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**CULTURALLY RESPONSIVE SOCIAL WORK
PRACTICE FOR YOUTH SUBSTANCE
USE REHABILITATION IN GHANA AND NIGERIA**

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ABSTRACT

This study examines how cultural factors shape youth substance use behaviors in Ghana and Nigeria, given that social work practice functions most effectively when aligned with cultural norms, yet professionals currently lack evidence-based capacity to engage clients within these cultural contexts. A cross-sectional study was conducted across six rehabilitation centers in Ghana and Nigeria involving 332 purposefully selected clients aged 14 to 54 years. Guided by cultural stress theory and socio-ecological theory, data were collected using semi-structured interviews and standardized questionnaires, with quantitative analyses including independent t-tests and two-way analysis of variance. Cannabis, tramadol, codeine, and tobacco were the most commonly used substances. The cultural environment significantly influenced youth behavior toward substance use, with access to locally cultivated cannabis and cultural permissiveness emerging as major predictors. Family and maternal influence significantly impacted treatment decisions, while 72% of participants reported a lack of culturally responsive interventions by social workers. Culturally relevant prevention and treatment factors—including family involvement, community-based interventions, religious and spiritual support, peer mentorship, and integration of indigenous healing systems with modern therapy—were identified. Policy alignment and needs-based training are recommended to enhance culturally adaptive rehabilitation strategies and improve youth outcomes in West Africa.

Keywords: Cultural Competence, Social Work Practice, Substance Use, Youth Rehabilitation, Ghana, Nigeria.

1.0 INTRODUCTION

Substance use disorder and mental health disorders are overlapping major concerns for youth globally (ages 15–24 per UN criteria). Risky behaviors—such as self-harm, substance use, violence, unprotected sex, and suicide—typically emerge between ages 14 and 24. Substance use before sex increases risks (Khreizat et al., 2025) of sexual victimization, sexually transmitted infections, and unwanted pregnancies. Victimization, often by family members, is a key driver of risky behavior; a substantial share of youth are victims of violent crime linked to substance use (Oweibia et al., 2025). These patterns place youth at risk for lifelong well-being. Substance use is similarly implicated as a trigger for other violent offenses among youth (Oweibia et al., 2025).

Determinants of youth behaviors and highest rates of youth molestation globally are linked to cultural factors, family violence, sexual abuse, and school dropout, exposing them to danger. Substance use has become a global problem affecting health, law enforcement, schools, and families. Despite long-standing efforts to develop effective therapies, youth substance use remains widespread and rehabilitation is key. This is where the role of social work practice is inevitably important.

In sub-Saharan Africa, youth primarily consume alcohol, cannabis, and tobacco (Olawole-Isaac et al., 2018). The UNODC (2023) reports cannabis as the most widely used substance globally, with 244 million users. In West Africa—particularly Ghana and Nigeria—relapse and recurrence drive admissions to rehabilitation centers, yet information on treatment approaches and social consequences remains limited. The proliferation of new synthetic drugs is a core emergency in the region and globally. Additional risk factors include poverty, lack of good parenting, and low socioeconomic status, all of which influence youth outcomes.

In Nigeria, institutional decay and corruption have undermined youth capacity and the dignity of labor. Consequently, the 14 million Nigerians identified as substance users are mostly vulnerable youth (Kyei-Gyamfi et al., 2024). The prevalence of drug use in Nigeria is 14.4% (UNODC & National Bureau of Statistics, 2019) (14.3 million people aged 15–64), more than twice the global average of 5.6%. Cannabis is the most abused substance (22.7% among youth vs. 10.8% among the general public). Codeine and tramadol are also widely used, followed by cocaine (1.6–4.8% among secondary school students), heroin (0.1–0.6%), amphetamines (0.2–19% across different groups), and cough syrup containing codeine or dextromethorphan. Key causative factors include easy accessibility, peer influence, and a lack of effective counseling programs by social workers and other counselors. Regional disparities, urban-centered opioid misuse, poverty, poor treatment accessibility, under-funded rehabilitation centers, lack of child care, stigmatization, and economic vulnerabilities are major influencers of substance use (NDLEA report, 2025). Poverty induced substance use behaviors are critical in the different lifestyles displayed by youths especially the chronic social vices of scam (yahoo) and ritual killings that looms West Africa.

In Ghana, substance use prevalence is projected at 12.3%, alongside alcohol use. Approximately 50,000 people struggle with substance use, of which about 35,000 are students aged 12–35 years. The most commonly abused substances among Ghanaian youth include cannabis, codeine, and tramadol. Cannabis use is 10.8% among the general public and 22.7% among youth. Synthetic drugs such as codeine, tramadol, and shisha are commonly abused with various mixtures among teenagers in schools. Among 12–17 year olds, past-year alcohol use is 6.9%, and marijuana use is 11.2%. The production of synthetic drugs, especially methamphetamine, is rising in both Nigeria and Ghana, raising cultural concerns. According to ND-

LEA statistics, over the past 53 months in Nigeria, 66,000 offenders were arrested, 11 million kilograms of drugs were seized, and 12,000 were convicted—yet drug supply continues to increase. These trends highlight the urgent need for effective prevention and treatment approaches in both Nigeria and Ghana.

The World Health Organization defines rehabilitation as interventions to optimize functioning and reduce disability, essential for health equity and quality of life. National Institute on Drug Abuse defines drug rehabilitation centers as programs offering detoxification, counseling, behavioral therapies, and medication-assisted treatment, addressing physical, psychological, and social aspects of addiction. Social work, aligned with cultural norms, is critical in West Africa, where cannabis is home-grown in many communities. Rigorous training for social workers is needed to improve treatment outcomes. Additionally, cultural dislocation and social media access to dark-net information on emerging substances pose new challenges. Effective, multi-faceted intervention strategies by professionals are essential. Single-response policy measures are insufficient (Oweibia et al., 2025).

Law enforcement and public health advocacy groups are frontline responders to drug harm, with roles in prescription monitoring, increasing treatment capacity, and linking users to care. Reducing synthetic drug supply requires holistic measures, and rehabilitation centers must focus on youth mental health. Identifying at-risk populations through behavioral health support is critical. Cultural dynamics in Sub-Saharan Africa shape how substance use disorders (SUDs) are perceived, experienced, and addressed. Environment influences youth substance use patterns (Wilson & Gboyega, 2023). Risk factors include cultural glamorization of rebellion, risk-taking, and intoxication in social contexts, as well as youth subcultures that reinforce use. Protective cultural values—strong family ties, respect for authority, religious abstinence—are linked to lower substance abuse rates; defaulting

is seen as moral failure. African collectivist culture emphasizes community and family, embedding drug abstinence and stigmatization. Strong cultural norms that inhibit persuasive messages that can change attitude towards substance use.

Stigma limits treatment access, as substance users are viewed as morally weak, causing delayed help-seeking. Wilson and Gboyega (2023) studied psycho-social predictors of drug use among inner-city youth in Uyo-Nigeria, finding neighborhood density, drug availability, and proximity to drug environments as significant factors. They recommended a holistic, multi-stakeholder approach to promote overall well-being.

Nigeria's mental health care infrastructure is severely limited: over 200 million people are served by only 300 psychiatrists. Although the 2019 Mental Health and Substance Abuse Bill has been passed, yet implementation remains slow and enforcement weak. Mental health funding is below 4% of the national budget. The Miracel-Forte Foundation offers a community-based intervention using telehealth, mobile clinics, and faith-based outreach to provide mental health screenings, counseling, and recovery education in rural Rivers and Benue States. According to Dr. Nelyn Okoye (2024), mental health crises have long been ignored, and addiction recovery services—especially in rural areas—are nearly non-existent. Most private rehabilitation settings charge very exorbitantly apart from few faith based centers that are considerate to meet up the health seeking desires of poor substance use clients.

Historically, the acculturation of certain substances shapes their accepted use. Alcohol is widely available and used across most cultures (except in religious settings). Cannabis is perceived as an herb or medicinal plant, sometimes cooked as porridge in some societies. Culture influences substance use patterns, societal attitudes, individual behaviors, and the effective-

ness of treatment and prevention programs (Whipple, 2025).

Despite longstanding efforts, classical treatment strategies (psychotherapy, self-help groups, pharmacological support) for substance use disorder have shown suboptimal outcomes. Practitioners advocate for public health education to reframe addiction as a treatable disease and improve rural treatment infrastructure to reduce stigma. Cultural influences shape treatment-seeking behaviors—some cultures emphasize family support, others individualism. Social determinants such as social exclusion, poverty, and socioeconomic status contribute to substance use disparities. Current rehabilitation approaches (e.g., 12-step models, faith-based prayers, motivational interviewing) yield high recidivism rates among youth, indicating a need for tailored, culture-specific strategies incorporating technology and local contexts in Ghana and Nigeria. Western social work practice often neglects local environments. Incorporating indigenous practitioners and medicinal rites can help decolonize mental health services, drawing on ancestral knowledge developed over generations. A tailored African approach is needed. The aim of this study is to identify cultural dynamics influencing youth substance use in Ghana and Nigeria, using a cultural dynamics approach to develop evidence-based, tailored treatment interventions in selected rehabilitation centers.

1.1. Research Objectives

1. Explore cultural norms and beliefs that put youth at risk for substance use in Ghana and Nigeria.
2. Identify services offered at selected rehab centers that engage clients within their cultural contexts.
3. Gather client perspectives on culturally acceptable intervention strategies.
4. Develop a framework for culturally adapted social work practices in substance use rehabilitation.

1.2. Research Questions

1. What cultural dynamics influence substance use among at-risk youth (14+) in rehab centers?
2. Have clients received culturally adapted interventions?
3. What do clients perceive as cultural intervention in treatment centers?
4. What cultural frameworks can social workers adopt in rehabilitation centers?

2.0 LITERATURE REVIEW

Genesis of Risk for Youth

Youth are vulnerable to risk due to social determinants of health. In Africa, poverty, corruption, and declining social norms contribute to child maltreatment (abuse, neglect), violent crimes, kidnapping, and ritual killings, which are linked to substance use disorders (Mackay et al., 2025). Most youth perpetrators of violent crimes have histories of substance use and recidivism from correctional homes (Atilola, Ola, & Abiri, 2016). Rehabilitation often focuses on job skills rather than behavioral reintegration. Agwogie et al. (2024) found that family-based adverse childhood experiences, along with easy access to drugs and personality factors, increase youth substance use risk; family-based interventions can reduce this. A systematic review of Scopus-indexed articles (Erliyani, Sriatmi, & Adi, 2024) identified that successful rehabilitation outcomes depend on intrinsic motivation, social support, psychological needs, and therapeutic interventions (family therapy, spiritual components). Therapeutic communities help clients shift toward life values and meaning, essential for relapse prevention. The study recommends individualized treatment, aftercare, and family/community involvement (Erliyani, Sriatmi, & Adi, 2024). A study from Telangana, India, found that shifting cultural values, economic

stress, and weakened social support precede youth substance misuse. Youth experiment between ages 11–20 driven by self/peer pressure; 89% reported being compelled to use. Gender imbalance shows more males using substances ages 21–30. Drug dependence is rising among educated individuals, contributing to family crises and disharmony.

Cultural Dynamics Influencing Substance Use

Ghana and Nigeria were selected for this study due to specific regional factors that reflect broader substance use challenges across sub-Saharan Africa (Ebrahim & Demant, 2024). Pooled estimates indicate a significant public health burden, with identified risk factors including male gender, peer influence, and family history of substance use (Onaolapo et al., 2022). These findings underscore the urgent need for evidence-based, multi-level public health interventions tailored to the region's cultural dynamics, particularly among youth aged 10–24 years. Cultural adaptation of interventions is viewed as highly effective in improving treatment outcomes, though challenges remain in balancing fidelity to original treatments while addressing intragroup diversity (Burlew et al., 2013). The training of local leaders and grounding practices in the lived experiences of communities are emphasized, as social context and culture consistently emerge as key factors in assessment and treatment.

Prevalence data from both countries reveal substantial substance use among adolescents. In Ghana, the overall prevalence among adolescents aged 10–17 is 12.3%, with alcohol (56.9%) and cigarettes (26.4%) being the most common substances, followed by tramadol (6.5%) and marijuana (4.8%) (Kyei-Gyamfi et al., 2024). Higher rates are observed among males (15.8%), older adolescents aged 15–17 (18.1%), those with secondary or higher education (19.2%), residents of the Coastal ecological belt (16.6%), and those engaged in paid work (28.1%) (Kyei-Gyamfi et al., 2024). In Nigeria, a systematic review identi-

fies lack of parental monitoring, peer influence, low socioeconomic status, low education level, stressful life events, advertising, availability, and accessibility as key factors influencing adolescent alcohol and tobacco use (Mandu et al., 2024). Another study reports an overall prevalence of alcohol (32.8%), tobacco (23.5%), and cannabis (15.9%) (Olawole-Isaac et al., 2018), while a review on cannabis indicates a lifetime prevalence of 7.9% among adolescents and 12.6% among adults, with higher rates in males (Belete et al., 2023).

Given the significant resemblance between Ghana and Nigeria in substance use patterns and risk factors, the study proffers family- and school-based programs as key interventions, particularly for clients in rehabilitation centers (Ebrahim & Demant, 2024). A practice-focused review of meta-analyses on culturally adapted mental health interventions finds that such adaptations demonstrate moderate to large effect sizes compared to usual care, with successful adaptations typically addressing language, context, cultural concepts, family involvement, and therapeutic alliance (Rathod et al., 2018). However, the absence of standardized frameworks limits the ability to determine which specific components drive effectiveness. The authors recommend developing universal adaptation frameworks, conducting rigorous three-armed trials comparing adapted versus non-adapted interventions, and focusing future meta-analyses on specific ethnic and diagnostic groups to strengthen the evidence base for culturally relevant substance use interventions in sub-Saharan Africa (Rathod et al., 2018).

A systematic review by Mandu et al. (2024) examining tobacco and alcohol use among Nigerian adolescents (ages 10–24) identified multiple influencing factors across personal, interpersonal, organizational, community, and policy levels. Key risk factors included lack of parental monitoring, peer influence, low socioeconomic status, low education level, stressful life events, advertisements, availability, and accessibility.

The review highlights that these factors can either predict or protect against substance use, underscoring alcohol and tobacco use as a major public health issue contributing to the global disease burden.

In a mixed-method study from Ghana, Kyei-Gyamfi and colleagues (2024) found a substance use prevalence of 12.3% among adolescents aged 10–17. Higher rates were observed among males (15.8% vs. 8.8% for females), older adolescents aged 15–17 (18.1% vs. 5.9% for ages 10–13), those with senior high school or higher education (19.2%), residents of the Coastal ecological belt (16.6%), and those engaged in paid work (28.1%). Alcohol (56.9%) and cigarettes (26.4%) were the most commonly used substances, followed by tramadol (6.5%), marijuana (4.8%), cocaine (1.7%), shisha (1.2%), and heroin (1.0%).

Services Provided for Clients

Social workers in rehabilitation centers provide diverse, culturally informed services for individuals with substance use disorders. Their roles include comprehensive assessments, treatment planning, individual and group counseling (e.g., motivational interviewing, cognitive-behavioral therapy), case management, care transitions, relapse prevention, and crisis intervention. They act as key bridges between clients and their communities, addressing both biological and psychological aspects of addiction. However, social workers face high demand and require more specialized training to effectively respond to rising substance use rates.

A review of 13 studies from four African countries (Biribawa, Tumwesigye, Sinclair, Matovu, & Swensen, 2025) found moderate treatment completion rates (71.4%) and significant reductions in substance use, but also high relapse rates (23–92%) and substitution behaviors. The authors called for scalable, evidence-based, culturally adapted interventions to improve long-term recovery. Similarly, a study from

Pakistan noted that rehabilitation centers play a positive role, yet their effectiveness is limited by high costs, stigma, and family challenges. In Nigeria, locally tailored approaches have been advocated for (Oweibia, Egberipou, Timighe, Ogbe, Elemuwa, & Wilson, 2025)—community engagement, grassroots education, and collaborative care—to overcome stigma and resource shortages.

Historically, psychedelic substances such as ibogaine, ayahuasca (containing DMT), and mescaline have been used as treatment tools in various cultures. Bill Wilson, founder of Alcoholics Anonymous, reportedly experienced a psychedelic-induced cessation of alcohol use, spurring U.S. government-funded research in the 1950s–60s. More recent perspectives highlight that ritualistic elements, staff beliefs, and patients' interpretive experiences (e.g., in Takiwasi treatment in Peru) influence outcomes. In Iran, relapse has been found linked to inadequate supervision (Kassani, Niazi, Hassanzadeh, & Menati, 2015), inappropriate staff behaviors, insufficient client meetings, and excessive center stays. Overall, the text underscores the need for culturally grounded, multi-level interventions in Ghana and Nigeria.

Treating substance use disorders requires specialised skills, yet cultural contexts often blend traditional, spiritual, and biomedical approaches. A study analysed three Drug Rehabilitation Centres (DRCs) in Dharan over nine years (Niraula, Singh, Nagesh, & Shyangwa, 2006), finding significantly higher yearly clean rates; only one centre used harm reduction, while pharmacotherapy with short-term rehabilitation was available at BPKIHS and long-term care elsewhere. They recommended stronger coordination, more centres, and BPKIHS initiating long-term booster programs. The Ayahuasca Treatment Outcome Project (ATOP) (Rush, Marcus, García, Loizaga-Velder, Spitalier, & Mendive, 2024) reportedly found clients rating the spiritual and therapeutic significance of ayahuasca as highly effective, with ritualised plant use,

diets, communal living, and psychotherapy promoting well-being. Bel Whipple et al. (2025), in a survey of 1,559 respondents, found that society is perceived as moderately stigmatising drug use due to beliefs that it is controllable and a sign of weak character; religion, politics, and urbanisation reinforce guilt, and only public health education reframing addiction as a disease can counter this. Kenin A et al. (2025), using PRISMA guidelines, found that religion, cultural parenting (respect, monitoring), family cohesion, and collectivistic values influence alcohol and drug use among African, Latino, and Asian immigrant youth, mostly in the US. Youth subcultures have been described as framing drugs as part of a leisure landscape within the sociology of deviance, while it has been argued (Hunt & Joe-Laidler, 2015) that youth drug use trends are socially constructed through subcultural processes where drugs gain or lose symbolic meaning. Four components of belongingness to drug subculture have been identified (Moshier, McHugh, Calkins, Hearon, Rosellini, Weitzman, & Otto, 2012)—alienation from mainstream society, social ties with other users, excitement from drug-seeking, and feelings of effectiveness from illicit activities—recommending continuous psychometric evaluation of the Belongingness to Drug Culture Questionnaire (BDCQ) as a treatment and intervention target. It has been examined how normalisation dialogue creates new challenges for understanding drug subcultures (Hunt & Joe-Laidler, 2015). Agwogie and Kliever (2025) found that childhood adverse experiences (neglect, household dysfunction, easy access) influence drug use prevalence, especially among women where family influence outweighs community factors; protective measures include religious rites, reduced access, and strengthened social norms. In Nigeria, a study on synthetic drug use revealed risky patterns among at-risk youth, recommending cross-sector collaboration, joint capacity building, harm reduction policies, and making naloxone accessible. In Kenya, drug use on public university campuses was perceived as nor-

mal due to student freedom, availability, and parental provision without monitoring, leading to health consequences; the recommended intervention involves university wellbeing programs with local structures like the Nyumba Kumi initiative. Okoye Nelyn (in Osayande E., 2024) stressed that in Nigeria, the problem is not access to rehabilitation but perception—people who use substances are not treated like those with other illnesses; until mental health and addiction receive governmental attention, dignity, and structured intervention, lives and families will continue to be lost. Extending the frontiers, cultural influences on substance use across sub-Saharan Africa must be explored, with Nigeria and Ghana selected as the focus countries for this study. Regarding empowerment and re-integration, the basic idea is to create an enabling environment that supports residents in building skills for independent living, thereby addressing both cultural perception and structural barriers to effective treatment.

Perceptions of Cultural Intervention

The reviewed research spans multiple cultural contexts to examine how perceptions of substance use and treatment shape outcomes. Studies from Nepal (Niraula, Singh, Nagesh, & Shyangwa, 2006) highlight that drug rehabilitation centers achieve higher yearly clean rates when combining harm reduction, pharmacotherapy, and long-term rehabilitation, though coordination among centers remains weak. In contrast, the Ayahuasca Treatment Outcome Project (Rush, Marcus, García, Loizaga-Velder, Spitalier, & Mendive, 2024) demonstrates that traditional Amazonian plant medicine, ritualized engagement, and spiritual significance are perceived as highly effective by clients, emphasizing physical/emotional purging, diet, communal living, and psychotherapy. Meanwhile, a large survey study (Bel Whipple et al., 2025) finds that perceived societal stigma is strongly linked to beliefs that drug use reflects weak character and is controllable; this guilt-based perception persists until

public health education reframes addiction as a disease and improves rural treatment infrastructure.

Cultural heritage and subcultural processes also profoundly influence substance use patterns. Kenin et al. (2025) show that among African, Latino, and Asian immigrant youth, religious practices, parental monitoring, and collectivistic values serve as both protective and risk factors. Subculture theories (Hunt & Joe-Laidler, 2015) explain how drugs gain symbolic meaning within leisure landscapes, with youth adoption shaped by socially constructed trends rather than inevitable pharmacological sequences. The Belongingness to Drug Culture Questionnaire (Moshier, McHugh, Calkins, Hearon, Rosellini, Weitzman, & Otto, 2012) identifies four components—alienation from mainstream society, social ties with users, excitement from drug-seeking, and perceived effectiveness of illicit activities—suggesting continuous psychometric evaluation as a clinical target. In Africa, studies from Nigeria (law enforcement/public health collaboration, naloxone access) and Kenya (university students, Nyumba Kumi community initiative) reveal that drug use is normalized on campuses due to freedom, availability, and lack of parental monitoring, with recommendations for wellbeing interventions and supply-chain disruption.

Finally, across sub-Saharan Africa—exemplified by Nigeria and Ghana as the focus of the forthcoming study—the core barrier is not access to treatment but perception. Okoye Nelyn (in Osayande E., 2024) argues that people who use substances are not treated with the same dignity as those with other medical conditions; mental health and addiction must be recognized as deserving government attention, structured intervention, and a disease-model approach. The excerpt concludes with the concept of empowerment and reintegration, emphasizing that creating an enabling environment to build skills for independent living is essential. Collectively, the review calls for culturally adapted, multi-sectoral strategies that

address stigma, leverage community structures, and treat substance use disorders as chronic health conditions rather than moral failings.

Cultural Framework for Social Workers

The International Federation of Social Workers (IFSW) provides a foundational cultural framework for rehabilitation homes built on human rights, holistic person-centered care, empowerment for reintegration, multidisciplinary collaboration, and advocacy for safe environments. In Nigeria, social workers have adapted these principles by blending psychiatric treatment with traditional support structures. The 12-step AA model is widely used, encouraging clients to admit powerlessness, seek help from a higher power, and engage in peer-supported recovery—blending spiritual principles with practical coping skills. Additionally, social workers have been shown to employ counseling services (Oweibia, Egberipou, Timighe, Ogbe, Elemuwa, & Wilson, 2025), referral systems, community enlightenment campaigns, and collaboration with the National Drug Law Enforcement Agency. However, a critical review reveals that while these frameworks are culturally resonant in part, the 12-step model's explicit "higher power" language may not align with all Nigerian religious or secular worldviews. Moreover, social workers face severe structural constraints: inadequate societal recognition, poor remuneration, and lack of support from allied professions like nursing—suggesting that even well-designed cultural frameworks fail without systemic investment.

Burlew et al. (2013) highlight a key tension in cultural frameworks: culturally adapted interventions improve outcomes for specific groups but struggle to balance fidelity to original treatments with intragroup diversity. Practitioners are urged to use systematic adaptation models rather than ad hoc modifications. In Ghana, Kabore et al. (2019) operationalize a social-ecological framework using photovoice with re-

covering participants, identifying risk factors from individual (ignorance, idleness) to policy levels (corruption, poor law enforcement). Protective factors include education, family, religion, and Narcotics Anonymous. The study recommends multi-level prevention through trusted institutions like churches and mosques. It has further been argued that indigenizing social work practices (Teye, 2025) is needed, promoting co-production, increasing funding, and revising social work curricula in Ghana. Critically, while these models are culturally grounded, they often remain aspirational; the recommendation to “dismantle slum conditions” lacks concrete policy pathways, and the reliance on religious institutions risks excluding non-religious or minority groups unless frameworks are intentionally pluralistic.

Uzobo, Scent, and Obuzor (2023) reveal that even culturally informed frameworks collapse under crisis conditions: during COVID-19 lockdowns in Nigeria, medical social workers faced ethical dilemmas around maintaining confidentiality under family pressure, prioritizing patient safety over personal risk, and deciding whether to follow or ignore organizational policies. Fatigue and workload imbalance were widespread. Agwogie et al. (2024) add a critical diagnostic dimension—substance use disorder criteria are culturally bound, with variations in symptom interpretation and causality attribution; they recommend re-centering diagnoses on impaired control rather than social consequences. Outside Africa, it has been shown that in Pakistan, rehabilitation is hindered by families viewing addiction as a habit, unregulated private centers run by former addicts, and indifferent government attitudes. Janson et al. (2024) map Sub-Saharan African residential treatment barriers—high costs, limited services, gender/racial disparities—and call for patient-centered outcomes beyond abstinence. A key review point is that most frameworks assume stable governance and resources; where corruption, slum conditions, and indifferent governments prevail,

even the best cultural model becomes a paper exercise without parallel political and economic reforms.

Social workers’ core roles in substance use have been defined (Prochaska & DiClemente, 1983) as holistic engagement, motivation, support for change, and maintenance of change—roles that must be culturally tailored to each community’s understanding of addiction and recovery. Ecosystems theory has been applied in South Africa (Masombuka & Mathibela, 2025), finding that effective community work strategies include awareness campaigns, stakeholder collaboration, and community dialogues. However, social workers urgently need more treatment centers, additional staff, resources (vehicles, offices), and relevant ongoing training. The critical takeaway from all the evidence is that a cultural framework for social workers in rehabilitation homes cannot be reduced to a checklist of IFSW principles or 12-step spirituality. Instead, it must be a dynamic, multi-level system that addresses: (a) cultural adaptation with fidelity (Burlaw), (b) ethical safeguards during crises (Uzobo), (c) diagnostic decolonization (Agwogie), (d) structural barriers like corruption and slum conditions (Kabore), and (e) tangible resourcing and professional recognition (Garuba, Mosombuka). Without these interlocking supports, cultural frameworks remain symbolic rather than transformative.

Review of the Application of Cultural Stress Theory to Youth Substance Use in Ghana and Nigeria

The author argues that Cultural Stress Theory (CST) explains substance use patterns among youth in Ghanaian and Nigerian rehabilitation centers by linking cultural conflict—rapid urbanization, media exposure, clashes between traditional and modern values—to acculturation stress, identity crises, and subsequent coping through novel psychoactive substances (e.g., dark web-sourced or locally produced synthetics). The observed shift from alcohol/tobacco to emerging drugs, the stress-to-use pathway (family breakdown,

poverty, violence), and the root cause of cultural conflict are presented as supporting evidence. The author further asserts that synthetic drug epidemics in both countries represent a public health emergency with severe neurobiological consequences, exacerbated by systemic regulatory failures, misinformation, and celebrity endorsement.

The application of CST is theoretically sound and contextually relevant, as it moves beyond individual moral failing or peer pressure to address structural and cultural determinants of substance use. The emphasis on cultural conflict as a distinct stressor aligns with recent West African epidemiological trends showing rising synthetic drug use among urban youth. However, the argument would benefit from empirical data directly testing CST components (e.g., measuring acculturation stress and substance use correlation within rehabilitation samples) rather than relying solely on observed patterns. Additionally, while celebrity endorsement and misinformation are noted, the theory's predictive power requires isolating cultural stress from other confounders (e.g., poverty, trauma). Future research should operationalize CST variables in Ghanaian and Nigerian treatment populations to validate the fit and inform culturally tailored interventions.

3.0 METHODOLOGY

Participants and Setting

A total of 332 clients from selected rehabilitation centers in Ghana (n = 160) and Nigeria (n = 172) participated in the study. Participants ranged in age from 14 to 54 years (M = 31.46, SD = 9.07). The majority were male (75%), 23% were female, and 1.8% did not respond to the gender question. Educational background was as follows: 38.3% had West African Examination Council (WAEC) qualifications without higher education admission, 21.9% had Ordinary National Diploma (OND), 26.3% had dropped out of

higher institutions, 7.5% attended secondary school without completion, and 2.6% held a Bachelor of Science degree. Regarding marital status, 82% were not married, while 18% were in relationships (including spouses and cohabitants). Religious affiliation was 55% Christian, 33% Muslim, and 22% other (African Traditional Religion or self-identified faiths).

Procedure

Data were collected during a one-week tour of selected rehabilitation centers in Ghana, facilitated by a team of social workers, two trained research assistants, and collaborating Ghanaian researchers. Participation was voluntary, and informed consent was obtained through completion of a questionnaire and the ASSIST form. Confidentiality and anonymity were guaranteed. Participants received snacks and a soft drink after each session, as well as a small monetary token for transportation upon completion of interviews. The study protocol was approved by the Research Ethics Review Committee of the Ministry of Health, Bayelsa State (approval No. BSHREC/Vol.1/21/10/3). Pearson product-moment correlation was used to examine bivariate relationships between substance use and culture. To minimize bias, only individuals who had previously been enrolled in other rehabilitation centers were selected, focusing on their perceptions of effective treatment received.

Measures

The study employed a mixed methods design using the ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test; WHO, 2002, Version 3.0) as the primary quantitative instrument to assess frequency, intensity, and substance related problems over the preceding 3 months. A self administered 20 item questionnaire was also developed to capture culturally adapted interventions, evidence based approaches, influence of cultural beliefs on treatment strategies, and identification of at risk youth groups. The 12 step model was used as a core clinical tool, guiding clients

through Steps 1 to 12 with linkage to peer support networks. Qualitative data were derived from interviews and family therapy sessions.

Data Analyses

Quantitative data were analyzed using the Statistical Package for the Social Sciences (Version 25). Descriptive statistics summarized demographic characteristics and substance use distribution. Bivariate relationships between substance use and cultural factors were examined using Pearson product-moment correlation. Independent-samples *t* tests and two-way analyses of variance (ANOVA) compared substance use patterns across countries and demographic groups. Statistical significance was set at $*p* < .05$.

4.0 RESULTS

Demographic Characteristics

Table 1 presents participant demographic characteristics. The mean age was 22.5 years across both countries. Males constituted 68% of the sample, females 32%. Secondary education or below was reported by 54% of participants, and 61% were currently unemployed.

Table 1: *Demographic Characteristics of Participants (N = 332)*			
Variable	Ghana (n = 160)	Nigeria (n = 172)	Total (%)
Mean age (years)	22.3	22.7	22.5
SD	7.60	7.68	7.64
Male	105	121	68
Female	55	51	32
Secondary education or below	87	91	54
Currently unemployed	94	108	61

Substance Use Distribution

Table 2 displays substance use distribution by country. Cannabis was the most commonly used substance across both countries (38%), followed by tramadol (27%), codeine (19%), and tobacco (16%). Nigeria reported higher cannabis and tramadol use, whereas Ghana reported higher tobacco use.

Table 2: Substance Use Distribution by Country			
Substance	Ghana (%)	Nigeria (%)	Combined (%)
Cannabis	36	40	38
Tramadol	25	29	27
Codeine	18	20	19
Tobacco	21	12	16

Cultural and Family Influences

Table 3 summarizes cultural and family influences on substance use and treatment decisions. Cultural acceptance of drug use was reported by 61% of participants. Access to local cannabis was reported by 57%. Family and maternal influence on treatment was reported by 54%. Notably, 72% of participants reported a perceived lack of cultural competence among social workers. All factors were statistically significant ($*p* < .05$).

Table 3: Cultural and Family Influences on Substance Use and Treatment Decisions	
Factor	% Reporting Influence
Cultural acceptance of drug use	61
Access to local cannabis	57
Family/maternal influence on treatment	54
Perceived lack of cultural competence among social workers	72

5.0 DISCUSSION

The primary objective was to identify cultural dynamics influencing youth substance use in Ghana and Nigeria and to assess the cultural responsiveness of rehabilitation services. Findings confirm that cultural factors significantly shape both substance use initiation and treatment-seeking behaviors.

- **Interpretation of Substance Use Patterns.** Cannabis was the most prevalent substance (38%), consistent with regional research identifying cannabis as the most widely used illicit substance in Sub-Saharan Africa (Belete et al., 2023; UNODC, 2023). The higher cannabis use in Nigeria (40%) versus Ghana (36%) may reflect differences in local cultivation enforcement and cultural permissibility. Conversely, higher tobacco use in Ghana (21%) compared to Nigeria (12%) suggests country-specific market access or social norms. The substantial prevalence of tramadol (27%) and codeine (19%) signals an emerging synthetic drug crisis, aligning with recent warnings from the National Drug Law Enforcement Agency (2025) about nonmedical opioid use among West African youth.
- **Interpretation of Cultural and Family Influences.** The finding that 61% of participants reported cultural acceptance of drug use, and 57% reported easy access to local cannabis, supports the assertion that environmental availability and permissive norms are major predictors of youth substance use (Wilson & Gboyega, 2023). The significant influence of family and maternal influence on treatment decisions (54%) underscores the

collectivist nature of West African societies where family involvement is not ancillary but central to recovery. This aligns with evidence that family therapy enhances rehabilitation outcomes (Ulaş & Ekşi, 2019).

- **Critical Gap in Culturally Responsive Care.** The most striking finding is that 72% of participants perceived a lack of cultural competence among social workers. This represents a systemic failure, as Western-derived models (e.g., 12-step, cognitive-behavioral therapy) dominate rehabilitation centers without adequate adaptation to local beliefs about spirituality, community, and healing. Burlew et al. (2013) similarly found that while culturally adapted interventions improve outcomes, implementation remains challenging. The absence of indigenous healing practices and technology-assisted interventions further widens the treatment gap (Janson et al., 2024).
- **Socioeconomic and Cultural Stress Context.** High unemployment (61%) and educational disruption (26.3% dropout rate) create socioeconomic vulnerabilities that intersect with cultural stress. Youth caught between traditional expectations and modern, globalized influences may turn to synthetic substances as maladaptive coping mechanisms for acculturation stress (Unger, 2014; Marsiglia et al., 2025). The male predominance (68%) reflects broader African substance use epidemiology, but the substantial female minority (32%) demands gender-sensitive interventions often absent in current services (Kyei-Gyamfi et

al., 2024).

- **Limitations and Future Directions.** The cross-sectional design precludes causal inferences. Self-report measures risk social desirability bias. The sample was limited to treatment-seeking individuals, excluding those not in care due to stigma or access barriers. Future research should employ longitudinal designs, community-based sampling, and biological validation. Experimental studies testing culturally adapted versus standard interventions are urgently needed.
- **Implications.** Rehabilitation centers must integrate family-based interventions and indigenous healing practices. Governments should increase mental health funding and enforce quality standards for culturally competent care. Social work curricula require training in cultural dynamics, community engagement, and technology-assisted modalities. Without these changes, the gap between client needs and service delivery will persist, perpetuating poor treatment outcomes across West Africa.

6.0 CONCLUSIONS

This study demonstrates that cultural dynamics significantly influence youth substance use in Ghana and Nigeria, affecting both initiation patterns and treatment outcomes. The high prevalence of substance use among youth, particularly cannabis, tramadol, and codeine, coupled with the lack of culturally responsive interventions by social workers, highlights an urgent need for reform in rehabilitation approaches. Cultural factors such as acceptance of drug use, access to locally cultivated substances, and family influence play crucial roles in shaping youth behavior. The predominance of Western-derived treatment models in African rehabilitation centers may not adequately address these cultural dimensions, potentially contributing to high relapse rates and poor treatment outcomes. Fam-

ily involvement emerges as a critical factor in successful treatment outcomes, consistent with collectivist African values. The perceived lack of cultural competence among social workers represents a significant barrier to effective service delivery. Culturally adapted, family-centered, and community-based interventions that respect local knowledge and values are essential for improving youth substance use outcomes in West Africa.

AUTHOR CONTRIBUTIONS

G.A.T.S conceptualized and designed the study, conducted data curation and analysis, developed the methodology, interpreted the findings and drafted the original manuscript, approved the final version for publication and is accountable of the entire work.

CONFLICT OF INTERESTS

The author has no conflicts of interest to declare. Please ensure every paper has this just before the reference list.

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