and socially. Relationships are usually affected by alcohol abuse which makes a person unproductive and unreliable to support their families. Conflicts arising as a result of this make them indulge more into drinking and eventually severing more the social relationships. Findings on abstinence in this study indicated a notable decrease in alcohol and drug use. This can also be attributed to improved social relationships.

The respondents also seem to have favorable perceptions of their environment. Favorable perception can result to favorable psychological health which can prevent relapse. Negative mental state is one of the high risk factors of relapse in the Marllat's Cognitive-Behavioral Model of Relapse.

Overall perception of quality of life compares with those of prior studies. Parsareanu, Opsal and Vederhus, (2015) found significant improvements in quality of life among persons recovering from addiction in Norway. However, it was considered to be modest. Better perceptions in the current study can be attributed to community support groups. Improvement in quality of life is a predictor of treatment success.

Overall perception on quality of health can be attributed to better abstinence outcomes and adherence to support groups resulting

to improved health. Faller, da Rocha, Benzano, Lima & Stolf (2015) indicates that the problems observed in alcoholics such as medical issues are associated with the decrease in health quality of life more than with alcohol use itself. This implies that it's important to measure the problems associated with drugs and alcohol abuse in order to establish the status of health quality of life.

Conclusions of the Study and Implications to Treatment

The results indicate favorable perceptions on quality of life among respondents in Kirinyaga County in all the four domains. This can be attributed to achievement of abstinence and benefits reaped from participating in support groups.

After crackdown and subsequent rehabilitation, there is need for establishment of support groups. These can be either community based or those inclined to the 12 steps for continuum of care and to follow-up on the progress.

There is need for managers and rehabilitators in the rehabilitation centres and support groups to view the persons addicted to drugs and alcohol and recovering from addiction holistically and invest into the domains affected by poor quality of life. This would facilitate recovery.

Assessment for perceptions of quality of life on admission and throughout the treatment stages is necessary. This would help determine the effectiveness of the rehabilitation programs. Assessment after rehabilitation period should also be done as they transit to the support groups. This can be done during the termination of the residential program. Continuous assessment as well, may help determine the success of support group programs in sustaining the achieved quality of life.

Recommendation for further study

The current study used descriptive survey research method to establish perceptions of quality of life. There is need to conduct an experimental study to establish a causal relationship of attendance to support groups and perceptions of quality of life.

References

Abdu-Raheen, B.O. (2013). Sociological factors to drug abuse and the effects on secondary African perspective; South African Family Perspective, 50 (6), 44-44d.doi:10.1080/20786204.2008.1087382

Abiama, E.E., Abasiubong, F., Usen, K.B. & Alexander,U.E (2014). Prevalence of substance use and association with psychiatric illness among patients in UYO, Nigeria. African Journal of Drug and Alcohol Studies, 13(2)

American Psychiatric Association (2013). Diagnostic and statistical manual of mental disorders (5th ed.). Washington, DC: Author.

Srivasstava S., Bhatia M.S., Rajender G., Angad S (2009). Quality of Life in Substance Use Disorders Delhi Psychiatry Journal 2009;12: (1)

Borges, C.F. Ketsela, T., Munodawafa & DAlisalad, AD. (2013) Reduction of the harmful use of alcohol: a strategy for the WHO African Region. African health monitor,Retrieved from http://www.adarc.musph.ac.ug/downloads/findings/august_2019/

Donovan, D.M., Ingalsbe, M.H., Benbow, J.& Daley, D.C. (2013). 12-Step Intervention and Mutual Support Programs for Substance Use Disorders. An Overview, Sos work

public health. Retrieved from http://www.ncbi.nlm.ih.gov/pmc/artiles/PMC3753023

Dattalo, P. (2008). Determining sample size: Balancing power, precision and practicality. U.S.A: Oxford University Press.

Dawson.D.A., Li, T.K., Chou, P & Grant, B.F.) 2009) Transitions in and out of alcohol use disorders: their associations with conditional changes in quality of life over a 3-year follow-up interval. Alcohol and Alcoholism, 44(1), 84-92.

Faller S, da Rocha NS, Benzano D, Lima AFS, Stolf AR, et al. (2015) Factors Associated With a Quality of Life Decrease in Alcoholic Patients Who Sought Treatment. J Addict Res Ther 6:232. doi:10.4172/2155-6105.1000232

Hendershot, C.S., Witkiewitz, K., George, W.H & Marlatt, G.A (2011) Relapse prevention for addictive behaviors. Substance Abuse Treatment Prevention and Policy, 6:17. doi: 10.1186/1747-597X-6-17.

Humphreys, K., Kaskuta, L.&Weisner, C. (1998). The alcoholics anonymous affiliation scale: development, reliability and norms for diverse treatment and untreated populations. Alcoholic Clinical and Experimental Research, 22,974-978.

Kanyoni,M.Gishoma,D.Ndahindwa,V. (2015). Prevalence of psychoactive substance use among youth in Rwanda. BMC Research Notes, 8,190,doi:10:1186/s 13104-015-1148-2

Kathuri, J.N & Pals, D.A (1993). Introduction to Education Research. Egerton University, Njoro: Educational Media Centre. Kenya declares war on illicit alcoholic brews: Retrieved from https://www.aa.com.tr/en/world/kenya-declares-war-on-illicit-alcoholic- brews/29120

Laudet, A.B. (2011). The case of considering quality of life in addiction research and clinical practice. Addiction Science and Clinical Practice, 6(1), 44-55.

Muller, A.E., Skurtveit, S. Clausen, T.(2016). Many correlates of poor quality of life among substance users entering treatment are not addiction –specific. Health Quality life outcomes, (14), 39. Retrieved from https://doi.org/10.1186/s12955-016-0439-1

NACADA. "A Baseline Survey on Alcohol and Drug Abuse in Central Province, Kenya", Nairobi: NACAD Authority; 2010.

NIDA (2016). Principles of drug treatment: A research based guide 3rd ed. Retrieved from http://www.drugabuse.gov/publications/prinsiples-drug-addiction-treatment-research

Office of Disease Prevention and Health Promotion (2020) Health-Related Quality of Life & Well-Being. Retrieved from https://www.healthypeople.gov/2020

Pasareanu, A.R. Opsal, A. Vederhus, J.K. Kristensen, Q. & Clausen, T. (2015). Quality of life improved following in-patient substance use disorder treatment. BioMed Central, 10. https://doi.org/10.1186/s12955-015-0231-7

Poudel.A., Sharma, C., Gautam, S., & Poudel, A. (2016). Psychosocial problems among individuals with substance use disorder in drug rehabilitation centres, Nepal. Substance abuse treatment, prevention and policy, 11:28. https://doi.org/10.1186/s13011-016-0072-3

Preau. M., Protopopescu, C., Spire, B., Sobel.A., Dellamonica. P., Moatti.j.p. , Carrieri. M.P & MANIF-2000 Study Group (2007). Heath related quality of life among both current and former injection drug users who are HIV infected. Drug and Alcohol Dependence. 86(2-3), 175-182.

Substance Abuse and Mental Health Services Administration (2020) Recovery and Recovery Support. Retrieved from https://www.samhsa.gov/find-help/recovery

Srivastava,S., Bhatia,M.S Rajender, G.& Angad, S. (2009) Quality of life in substance use disorders. Delhi Psychiatry Journal, 12(1), 114-120.

Tracy,K. Wallace,S.P. (2016). Benefits of peer support groups in the treatment of addiction. Substance Abuse and Rehabilitation. (7) 143-154. doi:10.2147/SAR.581535

Vederhus, J.,Pripp, A.H & Clausen,T.(2016). Quality of life in patients with substance use disorders admitted to detoxification compared with those admitted to hospitals for medical disorders. Research and Treatment, (10), 31-37.

World Health Organization (1997). Measuring Quality of Life. Retrieved from https://www.who.int/mental_health/media/68.pdf

Zubaran,C., Emerson.J.,,Sud,R.,,Zolfaghari,E. & Angad. (2012) The application of the Drug User Quality of Life Scale (DUQOL) in Australia. Health and Quality of Life Outcomes 10(1):31.