COLLEGE OF EDUCATION AND LANGUAGE STUDIES

SCHOOL OF PSYCHOLOGY

READINESS TO CHANGE AMONG PEOPLE WITH SUBSTANCE USE DISORDER WHO ARE ADMITTED FOR TREATMENT IN PSYCHIATRIC AND REHABILITATION CENTERS IN ADDIS ABABA

BY; MEKONNEN ANLEY BEKELE

A THESIS SUBMITTED TO SCHOOL OF PSYCHOLOGY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF MASTER OF ARTS IN COUNSELING PSYCHOLOGY

JUNE, 2025

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Approval of board examiner

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Adviser	Signature	Date
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Internal examiner	signature	Date
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External examiner	Signature	Date
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Chairperson	Signature	Date

Declaration

Mekonnen Anley Bekele, hereby declares that the thesis on the tittle "**Readiness to change among people with substance use disorder who are admitted for treatment in psychiatric and rehabilitation centers in Addis Ababa** '' is my original work and it has not been presented for any academic purpose in any other university prior to this time and that all source of materials used for thesis have been properly acknowledged.

Name: -Mekonnen Anley Bekele

Signature: ……..

Date; ……

The thesis has been submitted for examination with my approval as a university advisor.

Name of advisor; Seleshi Zeleke (PhD)

Signature…….

Date; ……

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Abstract

*The purpose of this study was to assess the readiness to change, explore factors influencing readiness to change and assessing level of voluntariness among people with substance use disorder who are admitted for treatment in **Jadber** psychiatry and substance rehabilitation center, Ethiopian Prosthetic and Orthotic services (**EPOS**) mental and substance rehabilitation center and **new life** substance rehabilitation centers in Addis Ababa. The study was conducted in sequential explanatory mixed-methods research design. The research was conducted from 60 participants; complemented by insights from three key informants and three selected substance abusers. The quantitative data was collected through self-reported questionnaires by using socio demographic questionnaires, substance use history assessment and SOCRATES with three subscales; ambivalence, recognition and taking steps and the qualitative data was collected through in depth interview. The quantitative data was analyzed through descriptive statistics like mean, standard deviation, frequency and inferential statistics like independent samples t test, multiple linear regressions by using SPSS version 26 and the qualitative data was analyzed through thematic analysis. The findings of the study revealed that the participant's readiness to change within three subscales; ambivalence, recognition and taking steps was low. While the majority of participants entered the rehabilitation centers voluntarily, there was no significant difference in their readiness to change across three subscales; ambivalence, recognition, and taking steps between voluntarily and involuntarily admitted individuals with alcohol and other drug abuse issues. The qualitative component of the study explored various factors influencing readiness to change, which were categorized into different themes. Psychological factors identified included low self-confidence, perceived fear of withdrawal symptoms, fear of relapse, and cravings. Environmental factors encompassed the availability of substances, exposure to previous destination and lack of job opportunities, while social factors highlighted poor family and social support, peer pressure, ineffective family approaches, and perceived stigma*

Key terms; level of voluntariness, readiness to change, rehabilitation centers, stages of change, substance abuse

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Abbreviations

A.A –Addis Ababa

AAU-Addis Ababa University

ADCQ- Alcohol and Drug Consequences Questionnaires

APA- American Psychiatric Associations

AATC- Northeast and Caribbean Addiction Technology Transfer Center

DSM- Diagnostic and Statistical Manual of Mental Disorders

EPOS- Ethiopian Prosthetic and Orthotic Services

SOCRATES- Stages Of Change Readiness and Treatment Eagerness Scale

SPSS- Statistical Package for the Social Sciences

SUD- Substance Use Disorder

TTM- Trans Theoretical Model

USA-United States of America

WHO-World Health Organization

CHAPTER ONE

INTRODUCTION

1.1 Background of the study

Substance is any drug, medication or other ingestible materials that can be harmful or toxic to human body when it is used frequently and inappropriately. According to Diagnostic and statistical Manual of mental disorders 4th edition(DSM-4), substance abuse is a maladaptive pattern of substance use leading to clinically significant impairment or distress. When Substance is used excessively and inappropriately, it can cause temporary change in mood, behavior, emotion and thoughts (American Psychiatric Association, APA, 2000).

In the United States, the most frequently abused substances include tobacco, alcohol, cannabis, opioids, benzodiazepines, barbiturates, hallucinogens, cocaine, stimulants, and various prescription medications (Ignaszewski, 2021). In Africa, the primary abused substances are marijuana (also known as ganja), tobacco, khat, alcohol, cocaine, heroin, and other psychotropic drugs. A study in Nigeria found that the most commonly used substances were alcohol, sedatives, and cannabis (Gureje et al., 2007).

Ethiopia, like many developing countries, faces a growing challenge with substance abuse. Rapid urbanization, socio-economic changes, and increased availability of substances have contributed to this issue, particularly in urban centers like Addis Ababa (Abegaz, 2021, Alebachew et al., 2019, Birhanu et al., 2014, Dida et al., 2014). The commonly abused substances in Ethiopia are alcohol, khat, tobacco, hashish, benzene, benzodiazepines, and opioids such as tramadol and morphine (Teferra, 2018, Weldeyohanes et al., 2021).

Substance abuse can be treated through various treatment modalities. These treatments can be conducted in psychiatric and rehabilitation centers, government and private hospitals, as well as community and spiritual service areas. One approach is inpatient treatment (Félix-Junior et al., 2022), which involves a structured program where individuals admitted at a facility for a specified period of time to receive intensive care and support in a controlled treatment setting.

Another option is outpatient treatment, which allows individuals to live at home while attending therapy sessions and support groups at a treatment facility (Campbell et al., 1997). Rehabilitation treatment is another widely used modality that delivers a range of therapeutic approaches including motivational interviewing designed to help individuals recover from substance use disorders (Tober, 2013). Additionally, the detoxification protocol is a modality that allows the body to remove toxins accumulated from substance abuse and it is usually used in substance withdrawal treatment (Gowing et al., 2017).

Understanding the readiness to change and stages of change is important in addressing substance abuse effectively. The readiness to change to modify substance abuse behaviors and the ability to adapt to different treatment approaches can be understood through the framework of stages of change (Petrocelli, 2002). This concept stems from the Trans theoretical Model, which posits that individual's progress through stages of change: pre contemplation, contemplation, preparation, action, and maintenance (Petrocelli, 2002). In recent years, there has been increasing awareness of the importance of readiness to change in substance abuse treatment. Research shows that individuals with higher readiness levels are more likely to engage in treatment and achieve positive outcomes (DiClemente et al., 2004). Motivation and readiness to change are consistently associated with increased help seeking, treatment adherence and completion of positive substance use disorder treatment outcome (SAMHSA, 2019). A study revealed that readiness to change (RTC) significantly influenced the effectiveness of substance use interventions. In particular, participants who acknowledged that their substance use was a problem and recognized the necessity for change experienced greater decreases in their substance use after the intervention (Myers et al., 2016).

Readiness to change may be influenced by several factors. A study conducted in South Africa revealed that participants who had more recognition of the need for change at the beginning of the intervention may have paid more attention and been more receptive to the treatment content and intervention materials, may have practiced implementing the skills learned during the intervention with more curiosity , and may have sought out additional information about how to

reduce their substance use involvement than participants with lower levels of recognition (Myers et al., 2016). All of these factors may have contributed to participants with higher levels of recognition being more successful at reducing their substance use involvement. Interventions to modify substance use should consider including components that enhance problem recognition and awareness of the need for change (Myers et al., 2016).

Voluntariness in the process of substance abuse treatment is another crucial issue which emphasized the willingness or motivation of abusers to enter to psychiatric and rehabilitation centers (Yazici et al., 2014). A prospective study conducted in Southern Norway reported that, involuntary admitted patients had significantly lower levels of motivation to change than voluntary admitted patients at the time of admission (Opsal et al., 2019). A study carried out in Texas, which primarily examined substance abuse counseling, assessed the notable relationship between treatment resistance among voluntary and involuntary participants in treatment settings. The results indicated that 32% of the participants were coerced or involuntary, while 68% voluntarily sought substance abuse treatment. Additionally, the study revealed that treatment resistance was significantly lower among those who participated voluntarily (Shearer & Ogan, 2002). The purpose of this study was to assess level of readiness to change among people with substance use disorder who are admitted for treatment in psychiatric and rehabilitation centers in Addis Ababa.

1.2 Statement of the problem

The rising production, distribution, promotion, and accessibility of substances, added with evolving societal values and challenges, have led to an increase in substance abuse issues, which have become a significant public health concern globally (Sahu et al, 2012). A recent report from the World Health Organization (WHO) in 2024 reports that alcohol consumption is responsible for approximately 2.6 million deaths annually, representing 4.7% of all deaths, while psychoactive drug use accounts for around 0.6 million deaths. Notably, 2 million of the alcohol-related deaths and 0.4 million of the drug-related deaths occurred among men. Substance abuse poses serious risks to individual health, heightening the likelihood of chronic diseases and mental

health disorders, and contributing to millions of preventable deaths each year. It also places a substantial strain on families and communities, increasing the risk of accidents, injuries, and violence (Stein, 1999; World Health Organization, 2024). Additionally, literature indicates that drug abuse can lead to criminal acts, ranging from theft to violent behavior (Saladino et al., 2021). Substance abuse also has a negative impact on educational acceptance and leads to poor academic achievement (Bojago & Wendimu, 2021).

Substance abuse presents a significant public health challenge in Ethiopia. Among the various substances, alcohol abuse seen as a particularly critical issue, ranking as the sixth leading cause of morbidity and mortality in the country (Gebremedhin et al., 2021). In addition to alcohol, other substances such as khat, tobacco, cannabis, and various illegal drugs are frequently abused, contributing to both mental and physical disabilities (Gebremedhin et al., 2021; Mihretu et al., 2017). The pervasive nature of substance abuse not only affects individual health but also has broader social and economic implications for communities across Ethiopia (Gebremedhin et al., 2021). Addressing this complicated problem requires a comprehensive understanding of the underlying factors contributing to substance abuse, as well as effective intervention strategies tailored to the unique cultural and social context of the country. While treatment services are available in Addis Ababa, their effectiveness is often influenced by factors such as limited resources, stigma, lack of readiness and motivation to treatment (Teffera, 2018).

According to Opsal and his colleagues, Substance individuals with substance use disorder often enter psychiatric and rehabilitation centers facing various challenges, including psychological disorders and social stigma. Also they are often not ready to make the necessary changes for recovery, frequently being unwilling or even involuntary in modifying their addictive behaviors. This can lead to poor treatment outcomes and an increased tendency to relapse after-treatment (Opsal et al, 2019). Low intrinsic motivation during the substance abuse treatment process may increase relapse rates, resulting in feelings of hopelessness and guilt for both clients and their families, which leads to diminishing trust in the treatment. These issues indirectly deplete the time, resources, energy, and manpower of the country. If they are not prepared to change and act,

substance abusers may never fully recover and enjoy the benefits of treatment (Bradshaw et al., 2013).

Major challenges faced by substance abusers for rehabilitation and readiness to change includes lack of awareness of the problem or misconception concerning substance abuse by patients and their families, economic burden, history of multiple relapse, stigmatization of the problem and poor family support (Ali, 2024). Sereta (2016) further examined the significant challenges that substance abusers encounter during rehabilitation. These challenges include the easy accessibility of drugs, their affordability, insufficient resources to combat drug trafficking organizations, a lack of concern from both the government and society, and inadequate professional supervision and inconsistent follow up in rehabilitation centers. Assessing their readiness to change can illuminate the motivations driving their behavior and tailor interventions accordingly (Sereta, 2016). A cohort study conducted within 353 participants reported that, many individuals seek treatment for reasons other than internal motivation to change including family pressure, mandated from the criminal justice system, physical health concern, mental health concern, fear of losing job, tired of using and child custody (Pollini et al., 2006).

Most existing studies in Ethiopia concerning substance abuse have primarily focused on prevalence (Alebachew et al., 2019, Birhanu et al., 2014, Dida et al., 2014), associated factors (Melkam et al., 2023, Tesfaye et al., 2014, Zerihun & Tesema, 2022), and factors associated with relapse after treatment (Abegaz, 2021, Adem et al., 2024,). However, a critical factor that has received no attention in Ethiopian research is the 'readiness to change' among individuals with substance use disorder seeking treatment. The lack of empirical evidence on readiness to change in the Addis Ababa context has several adverse consequences. It makes difficult for treatment providers to accurately assess a patient's motivation, predict their treatment adherence, tailor interventions to their specific needs, and evaluate the effectiveness of treatment programs. This may contribute to higher relapse rates, treatment dropout, and inefficient use of resources.

1.3 Objectives of the study

General objective; to assess readiness to change among people with substance use disorder who are admitted for treatment in psychiatric and rehabilitation centers in Addis Ababa.

Specific objectives;

1. To assess level of readiness to change among substance people with substance use disorder who are admitted for treatment in psychiatric and rehabilitation centers

2. To explore factors influencing readiness to change among people with substance use disorder who are admitted for treatment in psychiatric and rehabilitation centers.

3. To identify the factors that significantly predicts the readiness to change among people with substance use disorder

4. To assess the level of voluntariness of substance abusers who are admitted for treatment during the time of admission.

1.4 Research questions;

1. Are people with substance use disorders (SUD) who are admitted for treatment in psychiatric and rehabilitation centers ready for treatment?

2. What factors influence readiness to change among people with SUD who are admitted for treatment in psychiatric and rehabilitation centers?

3. What demographic factors are associated with readiness to change among people with SUD who are admitted for treatment in psychiatric and rehabilitation centers?

4. Are people with SUD who are admitted for treatment in psychiatric and rehabilitation centers volunteer during the time of admission?

1.5 Significance of the Study

The readiness and motivation to change are critical factors in the effective treatment of substance abuse. This study holds particular significance as it aims to assess the levels of readiness and voluntariness among substance abusers to engage in treatment at selected psychiatric and rehabilitation centers. By exploring these factors, the research gives valuable insights for participants, their families, and mental health professionals regarding the impact of readiness for change on treatment outcomes. Furthermore, the findings may inform the development of

appropriate treatment that enhance motivation and support individuals in their recovery journey. Ultimately, this study seeks to contribute to the broader understanding of how readiness for change can influence not only individual recovery but also the effectiveness of treatment programs within the mental health field. The findings from this study contribute valuable insights to the treatment processes for substance abusers in Addis Ababa. By understanding the factors that influence readiness to change, mental health professionals and policymakers can better deliver interventions and support systems to enhance rehabilitation outcomes for clients struggling with addiction.

1.6 Scope of the Study

Substance abuse represents a significant challenge that adversely affects individuals' social, mental, economic, spiritual, and physical well-being. This study primarily focused on assessing the readiness to change among substance abusers who are admitted for treatment at Jadber, New life and EPOS psychiatric and rehabilitation centers in Addis Ababa.

1.7 operational definitions of terms

1. **Readiness to Change**: refers to an individual's commitment and motivation to alter their addictive behavior as measured by SOCRATES scale.

2. **Taking Steps**; refers to the actions that substance abusers begin to implement in order to change their addictive behaviors, indicating a proactive approach toward recovery as measured by SOCRATES , taking step sub scale.

3. **Recognition**: is the awareness that individuals have regarding their substance abuse problem and its consequences on their lives as measured by SOCRATES, recognition sub scale.

4. **Ambivalence**: refers to the uncertainty or mixed feelings that substance abusers may experience regarding their substance use and the desire to change as measured by SOCRATES, ambivalence sub scale.

5. **Psychiatric and Rehabilitation center**; is a place for people to recover from mental and substance use disorder and to rejoin to real life.

6. **Substance abuse**; is the harmful use of psychoactive substances including alcohol and other illicit drugs.

CHAPTER-TWO

REVIEW OF RELATED LITERATURES

2.1 substance abuse, substance related disorders and treatment modalities

2.1.1 Substance abuse and substance related disorders

The DSM-IV defines substance abuse as a maladaptive pattern of substance use leading to significant impairment or distress, evidenced by recurrent use resulting in failure to meet obligations, hazardous situations, legal problems, or continued use despite social issues (American Psychiatric Association, APA, 2000). Substance-related disorders are categorized into substance use disorders and substance-induced disorders. The DSM-5-TR defines substance use disorder to include both prescribed medications and uncontrolled consumption. Symptoms include consuming larger amounts than intended and a persistent desire to cut down (APA, 2022).

Substance/medication-induced mental disorders arise from the physiological effects of substances on the central nervous system, encompassing a range of conditions, including psychotic disorders, mood disorders, personality disorders, anxiety disorders and other common mental disorders (APA, 2022). It is common for individuals to be diagnosed with both mental disorders and substance use disorders simultaneously, a phenomenon often referred to as comorbidity (Palomo et al., 2007; Roberts et al., 2007).

A study conducted in the Netherlands identified several risk factors associated with the comorbidity of mood disorders, anxiety disorders, and substance use disorders. The findings suggested that female gender, younger age, low educational status, unemployment, and childhood trauma were significant contributors to this comorbidity (De Graaf et al., 2002). Supporting these findings, a study involving 158 male inpatients in Egypt examined risk factors linked to comorbid psychiatric disorders and substance use. The results revealed that 60% of the participants were diagnosed with common mental disorders, with 26% exhibiting psychosis and

21% diagnosed with borderline personality disorder. The researchers noted that factors such as unemployment, a history of childhood abuse, high levels of cannabis, opioid, and tramadol abuse, frequent overdosing, prolonged hospitalization, aggressive behavior, family dysfunction, and occupational and legal issues were significantly more prevalent among patients with comorbidity. Furthermore, they identified predictive risk factors for comorbidity, including familial problems, aggressive symptoms, cluster B personality traits, past psychiatric disorders, longer length of stay in hospital, and lower Global Assessment of Functioning scores (Khalil et al., 2019).

A study conducted in northwest Ethiopia also identified factors associated with anxiety disorders and substance abuse. The findings revealed that low educational status, parental loss, friends' substance abuse, and low family support were associated with both anxiety disorders and substance abuse. In contrast to the aforementioned studies, this study found that being male was significantly associated with the comorbidity of anxiety disorders and substance abuse (Melkam et al., 2024).

2.1.2 Treatment modalities for substance use disorders

Researchers categorized alcohol and drug treatment modalities into several distinct approaches (McLellan, 1982, Mojtabai & Zivin, 2003,). The combined treatment for alcohol and drug addiction in inpatient treatment is one of a short-term treatment program lasting 45 days or more depending on the severity of substance abuse, focusing on intensive addiction management therapy (McLellan, 1982). This method aims to address both alcohol and drug dependencies simultaneously. Another modality is the drug/alcohol abuse rehabilitation, which encompasses the physical, psychological, social, and environmental dimensions. Rehabilitation interventions include health assessment, psychological assessments, health education, addiction counseling, group therapy, family therapy, client and family monitoring, relapse prevention therapy, and post rehabilitation services, emphasizing personal development and social skills necessary for recovery (Utomo et al., 2024). Additionally, the outpatient treatment service serves as an accessible option for individuals seeking help while maintaining their daily routines ranging in length from 2 month to 1 year (Winters et al., 2011). These treatment methods illustrate a range

of interventions tailored to meet the varying needs of individuals struggling with substance use disorders, promoting a comprehensive approach to addiction recovery (Mojtabai & Zivin, 2003).

Substance abuse treatment can be delivered through various therapeutic techniques and orientations in the settings/ approaches mentioned earlier. Winters et al. (2011) assessed the most commonly used therapeutic models, which include family-based therapy, individual therapies such as cognitive-behavioral therapy (CBT), motivational interviewing, contingency management reinforcement, group therapy, therapeutic communities (long-term residential programs), and pharmacotherapy. Additionally, Breslin et al. (2003) investigated holistic approaches to substance abuse treatment. They found that holistic treatment develops personal growth through self-exploration, appropriate emotional expression, recognition of challenging emotional states, and the development of more adaptive strategies for soothing and comforting the mind, body, and spirit. The treatment aspects they discussed include dance/movement therapy, art therapy, leisure and recreational therapy, spiritual growth and development, cultural awareness and appreciation, vocational rehabilitation services, psychiatric care, and physical health (Breslin et al., 2003).

2.2 Concept of Readiness to change, stages of change in substance abuse treatment

A foundational model for understanding readiness to change is the Trans theoretical Model (TTM), often referred to as the Stages of Change model which originally developed by Prochaska and DiClemente in the 1970s (DiClemente et al. 2004, Northeast and Caribbean Addiction Technology Transfer Center (ATTC), 2021). This model posits that individuals move through a series of stages when modifying problematic behaviors, including substance use (DiClemente et al. 2004). Understanding stages of change in the process of substance abuse treatment encourages therapists and other mental health professionals to teach their patients the stages and specific tasks and to evaluate themselves whether they are ready to move forward (ATTC, 2021). This model outlines stages individuals go through when changing behavior: pre contemplation, contemplation, preparation, action, and maintenance. Assessing where an individual falls within these stages can significantly affect treatment planning and outcomes.

This model has been widely adopted to evaluate an individual's readiness for change. According to Connors et al. (2013), the TTM effectively addresses this readiness. The stages are defined as follows. The first stage, **Pre contemplation**, is characterized by a lack of awareness of a problem or a denial of its existence. Individuals in this stage are not considering change in the foreseeable future (ATTC.2021, Connors et al. 2013).The second stage, **Contemplation**, involves an awareness of the problem and a consideration of the possibility of change. Individuals in this stage are often ambivalent, weighing the pros and cons of substance use against the pros and cons of change (ATTC.2021, Connors et al. (2013). **Preparation**, the third stage, is marked by a decision to change and the initiation of small steps towards that goal. Individuals in this stage intend to take action in the near future (ATTC.2021, Connors et al. (2013). The fourth stage, **Action**, is when individuals actively implement behavioral changes to stop or reduce their substance use (ATTC.2021, Connors et al. (2013). **Maintenance**, the fifth stage, involves sustaining the changes made and working to prevent a return to previous substance use patterns (ATTC.2021, Connors et al. (2013). Finally, **Relapse** is sometimes considered a sixth stage, representing a return to old behaviors (ATTC, 2021).

Readiness to change, in the context of substance use, can be defined as the degree of an individual's motivation, willingness, and preparedness to initiate and sustain specific behavioral alterations aimed at reducing or eliminating their substance use (DiClemente et al. 2004). This concept acknowledges that change is a process, not an event, and that individuals exist along a continuum of motivation. (Witkiewitz,et al., 2022). Readiness to change and readiness for treatment are indeed distinct concepts often explored in research. While readiness to change focuses on an individual's intrinsic motivation and willingness to alter behavior, readiness for treatment, as defined by DiClemente et al. (2004), centers on a person's motivation to seek help, preparedness for engaging in treatment activities, and the influence these factors have on treatment attendance, compliance, and overall outcomes. Emphasizing both concepts enriches the discussion and facilitates improved patient care strategies in substance use treatment and rehabilitation contexts. Understanding a person's readiness is essential, as it informs tailored interventions that enhance motivation and engagement, ultimately improving treatment

adherence and success rates. Addressing readiness can lead to more effective strategies that meet individuals where they are in their journey toward recovery (Rapp et al., 2007).

Weiner (2020) proposed that readiness encompasses both psychological and behavioral preparedness. Beasley et al. (2021) further elaborate, stating that readiness for change is a multifaceted construct influenced by both structural (e.g. socioeconomic status, drug use severity, access to substances, family and community support) and psychological factors (e.g. emotional distress, self-efficacy, trauma, mental health conditions) (Alley et al., 2013, Ghouchani et al., 2016,). Collectively, these perspectives highlight that readiness to change is not a one-dimensional concept, but rather a complex interplay of personal awareness, belief in one's capabilities, and external influences that drive behavioral transformation (Beasley et al. 2021).

Miller and Rollnick (2013) proposed that motivational interviewing helps to address the challenges that mental health professionals face when exploring substance abusers' motivations for change. During the change process, ambivalence may arise; individuals may have a desire to change while simultaneously resisting it, which is a natural human condition. They suggest that ambivalence is a common obstacle encountered on the path to change. Motivation is not static and may vary with time. Patients can change from one moment to another according to perceived environmental stimuli and from internal motivation (Opsal et al., 2019).

The follow up of treatment for substance use disorders (SUD) is frequently motivated by external pressures, such as demands from family members, legal obligations, or employer requirements (Edlund et al. 2012, Mihretu et al., 2017), rather than internal motivation. While individuals with more severe problems related to SUD are more inclined to seek help (Edlund et al. 2012), it’s important to acknowledge the impact of social networks, which can either encourage or hinder both substance use and the decision to seek treatment (Longabaugh et al. 2010). However, the method of entering treatment does not necessarily dictate treatment outcomes; studies show that forced individuals often achieve results comparable to those who enter treatment voluntarily (Weisner et al. 2009). A qualitative research study involving 30 participants at a substance use

disorder rehabilitation center in the USA revealed that clients were driven to seek treatment due to their perceived vulnerability to the issue, recognition of its severity, and consideration of potential barriers and benefits. Additionally, motivations included the desire to avoid legal trouble, gain opportunities for an improved life, and strive for a brighter future (Dillon et al., 2020).

A prospective study conducted in the south-eastern part of Norway by Opsal et al. (2019) investigated the stages of readiness to change between involuntarily and voluntarily admitted patients in substance treatment. The findings revealed that a significant majority of patients were positioned in the highest readiness stage to seek treatment. This was consistent with a quantitative study in Indiana, USA, involving 197 participants, indicated that regarding readiness to change, 21.8% were in the pre contemplation stage, 65% in the contemplation stage, and 13.2% in the action stage. The findings suggested that those in the re-entry and recovery programs experienced improved treatment outcomes when they had higher baseline readiness to change scores. Additionally, a strong commitment to action was found to significantly predict the success of the program (Watterson et al., 2024). Another study found that majority of participants exhibited high readiness in the dimensions of recognition, taking steps to change, and recovering from drug addiction (Opsal, 2019). This was supported by a study conducted in Cape Town, South Africa, focused on psychiatric morbidity and readiness for change, examining the factors associated with this readiness. The findings indicated that 60% of the participants were in the "Taking Steps" stage of readiness. Additionally, the research identified several factors related to readiness for change, including gender, religious affiliation, previous psychiatric history, treatment duration, leisure activities, and educational status (Akindipe, T. 2011). However, many participants also expressed ambivalence regarding their readiness to change. Ambivalence refers to the uncertainty or indecision about whether one is prepared to change and recover from substance abuse.

2.4. Readiness to Change in Ethiopian Rehabilitation Centers

While an examination of the existing research, there were no studies that directly assess "readiness to change" among substance abusers admitted to rehabilitation centers in Ethiopia.

The existing research in this area primarily focuses on the prevalence of substance use (Alebachew et al., 2019, Birhanu et al., 2014,), the identification of associated risk factors (Melkam et al., 2023, Tesfaye et al., 2014), and the factors contributing to relapse after treatment (Adem et al., 2024). While direct measurement of readiness to change might be lacking, these related studies offer valuable indirect insights into the motivational landscape of individuals undergoing substance abuse treatment in Ethiopia.

Studies investigated relapse among substance abusers who have completed treatment in Ethiopian rehabilitation centers provide some clues about the initial readiness to change and the factors that might influence its maintenance (Abegaz, 2021, Adem et al., 2024, Shiferaw, 2021). For instance, a study conducted in the Tigray region of Ethiopia found that resentment against confinement at rehabilitation centers was reported among individuals who had previous assisted attempts at quitting (Adem et al., 2024). This suggests that for some clients, particularly those who has been admitted involuntarily, the initial intrinsic motivation and therefore readiness to change process could be lower. Furthermore, the same study noted that rehabilitation should ideally be initiated with the motivation of the individual, followed by awareness delivery for the family and avoidance of unnecessarily long stay in the rehabilitation center without the individual's consent (Adem et al., 2024). This conclusion gives clue to the critical role of pre-treatment motivation, which is closely linked to readiness to change, in the overall success of the rehabilitation process.

Emotional instability and a lack of family cooperation were identified as key reasons for relapse (Adem et al., 2024). This implies that addressing these issues during the rehabilitation process could enhance an individual's readiness to cope with challenges and maintain their commitment to change post-discharge. Additionally, the finding that individuals hospitalized for shorter durations (one to three months) were more likely to relapse compared to those with longer stays suggests that sufficient time in treatment might be necessary to foster and solidify an individual's readiness for long-term change (Adem et al., 2024). Adem et al., (2024), further highlights the importance of intrinsic motivation and initial readiness in predicting treatment outcomes. The emphasis in relapse prevention strategies on providing support, care, and a positive attitude

(Adem et al., 2024) also points to the need to enhance and maintain readiness to change throughout the rehabilitation process.

2.3 Factors influencing readiness to change

The readiness to change is influenced by various factors, including social support, personal motivation, mental health status, and previous experiences with treatment (Bradshaw et al., 2013, Chang et al., 2020). Holt et al. (2010) examined various factors that influence readiness to change, distinguishing between individual and organizational levels. They categorized these factors into psychological and structural elements. Psychological factors encompass aspects such as low self-efficacy, a reliance on external motivation (as opposed to intrinsic motivation), and the apprehension of relapse. On the other hand, structural factors pertain to the context in which change is taking place, specifically how these conditions can either facilitate or obstruct the process of implementing change. Bradshaw et al. (2013) also investigated how individual traits such as hope and resilience, as well as family dynamics and cravings, affect readiness to change. Their findings indicated that hope and cravings significantly influence readiness to change, whereas no significant effects were observed for family functioning and resilience (Bradshaw et al., 2013).

Several studies have indicated that readiness to change is linked to self-efficacy (Chang et al., 2020, Demmel et al., 2004, Moeini et al., 2020). One study found that the initiation of behavior change, as evidenced by high scores in taking steps, was associated with the expectation of successfully managing high-risk or stressful situations (Demmel et al., 2004). Consequently, low self-efficacy may be a significant factor influencing readiness to change in substance abuse treatment (Demmel et al., 2004).

The comorbidity of mental illnesses and substance use disorders (SUD) is another factor influencing readiness to change, as highlighted in several studies (Chang et al., 2020, Morris et al., 2018). According to DiClemente et al. (2007), individuals with two or more diagnosable psychiatric conditions often exhibit lower motivation for substance abuse treatment. This is because they tend to prioritize addressing their mental health issues during hospitalization and may avoid all forms of treatment after discharge. Additionally, the severity of mental illness can

lead to more dysfunctional thought processes, impaired decision-making, critical thinking deficits, and a lack of insight, all of which hinder the ability to recognize the need for treatment and diminish readiness to change regarding substance abuse. Consequently, comorbid mental disorders significantly impact an individual's readiness for SUD treatment (DiClemente et al. 2007).

Social or familial support plays a crucial role in an individual's recovery from substance use disorders (Cavaiola et al., 2015). A cross-sectional study conducted in Taiwan with 87 patients diagnosed with alcoholic liver disease found several factors that affect readiness to change concerning alcohol abuse treatment. The findings indicated that poor social support, the severity of alcohol consumption, and age significantly influence an individual's readiness to pursue change (Chang et al., 2020). Additionally, Cavaiola et al. (2015) noted that social support not only aids in the decision to start treatment but also helps individuals maintain their abstinence..

A study involving 70 patients in Northern Nigeria identified personality traits as predictors of readiness to change among individuals with substance use disorders seeking treatment. The findings revealed that traits such as openness to experience, conscientiousness, extraversion, and neuroticism did not significantly predict recognition, ambivalence, or the taking of steps toward recovery. In contrast, agreeableness was found to negatively predict recognition but positively predicted taking steps; however, it did not significantly influence ambivalence (Oguizu et al., 2019). Conversely, Shahrazad et al. (2010) examined the predictive relationship between personality traits and readiness to change among drug addicts in Malaysia. Their study indicated that neuroticism and psychoticism significantly predicted recognition, ambivalence, and the taking of steps toward recovery. They concluded that personality traits were significant predictors of readiness to change among drug addicts (Shahrazad et al., 2010).

A mixed research study conducted at Amanuel Mental Specialized Hospital in Addis Ababa, Ethiopia, focused on the prevalence of drug addiction relapse and its associated risk factors among substance users. The study found that the reasons for quitting drug use after treatment included feelings of guilt (43.9%), other health problems (37.8%), family pressure (29.6%), disharmony with family (26.5%), financial problems (24.5%), and non-availability of drugs

(Abegaz, R., 2021). This study was supported by a mixed-method exploratory research conducted in Addis Ababa, Ethiopia, which examined the reasons individuals chose to stop or reduce their khat consumption. Key factors identified included time wastage, psychological dependence, pressure from family and friends, as well as the overall health impacts and psychosocial and economic harms associated with khat chewing (Mihretu et al., 2017).

2.5 Voluntary and involuntary admission for substance abuse treatment

Voluntary admission is often the preferred approach and primary pathway to treatment. However, in the field of substance use disorders (SUD), voluntary admission may not always yield the desired positive outcomes, leading some patients to persist in harmful substance use patterns. In such cases, various options exist for implementing compulsory or involuntary inpatient drug treatment based on the medical needs of the patient, rather than relying on legal measures to compel treatment through the criminal justice system (Pasareanu et al., 2017).

Voluntarily admitted patients are typically seen as more motivated and cooperative in their treatment and rehabilitation process compared to those who are admitted involuntarily (Opsal et al., 2013). A prospective study examined the readiness to change in 65 involuntarily admitted patients and 157 voluntarily admitted patients at addiction centers in southern Norway. The results indicated that involuntarily admitted patients exhibited a significantly lower level of motivation to change compared to their voluntarily admitted counterparts at the time of admission (Opsal et al., 2019).

A cross-sectional study which investigated the factors linked to the involuntary admission of substance abusers to hospitals. The findings indicated that females, individuals with severe substance use patterns, those who frequently visited physicians for physical complaints, and patients with co-occurring mental disorders were more likely to be admitted involuntarily. The study also noted that diagnoses involving poly drug use were more prevalent among involuntarily admitted patients. Additionally, it was found that the injection of illicit drugs,

repeated overdose incidents, and poly drug use were associated with involuntary hospitalization (Opsal et al., 2013).

Racine and Rousseau-Lesage (2017) highlighted that risk-taking behaviors and harmful actions do not necessarily oppose the capacity for voluntary decision-making in individuals struggling with addiction. Their study suggests that addiction, as it is typically understood, impairs an individual's ability to make informed choices or exercise self-control regarding substance use. This perspective considers both internal factors (such as cravings) and external influences (like perceived freedom related to available options) that impact decision-making. Therefore, similar to other elements of autonomous choices—such as the level of information available—voluntariness can vary significantly (Racine & Rousseau-Lesage, 2017).

Involuntarily admitted patients are more likely to relapse after rehabilitation than voluntarily admitted patients (Huang et al., 2021). A cross-sectional study conducted in Brazil evaluated the association between relapse and admission type (voluntary vs. involuntary). The findings of the study revealed that there was no significant difference between individuals who were admitted involuntarily and those who were admitted voluntarily in terms of relapse (Sant'Anna et al., 2020), which contradicts the conclusions of the aforementioned study. Another prospective study investigated treatment outcomes related to drug use at a six-month follow-up for inpatients undergoing substance use disorder (SUD) treatment, comparing those admitted voluntarily and involuntarily. The findings indicated that patients who were voluntarily admitted experienced better outcomes; however, the study also noted positive treatment results among patients who were admitted involuntarily (Pasareanu et al., 2016).

CHAPTER THREE

METHODOLOGY

3.1 Research Approach

The study was conducted using mixed research approach. According to Saraswati and Devi, Mixed methods research approach is an innovative and increasingly popular approach in the field of social sciences, designed to bridge the gap between qualitative and quantitative research paradigms (Saraswati &Devi.., 2023). . Furthermore, most research relies heavily on quantitative methods, offering limited insights into participants' experiences. This study addressed these gaps by employing a mixed-methods approach. This method was used to obtain a clearer picture from the quantitative data, and then to use the qualitative data to provide better understanding and explanation of the study in question.

3.2 Research Design

Many existing studies use longitudinal methods, which are time-consuming and costly, posing challenges for researchers in developing countries like Ethiopia. This research assessed the readiness to change among substance abusers in psychiatric and rehabilitation centers using sequential explanatory research design. Initially, quantitative data was collected and analyzed to identify trends and patterns related to readiness to change. Following this, qualitative data were gathered to explore and assess readiness to change, factors influencing readiness to change and experiences that contribute to these patterns, thereby provided deeper insights into the participants' perspectives.

3.3 Participants

The participants of the quantitative study were individuals diagnosed with substance use disorders who were admitted for treatment in selected psychiatric and rehabilitation centers in Addis Ababa during the time of data collection. The participants of the qualitative part were individuals with substance use disorder who are admitted for treatment in these rehabilitation

centers who are not participated in the quantitative data collection and key informants (mental health professionals) who worked in the rehabilitation centers.

3.4 Inclusion Criteria

Participants were included in the study with the following criteria:

• A confirmed diagnosis of substance use disorder based on DSM-5.

• Currently admitted for treatment in rehabilitation centers.

• Willingness of participants during the time of data collection

3.5 Exclusion Criteria

Participants were excluded from the study based on the following criteria:

• Presence of severe psychotic disorders (e.g., agitation, aggression, disorganization).

• Severe neurocognitive disorders like dementia that impedes participation.

• Age less than 18 years or older than 60 years.

• Unwillingness of participants during the time of data collection

3.6 Sampling Technique

A census method was employed to conduct the study with those who met the inclusion criteria. Individuals who met the inclusion criteria during the time of data collection were selected for the study. The census method was chosen for reasons like the participants were small, number of individuals with SUD from each study area were within the range of 15 to 25. The researcher reviewed patient charts and consulted with attending physicians or mental health professionals to gather necessary information regarding the diagnosis and substance abuse status of potential participants. The participants for the qualitative study were selected purposively by the researcher. Individuals with SUD were selected based on their willingness, good understanding of the problem and history of poly substance abuse which gave the researcher deeper

experiences. The key informants were selected from different disciplines based on their long experience in the rehabilitation centers.

3.7 Sample Size

The quantitative study was conducted with a total of 60 participants from three psychiatric and rehabilitation centers. There were 16 individuals with substance use disorder in New Life rehabilitation center; from this 15 participants were involved in the study. One participant was excluded due to age less than 18. There were 35 individuals with substance use disorder in EPOS at the time of data collection, of them the participants of the study were 25. The 10 individuals were excluded due to age, unwillingness and presence of comorbid psychotic disorders which were restless and uncooperative. There were 20 individuals with substance use disorder in Jadber and all of them were recruited for the study.

Additionally, 3 substance abusers and 3 mental health professionals were recruited from these study areas for the qualitative study. The researcher conducted in-depth interviews and key informant interviews with them respectively.

3.8 Study Area

The research was conducted in three selected psychiatric and rehabilitation centers:

1. **New Life Substance Rehabilitation Center**

This rehabilitation center is a charity organization which was established on August, 2017 (8 years ago). This rehabilitation center is located in Gullele sub city, Addis Ababa and works in collaboration with St. Paul hospital millennium medical college. The individuals with substance use disorder are first assessed and admitted from St. Paul hospital millennium medical college. The average length of stay in the rehabilitation center is 2- 3 months. The total number of beds in the center is 25. The services delivered in this rehabilitation centers are individual therapy, group therapy, art and music therapy.

2. **EPOS mental and substance rehabilitation center.**

Ethiopian prosthetics and orthotics services mental and substance rehabilitation center is one of the biggest and well organized governmental mental and substance rehabilitation center which was established in 1982. It is located in Addis Ketema Sub city in Addis Ababa. It delivers a holistic treatment for psychiatric patients and individuals with SUD including medication therapy, art therapy, group therapy and occupational therapy. There are a total of 288 beds, of these 72 beds are for substance abuse rehabilitation.

3. **Jadber Psychiatry and Rehabilitation Center**

Jadber psychiatry and rehabilitation center is a known private rehabilitation center which was established in 2017 G.C. it is located in Lafto sub city in Addis Ababa. The total number of beds in the center is 28. There were 20 substance abusers at the time of data collection and all of them were recruited for the study. Individual therapy, group therapy, medication therapy, art and music therapy are services delivered in this rehabilitation center.

These centers have been chosen purposively based on criteria such as high patient flow in substance treatment, quality of care provided, presence of multidisciplinary treatment approach and early establishment.

3.9 Data Collection Tools and measures

The quantitative data were collected by using the following tools from 19 Feb 2025 to 1 Mar 2025. All the data collection tools were translated to Amharic by two mental health professionals and one English teacher and then translated back to English for comparison with the original English version of the tool.

• Quantitative Data: A self-administered questionnaire was developed for the purpose of this study to assess various factors related to readiness to change, including demographic

information, substance use history, and stages of change readiness and treatment eagerness scale (SOCRATES) questionnaires.

The demographic data collection encompassed various factors to provide a comprehensive profile of participants. Key components include: age, sex, marital status, residence, religion, educational status, occupation, health status and length of stay. Detailed substance use history was captured: type of substance abused, onset of abuse, duration of abuse, frequency and amount of abused substances, level of voluntariness during time of admission.

SOCRATES; is a 19-item tool designed to assess readiness for change among substance abusers. It covers multiple dimensions of readiness to change (Recognition, Ambivalence, Taking Steps), providing a well-rounded assessment of an individual's readiness to change their addictive behavior. It consists of two parts; version 8A, focused on alcohol use, and version 8D, focused on drug use (Miller, & Tonigan, 1996).

Administration: The scale was administered as a self-report questionnaire, It typically employs Likert-type response options (ranging from strongly disagrees to strongly agree), allowing respondents to express their level of agreement with various statements about their readiness for change.

Scoring: Scores were recorded on the SOCRATES Scoring Form, and each column's sum yields the three scale scores. High scorers in Recognition acknowledge substance-related problems and express a desire for change, while low scorers may deny issues. High scorers in Ambivalence reflect uncertainty about their substance use, indicating openness to reflection, while low scorers do not question their use. For Taking Steps, high scorers are actively engaged in positive changes, predictive of successful outcomes, whereas low scorers report inaction and don’t want to make changes and go forward regarding their substance use (Miller, W. R., & Tonigan, J. S., 1996).

The tool has been validated in various studies, demonstrating strong reliability and validity. (Miller, & Tonigan, 1996, Mohammed, et.al. 2024, Burrow-Sánchez et al., 2018). Reliability; it has had good internal consistency. From the current study the internal consistency based on Cronbach’s alpha were 8A; recognition - 0.787, ambivalence - 0.672, taking steps - 0.861 and

8D; recognition - 0,86, ambivalence - 0.641 and taking steps 0.803 respectively. This is consistent with Miller, & Tonigan's range (Ambivalence; 0.6-0.88, recognition; 0.85-0.95 and taking steps; 0.83-0.96). SOCRATES showed acceptable face and content validity (Burrow-Sánchez et al., 2018, Mohammed, et.al. 2024).

• Qualitative Data: it was conducted from 15 April 2025 to 20 April 2025. In-depth interviews and key informant interview was conducted with 3 purposively selected participants and 3 key informants respectively from the three study areas to gather detailed information regarding their experiences with substance use, treatment processes, level of voluntariness, factors influencing their readiness and perceptions of readiness to change. The interview was conducted with audio recording in Amharic and it was transcribed then translated to English by mental health professionals. The credibility of qualitative interview findings was checked through peer debriefing.

3.10 Data Analysis

• Quantitative Data Analysis: the quantitative data were analyzed through SPSS version 26. The socio demographic data and SOCRATES sub scales were analyzed using descriptive statistics such as mean, standard deviation and frequency to summarize participant characteristics and readiness levels. Inferential statistics like independent samples t test and multiple linear regression were used. The independent samples t test was used to compare the difference between readiness to change within 3 sub scales between those who were voluntarily and involuntarily admitted alcohol and substance abusers and multiple linear regression was used to assess predictors of readiness to change using the 3 sub scales; ambivalence, recognition and taking steps as dependent variables and several independent variables like age, educational status, occupation, health status and length of stay in the rehabilitation center.

• Qualitative Data Analysis: The qualitative data obtained from in-depth interviews were analyzed using thematic analysis. This process involves, coding the data , identifying themes and patterns, and the findings were interpreted to understand the participants' experiences and motivations related to readiness to change, their level of voluntariness and factors influencing their readiness.

The quantitative and qualitative findings were integrated at the interpretation stage. This was performed using qualitative data to explain and further explore the quantitative results, and developed a more holistic understanding of readiness to change, level of voluntariness and factors influencing readiness to change.

3.11 Ethical Considerations

Support letter was obtained from Addis Ababa University, School of Psychology and was submitted to each study site. Prior to the data collection procedure, all study areas gave permission. Informed consent was obtained from all participants; the researcher ensured the participants that they understand the purpose of the study, their right to withdraw at any time, and the confidentiality of their responses.

CHAPTER FOUR

FINDINGS

The findings of this sequential explanatory mixed-methods study are presented with the quantitative findings further explored by qualitative. The following section details the socio-demographic characteristics of the participants (n=60), their level of voluntariness upon admission, their assessed readiness to change across the subscales of ambivalence, recognition, and taking steps, and the quantitative assessment of factors influencing their readiness, which will be further explored and contextualized by the qualitative findings.

4.1 Socio demographic Characteristics of Participants

The socio-demographic characteristics of the participants (n=60) as examined in Table 1 revealed that the study sample was predominantly male (93.3%), with a wide range of educational backgrounds but a majority holding a certificate (43.3%). Most participants were single, identified themselves as Orthodox, and are currently employed. The vast majority resides in urban areas, and the length of stay in the rehabilitation center varies considerably among participants with a minimum length of stay of 3 days and a maximum of 90 days at the time of data collection. The participants' health status indicated that majority of the participants report ‘no health problem’ but (38.3%, n=23), reported experiencing health issues with the most frequently mentioned concerns being mental health-related, including anxiety, depression, and sleep disturbances.

The substance abuse history of the participants in this study was characterized by a long duration of abuse, with over half reporting more than 10 years of substance use. There was a high rate of poly substance abuse, with alcohol being the most frequently mentioned single substance. Furthermore, the pattern of use was predominantly daily

Table 1; socio demographic characteristics of participants

Socio demographic variables		Frequency	Percent
Sex	Male	56	93.3
	Female	4	6.7
Educational status	Certificate	26	43.3
	Diploma	10	16.7
	Bachelor's degree	14	23.3
	Master's degree	3	5.0
	Doctorate degree	2	3.3
	Others	5	8.3
Marital status	Single	36	60.0
	Married	14	23.3
	Divorced	8	13.3
	Widowed	1	1.7
	Separated	1	1.7
Religion	Orthodox	39	65.0
	Protestant	9	15.0
	Islam	7	11.7
	Catholic	2	3.3
	Others	3	5.0
Occupation	Employed	26	43.3
	Unemployed	20	33.3
	Student	4	6.7
	Retired	4	6.7
	Others	6	10.0
Residence	Rural	3	5.0
	Urban	57	95.0

Table 2 ; other socio-demographic characteristics of respondents

Do you have any health issue?	**Yes**	**23**	**38.3**
	No	**37**	**61.7**
Did you choose to enter this center voluntarily?	**Yes**	**40**	**66.7**
	No	**20**	**33.3**
Types of substances abused	**Alcohol**	**11**	**18.3**
	Khat	**2**	**3.3**
	Cannabis	**3**	**5.0**
	Tobacco	**3**	**5.0**
	More than one substance	**41**	**68.3**
Frequency of substance abuse	**Daily**	**53**	**88.3**
	Weekly (once, twice...)	**6**	**10.0**
	Occasionally	**1**	**1.7**
Duration of substance abuse	**Less than 1 year**	**1**	**1.7**
	1-3 years	**7**	**11.7**
	4-6 years	**11**	**18.3**
	7-10 years	**10**	**16.7**
	more than 10 years	**31**	**51.7**

Table 3; socio demographic characteristics of the qualitative respondents

Code	Sex	Age	Educational status	Occupation	Work experience(in year)	Length of stay(in days)	Type of substance abused(for substance abusers)	Duration of substance abuse(for substance abusers) (in years)
JC	M	21	12	Student		21	Cigarrete, khat, cannabis	3
JP	M	69	Doctorate	Expert psychiatrist	40			
NLC	M	30	10	Merchant		14	Cigarrete, khat, alcohol	10
NLP	F	29	Master	Psychologist	5			
GC	F	39	10	Sanitary	4	37	Alcohol, khat, Cigarrete	4
GP	M	34	Master	Mental health specialist	9			

4.2 Level of voluntariness during the time of admission in the rehabilitation centers

The quantitative data indicates that when asked, "Did you choose to enter this psychiatric and substance rehabilitation center voluntarily? A significant majority of the participants (66.7%, n=40) responded "Yes." On the other hand, 33.3% (n=20) of the participants indicated "No,"

suggesting their entry was not voluntary. This level of voluntariness was further explored by the interview from three substance abusers and three key informants (mental health professionals).

Theme 1: Level of Voluntariness during Time of Admission

This theme explores the circumstances of the participants' admission to the substance rehabilitation center, focusing on the extent to which their entry was self-initiated or influenced by external pressures. The analysis of interview data revealed two primary sub-themes: Self-initiated Admission/Voluntary and External Pressure/Involuntary.

Sub-theme 1.1: Self-initiated Admission/Voluntary

This sub-theme gives instances where participants reported making their own decision to seek treatment at the rehabilitation center. While the data suggests this was not the most common pathway, some participants, particularly the mental health professionals, implied to its occurrence, although infrequently.

Mental health professional GP noted, "…*some of them enter voluntarily*." However, this was often presented as a less frequent occurrence compared to externally driven admissions. Another professional, JP, elaborated on the complexity of voluntary admission, stating, "*There are very few people who enter voluntarily, some who agree to it in time and leave, some who start again, and some who come again*." This suggests that even when initial agreement exists, the journey of recovery and resilience with treatment can be complex and non-linear.

Sub-theme 1.2: External Pressure / Involuntary

This sub-theme highlights the significant role of external factors in the participants' admission to the rehabilitation center. Several sources of pressure were identified:

Pressure from Employers: One client, GC, explicitly stated a lack of personal decision, explaining, "*It wasn't my decision. I didn't want to quit the addiction. It was the same thing that happened when they brought me; it is for the sake of not losing my job and said I would be*

fired." This indicates that the threat of job loss served as a primary motivator for entering treatment.

Due to Family Pressure: Family influence emerged as a prominent factor across both client and professional accounts. Client GC shared, "*Around February of this year, my family put me on Alert hospital before I came to here. It wasn't inside me that I stopped it was for the family. I was there, and then I went back and continue*." This statement directs a sense of compliance driven by familial intervention rather than internal motivation. Mental health professional GP corroborated this, stating,

> *Most of them entered to our rehab center due to family pressure. There are patients who come to them with promises from some families; for example, family members might say to the client, 'after you go there and get treated, we will do this for you, buy you a car, etc.,'...and the balance is due to pressure from other people, not much due to the initiative of the patients, that is what it shows*.

This indicated the use of incentives and a general lack of self-motivated admission. Client JC also supported this sentiment, stating, "*I came under pressure. My father brought me here, It was a family decision*," while professional NLP noted that "*many of them come under family pressure."*

Due to Presence of Mental Illness: Mental health professional JP clear out another way to admission linked to co-occurring mental health issues, explaining,

> "*The first ones who come here are mostly people who are addicted to drugs and not on their own; those who come often suffer from other mental illness and, for example, from being out of the reality; there is a very high level of stress like that and that family brings them with attention to this*."

This suggests that for some individuals, admission was a consequence of managing both addiction and related mental health conditions, often initiated by concerned family members.

Due to Court and Law Enforcement: Finally, professional JP identified legal mandates as a reason for admission, He stated that,

> "*Sometimes the police arrest them and during the investigation process we found that they have addictive substances and this is one of the compelling reasons. Secondly, they can commit any crime, for example, there is hashish or other illegal substances, they use it and they have mental illness and then there is a possibility that they will come for treatment from court*."

This highlights the role of the legal system in mandating treatment for some individuals involved in substance-related offenses.

4.3 Readiness to change among individuals with SUD

Readiness to change among individuals with SUD was assessed using the SOCRATES scale, which comprises three subscales: ambivalence, recognition, and taking steps. These quantitative findings were further explored through in-depth qualitative interviews with three substance abusers and three mental health professionals. Table 3 presents the descriptive statistics for the SOCRATES subscales for both alcohol abusers (8A) and other drug abusers (8D)

Table 4; Descriptive Statistics on the Readiness to Change within three Subscales among alcohol and drug users

Subscale	N	Mean	SD	Minimum Score	Maximum Score
Ambivalence (8A)	50	13.44	3.996	6	20
Recognition (8A)	50	26.60	5.887	12	35
Taking Steps (8A)	50	32.14	7.171	12	40
Ambivalence (8D)	49	14.92	3.651	4	20
Recognition (8D)	49	27.88	6.274	7	35
Taking steps (8D)	49	33.14	5.71	8	40

The quantitative results indicated that, the ambivalence level for both alcohol and drug users showed scores in low to medium, recognition very low score and taking steps medium.

To provide a deeper understanding of these levels of readiness and the meaning within each stage, the qualitative data from the interviews with substance abusers and mental health professionals were analyzed below based on themes related to ambivalence, recognition, and taking steps.

Recognition of Problem

The quantitative findings suggest that participants, on average, demonstrated a low level of recognition regarding their substance abuse problems. This limited awareness is reflected in the qualitative data. For instance, client GC stated, "*I came to this center because I drink too much*," which acknowledges a problem, but this acknowledgment was not consistently reflected across participants.

Mental health professional GP observed this lack of consistent recognition, noting, "*I think, and some of them seem to be saying that it is something that comes out of themselves and so far, they have not accepted positively what is given to them in the medical field, thinking about it for themselves. This is because their readiness has decreased.*" GP highlights that some clients minimize their problem and resist professional perspectives, indicating lower readiness.

Furthermore, client JC's statement, "*I didn't feel happy that they were going to leave me here...If I had known that they were going to leave me here, I wouldn't have come*," reveals a resistance to engage with treatment, suggesting a lack of full problem recognition.

Client NLC provided a contrasting view with the above respondents, describing the negative consequences of addiction: "*The addiction played a big role in me and I lost many things...I sold all my furniture, I sold all my clothes, and I was isolated from society...that thing also causes mental disorders*." NLC's statement indicates a higher level of problem recognition, acknowledging the significant damage caused by substance use.

Ambivalence / Uncertainty

Based on the manual of SOCRATES, the quantitative results in table 3 above showed that participants scored in the low to medium range on ambivalence. This ambivalence was reflected in the qualitative data.

GC stated, "*It wasn't inside me that I stopped it was for the family. I was there, then I went back and continue*," illustrating the push and pull between external pressure and internal resistance. JC expressed anxiety about leaving treatment and facing triggers: "*Unless I start going out to relax. The problem is that when I lose pleasure and relaxation, I get anxious and the thought of leaving comes to me.*" JC also demonstrated conditional commitment: "*To begin with, I am only addicted to cigarettes. I will give up khat and ganja. The only thing that can be a burden to me is cigarettes. I believe that it is possible to stop completely, but it is difficult to get something for a small amount of money*."

Taking Steps

Quantitatively, participants results as shown in table 3, showed a medium level of taking steps. The qualitative data provided further context.

GC's statement, "*I'm thinking about changing the situation I was in before,*" suggested an intention to change. JC's concern, "*when my peers are using I will not remain silent, and when I go out, it is what I fear,*" highlights the awareness of challenges in maintaining change.

NLP's observation that "*there are those who are very motivated, and there are those who try to change, but there are not many such patients*" aligns with the quantitative finding of a medium level of taking steps, indicating that while some individuals are making efforts, this is not a universal characteristic of the sample. NLP also stated that "*they are in a hurry to leave after they enter...,*" suggesting that some actions might be more about escaping the immediate situation than a committed effort to change.

NLC's statements indicate a more future-oriented approach and a desire for long-term change: "*I want to stay a little longer in this rehab center...I don't want to disappoint my family" and "I have started thinking that I will get married in the future...I have the idea that I will get out of the family dependency and live like any young person.*" These statements suggest a deeper level of commitment.

In summary, the quantitative findings indicate that participants, on average, show low recognition of their substance abuse problems, low to medium ambivalence about change, and a medium level of taking steps. The qualitative data supports and enriches these findings, highlighting the variability in participants' awareness, the presence of internal conflicts and external pressures, and the range of motivations and actions taken towards change.

4.4 Factors influencing readiness to change

Independent-samples t test was conducted to examine whether there were significant differences in the readiness to change (measured across the subscales of Ambivalence, Recognition, and

Taking Steps) between participants who voluntarily entered rehabilitation and those who did not, among both alcohol abusers (8A) and other drug abusers (8D). Prior to conducting independent-samples t test, assumptions of normality and homogeneity of variance were assessed. Based on Levene's Test for Equality of Variances, the assumption of equal variances was met for all variables, as all significance values were greater than 0.05 ($p > .05$). Therefore, equal variances were assumed in all subsequent t tests.

Differences in Readiness to Change between Voluntary and Involuntary substance abusers

The results are summarized in the table below.

Table 5; Comparison of Readiness to Change Scores between Voluntary and Involuntary Participants

Substance Type	Subscale	Voluntariness	N	Mean	SD	t	p-value
Alcohol (8A)	Ambivalence	Yes	32	13.69	4.22	0.580	0.565
		No	18	13.0	3.63		
	Recognition	Yes	32	27.25	5.8	1.042	0.303
		No	18	25.44	6.03		
	Taking Steps	Yes	32	33.09	7.57	1.261	0.213
		No	18	30.44	6.25		
Other drugs (8D)	Ambivalence	Yes	32	14.66	3.89	0.686	0.496
		No	16	15.41	3.2		
	Recognition	Yes	32	28.0	6.46	0.186	0.854
		No	17	27.65	6.09		
	Taking Steps	Yes	32	33.97	6.46	1.402	0.168
		No	17	31.59	3.62		

Within both alcohol and other drug abusers, there were no statistically significant differences between voluntary and involuntary participants on any of the readiness to change subscales. Though voluntarily admitted participants scored slightly higher in the recognition and taking steeps subscales, this difference were not significant.

To learn more about voluntariness and if it could influence readiness to change, qualitative interview were also conducted with three substance abusers and three mental health professionals. The most common theme emerged from the interview was self-initiated (voluntary) admission and admission under external pressure (involuntary).

The key informants saw that although some clients admitted voluntarily, others were forced by external factors like; employment based threats, comorbidity of mental illness, legal and court order as indicated above. These qualitative results substantiate the truth that most of the admissions are not voluntary choice made by the person but rather through external pressure. This makes quantitative findings into perspective by suggesting that voluntariness is a condition that is complex and more frequently controlled externally, which might explain differences in readiness to change between voluntary and involuntary clients were no statistically significant; because even those which seem to be voluntary can actually be subtly pressured.

Socio demographic Predictors of readiness to change

Multiple linear regression analyses were conducted to examine the influence of age, education, occupation, length of stay in the rehabilitation center, and having a health issue on each of the three readiness to change subscales: ambivalence, recognition, and taking steps.

The following table presents the multiple linear regression results for predicting readiness to change across three subscales (Ambivalence, Recognition, Taking Steps) among alcohol and other drug users. The table reports unstandardized coefficients (B), standardized coefficients (Beta), and model R^2 values.

Table 6; Summary of Multiple Regression Analyses Predicting Readiness to Change Subscales

Predictors	Ambivalence						Recognition						Taking steps					
	B	β	p	F	P	R^2	B	β	p	F	P	R^2	B	β	p	F	P	R^2
Age	.115	.197	.056	1.361	.160	.081	.74	.121	.234	3.259	.009	.149	.084	.125	.222	1.423	.223	.071
Educational status	-.174	-.113	.267				.478	.324	.002				.145	.087	.399			
Occupation	.428	.143	.166				.257	.075	.466				.358	.102	.785			
Length of stay	-.037	-.074	.469				.037	.066	.52				.017	.028	.785			
Health status	-.377	-.56	.585				-.892	-.126	.223				-1.134	-.158	.125			

This section integrates the quantitative findings from the multiple regression analyses with qualitative data to provide a deeper understanding of the factors influencing readiness to change among substance abusers.

- Ambivalence: The overall model was not statistically significant (R^2 = .081, F (5, 93) = 1.631, p = .160). None of the independent variables significantly predicted ambivalence.
- Recognition: The overall model was significant (R^2 = .149, F (5, 93) = 3.259, p = .009). Education significantly predicted recognition (B = .478, β = .324, p = .002), with higher education associated with greater recognition of a problem.
- Taking Steps: The overall model was not significant (R^2 = .071, F (5, 93) = 1.423, p = .223). None of the independent variables significantly predicted taking steps.

Qualitative Themes exploring factors influencing readiness to change

The qualitative data revealed several themes related to factors influencing readiness to change including Psychological factor, environmental factors, Social factors, coping mechanisms and treatment/intervention-related factors. The integration of the quantitative and qualitative findings suggests a complex interplay of factors influencing readiness to change.

Education and Recognition: The quantitative finding that higher education is associated with greater recognition of a problem aligns with the qualitative theme of psychological factors. The qualitative data indicates that a "lack of awareness of addiction" and the perception that "addiction is not a problem" can make readiness to change difficult. As GP stated, "*what reduces their motivation is first lack of awareness...because they don't think addiction is a problem*." It's possible that higher education provides individuals with greater awareness of the nature of addiction and its consequences, as a result increasing their recognition of the problem.

Other Factors: The quantitative analyses did not find significant relationships between age, occupation, length of stay, or health issues and readiness to change. However, the qualitative data suggest that these factors, along with environmental and social factors, may still play a role in the change process.

- Psychological Factors: Fear of stigma, fear of withdrawal symptoms, and low self-confidence were identified as barriers to change. GP noted, "*There are those who say we will be stigmatized," and "the effect of addiction itself will not allow you to get out of that thing; there are symptoms that come when you stop the addiction (withdrawal symptoms), but that fear, that worry*..."
- Environmental Factors: Participants expressed concern about returning to environments where substance use is prevalent, including peers influences and the potential for being job loss. GP mentioned the concern about "*losing a job*" and JC stated, "*It is a habit that everyone should use; when you go here, hashish, when you go there, khat; the neighborhood itself will deceive you*..."
- Social Factors: Lack of family and community support, inappropriate family interactions and approach (e.g., being told "*would have been better off if you had not been born*"), divorce, and peer pressure were identified as significant social barriers. GC described her divorce as a trigger: "*It's frustrating because I went through a lot with my husband and we got divorced. I try to hide it with addiction*." JP also highlighted the impact of negative family interactions, stating, "...*some family member told to the addicts, 'would have been better off if you had not been born,' family conflict, without accepting, judging, accusing and blaming too much, it reduces their readiness*."
- Coping Mechanisms: Addiction was described as a way to hide from external problems. As GC stated, "*I try to hide it with addiction*."
- Treatment/Intervention Related Factors: The quality of treatment services and feeling confined in the rehabilitation center were seen as factors that could reduce motivation. GP stated, "*The service situation determines, sometimes the services we provide determine; if they get what they want, if they get the professional they want; because of these problems, their motivation is a little gap*," and JC expressed discomfort with the treatment environment: "*It is not pleasant to sit here in one place and be confined*."

CHAPTER FIVE

DISCUSSION

This study employed a sequential explanatory mixed-methods design to investigate readiness to change among people with SUD, factors influencing readiness to change, level of voluntariness during the time of admission, treatment approaches, and recommendations for rehabilitation centers in Ethiopia. The quantitative findings detail the socio-demographic characteristics of the participants, their level of voluntariness upon admission, and their readiness to change. These quantitative results are then contextualized and expanded upon by the qualitative findings from the interview conducted with substance abusers and mental health professionals.

5.1 Socio-demographic Context

The study population (n=60) was predominantly male (93.3%), which aligns with global trends indicating higher rates of substance use disorders among males. This finding is similar with a study conducted in Ethiopia (Teferra, 2018). The educational background of participants varied, with the largest group holding a certificate (43.3%), indicating that substance abuse affects individuals across different educational levels. A majority of the participants were single (60.0%), which may indicate that lack of social support from a spouse and being alone may be a risk factor for substance abuse. Menasco and Blair (2014) reported that heavy drinking was found to be more likely among those who were being single or divorced and heavy drinking declined sharply among those who transitioned from being single to being married. Most participants identified as Orthodox Christian (65%) and a substantial portion of the sample was employed (43.3%), indicating that substance abuse is not limited to unemployed individuals. Most participants were from urban areas (95%), which may reflect increased accessibility of substances and social stressors associated with urban living than rural areas.

The duration of substance abuse was substantial, with over half of the participants reporting a history of more than 10 years of substance use (51.7%), indicating long patterns of abuse. A high rate of poly substance abuse (68.3%) was observed, with alcohol being the most common single substance, consistent with the reports of high alcohol consumption in Ethiopia (Tessema &

Zeleke, 2020) . Daily substance use was prevalent (88.3%), which may suggest the severity of dependence among these participants. A minority (38.3%) of participants reported experiencing health issues, predominantly mental health-related, such as anxiety, depression, and sleep disturbances, which implies the comorbidity of substance abuse and mental health problems. This finding is inconsistent with a study conducted in Lowa with 125 male inpatients admitted in substance abuse treatment center, which showed presence of high comorbidity of mental illness and substance abuse (Skinstad & Swain, 2001). This may be due to participant's unwillingness to disclose their mental health status due to fear of being labeled and stigmatized.

5.2 Readiness to change among substance abusers

The quantitative study revealed low level of problem recognition among participants, associated with low to medium ambivalence and a medium level of taking step. The results suggest that Ambivalence: among both alcohol abusers and other drug abusers showed scores in the "low" to "medium". This finding indicates that participants experienced some level of uncertainty and indecisiveness about their substance use and the need for change. Given that the mean Recognition score for the sample (8A: M = 26.60; 8D: M = 27.88) falls within the Low Recognition range, it is highly likely that the individuals with low Ambivalence also exhibit very low Recognition of their drinking as problematic. This suggests that these individuals are not experiencing internal conflict about their drinking because they largely do not perceive it as a source of concern. It is likely that they do not believe they drink or abuse drugs excessively, feel in control, and do not recognize any negative impacts of their alcohol and drug use. This lack of recognition contributes to their low ambivalence towards change. Taking Steps was also low. The finding is consistent with two studies, conducted on 87 alcoholic patients, which revealed their scores in all three dimensions of readiness to change; recognition, ambivalence and taking steps, were low (Chang et al., 2020) and another study which was conducted with 69 psychoactive substance abusers showed that about half (50.5%) of the participants have low Recognition, more than half (55.0) are low on Ambivalence and less than half (41.6%) are Taking moderate Steps towards changing their substance abusing behavior. But the finding is inconsistent with a study conducted in Norway by Opsal, et.al, (2019).

5.3 Level of voluntariness during time of admission and readiness to change

Majority of the participants (66.7%) entered to the psychiatric and rehabilitation center voluntarily. This finding is inconsistent with a study conducted in Southern Norway in which majority of the participants were admitted involuntarily (Opsal et al., 2019). This inconsistency resulted from two of the study areas which were EPOS and New Life substance rehabilitation centers, which admit substance abusers based on their voluntariness, the high percentage of "Yes" responses (66.7%) corresponds with this admission criterion in those specific rehabilitation centers. The qualitative data provided a deep perspective on voluntariness. While some participants, particularly professionals, acknowledged the existence of self-initiated admission, it was often described as rare. The interviews revealed that a substantial proportion of admissions were driven by external pressures, including influence of job loss, family pressure, co-occurring mental illness, and legal mandates.

The study found no significant differences in readiness to change on the three sub scales; ambivalence, recognition and taking steps between participants (alcohol and other drug abusers) who entered treatment voluntarily and those who were externally pressured/ involuntary admission. This finding challenges the assumption that voluntary admission is consistently associated with greater readiness to change (Opsal et al., 2019). The lack of a significant quantitative difference may be explained by the qualitative finding that even those who present as “voluntary” may be experiencing subtle forms of external pressure. External pressures from family, employers, or the legal system often decrease the lines of self-motivated admission. Individuals complying with external demands may not necessarily exhibit higher initial readiness than those mandated to treatment. This finding is consistent with the strong influence of family and community in Ethiopian culture, where decisions about health and well-being are often collective.

5.4 Factors Influencing Readiness to Change

Based on the multiple linear regression analysis, age, occupation, length of stay and presence or absence of health issue were not significantly associated with the three subscale scores of

readiness to change (i.e. recognition, ambivalence and taking steps) among alcohol and drug abusers. Chang et al. (2020) found that age was positively associated with readiness to change. Younger patients with higher drinking severity, higher self-stigma, higher self-efficacy and severe depression are more likely to change substance abuse. This lack of significance association and inconsistency may be due to small sample size. But education level was a significant predictor of recognition of the problem, with higher education associated with greater recognition. This is consistent with research demonstrating that higher education is often associated with increased health awareness and literacy, which may facilitate the recognition of substance abuse as a problem (Teferra, 2018).

The qualitative data support this finding, with mental health professionals noting that a lack of awareness of addiction can hinder readiness to change. Teferra, (2018), also reported that addict ion to alcohol and drugs is considered a moral failure and personal weakness and not as a health problem (no recognition of problem). Consequently, there is low treatment seeking behavior (low level of taking steps to change) both by patients themselves as well as their caregivers. This indicates that lack of awareness to substance addiction problem and treatment decreases the abuser's readiness to change (Teferra, 2018).

The qualitative data also highlighted several other factors influencing readiness to change that were not captured in the quantitative analysis, including psychological factors (stigma, fear of withdrawal symptoms, low self-confidence, craving, perceived fear of relapse), environmental factors (exposure to substance use, lack of employment), and social factors (lack of family support, negative family interactions, peer pressure, perceived fear of stigma, poor family support, family conflict). The influence of these factors is consistent with the broader literature on substance abuse, which emphasized the role of individual, social, and environmental influences on readiness to change (Jang et al., 2021; Rapp et al., 2007). The qualitative data also identified coping mechanisms and treatment/intervention-related factors (quality of services, feeling confined, perceived treatment failures) as important influences on readiness to change. This is supported by a study which reported that perceived fear of treatment barriers had influence on readiness to change (Rapp et al., 2007).

Limitations of the study

The limitation of the study was the following. The cross-sectional design limits the ability to infer causality and the progress of substance abuser's readiness to change over time. The small sample size, while providing valuable data, may limit the generalizability of the findings. Future research should employ longitudinal designs to examine the causal relationships between voluntariness, readiness to change, and treatment outcomes. Larger, more diverse samples would also enhance the generalizability of the findings. Also there was a convergent and divergent findings.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATION

6.1 Summary

This sequential explanatory mixed-methods study was conducted with 60 quantitative and 6 qualitative participants. The aim of the study was to assess the participants' readiness to change, evaluate the level of voluntariness at the time of admission, and exploring factors influencing readiness to change. The study answered the following questions.

1. Are people with SUD who are admitted for treatment in psychiatric and rehabilitation centers ready for treatment?
2. What demographic factors are associated with readiness to change among people with SUD who are admitted for treatment in rehabilitation centers?
3. What factors influence readiness to change among substance abusers who are admitted for treatment in psychiatric and rehabilitation centers?
4. Are substance abusers who are admitted for treatment in psychiatric and rehabilitation centers volunteer during the time of admission?

The quantitative data was collected through self-administered socio demographic variables, substance use history assessment questionnaires and SOCRATES. It was also analyzed through SPSS version 26 software through descriptive and inferential statistics. The descriptive statistics included in the study were mean, standard deviation, frequency, minimum and maximum. Socio demographic characteristics and the SOCRATES subscales were analyzed through these descriptive statistics. Independent samples t test was used to compare the significance difference of readiness to change within three sub scale between voluntarily and involuntarily admitted substance abusers. Also, multiple linear regressions were used to assess whether independent variables like age, educational status, occupation, health status and length of stay predict the dependent variable readiness to change within ambivalence, recognition and taking steps.

The qualitative data was collected through in-depth interview with interview guide from three substance abusers and three mental health professionals. It was very insightful to explore and expand the quantitative findings. The findings of the quantitative and qualitative data were integrated.

6.2 Conclusion

The findings of the study revealed that the participants' readiness to change was low within three subscales; ambivalence, recognition and taking steps. While the majority of participants entered the rehabilitation centers voluntarily, there were no significant difference in their readiness to change across three subscales; ambivalence, recognition, and taking steps between voluntarily and involuntarily admitted individuals with alcohol and other drug abuse issues. Even though, the numbers of voluntarily admitted participants were high, the admission was not self-initiated; rather it was due to external pressures. These external pressures includes family pressure, job related factors (for the sake of not losing job), legal or court enforcement and the presence of comorbid mental illness. From the quantitative analysis, education emerged as a significant predictor of problem recognition. Additionally, the qualitative component of the study explored various factors influencing readiness to change, which were categorized into different themes. Psychological factors identified included low self-confidence, perceived fear of withdrawal symptoms, fear of relapse, and cravings. Environmental factors encompassed the availability of substances and lack of job opportunities, while social factors highlighted poor family and social support, ineffective family approaches, and perceived stigma. Overall, these findings suggest that while voluntary admission may not significantly enhance readiness to change, targeted interventions like motivational interviewing focusing on educational initiatives and addressing psychological, environmental, and social factors could improve participant’s readiness to engage in recovery.

6.3 Recommendations

6.3.1 for mental health professionals

The researcher's findings have several implications for practice. Firstly, routine and holistic assessment of readiness to change during admission is important, regardless of the perceived voluntariness of entry. Secondly, treatment approaches should prioritize enhancing problem recognition, particularly among individuals with lower levels of education, potentially through targeted psycho education. Thirdly, addressing ambivalence through motivational interviewing techniques should be a core component of early intervention. Finally, treatment programs need to consider and address the significant psychological, social, and environmental factors identified by substance abusers.

6.3.2 for researchers

Future research could explore readiness to change using longitudinal designs to track its evolution throughout the treatment process and identify predictors of successful outcomes. Larger and more diverse samples would enhance the generalizability of quantitative findings. Further investigation into the deep understanding of voluntariness and its impact on treatment engagement and outcomes is necessary.

Further research is also needed to explore the specific cultural factors that influence substance abuse and treatment in Ethiopia. This could include the role of traditional healing practices, religious beliefs, and cultural norms. Additionally, research is needed to evaluate the effectiveness of different treatment approaches in the Ethiopian context and to identify culturally adapted interventions.

6.3.3 For family and society

While treating the addiction problem of substance abusers, individual's family and other societies around them should be aware of that substance abuse is a chronic and relapsing mental illness. Due to this the researcher recommends for family members to understand substance

abusers problem; they should be non-judgmental, empathic and supportive for them. The family should arrange the living and working environment to prevent relapse.

6.3.4. For ministry of health and other significant stakeholders

It is known that substance abuse is the most problematic issue worldwide. Due to this special emphasis should be there for the treatment and rehabilitation process of substance abusers. Both governmental and private substance rehabilitation centers should be expanded and the necessary professional and materials should be fulfilled to deliver satisfactory treatment services.

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Appendices

Informed Consent Form

Hello! My name is Mekonnen Anley Bekele, and I am a graduate student at Addis Ababa University, School of Psychology. This study aims to assess readiness to change among substance abusers who are admitted for treatment in psychiatry and substance rehabilitation centers. The study will be conducted at Jadber psychiatry and rehabilitation center, Ethiopian prosthetic and orthostatic Services (EPOS) mental and substance rehabilitation center and New Life substance rehabilitation center. I am doing this study for the partial fulfillment of my master's degree in counseling psychology from Addis Ababa University.

You have been selected to participate in this study, and I kindly request your participation in providing the information required. Your participation is completely voluntary. Your name will not be recorded on this form, and it will never be used in connection with any of the information you provide. You will be asked some very personal questions, and you have the right to refuse to answer any question you do not wish to respond to and also you can withdraw the participation as soon as you feel discomfort in responding to the items. Your responses will be kept confidential, and there will be no way to link your individual responses to the final results of the study findings.I want to emphasize that your responses are essential, not only for the successful completion of the study but also for producing relevant information that will help in designing preventive strategies. We would greatly appreciate your support in responding to our questions. If you have any question, you can contact the researcher using phone number 0930705763.

Are you willing to participate in the study?

1. Yes _____Signature _____2, No _____

3, Date _____

Thank you for considering participation in this important research!

Data collection tools (English version)

Socio-Demographic Information

Q1. Sex:

1, Male

2, Female

Q2. Age: ……

Q3. Marital Status:

1, Single

2, Married

3, Divorced

4, Widowed

5, Separated

Q4. Educational Status:

1, Certificate
2, Diploma
3, Bachelor's Degree
4, Master's Degree
5, Doctorate Degree
6, others (please specify)……..

Q5. Occupation:

1, Employed (please specify job title)

2, Unemployed

3, Student

4, Retired

5, other (please specify)

Q6. Religion:

1, Orthodox

2, Protestant

3, Islam

4, Catholic

5, other (please specify)

Q7. Residence:

1, Rural

2, Urban

Q8. Length of Stay in the rehabilitation center:

- Length of Stay (in days): _____

Q9. Do you have any health issue? If yes, please specify (e.g. diabetic mellitus, hypertension, mental illnesses like depression, anxiety, sleep disorder, schizophrenia, bipolar disorder…):

-1, Yes (please specify: _____)

-2, No

Substance Use History Assessment

SU1. Did you choose to enter this psychiatric and substance rehabilitation center voluntarily?

1, Yes

2, No

SU2. What types of substances have you abused? (You may choose more than one)

1, Alcohol

2, Khat

3, Cannabis

4, Tobacco

5, Prescription medications (please specify……..)

6, More than one substance

7, other (please specify……..)

SU3. For how long have you abused these substances?

1, Less than 1 year

2, 1- 3 years

3, 4-6 years

4, 7-10 years

5, More than 10 years

SU4. How frequently did you abuse these substances?

1, Daily

2, Weekly (once, twice, three times…per week)

3, Monthly (once, twice, three times…per month)

4, Occasionally

SOCRATES (Stages of change Readiness and Treatment Eagerness scale)

Personal Drinking Questionnaire (SOCRATES 8A)

INSTRUCTIONS:

Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drinking. For each statement, Please tick 'X' one number from 1 to 5, to indicate how much you agree or disagree with it right now in front of each statement.

1, Strongly Disagree

2, Disagree

3, Undecided or Unsure

4, Agree

5, Strongly Agree

No	Personal Drinking Questionnaire	1	2	3	4	5
1	I really want to make changes in my drinking					
2	Sometimes I wonder if I am an alcoholic					
3	If I don't change my drinking soon, my problems are going to get worse					
4	I have already started making some changes in my drinking.					
5	I was drinking too much at one time, but I've managed to change my drinking.					
6	Sometimes I wonder if my drinking is hurting other people.					
7	I am a problem drinker					
8	I'm not just thinking about changing my drinking, I'm already doing something about it					
9	I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.					
10	I have serious problems with drinking					
11	Sometimes I wonder if I am in control of my drinking.					
12	My drinking is causing a lot of harm					
13	I am actively doing things now to cut down or stop drinking.					
14	I want help to keep from going back to the drinking problems that I had before.					
15	I know that I have a drinking problem					
16	There are times when I wonder if I drink too much.					
17	I am an alcoholic					
18	I am working hard to change my drinking.					
19	I have made some changes in my drinking and I want some help to keep from going back to the way I used to drink					

Personal Drug use Questionnaire (SOCRATES 8D)

INSTRUCTIONS:

Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drug use. For each statement, Please tick ‘X’ one number from 1 to 5, to indicate how much you agree or disagree with it right now in front of each statement.

1, Strongly Disagree

2, Disagree

3, Undecided or Unsure

4, Agree

5, strongly Agree

No	Personal Drug use Questionnaire	1	2	3	4	5
1	I really want to make changes in my use of drugs					
2	Sometimes I wonder if I am an addict.					
3	If I don't change my drug use soon, my problems are going to get worse.					
4	I have already started making some changes in my use of drugs.					
5	I was using drugs too much at one time, but I've managed to change that.					
6	Sometimes I wonder if my drug use is hurting other people					
7	I have a drug problem					
8	I'm not just thinking about changing my drug use, I'm already doing something about it					
9	I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern					
10	I have serious problems with drugs.					
11	Sometimes I wonder if I am in control of my drug use.					
12	My drug use is causing a lot of harm.					
13	I am actively doing things now to cut down or stop my use of drugs.					
14	I want help to keep from going back to the drug problems that I had before.					
15	I know that I have a drug problem.					
16	There are times when I wonder if I use drugs too much					
17	I am a drug addict					
18	I am working hard to change my drug use.					
19	I have made some changes in my drug use, and I want some help to keep from going back to the way I used before					

Qualitative data collection tools

Informed consent

My name is Mekonnen Anley Bekele, and I am a graduate student at Addis Ababa University, school of psychology. Currently, I am conducting research which aims on assessing readiness to change among substance abusers who are admitted for treatment in psychiatric and substance rehabilitation centers in Addis Ababa. You have been selected to participate in this study, and I kindly request your participation in providing the information required. Your participation is completely voluntary. Your name will not be recorded on this form, and it will never be used in connection with any of the information you provide. Therefore, your participation in the study will have greater contribution and involve an in-depth interview. The in-depth interview is with an estimated length of 30 minutes. This interview will include audio recorded for later data analysis. You can miss the question which is not comfortable to you or you can stop the interview session at any time. If you have any question, you can contact the researcher using phone number **0930705763**. After read and understood the above information expresses your agreement to participate in this study by signing your signature below.

Are you willing to participate in the study?

Yes_____ Signature _____

No _____

Date _____

Thank you for considering participation in this important research!

Qualitative data collection

Interview guide

Interview guide questions for Selected Participants (Substance Abusers)

Q1, Can you tell me a bit about yourself? Age, sex, occupation/profession, educational status, How long has it been since you entered the rehabilitation center? What type of substance do you abuse? For how long do you abuse this substance? …

Q2, Can you tell me about, how you came to this rehabilitation center?

2.1. Who brought you here? Is it your own decision or the decision of relatives? Who in particular?

2.1 What did you feel when you were admitted? What about now?

Q3, What do you feel now that you are in this rehabilitation center?

3.1. What are some of the thoughts you've had recently about your substance use?

3.2. How hopeful are you about the future beginning from now? Regarding to your substance abuse, what do you see about your life in the near future?

Q4, What challenges or barriers have you faced in trying to reduce or stop your substance use?

4.1. Did you overcome the challenges? If so, tell me how?

Q5, what are your goals for the future regarding your substance use and overall well-being?

Interview guide Questions for Key Informants (Mental health Professionals)

Q1, Can you tell me about yourself? Age, sex, occupation/profession, year of work experience, how long do you work in this rehabilitation center?

Q2, Based on your experience, how do you think about your client's (patient's) level of voluntariness for substance abuse treatment while they are admitted to this rehabilitation center? Could you tell me more about factors for their involuntariness?

2.1. Tell me more about their readiness to change for substance abuse treatment. How do you evaluate the readiness of most clients to change? Are you satisfied with what you see in this regard?

Q3, What factors do you believe influence an individual's readiness to change their substance use behavior?

የአማርኛ የመረጃ መሰብሰቢያ ቅጽ

የስምምነት ቅጽ

ጤና ይስጥልኝ ! መኮንን አንለይ በቀለ እባላለሁ በአዲስ አበባ ዩኒቨርሲቲ የስነ ልቦና ትምህርት ቤት የድህረ ምረቃ ተመራቂ ተማሪ ነኝ። ይህ ጥናት በስነ አእምሮ እና የሱስ ማገገሚያ ማዕከላት ውስጥ ለህክምና ከገቡት የአደንዛዥ ዕጽ ተጠቃሚዎች መካከል ለመለወጥ ያላቸዉን ዝግጁነት ለመገምገም ያለመ ነው። ጥናቱ የሚካሄደው **በጃድበር** ስነ አእምሮ እና ሱስ ማገገሚያ ማእከል፣ **የኢትዮጵያ የአካል ድጋፍ** የአእምሮ እና ሱስ ማገገሚያ ማእከል እና **አዲስ ህይወት** ሱስ ማገገሚያ ማእከል ነው። ይህንን ጥናት የማደርገው ከአዲስ አበባ ዩኒቨርሲቲ በካውንስሊንግ ሳይኮሎጂ የማስተርስ ዲግሪዬን በከፊል ለማሟላት ነው።

በዚህ ጥናት ላይ ለመሳተፍ እርስዎ ተመርጠዋል፣ እናም አስፈላጊውን መረጃ በማቅረብ እና በመስጠት እንዲሳተፉ በአክብሮት እጠይቃለሁ። የእርስዎ ተሳትፎ ሙሉ በሙሉ በፈቃደኝነት ላይ የተመሰረተ ነው። የእርስዎ ስም በዚህ ቅጽ ላይ አይመዘገብም እና እርስዎ ከሚሰጡት ከማንኛውም መረጃ ጋር በተያያዘ በጭራሽ ጥቅም ላይ አይውልም። አንዳንድ በጣም የግል ጥያቄዎች ይጠየቃሉ፣ ምንም አይነት ምላሽ ለመስጠት ለማትፈልጉት ማንኛውንም ጥያቄ ለመመለስ እምቢ የማለት መብት አለዎት እንዲሁም ለጥያቄዎቹ ምላሽ ሲሰጡ አለመመቸት ሲሰማዎት ተሳትፎውን ማቋረጥ ይችላሉ። ምላሾችዎ በሚስጥር ይያዛሉ፣ የግል ምላሾችዎን ከጥናቱ ግኝቶች የመጨረሻ ውጤቶች ጋር የሚገናኝበት ምንም መንገድ አይኖርም።

ለጥናቱ በተሳካ ሁኔታ እንዲጠናቀቅ ብቻ ሳይሆን ከሱስ ለማገገም የሚረዱ የመከላከያ ስልቶችን ለመንደፍ የሚያግዙ ጠቃሚ መረጃዎችን ለማዘጋጀት የእርስዎ ምላሾች አስፈላጊ መሆናቸውን አፅንዖት መስጠት እፈልጋለሁ። ለጥያቄዎች ምላሽ ስለሚሰጡኝ እና ድጋፍዎትን ስለሚለግሱኝ በጣም አመሰግናለሁ። ማንኛውም አይነት ጥያቄ ካልዎት በስልክ ቁጥር **0930705763** ማግኘት ይችላሉ።

በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት?

1. አዎ _____ ፊርማ _____

2. አይ _____

3 ቀን _____

በዚህ ጠቃሚ ጥናት ላይ ስለተሳተፉ አመሰግናለሁ!

የግል መረጃዎች

ጥ1. ጸታ:

1 ወንድ

2 ሴት

ጥ2. ዕድሜ፡…….

ጥ3. የጋብቻ ሁኔታ፡-

1, ያላገባ/ች

2, ያገባ

3, የፈታ/ ች

4, ባሏ የሞተባት/ ሚስቱ የሞተችበት

5, የተለያየ/ች

ጥ4. የትምህርት ሁኔታ/ደረጃ፡-

1, የምስክር ወረቀት

2, ዲፕሎማ

3, የባችለር ዲግሪ

4, የማስተርስ ዲግሪ

5, የዶክትሬት ዲግሪ

6, ሌሎች (እባክዎ ይግለጹ) …….

ጥ5. ሥራ፡-

1,ተቀጣሪ (እባክዎ የስራ ስም ይግለጹ.....)

2, ሥራ አጥ

3, ተማሪ

4, ጡረተኛ

5, ሌላ (እባክዎ ይግለጹ.....)

ጥ6. ሃይማኖት፡

1, ኦርቶዶክስ

2, ፕሮቴስታንት

3, እስልምና

4, ካቶሊክ

5, ሌላ (እባክዎ ይግለጹ.....)

ጥ7. የመኖሪያ ቦታ፡-

1, ገጠር

2, ከተማ

ጥ8. ህክምና ማእከሉ ዉስጥ የቆዩበት ጊዜ፡-

- የቆይታ ጊዜ (በቀናት)፡ _____

ጥ9. የጤና ችግር አለብዎት? አዎ ከሆነ፣ እባክዎን ይግለጹ፡-(ምሳሌ፤ የስኳር ህመም፣ደም ግፊት፣ የአእምሮ ህመም ለምሳሌ ድብርት፣ጭንቀት፣የእንቅልፍ ችግር፣ ስኪዞፈርኒያ፣ባይቦላር ዲሶርደር.....)

1 አዎ (እባክዎ ይግለጹ: .....)

2 አይ

የእጽ አጠቃቀም ታሪክ ማምገማ

ጥ1. ወደዚህ የአእምሮ ህክምና እና የሱስ ማገገሚያ ማእከል ሲገቡ በፈቃደኝነት ነበር?

1, አዎ

2, አይደለም

ጥ2. ምን አይነት አደንዛዥ እጽ አላግባብ ተጠቅመዋል? (ከአንድ በላይ መምረጥ ይችላሉ)

1, አልኮል

2, ጫት

3, ካናቢስ/ ዊድ/ ማሪዋና/ ሃሺሽ / ሺሻ

4, ትምባሆ/ ሲጋራ

5, በሐኪም የታዘዙ መድኃኒቶች (እባክዎ ይግለጹ……..)

6, ከአንድ በላይ እጽ

7 ሌላ (እባክዎ ይግለጹ.....)

ጥ3. እነዚህን አደንዛዥ እጾች ለምን ያህል ጊዜ አላግባብ ተጠቅመዋል?

1, ከ1 አመት በታች

2, ከ1-3 አመት

3, ከ4-6 አመት

4, ከ7-10 አመት

5, ከ10 አመት በላይ

ጥ4. እነዚህን አደንዛዥ እጾች ምን ያህል ጊዜ አላግባብ ተጠቀሙ?

1, በየቀኑ

2, በሳምንት (አንዴ፣ ሁለቴ፣ሶስቴ...)

3, በወር (አንዴ፣ ሁለቴ፣ሶስቴ...)

4, አልፎ አልፎ

SOCRATES (የለውጥ ደረጃዎች፣ ዝግጁነት እና የህክምና ጉጉት መለኪያ)

የግል የመጠጥ ሁኔታ መጠይቅ (SOCRATES 8A)

መመሪያዎች፡-

እባክዎ የሚከተሉትን *መግለጫዎች* በጥንቃቄ ያንብቡ። እያንዳንዳቸው ስለ አልኮል መጠጥዎ ሊሰማዎት የሚችለውን (ወይም ያልተሰማዎትን) *መንገድ* ይገልፃል። በእያንዳንዱ አረፍተ ነገር ፊት ለፊት ምን ያህል እንደተስማሙ ወይም እንደማይስማሙበት ለማመልከት እባክዎትን 'X' ምልክት ከ1 እስከ 5 ካሉት አንድ ቁጥር ላይ ምልክት ያድርጉ።

1, በጣም አልስማማም

2, አልስማማም

3, እርግጠኛ አይደለሁም

4, እስማማለሁ

5, በጣም እስማማለሁ

ተ.ቁ	**የግል የመጠጥ ሁኔታ መጠይቅ**	1	2	3	4	5
1	በአልኮል መጠጥ ላይ የእውነት ለውጦችን ማድረግ እፈልጋለሁ					
2	አንዳንድ ጊዜ የአልኮል ሱሰኛ መሆኔን አስባለሁ					
3	የአልኮል መጠጥን ቶሎ ካልቀየርኩ፣ ችግሬ እየባሰ ይሄዳል					
4	በአልኮል መጠጥ ላይ አንዳንድ ለውጦችን ማድረግ ጀምሬያለሁ					
5	በአንድ ጊዜ ከመጠን በላይ እጠጣ ነበር፣ ነገር ግን መጠጡን ለመለወጥ ራሴን መግራት/መቆጣጠር ችያለሁ					
6	አንዳንድ ጊዜ የእኔ መጠጣት ሌሎች ሰዎችን እየጎዳ እንደሆነ አስባለሁ					
7	እኔ ችግረኛ ጠጪ ነኝ					
8	እያሰብኩ ያለሁት መጠጥ ለመቀየር ብቻ አይደለም፣ በዚህ ጉዳይ ላይ የሆነ ነገር እያደረግሁም ነው					
9	የአልኮል መጠጤን ለውጫለሁ፣ እናም ወደ ቀድሞው ልማዴ እንዳልመለስ መንገዶችን እየፈለግሁ ነው					
10	በአልኮል መጠጤ ላይ ከባድ ችግሮች አሉብኝ					
11	አንዳንድ ጊዜ በአልኮል መጠጥ ቁጥጥር ውስጥ እንደሆንኩ አስባለሁ					
12	አልኮል መጠጣቴ ብዙ ጉዳት እያደረሰብኝ ነው					
13	አሁን የአልኮል መጠጥን ለማቆም ወይም ለመቁረጥ በንቃት እየሰራሁ ነው					
14	ከዚህ በፊት ወደነበሩት የመጠጥ ችግሮች ላለመመለስ እርዳታ እፈልጋለሁ					
15	የአልኮል መጠጥ ችግር እንዳለብኝ አውቃለሁ					
16	አልኮል አብዝቼ እንደጠጣሁ የምጠራጠርበት ጊዜ አለ					
17	እኔ የአልኮል ሱሰኛ ነኝ					
18	የአልኮል መጠጤን ለመለወጥ ጠንክሬ እየሰራሁ ነው					
19	በአልኮል መጠጥ ላይ አንዳንድ ለውጦችን አድርጌያለሁ እናም ወደ ቀድሞው መጠጥ ላለመመለስ እርዳታ እፈልጋለሁ.					

የግል አደንዛዥ እጽ አጠቃቀም መጠይቅ (SOCRATES 8D)

መመሪያዎች፡-

እባክዎ የሚከተሉትን መግለጫዎች በጥንቃቄ ያንብቡ። እያንዳንዳቸው ስለ አደንዛዥ እጽ (ሲጋራ፣ጫት፣ሃሺሽ፣ዊድ፣በሃኪም የሚታዘዙ መድሃኒቶች ወዘተ...) አጠቃቀምዎ ሊሰማዎት የሚችለውን (ወይም የማይሰማዎትን) መንገድ ይገልፃል። በእያንዳንዱ አረፍተ ነገር ፊት ለፊት ምን ያህል እንደተስማሙ ወይም እንደማይስማሙበት ለማመልከት እባክዎትን 'X' ምልክት ከ1 እስከ 5 ካሉት አንድ ቁጥር ላይ ምልክት ያድርጉ።

1, በጣም አልስማማም

2, አልስማማም

3,እርግጠኛ አይደለሁም

4, እስማማለሁ

5, በጣም እስማማለሁ

ተ.ቁ	**የግል አደንዛዥ እጽ አጠቃቀም መጠይቅ**	1	2	3	4	5
1	በእጽ አጠቃቀሜ ላይ የእዉነት ለውጦችን ማድረግ እፈልጋለሁ					
2	አንዳንድ ጊዜ የአደንዛዥ እጽ ሱሰኛ መሆኔን አስባለሁ					
3	የእጽ አጠቃቀሜን ቶሎ ካልቀየርኩ፣ ችግሬ እየባሰ ይሄዳል					
4	በእጽ አጠቃቀሜ ላይ አንዳንድ ለውጦችን ማድረግ ጀምሬያለሁ					
5	በአንድ ጊዜ ከመጠን በላይ እጾችን እጠቀም ነበር፣ ነገር ግን እጽ አጠቃቀሜን ለመለወጥ ራሴን መግራት/መቆጣጠር ችያለሁ					
6	አንዳንድ ጊዜ የእኔ አደንዛዥ እጽ መጠቀም ሌሎች ሰዎችን እየጎዳ እንደሆነ አስባለሁ					
7	እኔ አደንዛዥ እጽ የመጠቀም ችግር አለብኝ					
8	እያሰብኩ ያለሁት እጽ መጠቀምን ለመቀየር ብቻ አይደለም፣ በዚህ ጉዳይ ላይ የሆነ ነገር እያደረግሁም ነው					
9	የእጽ አጠቃቀሜን ለውጫለሁ፣ እናም ወደ ቀድሞው ልማዴ እንዳልመለስ መንገዶችን እየፈለግሁ ነው					
10	በእጽ አጠቃቀሜ ላይ ከባድ ችግሮች አሉብኝ					
11	አንዳንድ ጊዜ በእጽ አጠቃቀሜ ቁጥጥር ዉስጥ እንደሆንኩ አስባለሁ					
12	አደንዛዥ እጽ መጠቀሜ ብዙ ጉዳት እያደረሰብኝ ነው።					
13	አሁን የእጽ አጠቃቀሜን ለማቆም ወይም ለመቁረጥ በንቃት እየሰራሁ ነው					
14	ከዚህ በፊት ወደነበሩት የእጽ አጠቃቀም ችግሮች ላለመመለስ እርዳታ እፈልጋለሁ					
15	የአደንዛዥ እጽ መጠቀም ችግር እንዳለብኝ አውቃለሁ					
16	አደንዛዥ እጾችን አብዝቼ እንደተጠቀምኩ የምጠራጠርበት ጊዜ አለ					
17	እኔ የአደንዛዥ እጽ ሱሰኛ ነኝ					
18	የአደንዛዥ እጽ አጠቃቀሜን ለመለወጥ ጠንክሬ እየሰራሁ ነው።					
19	በእጽ አጠቃቀሜ ላይ አንዳንድ ለውጦችን አድርጌያለሁ እናም ወደ ቀድሞው አጠቃቀሜ ላለመመለስ እርዳታ እፈልጋለሁ					

የግል ቃለ መጠይቅ

የስምምነት ቅጽ

እኔ መኮንን አንለይ በቀለ እባላለሁ። በአዲስ አበባ ዩኒቨርሲቲ የስነ ልቦና ትምህርት ቤት የድህረምረቃ ተመራቂ ተማሪ ነኝ ። ይህ ጥናት በአዲስ አበባ በሚገኙ የስነ አእምሮ እና የሱስ ማገገሚያ ማዕከላት ውስጥ ለህክምና ከገቡት የአደንዛዥ ዕጽ ተጠቃሚዎች መካከል ለመለወጥ ያላቸዉን ዝግጁነት ለመገምገም ያለመ ነው። ይህ ጥናታዊ ጽሁፍ በካውንስሊንግ ሳይኮሎጂ የሁለተኛ ድግሪ የማሟያ ፅሁፍ ሆኖ ያገለግላል። በዚህ ጥናት ላይ ለመሳተፍ እርስዎ ተመርጠዋል፣ እናም አስፈላጊውን መረጃ በማቅረብ እና በመስጠት እንዲሳተፉ በአክብሮት እጠይቃለሁ። የእርስዎ ተሳትፎ ሙሉ በሙሉ በፈቃደኝነት ላይ የተመሰረተ ነው። የእርስዎ ስም በዚህ ቅጽ ላይ አይመዘገብም እና እርስዎ ከሚሰጡት ከማንኛውም መረጃ ጋር በተያያዘ በጭራሽ ጥቅም ላይ አይውልም። ይህን ቃለ መጠይቅ ለማካሄድ በግምት ሰላሳ ደቂቃ የሚወሰድ ሲሆን ይህ ቃለ-መጠይቅ ወደፊት ለሚደረገው የጥናቱ ትንተና እንዲያገለግል በድምፅ መቅጃ ይቀዳል። በመጠይቁ ውስጥ ካሉት ጥያቄዎች ውስጥ ለመመለስ የማይፈልጉትን ጥያቄ አለመመለስ ወይም መጠይቁን በማንኛውም ሰዓት ማቋረጥ ይችላሉ። በጥናታዊ ጽሁፍ ላይ ጥያቄ ወይም ሀሳብ ካለዎት በስልክ ቁጥር **0930705763** የጥናቱን ባለቤት ማነጋገር ይችላሉ።ይህን የስምምነት ቅጽ ካነበቡና በትክክል ከተረዱት በኋላ በጥናቱ ለመሳተፍ ፍቃደኛ መሆንዎን ለማረጋገጥ ከዚህ በታች በተዘጋጀው ቦታ ላይ በመፈረም ፍቃደኛነትዎን ያረጋግጡልኝ ዘንድ በትህትና እጠይቃለሁ።

በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት?

አዎ ----------ፊርማ ----------

አይ.....

ቀን ----------

በዚህ ጠቃሚ ጥናት ላይ ስለተሳተፉ አመሰግናለሁ !

የቃለ መጠይቅ መመሪያ

የቃለ መጠይቅ መመሪያ ጥያቄዎች ለተመረጡ ተሳታፊዎች (እጽ ተጠቃሚዎች)

ጥ1) ስለራስዎ ትንሽ ሊነግሩኝ ይችላሉ?

ዕድሜ.....

ጾታ.....

ሥራ(ሙያ).....

የትምህርት ደረጃ.....

ወደ ማገገሚያ ማእከሉ ከገቡ ምን ያህል ጊዜ ሆነዎት?.....

የምን አይነት እፅ ተጠቃሚ ነዎት? .....

የአደንዛዥ እፅ ተጠቃሚ ከሆኑ ስንት ጊዜ ሆነዎት? ….....

ጥ2) ወደዚህ የአእምሮ እና የሱስ ማገገሚያ ማዕከል እንዴት እንደመጡ ሊነግሩኝ ይችላሉ?

2.1. እዚህ ማን አመጣዎት? የራስዎት ውሳኔ ነው ወይስ የዘመዶችዎ ውሳኔ? በተለይ ማነው?

2.1 ወደ ማገገሚያ ማእከሉ ሲገቡ ምን ተሰምቶዎት ነበር ? አሁንስ?

ጥ3) በዚህ የሱስ ማገገሚያ ማዕከል ውስጥ ስለሆኑ አሁን ምን ይሰማዎታል?

3.1. ስለ እርስዎ እጽ አጠቃቀም በቅርብ ጊዜ ያጋጠሙዎት አንዳንድ ሀሳቦች ምንድናቸው?

3.2. ከአሁን ጀምሮ ስለወደፊቱ ምን ያህል ተስፈኛ ነዎት? ከሱስ አጠቃቀምዎ ጋር በተያያዘ በቅርብ ስላለ የወደፊት ህወትዎ ምን ይታይዎታል?

ጥ4) የዕፅ አጠቃቀምዎትን ለመቀነስ ወይም ለማቆም በመሞከር ሂደት ዉስጥ ምን ተግዳሮቶች ወይም እንቅፋቶች አጋጥመውዎታል?

4.1. ፈተናዎቹን አሸንፋችኋል? ከሆነ እንዴት እንደሆነ ይንገሩኝ ?

ጥ5) የዕፅ አጠቃቀምዎን እና አጠቃላይ ደህንነትን በተመለከተ የወደፊት ግቦችዎ ምንድናቸው?

ለቁልፍ መረጃ ሰጭዎች (የአእምሮ ጤና ባለሙያዎች) የቃለ መጠይቅ ጥያቄዎች

ጥ1) ስለራስዎ ሊነግሩኝ ይችላሉ?

ዕድሜ.....

ጾታ.....

የሥራ/ሙያ መጠሪያ.....

የሥራ ልምድ (በዚህ ማገገሚያ ማእከል ስንት አመት ሰሩ ?).....

ጥ2) በተሞክሮዎ መሰረት ታካሚዎች ወይም ደንበኞች ወደ ዚህ የሱስ ማገገሚያ ማእከል በሚገቡበት ጊዜ ለአደንዛዥ እጽ ህክምና ስላላቸው የበጎ ፈቃደኝነት ደረጃ እንዴት ያስባሉ?

2.1 ያለፈቃዳቸው ወደ ማእከሉ እንዲገቡ ስለሚያደርጓቸው ምክንያቶች የበለጠ ሊነግሩኝ ይችላሉ?

2.2 ለአደንዛዥ እጽ ህክምና እና ለመቀየር ስላላቸው ዝግጁነት የበለጠ ንገሩኝ። ብዙ ደንበኞችን ለመለወጥ ያላቸዉን ዝግጁነት እንዴት ይገመግማሉ? በዚህ ረገድ በሚያዩት ነገር ረክተዋል?

ጥ3) አንድ ግለሰብ የዕፅ አጠቃቀም ባህሪን ለመለወጥ ባለው ዝግጁነት ላይ ተጽዕኖ የሚያሳድሩ ነገሮች ምንድን ናቸው ብለው ያምናሉ?