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**PREVALENCE OF SUBSTANCE USE DISORDER AMONG PSYCHIATRY
PATIENTS IN ARMED FORCES COMPREHENSIVE SPECIALIZED HOSPITAL
AT PSYCHIATRY DEPARTMENT**

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**The prevalence of substance use disorder among psychiatry patients in Armed Forces
Comprehensive Specialized Hospital at psychiatry department**

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**A thesis Submitted to the Department of Social Work of St. Mary' s University in Partial
Fulfillment of the Requirements for the Degree of Masters of Art in Social Work.**

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DECLARATION

I hereby declare that the thesis entitled “ Prevalence of substance related disorder among psychiatric patients in Armed Force Comprehensive Specialized Hospital” submitted by me for the partial fulfillment of MSW to St Mary’ s university Addis Ababa is my own original work and has not been submitted earlier either to St Mary’ s university or to any other institution for the fulfillment of the requirement for any other program of study. I also declare that no chapter of this manuscript in whole or in part lifted an incorporated in this report from any other work done by others.

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Acronyms

AUD	Alcohol Use Disorder
MDD	Major Depressive Disorder
OPD	Out Patient Department
SUD	Substance Use Disorder
SPSS	Statistical Package for Social Science
US	United State
DSM	Diagnostic and Statistical manual of mental disorders
CNS	Central Nervous System
SMI	Severe Mental Illness

Abstract

The purpose of this study was to assess the prevalence of substance use disorder among psychiatry patients at psychiatry department of Armed Forces Comprehensive Specialized Hospital. Institution based cross sectional study design was used as study design. The target population of the study was inpatient and outpatient clients. Study Participants were selected by using Convenience sampling technique and purposive sampling technique. The respondents of the study were 92 clients of whom 74 were males and 18 females, two nurses and one senior psychiatrist those worked in AFCSH psychiatric department. Substance use disorder questionnaire, social support questionnaire and key informant interview regarding effects of SUDS on consumers and society were used to collect data. This study employed the mixed (quantitative and qualitative) method approach to collect and analyze data. Descriptive statistic tests like frequency, percentage, table and figure were employed to analyze and present the quantitative data and thematic analysis method was used for that of qualitative one. The finding of the study indicated that the prevalence of substance use disorder among respondents is (58.7%). The most commonly used substances among study respondents were tobacco, alcohol and khat that account about 40.74% of total substances. Most of patients have opportunity to get social support from others (friends/dorm-mates) if they face personal problems. The results of qualitative data revealed that SUDs impact the social functioning of individuals and create a burden for society as whole. Finally, a further research is recommended in order to examine the mechanisms that help to manage substance use disorders among psychiatry patients.

Key terms: prevalence, substance use disorders, psychiatry patients, substance use, Addis Ababa, Ethiopia .

CHAPTER ONE

INTRODUCTION

1.1. Background of the Study

The prevalence of patients with dual diagnosis (comorbidity) suffering from a psychiatric disorder along with co-occurring substance use disorder are increasing through time (Sepehrmanesh, Ahmadvand & Moraveji, 2014). Mental problems range from anxiety and depression that occasionally create problems in daily life, to serious mental health problems with permanent inability to function. There is often a physical and mental health problem, some of them very serious. At the same time, many people with serious mental illnesses have a substance abuse problem. Issues associated with mental health and drug dependency often also result in poor somatic health (NNO, 2013-2016). People cannot be detained solely on the basis of substance "dependency" under the statute. However, person could be detained if substance dependence: co- exists with “ a mental disorder, results in a mental disorder, or it is related to a mental disorder. This includes the mental distress people can experience withdrawing from substances, e.g. confusion, hallucinations. It also includes people who have as a result of their substance abuse, they develop brain damage. In the event of persistent alcohol use, memory loss and confusion might be symptoms of such damage, such as Wernicke's encephalopathy and/or Korsakoff's amnesic syndrome (Galvani & Livingston, 2012).

Globally, substance use disorders are a major public health concern currently with accompanying socio-economic problems. These patients compared with patients who are using drugs merely put more pressure on their families and society (Sepehrmanesh, et al, 2014). Studies show that particularly, substance use in developing countries has extremely increased. This situation poses serious social and public health problems similar to those in most Western societies (Duko, Ayano, Bekana & Assefa, 2015). Substance use disorder, according to diagnostic and statistical manual text (DSM-V) criteria is defined as use of any drug, usually by self-administration, in a manner that deviates from approved social or medical patterns while; substance dependence is the repeated use of a drug or chemical substance, with or without an altered physiologic state caused by repeated administration of a drug, the cessation of which results in a specific syndrome. Whereas a diagnosis of substance use disorder in DSM-5 requires two to three

symptoms from a listed 11 symptoms (DSM-5™ 2012-2013) Substance use disorders (SUDs) and other psychiatric disorders such as schizophrenia, bipolar disorder, depression, and anxiety disorders are highly prevalent disorders worldwide, and lifetime and 12-month use, harmful use as well as dependence of substances are documented to be more prevalent in psychiatric patient populations when compared to the general population (Wenche, Ottar, Turid, Stian & Marit, 2014). Adolescents are often the start of unhealthy habits including smoking, drinking, and using illegal drugs. These habits are linked to higher rates of morbidity and mortality, and they pose substantial public health concerns. Further, these behaviors have been linked to psychiatric disorders in adolescents (Nanna, Merete & Carsten, 2004). Co-morbid substance use disorders with psychotic patients are more prevalent than the general population. Compared to 17% in the general population, lifetime rates of substance abuse may rise to 47% for schizophrenic patients and 56% for bipolar patients. Recent reviews report a 9–36% substance use among psychiatric patients, depending on the setting and criteria for substance abuse definitions (Charles, Didier, Nadine & Anne Catherine, 2006). Accurate information about a patients' recent use of substance abuse is essential in making a diagnostic assessment and planning treatment. Unrecognized substance abuse may be frequent particularly in schizophrenic and in dementia can result in a higher incidence of adverse drug reactions and a less favorable therapy course (Matthew, 2014).

The prevalence of patients with dual diagnosis (co morbidity) suffering from a psychiatric disorder along with co-occurring substance use disorder are increasing through time. Response to treatment in patients with this co morbidity is difficult, regarding the high rate of recurrence and non-compliance to the treatment. Substance abuse has reached epidemic proportions in society, and mental units must address the resulting consequences. (Zahra, Afshin, & Alireza, 2014). Substance use disorders in these patients have negative consequences, including recurrence of disorder, higher admission rates, more severe symptoms, increased risk of suicide, homelessness and violence. Therefore, this co morbidity is high regarding to the rate of dependency and abuse of substance and its effects on course of psychiatric disorders. When compared to patients who do not use drugs, these people simply impose more strain on their family and society. (Aradom, Alemayehu & Hossein, 2018). Using substance such cannabis and amphetamines produce symptoms like schizophrenia that make diagnosis difficult. Many mental disorders are associated with an increased risk of later substance use conditions. Three types of relations are discussed

between substance use and psychosis: 1-Substance use may lead to psychosis onset; therefore, either a cause or precipitant factor; 2-Substance use after onset of psychosis; 3-Substance use beginning concurrent with psychosis onset without affecting each other (Wicomb, Jacobs, Ebrahim, Rensburg & Macharia 2018). Among psychiatric inpatients, a 50% prevalence of substance use disorder is commonly reported. Recent alcohol or drug consumption may have an impact on symptoms, prognosis, and treatment for patients in emergency rooms. Clinical examinations and laboratory studies are used to diagnose current substance use. Urine tests are commonly performed and can reveal information on current substance usage. (Jon, Jorgen, Bjorn et al, 2008). Drugs and metabolites detected in urine may represent intake several days (or weeks) earlier and will not necessarily be related to the acute condition or the current admission. Drugs detected in blood, however, usually indicate more recent drug intake and may be more closely related to the actual situation. For prescription drugs, blood drug concentrations can potentially be used to differentiate between therapeutic or non-therapeutic use (Kim, Mueser, Paul, Yarnold, Stanley & et al, 2000).

1.2. Statement of the problem

Substance use disorders with mental illness are highly prevalent in the general populations which often co-occur within the same individual and rising public health concern. Substance use disorder is a cluster of cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems (Miriam, Ana, Francine & et al, 2017). Substance-induced mental disorders develop in the context of intoxication or withdrawal from substances using and medication-induced mental disorders are seen with prescribed or over-the-counter medications that are taken at the suggested doses. Substance use disorder is frequently found as co morbidity among psychiatric patients, most of them is under diagnosed and a majority of substance using people were not get proper treatment as study shown (Birhanu et al, 2014). Some people who abuse drugs show symptoms similar to those of schizophrenia. Therefore, people with schizophrenia may be mistaken for people who are affected by drugs. Most researchers do not believe that substance abuse causes schizophrenia. However, people who have schizophrenia are much more likely to have a substance or alcohol abuse problem than the general population (Duko et al, 2015). The clinical implications of Co morbidity in mental disorders still remain unexplored.

Who use substance with psychiatric illness are spent more time on using substance, impairments of function, develops hostile behavior, increased severity of symptoms, more likely to relapse, more-frequent hospital admissions, violent and suicidal behavior, poor compliance with treatment (Jill, Jack, & Lisa, 1999). The presence of substance use disorder among psychiatric patient have negative impacts on prognosis, treatment of the patients and also diagnosis and assessment of these co morbid disorders are difficult because of the substantial overlap in the symptoms of substance intoxication, withdrawal, and psychiatric disorders(African Journal of Drug, Kenya, 2008). Little is known about the prevalence of co-occurring substance use disorders in patients with severe mental disorders in Ethiopia. So the aim of this study is to assess the prevalence of substance use disorder among psychiatry patient at Armed Forces comprehensive specialized hospital, Addis Ababa, Ethiopia.

1.3. Research Questions

1. What are the socio demographic factors that affect psychiatric patients?
2. What are the most dominant types of substances used by the psychiatric patients in AFCSH?
3. What is the pattern of SUDs prevalence among psychiatric patients in AFSCH?
4. What are the effects of SUDs on the victims and the society?

1.4. Objectives

1.4.1 General objective

The general objective of this study is to assess the prevalence of substance use disorder among psychiatry patients at Armed Forces Comprehensive Specialized Hospital, Addis Ababa.

1.4.2 Specific objectives

Subjected to psychiatry patients at Armed Forces Comprehensive Specialized Hospital, the study tries to attain the general objective through addressing the following objectives specifically to:

- ✓ Identify the major socio demographic factors that affect psychiatric patients in AFSCH.

- ✓ Assess the most common types of substances used by the clients at Armed Forces Comprehensive Specialized Hospital
- ✓ Examine the patterns of SUDs prevalence among psychiatry patients at Armed Forces Comprehensive Specialized Hospital
- ✓ Investigate the effects of SUDs on the victims and the society.

1.5. Significance of the study

Substance use disorders with mental illness are common in the general populations which often together within the same people and a big public health issue globally. The presence of substance use disorder in this population is a disabling consequence that results in impairment of patients ability to perform their daily tasks. Substance use disorder among psychiatric patients, it is often under recognized, unmanaged and also factors that are predicted to develop substance use disorder among psychiatric disorder is not yet well study.

People with substance use disorder are more likely suffering from mental illness and this leads to poor treatment outcomes, means that the presence of substance use disorder among people with psychiatric disorder have negative impacts on the prognosis and treatment of the patients, it leads to poor outcomes of treatment, behavioral change, suicide, frequent relapse of illness and poor compliance with treatment. As to my knowledge there is limitation of information in Ethiopia that addresses the magnitude of substance use disorder among psychiatric patients.

So the findings of this study will be intended to address the prevalence of substance use disorder among psychiatry patients at Armed Forces Comprehensive Specialized Hospital, and serve as sources of information for the institution, stake holders work on substance use disorder among psychiatric patients and mental health provider to recognize and offer interventions to filling gaps on this topic by formulation of appropriate strategy to modify and to enhance the treatment quality of substance use disorder among psychiatric patients management for the future in the country. The outcome of this study will be expected to serve as base line and comparison reference for further study done on substance use disorder among psychiatric patients in the institution.

1.6. Scope of the study

This study is delimited to assess the prevalence of substance use disorder among psychiatry patients those treated as outpatients and in patients of psychiatry department at Armed Forces Comprehensive Specialized Hospital. The psychiatry department of Armed Forces Comprehensive Specialized Hospital is taken as a focuses of this study because the problem of substance use disorder is more feasible in department especially among outpatient and inpatient clients. The study is confined to identify types of substance and specific categories of substance use disorder.

1.7. Limitation of the study

The study had some limitations that should be noted when considering the results: Social desirability bias may have affected respondents' response. Prevalence rate were also self-reported and dependent on the accuracy with which respondents recalled and reported such use. Additionally the cross sectional study only allows for description of behavior at one point in time. The physical contact of the researcher with adviser and his freely movement to library and other information areas to search for adequate material sources for this thesis work is limited due to COVID 19 spread. The strength of this study the result is consistence with past literature and increasing generalizability of this study.

1.8. Organization of the paper

The researcher has been tried to organized the proposal of study starts with chapter one or introduction part, in this chapter there are different sub topics these supports the researcher to give an overview about the study, also has statement of the problem, objectives, significance and scope of the study etc. are discussed. Next to this, chapter two has literature review that consists theoretical review, empirical review and conceptual framework; the researcher tried to assess different literatures theoretically and empirically, followed by chapter three. This part is very important because it has research design helps to study like compass. Also source and types of data, about sampling technique and processing additionally ethical consideration are discussed in chapter three. In chapter four and five, the researcher discussed about finding of the study, summary, conclusion and recommendation.

1.9. Operational definition of terms

Substance: - substance in this study context is the physical material of drugs or which has discrete existence of the drugs.

Substance use disorder: - Drug addiction, also called substance use disorder, is a disease that affects a person's brain and behavior and leads to an inability to control the use of a legal or illegal drug or medication. Substances such as alcohol, marijuana and nicotine also are considered drugs. Substance use disorders describes both the use of illicit, or illegal, substances and the misuse of legal substances like alcohol, nicotine, or prescription drugs

Prevalence: - The prevalence in this context refers to the widespread of both the use of illicit, or illegal, substances and the misuse of legal substances among psychiatry department patients of the study area.

Current use: those who use (non-medical use only) substance for the last 3 months.

Ever use - those who ever use (non-medical use only) substance in their life

Social support: Support at time when difficulties and critical conditions like financial, social and psychological assessed by Oslo -3 scales which has total of 14 scores & classified into three broad categories Poor support: 3– 8, Moderate support: 9– 11 and Strong support: 12– 14

Mental illness: currently diagnosed with mental illness and weather treated in the past and currently on treatment follow up.

CHAPTER TWO

REVIEW OF RELATED LITERATURE

2.1. Theoretical Review

2.1.1 Concepts and Definitions of SUD

The lives and histories of the persons who grew and used psychoactive drugs are intertwined with the history of psychoactive drugs. People wanted to alter levels of consciousness as well as the perceptions of our sensate bodies by taking substances such as herbs, alcohol, and other drugs. The drugs like opium, cannabis, cocaine have been associated with human cultivators for millennia. Ancient people in Egypt, China, and India e t c used as pain reliever, for robbing grief and anger , drive away evil spirits and anti-biotic effects; they use also for recreational purpose it is continue over time. Alcohol is probably one of the psychoactive substances used by man and remains one of the most widely used recreational substances. Alcohol was widely used in a variety of religious and cultural rites. Along with its functional uses, alcohol was used in the ancient world, as it is today, as an intoxicant (Robinson & Adinoff, 2016).

Substance use disorders reflect more than just substance use. It is strongly correlated with the level of substance use or heavy use over time that involve a pathologic pattern of behaviors in which patients continue to use a substance despite experiencing significant problems related to its use (John & Saunders, 2013). The importance of classifying them as disorders is that it determines whether or not therapy is required (including detoxification, maintenance treatment and other pharmacotherapies).

Drug addiction, also known as substance use disorder, is an illness that affects a person's brain and behavior, resulting in an inability to manage the use of any drug or prescription, whether legal or illicit. Substances like alcohol, marijuana, and nicotine are also classified as drugs (John Saunders, 2013). According to the diagnostic and statistical manual text revised (DSM-I-TR) criteria, substance abuse is defined as: se of any drug in a way that deviates from accepted societal or medical patterns, usually via self-administration; substance abuse The repeated use of a pharmacological or chemical substance, with or without an altered physiologic state generated

by repeated administration of a drug, resulting in a specific symptom after the medication is discontinued.

Medline plus medical encyclopedia defines Substance use disorder occurs when a person's use of alcohol or another substance (drug) leads to health issues or problems at work, school, or home.

The etiology of the high prevalence of substance use disorders in patients with severe mental illness (schizophrenia or bipolar disorder) is unclear (Tekalign, Damena, Andualem, Mossie, & Tesfaye, 2011). Many explanations have been proposed for the high rate of SUD in patients with SMI. A family history of substance abuse; personality features such as high impulsivity or sensation seeking; despair and anxiety; and exposure to physical and sexual violence are all risk factors for substance use disorder. Emotional abuse or trauma; and starting substance use at an early age (Yitayih, Abera & Tesfaye, 2018). A number of theories implicating a broad range of factors have been advanced to explain increased SUD among persons with mental illness. Different models may account for co morbidity in different groups of individuals, and more than one model may apply for a given individual. There are four general models of increased comorbidity, common factor models, secondary substance use disorder models, secondary psychiatric disorder models, and bidirectional models.

Common factors model: - According to common factor model, high rates of comorbidities are the outcome of shared vulnerabilities to both disorders caused by two risk factors: genetics and antisocial personality disorder. The history of one's family (genetics) has been linked to SUD in dually diagnosed people: According to several researches, such people are more likely than similar people to have relatives with SUD. There are at least two plausible causes of a family's shared genetic susceptibility. First, genetic vulnerability to one condition (e.g., SMI) may be related with increased risk to another condition within a family (e.g., SUD). Second, if family members with one condition (for example, SMI) were more likely to mate with those with the other condition (for example, SUD) than would be expected by chance alone. The offspring would be at increased risk to developing either or both disorders due to the individual genetic contributions from each parent. Antisocial personality disorder and its childhood precursor conduct disorder (CD) are strongly related to SUD accounts for some increased co morbidity. Furthermore, ASPD in persons with primary SUD has been consistently linked with a more severe course of illness, including an earlier age of SUD onset, more severe physical

dependence, and more adverse physical, social, and legal consequences of SUD. Socioeconomic status (SES) and cognitive functioning are other possible common factors may independently increase vulnerability to both SMI and SUD. Lower SES, including education, income, and occupation, poverty in general and Impairment in cognitive functioning like genetic factors, early environmental factors, or a combination of both are increasing risk for SMI (e.g. schizophrenia) and SUD (Mueser, Drake & Wallach, 1998).

Secondary substance use disorder models: - These models can be broadly divided into two types: psychosocial risk factor models and the super sensitivity model. Psychosocial risk factor models are consists, the self-medication model and the alleviation of dysphonia model. Self-medication is the most widely held an explanatory view of SUD denotes that individuals seek specific substances to alleviate particular painful affects (Alexander, et al 2004). The underlying assumption is that substances of abuse are not randomly chosen but are selected by the afflicted individual based on their specific psychopharmacologic effects on different internal states of dysphonia (Mueser, et al, 1998).

Alleviation of dysphonia represents a more general explanatory model; it indicates that people with SMI are prone to dysphonic experiences that make them also prone to use psychoactive substances. They are considered to be like others with SUD in that they initially use substances either to feel good or to alleviate feeling bad because individuals with SMI are particularly prone to feeling bad or dysphonic, their high rate of comorbid SUD could be attributed to attempts to alleviate the dysphonia. Psychosocial factors such as social networks, expectancies of drug effects, boredom, dysphonic, unemployment, and poverty “ are critically important in the presentation, development and course of substance abuse. (Alexander, et al, 2004)

The super sensitivity model: -This model is an elaboration of stress-vulnerability models proposed for SMI (e.g. schizophrenia). Vulnerability is defined in terms of a compromised biological sensitivity to stress; it may also apply to the effects of alcohol and drugs (Mueser, et al, 1998). Where by biological vulnerability due to psychiatric disorder results in sensitivity to small amounts of alcohol and drugs, leading to substance misuse (Alexander, et al, 2004). The super sensitivity model also suggests how very risky increased access to drugs and alcohol with deinstitutionalization can be for people with SMI (Mueser, et al, 1998).

Secondary psychiatric illness models: - The theory that SUD can lead to SMI has been hotly debated since the rise of recreational drug use in the 1960s. Most of this debate has centered on the effects of drugs such as stimulants, hallucinogens, and cannabis because of their psychotomimetic effects. In contrast, there is a general consensus that alcohol abuse does not cause mental illness, and may even mask their onset. Models proposing that psychotomimetic drug abuse can lead to long-term psychotic disorders.

Bidirectional models Bidirectional models suggest ongoing, interactional effects between SMI and SUD account for increased rates of comorbidity. For example, SUD could trigger SMI in a biologically vulnerable individual, which is subsequently maintained by continued SUD due to socially learned cognitive factors, such as beliefs, expectancies, and motives for substance use. Despite the intuitive appeal of bidirectional models, and evidence that SUD worsens the course of SMI (Mueser, et al, 1998).

2.1.2 Types of Substances

Any substance, be it prescribed or not, has an impact on the body's central nervous system (CNS). When people take substances it will affect their physical and mental state. For example,

Depressants (alcohol, solvents, sleeping tablets benzodiazepine e.g. diazepam) the effects are:- Depress the CNS, Relief of tension and anxiety, feeling of well-being and calm, possible drowsiness and loss of concentration.

Stimulants (cocaine, ecstasy, amphetamine, steroids, and khat) the effects are:- Stimulate the CNS. Feeling more lively and awake, increased energy and heightened mood, increased stamina, nervousness, anxiety and sleep loss.

Alter perceptual (cannabis, ketamine) the effects are Change people's perceptions, Heightened function senses and mood, Visual distortion and hallucination, euphoric and feeling of floating.

Reduce pain (heroin, codeine, methadone etc.) the effects are:- Reduce sensitivity to pain, Feelings of warmth and contentment. Sedation and sleep can mask symptoms of mental distress.

At high levels of substance use, or when withdrawing from heavy use, symptoms of psychosis are possible. (Galvani & Livingston, 2012)

2.1.3 Criteria for SUDs

Substance abuse, according to diagnostic and statistical manual text revised (DSM-IV-TR) criteria is defined as use of any drug, usually by self-administration, in a manner that deviates from approved social or medical patterns while; substance dependence is the repeated use of a drug or chemical substance, with or without an altered physiologic state caused by repeated administration of a drug, the cessation of which results in a specific syndrome. The DSM 5 recognizes that people are not all automatically or equally vulnerable to developing substance related disorder Some people have lower levels of self-control that predispose them to develop problems if they're exposed to drugs. Substance use disorders span a wide variety of problems arising from substance abuse and are defined by a number of factors:

Taking the substance in larger amounts or for longer than you're meant to

- wanting to cut down or stop using the substance but not managing
- Spending a lot of time getting, using, or recovering from use of the substance
- Cravings and urges to use the substance,
- Not managing to do what you should at work, home, or school because of substance use,
- Continuing to use, even when it causes problems in relationships.
- Giving up important social, occupational, or recreational activities because of substance use.
- Using substances again and again, even when it puts you in danger.
- Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the substance.
- Needing more of the substance to get the effect you want (tolerance).
- Development of withdrawal symptoms, which can be relieved by taking more of the substance.

2.1.4 Specific SUDs and Their Prevalence

In general, the DSM-5 divides substance abuse disorders into three categories, which include intoxication, withdrawal, and substance- or medication-induced disorders (Hasin, Brien, Auriacombe, Borges, Bucholz, Budney, & Grant, 2013). Substance/medication-induced mental disorders are mental problems that develop in people who did not have mental health problems before using substances (Khan, 2020). They include: Substance-induced psychotic disorder, substance-induced bipolar and related disorders, substance-induced depressive disorders, substance-induced anxiety disorders, substance-induced obsessive-compulsive and related disorders, substance-induced sleep disorders, substance-induced sexual dysfunctions and substance-induced delirium. Substance-induced mental disorders are mental changes produced by substance use or withdrawal that resemble independent mental disorders such as depression, psychosis, or anxiety. To be called substance-induced, a mental disorder must be caused by a substance that is known to cause the disease. Substances can be members of the 10 classes of drug that typically cause substance-related disorders: Alcohol, Antianxiety and sedative drugs, Caffeine, Cannabis (including marijuana and synthetic cannabinoids), Hallucinogens (including LSD, phencyclidine, and psilocybin), Inhalants (such as paint thinner and certain glues), Opioids (including fentanyl, morphine, and oxycodone), Stimulants (including amphetamines and cocaine), Tobacco and Other (including anabolic steroids and other commonly abused substances).

Intoxication refers to the immediate and temporary effects of a specific drug (Khan, 2020). Intoxication impairs the person's mental function and judgment and may alter mood, depending on the substance, the person may experience an increased sensation of well-being (or euphoria), or they may feel calmer, more relaxed, and less agitated, sleepier than usual. Many drugs impair physical functioning and coordination, leading to falls and vehicle crashes. Some drugs trigger aggressive behavior, leading to fighting. As more of the medication is consumed (referred to as an overdose), unfavorable effects become more apparent, leading to major difficulties and, in some cases, death. Substance intoxication is a group of substance-induced disorders, details the symptoms that people experience when they are "high" from drugs. Disorders of substance intoxication include: Marijuana intoxication, cocaine intoxication, methamphetamine intoxication (stimulants), heroin intoxication (opioids), acid intoxication (other hallucinogen intoxication or "acid trip") and substance intoxication delirium.

When people stop taking a substance or use much less than normal, they experience withdrawal symptoms (khan, 2020). Withdrawal results in a variety of unpleasant symptoms that vary depending on the substance. Withdrawal from certain drugs (such alcohol or barbiturates) can be dangerous and even fatal. Most people who are suffering from withdrawal are aware that increasing their subs will help them feel better will reduce their symptoms. The presence of withdrawal is determined solely by the substance and the length of time it has been used, not by whether the person has a substance use problem, is using the substance recreationally, or is using the substance illegally. Even when taken as prescribed for genuine medical reasons and for a relatively short period of time, several prescription medicines, particularly opioids, sedatives, and stimulants, can cause withdrawal symptoms. Previously, people who experienced withdrawal symptoms were labeled as physically dependent on the narcotic. However, because the term "dependency" has a negative connotation that suggests illicit drug usage, doctors prefer to avoid using it.

Substance-induced neurocognitive disorders Substance use disorders (SUDs) and other psychiatric disorders such as schizophrenia, bipolar disorder, depression, and anxiety disorders are highly prevalent disorders worldwide among psychiatry patients (Toftdahl, Nordentoft & Hjorthoj, 2016). World Health Organization (2004) documented that substance use or abuse disorders are important causes of disease burden accounting for 8.8% and 16.6% of the total burden of disease in low income and lower middle-income countries, respectively (as cited in Kiyati & Hauli, 2011).

2.1.5 Effects of SUDs on the Society and Users

Substance abuse problems not only mean a reduced life span and quality of life for the individual, but also high costs for society. SUDs impact the social functioning of individuals and create a burden for society as well (Daley, 2013). The drug use extends far beyond the user, often damaging their relationships with their family, community, health workers, volunteers, and wider society (Thomas. Social problems associated with SUDs include housing instability, homelessness, criminal behaviors and the transmission of HIV and hepatitis C due to IV drug use or high-risk sexual behaviors. Creating an economic burden for governments or payers who spend considerable sums of money on treatments for addiction, medical or psychiatric disorders, and other related problems such as those associated with welfare dependence, unemployment, or

involvement in the criminal justice or social service systems (Daley, 2013). In UK cost to the community and society of drug abuse is colossal. Drug abusers are estimated to commit 36 million drug-motivated crimes each year which financially accounts for 90% of the total cost to society. Drug abuse is associated with higher rates of foster care child placements, child abuse, college sexual assaults, prison sentences, and lost productivity coupled with increased work-related injuries. (Daley 2013).

Current trends showed that the use of psychoactive substances have considerably increased predominantly in developing countries (Hibro, et al 2019).The burden of substance use disorders (SUDs) in sub-Saharan Africa has been projected to increase by an estimated 130% by 2050 (Florence & Edith, 2020). Study shows that in south Africa high cases of drunken driving that increase mortality rate related to car accidents especially over the festive season is caused by alcohol abuse also alcohol and drug use are estimated to be responsible for around 5% of the global disease burden (Zamokuhle & Nirmala, 2020). Among both adults and adolescents in Kenya, substance use has been linked to risky sexual behavior which is a major driver of Human Immunodeficiency Virus (HIV) transmission.

2.1.6 SUDs in Ethiopia

Use of substances such as alcohol, khat leaves (*Catha edulis*) and tobacco has become one of the rising major public health and socioeconomic problems worldwide and dramatically increased in developing countries (Hibro, et al 2019). Substance abuse is on the rise in Ethiopia, as it is in many other developing countries. Alcohol and khat are the most frequent substance of abuse, followed by cannabis and solvents. Hard narcotics like heroin and cocaine are used infrequently. Even if substance abuse is a major factor to develop mental illness, there is no enough study done about the problem. Institution based cross sectional study done at Amanuel mental socialized hospital the prevalence rate of substance related disorders among patients with severe mental illness is high. About 84.4% (bipolar) and 82.7% (schizophrenic) patients were life time substance users, while 77.4% (bipolar) and 75% (schizophrenic) patients were current substance users (Duko, Ayano, Bekana, & Assefa, 2015). The most commonly used substance, 61.8% and 59.6% khat, and 61.3% and 59.2% alcohol for bipolar and schizophrenic patients respectively.

According to Duko, et al (2015) study conducted at Amanuel Mental Specialized Hospital, Addis Ababa, Ethiopia, of all substance users, 49.8% (bipolar) and 48.1% (schizophrenic) were poly substance users, of which 42.1% and 40 % were used Alcohol and khat in their life time and, 34.5% and 32.3% were life time users of Alcohol and nicotine respectively. According to Zenebe, Negash, Feyissa, and Krahl (2015) study result that conducted at Jimma University specialized Hospital, among the study participants the estimated prevalence rate of alcohol use disorders was 38.9%, with 23.3% hazardous drinking, 5.8% alcohol abuse and 9.8% alcohol dependence. Alcohol use disorders were reported by 45.3% males whereas only 21.4% of the females reported. The Same study done at Butajira revealed that the respondents (36% males and 15% females) admitted as they currently drank alcohol (Fikadu, 2007). Another study at Jimma correctional center indicated that, there was a high lifetime prevalence of substance abuse (64.1%) most notably khat in 44% of offenders 35.9% were mentally distressed (Tesfaye & Gurmu, 2016).

2.2. Empirical review

Recent studies in America indicated that nearly 21 million adults in the United States have a substance-related addictive disorder in 2019. The lifetime co-occurrence of mental disorders and substance abuse disorders is estimated at 50%. The onset of mental disorders however preceded the initiation of substance abuse in 83.5 % of the cases (Benson, et al, 2015). In Norway study, the result shows that, those with mood disorder reported the highest frequency of smoking, alcohol and illicit drug use, it increase prevalence of risky health behavior among adolescents with psychiatric disorder compared with the general population (Wenche, Ottar, Turid, Stian & Marit, 2014). A cross sectional study done in Swiss the lifetime prevalence of substance use among psychiatric patients was very high for alcohol (98%), benzodiazepines (86%) and cocaine (25%) opiates (20%). Regular current use of alcohol (32%), cannabis (17%) was the most frequent. Benzodiazepines are widely used in all diagnostic categories, with frequencies ranging from 40% for psychotic disorders to 58% for alcohol use disorders. Cannabis use is the most frequent among psychotic disorders with 22% of regular and 18% of sporadic cannabis users.

Cocaine appears the most frequent, most often sporadically among psychotic and mood disorder patients 6– 7% (Didier, Nadine, Anne & Catherine, 2006).

Charles An analytical-cross sectional study in Iran indicated that the prevalence of substance use disorder was (36.7%), which (18.1%) of them had more than one psychiatric disorder except substance use disorder mood disorders (52.9%) and anxiety disorders (14.7%), substance-induced psychotic disorder (11.9%) and psychotic disorders (11.9%), respectively. The most common pattern of substance use was opium with amphetamine and other substances (poly substances) in 55.8% patients (Zahra, Afshin & Alireza, 2014). Institutional based cross sectional study done at Jerusalem Mental Health Center in Israel revealed that the lifetime prevalence of drug abuse was 24%; (cannabis 19.7%, opiates in 5.7%, cocaine in 2.7%, amphetamines in 3.4% and methamphetamine in 1.1%. Current active abuse of drugs was 17.3%, cannabis 11.5%, opiates 4.9%, amphetamine 3.8%, cocaine 1.3% and methamphetamine 1.1% 28.2% of active abusers used two or more substances. In 41.6% the drug abuse appeared prior to symptoms of the mental disorder; in 37.1% the duration of the mental disorders and the drug abuse was relatively similar, and in 21.3% of cases the duration of mental problems was longer than the duration of drug abuse. In terms of mental disorder Schizophrenia, schizoaffective, schizophreniform (55%), Affective disorders (17%), Personality disorders (5%).(Gregory, et al, 2008). Study shows that the prevalence of mental illness and illicit substance use has increased markedly in South Africa. Case Study done in Northern Tanzania at Bugando Medical Centre indicated that the most frequently used substances were alcohol (59.3%), tobacco (38.6%) and cannabis (29.3%), whereas heroin and cocaine were the least used (2.1% and 1.6%, respectively) (Kiyeti, et al, 2011). A descriptive cross sectional study done in Kenya revealed that the most commonly abused substance was alcohol at 56% with more males (thirty one-41.7%) than females (Eleven 14.7%). Others included cigarette 25.3% and cannabis among others. Substance abuse was significantly associated with the diagnosis of schizophrenia 20% and bipolar mood disorders 13.3% (Gakinya, et al, 2015). Cross-sectional study done at Haramaya University in Ethiopia revealed that 41.0% were chewed khat at least once in their lifetime and the current use of khat is 23.6%. Concerning alcohol drinking 50.2% reported that they drank alcohol at least once in their lifetime while 20% were drinking alcohol over the last 30 days prior to the study. The study showed that 22% of the respondents smoked cigarettes at least once in their life time whereas 10.8% of the respondents have smoked cigarettes in the past 30 days. Furthermore, 17.4% of the study participants used illicit drugs like hashish at least once in their lifetime. 7.4% of the participants have used illicit drugs in the last 30 days (Gezahegn, Andualem, & Mitiku, 2014). A

cross-sectional community-based study was conducted in Jimma city over a quarter of the study indicated that participants (51.5%) were found to have mental distress (26.6%) of male and (24.9%) of female participants. Daily chat chewers and those who used khat for the last six months showed mental distress with a prevalence of 41.0% and 39.1%, respectively. Among the khat users with mental distress, 45.5% were smokers and 38.5% drank coffee during the chewing session and 43.9% took alcohol after chewing session Khat use, frequency and duration of khat use had significant association with mental distress (Kim, Robert & Michael, 2004). Institution based cross-sectional study was conducted at Amanuel Mental Specialized Hospital shows that 84.4% Bipolar patients and 82.7% Schizophrenic patients had used substance, 78.10% and 78.10% were current users, 84.4% and 82.7% were life time users of any substance respectively for bipolar and schizophrenic patients. The most commonly used substances are khat and alcohol. About half of the study participants (bipolar and schizophrenic patients), 49.8% and 48.1% were poly substance users, of which 42.1% and 40 % were used Alcohol and khat in their life time and, 34.5% and 32.3% were life time users of Alcohol and nicotine respectively (Duko, et al, 2015).

2.3. Conceptual frame work

Socio demographic factors

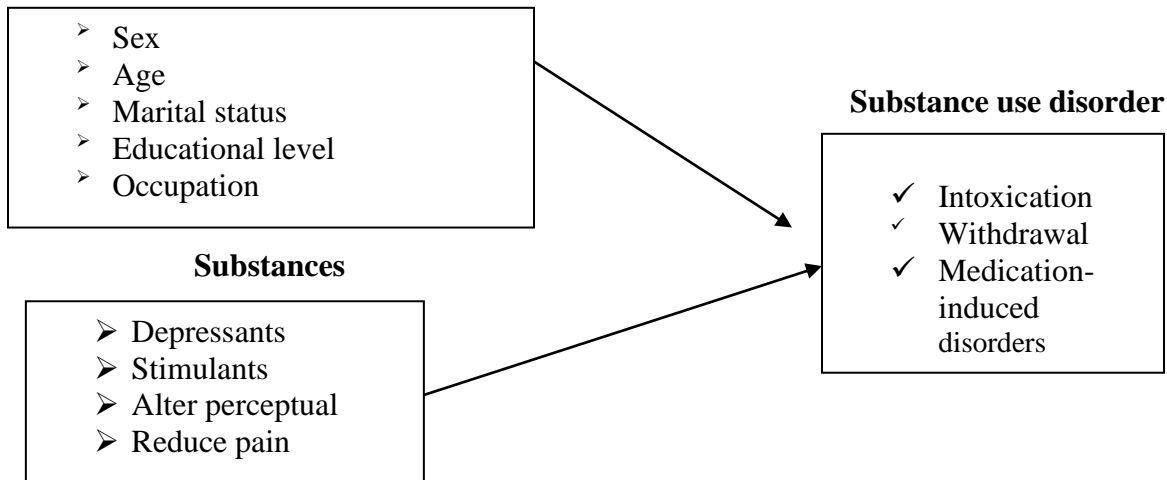


Figure 1: conceptual framework:

Source (Own literature)

CHAPTER THREE

RESEARCH METHODOLOGY

3.1. Description of the Study area

The study was conducted in Armed Forces Comprehensive Specialized Hospital at psychiatric clinic. AFCSH is found in Addis Ababa, capital city of Ethiopia. AFCSH is one of the oldest hospitals which were established in 1930 E.C during the marrow of Ethiopia-Italian war. It is located western part of Lideta sub city kebele 02/ 03 and far from Federal court of Lideta 1.5 KM western.

It provides service for approximately 8200 inpatient and 90,000 outpatient attendances per year, serving catchment population of about 1 million people. Out-patient treatment services for psychiatry were established in 1984 E.C. Now psychiatry department provide service for a total of 200 Patient at outpatient and inpatient level monthly. AFCSH has been taken referral from four army command referral hospitals, from 25 army health center and from all army clinics around Addis Ababa. Also give public service for those needs psychiatry treatment.

The hospital has 600 beds and well organized with human resources, instruments and infrastructure. This Hospital gives medical, surgical, pediatric, psychiatry, all HIV related services, obstetrics & gynecology etc. service.

3.2. Study design

An institutional based cross sectional study was conducted from May to June, 2020. In a cross-sectional study, the investigator measures the outcome and the exposures in the study participants at the same time (Setia, 2016). Unlike in case– control studies (participants selected based on the outcome status) or cohort studies (participants selected based on the exposure status), the participants in a cross-sectional study are just selected based on the inclusion and exclusion criteria set for the study. Once the participants have been selected for the study, the investigator follows the study to assess the exposure and the outcomes. Cross-sectional designs are used for population-based surveys and to assess the prevalence of diseases in clinic-based samples.

3.3. Sources of Data and data type

The study employed both primary and secondary data sources. Hence, primary data were gathered through questionnaire and interview, while secondary data were gained through document review of journals, articles and other researches.

3.4. Sampling Technique and Sample Size

The study population was psychiatric patients who come for treatment and follow-up in Armed Forces Comprehensive Specialized Hospital during study period and nurses and psychiatrist work at psychiatric department. The sample size of key informants was determined purposely based on the knowledge regarding the SUDS and voluntary of interviewees. Sample size for patient respondents was determined based on substance use disorder among Psychiatry patients by using Yamane's sample size determination formula. The patient target population number was approximately 120.

The sample size for this study was calculated by Yamane formula, of

$$n = \frac{N}{1 + N(e)^2}$$

With 95% confidence level. N=120, e=0.05; Then, n=92 and 3 key informant respondents were selected purposively; therefore the total number of respondents was 95.

3.5. Sampling techniques

In this study, the researcher used convenience sampling and purposive sampling techniques of non-probability sampling method. The respondents of this study for questionnaire were taken from psychiatric department in which people with mental disorder are seen. A convenience sample simply includes the individuals who happen to be most accessible to the researcher. It was used to select the study respondents from patients. Nearly 120 psychiatric patients in one month are attending at psychiatric clinic of Armed Forces Comprehensive Specialized Hospital. The respondents for interview questions were purposely taken from psychiatric clinic two nurses and one senior psychiatrist who were voluntary to be interviewed for the study.

Inclusion and exclusion criteria

All psychiatric patients aged 18 years and above were included in the study whereas the patients that are agitated, severely retarded and those who having impairment of hearing and severely ill patients who are unable to communicate were excluded from the study.

3.6. Data collection method

In this study, questionnaire and key informant interviews were used as data collection tools. Data was collected using standardized questionnaire from psychiatric outpatients and inpatient who attending treatment at psychiatric clinic of Armed Forces Comprehensive Specialized Hospital by two BSc nurses, one MSc supervisor and also the principal investigator partake in the supervision. For those data collectors and the supervisor one hour orientation was given. During the orientation the objective of the study, data collection methods and how to handle ethical issues was discussed with the data collectors and supervisor. The key informant interview was used to collect the data regarding the effects of SUDS on the users and society. The key informant interviewees were two voluntary nurses and one senior psychiatrist those work at psychiatric department. Patient chart reviews was done for recording types of illness. Data was collected at OPD and inpatient level from voluntary patients who were selected in the sample size.

The questionnaire was translated to local language (Amharic) with backward forward translation method in order to assure the same meaning given to the items of the instrument whereas the interview was used in English version since the interviewees could respond in the version as it is. The data was collected by using questionnaire which measure ever use and current use of substances by yes/no responses developed according to different literatures. Socio-demographic variables were assessed by using questioners.

To assure the data quality, high emphasis was given on data collection instruments. Pre-test was (pilot study) carried out on 5% AIR FORCES hospital two week before the actual data collection. During pre-test the questionnaire was checked for its clarity, simplicity, easily understandability, coherency and time needed for interview was estimated. Regular supervision, control as well as support for data collectors by one coordinators and principal investigator were made. The collected data was checked on daily basis for completeness and consistence.

3.7. Data processing, analysis, interpretation and presentation

The entire Questionnaire was checked for completeness. The data was edited, cleaned, coded and entered in the computer using Epic-data then it was exported to SPSS 20 version statistical software for analysis. Descriptive statistics was used for data analysis. Both Socio-demographic characteristics of respondents and data gathered from respondents through questionnaire were analyzed by descriptive statistics. Results is presented in the form of table, figures & chart using frequency & summary statistics by percentage to describe the study population in relation to relative variables and discussed with previous results.

3.8. Ethical consideration

Ethical clearance was obtained from Ethical Review Board of University of St. Mary' s research and training department Ethical Review committee. In addition, permission was taken from Armed Force comprehensive specialized hospitals Ethical Review committee, written informed consent was obtained from patients who were participate in the study. Each respondent was informed about the objective of the study that it was contribute necessary information for policy maker & other concerned body. Any who is not willing to participate in the study was not forced to participate. They were also informed that all data obtained from them would kept confidentiality by using code instead of any personal identifier & is meant only for the purpose of study. During the data collection time the data collectors takes safety aware measure to respondents to prevent COVID19 with social distance of 2 meter between individual according to WHO recommendations, effective hand washing with hand soap for 20 second before and after data collection, use sanitizer before and after data fill, appropriate mask use.

CHAPTER FOUR

RESULT AND DISCUSSION

This section presents findings of the study. It contains two main sections. In the first section, the socio-demographic information of respondents was presented. In the second section, the responses of respondents to questionnaire by using frequency, percent, table, figures & chart using frequency for the female and male groups and for inpatients and outpatients groups are presented.

4.1. Socio-demographic and Economic Characteristics of the Respondents

Table 1: The Socio-demographic and economic characteristics of enrolled psychiatry patients (n=92)

Variable		Frequency	Percent
Age	18-26	20	21.7
	27-34	15	16.3
	35 -43	30	32.6
	44-52	23	25.0
	> 53	4	4.3
Sex	Male	74	80.4
	Female	18	19.6
Marital status	Single	59	64.1
	Married	28	30.4
	Divorced & separated	5	5.4
Educational status	read and write only	9	9.8
	primarily school	20	21.7
	Secondary school	34	37.0
	College/university	29	31.5
Job	Active military	28	30.4
	Pensioned	39	42.4
	Civilian	13	14.1
	Others ^Y	12	13.0
Living condition	Alone	27	29.3
	With partner	22	23.9
	With family	43	46.7
Monthly income	< 750 ETB	11	12.0
	751- 3000 ETB	32	34.8
	3001- 5000 ETB	34	37.0
	>5000 ETB	15	16.3

4.1.1. Social support characteristics of respondents

As to this study result, 33 (35.9%) respondents were reported that 1 or 2 people may close to them if they have serious personal problems, 56 (60.9%) participants stated some were concerned about them and show what they do, regarding of getting help from friends/dorm-met when needed, 38 (41.3%) were listed getting help from friends or dorm-met is possible (Table 3).

Table 2: Social support characteristics of the respondents

Number of people close to you	1.None	9	9.8
	1 or 2	33	35.9
	3-5	23	25.0
	More than 5	27	29.3
Number of people concern about you	No concern and interest	8	8.7
	Little concern and interest	24	26.1
	Some	56	60.9
	a lot	4	4.3
Number of people help to you	Very difficult	2	2.2
	Difficult	29	31.5
	Possible	38	41.3
	Easy	22	23.9
	Very easy	1	1.1

4.1.2 Prevalence of substance use disorder among respondents

In this study, out of the 92 respondent, 54 (58.7%) of them had a history of substance abuse. This indicated that the prevalence of SUDS among respondents of this study is high. These substances included cigarettes, alcohol, khat chewing, tobacco and other illicit drugs. prevalence of substance use disorder among psychiatry patients at Armed Forces comprehensive specialized hospital, Addis Ababa, Ethiopia, 2020 (n=92) of total substance used participants 52 (56.5%) responded that they use substance currently followed by 38 (41.3%) no substance use history and the rest respondents 2 (2.1739%) ever use in their life time (figure2).

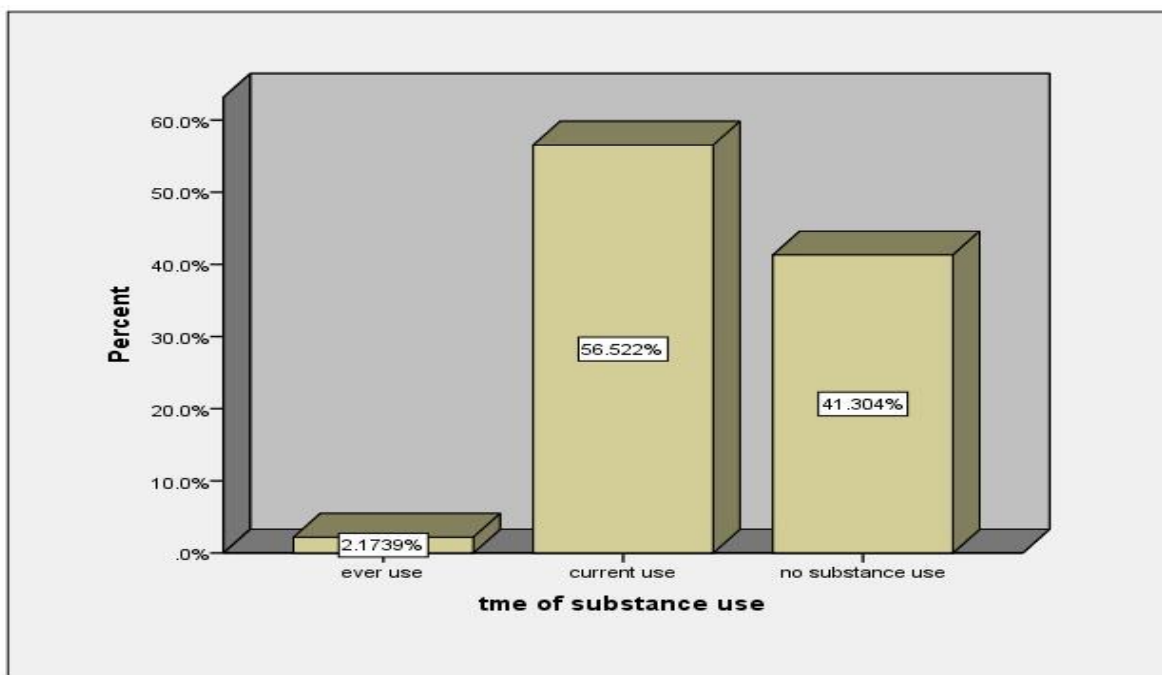


Figure 2: Time distribution of prevalence of substance use disorder among psychiatry patients (n=92)

As indicated in this study results, from total currently substance users people, 22 (40.74%) of respondents used tobacco, alcohol and khat followed by 11(20.36%) respondents were drinking any of the available types of alcoholic beverage or any combination of them and use tobacco, 9 (16.69%) of them were drinking any of the available alcoholic beverage, tobacco, khat and others (cannabis, diazepam and Pethidine) in the past year.

Table 3: Frequency and Percentage distribution of type of substance use among psychiatry patients (n=92)

Variable	Frequency	Percent
Tobacco	1	1.85
Alcohol	6	11.1
Tobacco and Alcohol	11	20.36
Tobacco, Alcohol and khat	22	40.74
Alcohol and khat	5	9.25
Tobacco, Alcohol, khat and others	9	16.69

4.1.3 The effects of SUDS on users and society

The key informant interviewees were asked the key informant interview questions regarding the effects of SUDS on users and society. The interviewees responded that SUDS have many negative effects both on the users and society as a whole. These effects described by respondents include increasing mental illness problems among users, social isolation, decreasing productivity capacity among users, decrease social economy by hindering productive man power and increasing cost in medical and in buying these substances both for the users and society as a whole.

4.2 Discussion

This study focused on different categorical status of psychiatric patients socio demographic, prevalence of substance related disorder among psychiatric patients at Armed Force Comprehensive Specialized Hospital in psychiatry ward clients who were admitted (in patients) and out patients.

The respondents completed the distributed questionnaire, 92(100%) properly and returned it to the researcher, which is 74(80.4%) were male whereas 18(19.6%) are females. As substance abuse is one of the problems among study respondents, males are more exposed to substance abuse. The age of the respondents was mainly between 35-43 years 30(32.6%). This study indicates that the majority of patients are at adult stage. 59 (64.1%) of the respondents were

single followed by married 28 (30.4%). The results of this study indicated that non married are more exposed to substance abuse and psychiatric problem than married. 43 (46.7%) of them were living with their family, it suggest that they have no confidence to live alone and they are dependents.

In this study, out of the 92 respondents, 54 (58.7%) of them had a history of substance use. This result indicated that the prevalence of SUDS among respondents of this study is high. These substances included cigarettes, alcohol, khat chewing, tobacco and other illicit drugs. The possible reason is the availability of substances and more of clients are not working or they are pensioned and substance abuse and mental illness are interrelated each other.

From total currently substance users people, 22 (40.74%) use tobacco, alcohol and khat followed by 11(20.36%) were drinking any of the available types of alcoholic beverage or any combination of them and use tobacco, 9 (16.69%) were drinking any of the available alcoholic beverage, tobacco, khat and others (cannabis, diazepam and Pethidine) in the past year. The reason is as mentioned above. The least substance used is tobacco only 1 (1.85%) khat and followed by alcohol which is 5 (9.25%).

The overall magnitude of substance use for at least one substance was 58.7%. This study is lower than a similar study done at the Moi Teaching and Referral Hospital, in Kenyan which was 87%(David M. Ndeti1, MatteoPizzoet al 2008) and Case Study done at Bugando Medical Centre; in Northern Tanzania was 68.5% (David M,Mary B.et al 2011). The possible reasons for this difference might be due to the difference in data collection instrument, socio-demographics and culture.

This Study result is higher than a study done at woreta town, in Northwest Ethiopia, where the magnitude of substance use was 47.9%(Anteneh.M, Telake, Solomon, 2014).The difference in magnitude from that of woreta town might be due to the difference in the study area where in this part of the country there is easy availability and accessibility of substances especially khat, tobacco and alcohol which are frequently taken by psychiatric patient, and are relatively socially acceptable due to different sociocultural environment. By the same case the study shows that in Amanuel mental specialized hospital (84.4%) (Bipolar patients) and (82.7%) (Schizophrenic patients) had used poly substance (Duko B, Ayano G, Bekana L, Assefa D, 2015).

The effects of SUDS on users and society include increasing mental illness problems among users, social isolation, decreasing productivity capacity of users, decrease social economy by hindering productive man power and increasing cost in medical and in buying these substances both for the users and society as a whole. The findings in previous study supported these results, for example, research conducted by Daley (2013) revealed that SUDs impact the social functioning of individuals and create a burden for society as whole. The drug use extends far beyond the user, often damaging their relationships with their family, community, health workers, volunteers, and wider society.

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1 Summary of Major Findings

The purpose of the study was to assess the prevalence of substance use disorder among psychiatry patients at psychiatry department of Armed Force Specialized General Hospital.

This study employed the mixed (quantitative and qualitative) method approach to collect and analyze data. Descriptive statistic tests like frequency, percentage, table and figure were employed to analyze and present the quantitative data and thematic analysis method was used for that of qualitative one. Institutional based cross sectional study design was used for this study.

The target population of the study was inpatient and outpatient clients. Regarding gender, the majority of respondents are males which account about 74 (80.4%) and only about 18 (19.6%) are female respondents. Regarding marital status, unmarried respondents are large in number which accounts about 59 (64.1%) followed by married respondents that account about 28 (30.4%).

Study Participants were selected by using Convenience sampling technique and purposive sampling technique. The substance use disorder and social support questionnaires were used as data collection instruments. The SPSS version 22 was used to perform data entry and statistical analysis such as frequencies, percentage and tables were used.

Accordingly, the major findings are summarized as follows; From the results of this study, most of patients have opportunity to get support from others (friends/dorm-mates) if they face personal problems. The prevalence of substance use disorder among patients is about 54 (58.7%). From total currently substance users people, 22 (40.74%) of respondents used tobacco.

The effects of SUDS on users and society include increasing mental illness problems among users, social isolation, decreasing productivity capacity of users, decrease social economy by hindering productive man power and increasing cost in medical and in buying these substances both for the users and society

5.2 Conclusion

The problem of substance use disorders continues to be a major public health challenge. This study has demonstrated that the prevalence of substance use among psychiatric patients in Armed Forces comprehensive specialized hospital is high at 58.7% with more Male users compared to the female. From total substance use participants 52 (56.5%) respondents used substance currently and in past years. The most commonly used substance 22 (40.74%) was tobacco, alcohol and khat followed by 11(20.36%) were drinking any of the available types of alcoholic beverage or any combination of them and use tobacco. Therefore, the researcher has concluded that the substance use disorder is the great problem among psychiatric patients at study area.

The results of qualitative data revealed that SUDs impact the social functioning of individuals and create a burden for society as whole.

To conclude, it can be said that the study revealed clear picture of substance use disorder among psychiatric patients. The results of this study indicated that non married are more exposed to substance abuse and psychiatric problem than married. And also it revealed that males are more exposed to substance abuse. Therefore, the researcher has concluded that it is better to mitigate the problem of SUDS among patients and its effects on the society at large. The great problem of SUDS among psychiatric patients is a potential venue calling for future research on handling mechanisms. Besides, the data will be valuable in investigating how a psychiatric clinic respond to managing SUDS in the use of a variety of organizational policies and practices, which is largely created to help manage substance abuse behavior and prevent SUDS issues.

5.3 Recommendation

Based on the major findings of this study and conclusions presented, the following recommendations can be given;

- ❖ The risk of substance use disorder is high in this study population; therefore, the government should design and provide advanced interventions program for the target group in order to handle the problem at large.
- ❖ Additional researches should be conducted by experts in the issue area to investigate the

effective mechanisms that help to handle substance use disorders and behaviors of the patients/clients.

- ❖ The increased costs of care and poor outcomes associated with substance use disorders needs the ongoing focus of the public, families, researchers, clinicians, practitioners, and other stakeholders. So, the Hospital should create conducive environment for those concerned body to work on the problem widely and deeply.
- ❖ There is high prevalence of substance use; this cannot be ignored in the management of psychiatric disorders in psychiatric hospitals. So, it needs call for routine screening for substance use in psychiatric patients and subsequent management of the same in addition to the psychiatric management. Therefore, screening, assessment, and integrated treatment plans for dual diagnosis that can address both the addiction disorder and the mental illness are recommended in order to provide accurate treatment, after-care, and other health care to accommodate patients' social and vocational needs.
- ❖ Psychiatry department of Armed Force Specialized General Hospital should give substance abuse management training for patients especially for male and unmarried patients.

Therefore, screening, assessment, and integrated treatment plans for dual diagnosis that can address both the addiction disorder and the mental illness are recommended in order to provide accurate treatment, after-care, and other health care to accommodate patients' social and vocational needs.

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Appendixes

English version consent form

Dear Participants:

My name is; I am here by in the behalf of Selamawit Nigussie who is a student undertaking a Master degree in social worker in university of St. Mary' s. One of the requirements for the degree is to conduct a research project. This letter serves to ask consent from you to take part in this research. The purpose of this study is to assess the prevalence of substance use disorder among psychiatric patient. This will be critical input for policy makers and institutions involved on care and support for substance use disorder patients. Your participation in this research is voluntary. If you decide not to participate there will be no negative consequences for you. Your participation on this study is very important for achievement of the study and for paving the way for the integration of mental health service in the care of substance use disorder thereby increasing the quality of care for this population. There is no any risk that will come to you because of your participation in this study. All the responses given by you and results obtained will be kept confidential using coding system whereby no one will have access to your response. You are not expected to give your name or phone number. Without permission from you and legal body, any part of this study will not be disclosed to third person. You have full right to refuse and withdrawal to participate in this study if you don' t wish. The interview period will take about 10 minutes. If you are willing to participate in this study, you need to understand and sign the agreement form, and then you will asked to give your responses by data collectors.

Name of investigator: Selamawit Nigussie tel. 0913212908

Are you voluntary to participate in the interview? Yes No

English version questionnaire

INSTRUCTION: The questionnaire has the following parts. It will take about 15 minutes to complete the questionnaire. Please try to respond all questions. Thank you very much for your patience.

Part 1: Socio demographic information

S.No	Questions	Alternative response	Coding
1	How old are you?	Age in years-----	
2	Sex	1. Male 2.Female	
3	What is your marital status?	1. Single 2. Married 3. Divorced 4. Widowed 5. Separated	
4	What is your educational level?	1. Cannot read andwrite 2. read and write only 3. primarilyschool 4. Secondaryschool 5. College/university	
5	What is your job?	1.Active military 2.Pensioned 3.Civilian 4.Specifyother_____	
6	Living condition	1. Alone 2. Withpartner 3. With family 4. Withothers	
7	How much in average do you think your Monthly Income? (ETB)	1. < 750Birr 2. 751- 3000Birr 3. 3001- 5000.Birr 4. >5000 Birr	

Part 2: Questions to assess social support (SSQ)

The following 3 questions ask about how you experience your social relationships. The inquiry is about your immediate personal experience.

S.No	Social Support questions	Response
1	How many people are so close to you that you can count on them if you have serious personal problems (choose one option)?	1.None 2.1 or 2 3.3-5 4.More than 5
2	How much concern do people show in what you are doing (choose one option)?	1. No concern and interest 2.Little concern and interest 3. Uncertain 4. some 5. alot
3	How easy is it to get practical help from friends or dorm-mates if you should need it (choose one option)?	5.Very easy 4. Easy 3.Possible 2.Difficult 1. Very difficult

Part - 3: Substance use assessment questions for Psychiatric Patients

S. No.	Questions
1	Do you use substance? 1. Yes 2. No
2	In your lifetime, which of the following substances have you ever used?(non – medical use only)
	1.Tobacco products(cigarette)
	2. Alcoholics beverages (beer, local areke wines, etc.)
	3.khat
	4.Cannabis
	5. Cocaine
	6.Opioids
	7. BZDs
	8.others

3	In the past three months, which of the following substances have you used?(non – medical use only)
	1.Tobacco products(cigarette)
	2. Alcoholics beverages (beer, local areke wines, etc.)
	3. Khat
	4.Cannabis
	5. Cocaine
	6.Opioids
	7. BZDs
	8.others

English Version key informant interview

INSTRUCTION: The interview has two questions. It will take about 10 minutes to complete. Please try to respond the questions honestly. Thank you very much for your cooperation!

1. What are the negative effects of substance use disorders on the users?
2. Do SUDS have negative effects on the society? If yes, what are the effects of it on the society?

Amharic version Questionnaire

ውድ የጥናቱ ተሳታፊ

ኮድ -----

ስሜ እባላለሁ ጥናቱን የሚያጠኑት ሰላማዊት ንጉሴ በቅድስት ማርያም ዩኒቨርሲቲ በሶሻል ወርክ ማስተርስ ዲግሪ በመማር ላይ ይገኛሉ። ይህም ጥናት ትምህርታቸውን ለማጠናቀቅና ለመመረቅ እንደአንድ ግብዓት ነው። ለዚህም ፈቃደኛ መሆንዎን እንጠይቃለን። የዚህ ጥናት ጥቅም ከሱስ ጋር ተያይዞ የስነ አዕምሮ ችግር ምን ያህል እንደሆነ ለማወቅ ወይም ለመረዳት ይጠቅማል። ይህም ጥናት ለተቋሙ እንዲሁም ለፖሊሲ መቅረጽ ጥሩ ግብዓት ይሆናል። በዚህ ጥናት ውስጥ የእርሶ ተሳታፊነት በፈቃደኛነት ላይ የተመሰረተ ነው። ይህም ለጥናቱ ውጤት ማለት ለሚሰጠው አገልግሎት ጥራት መጨመር ይጠቅማል። የርሶም መልስ እንዲሁም ማንነት ሚስጥራዊነት የተጠበቀ መሆኑን ለማሳወቅ እንፈልጋለን። ከእርስዎ ፈቃድ ውጭ ለሶስተኛ ወገን የዕርሶ መልስ ተላልፎ አይሰጥም። ስምዎንና አድራሻዎን ወይም ስልክዎን ማሳወቅ አይጠበቅብዎትም። ቃለ ምልልሱ 15 ደቂቃ ይወስዳል። ባስፈለግዎት ጊዜ ወይም ከልተመችዎት ቃለ ምልልሱን በማንኛውም ሰዓት ሊያቋርጡ ይችላሉ። ፈቃደኛ ከሆኑ ይፈረሙና እባክዎን ወደ ጥያቄው እንግባ!!

ስም ሰላማዊት ንጉሴ ስ.ቁ 0913 21 29 08

ለቃለ ምልልሱ ፈቃደኛ ነዎት

አዎ አይደለም

የአማርኛ መጠየቂያ ፎርም

መመሪያ- ጥያቄዎቹ እንደሚከተሉት ናቸው። አጠቃላይ ጥያቄዎቹን ለመመለስ አስራ አምስት ደቂቃዎች ያክል ይፈጃል እባክዎ በሙሉ ጥያቄዎቹ በመመለስ ይተባበሩን። እናመሰግናለን።

ክፍል አንድ

ተራ ቁጥር	ጥያቄዎች	አማራጭ መልስ	ኮድ
101	እድሜህ/ሽ ስንት ነው	በቁጥር-----	
102	ፆታ	1. ወንድ 2. ሴት	

103	የጋብቻ ሁኔታ	<ol style="list-style-type: none"> 1. ያለገባ/ች 2. ያገባ/ች 3. የተፋታ/ች 4. በሞት የተለዩ 5. የተለያዩ 	
104	የትምህርት ደረጃ	<ol style="list-style-type: none"> 1. መፃፍና ማንበብ የማይችል/የማትችል 2. መፃፍና ማንበብ ብቻ የሚችል/የምትችል 3. የመጀመሪያ ደረጃ ተማሪ 4. ሁለተኛ ደረጃ ተማሪ 5. ኮሌጅ/ ዩኒቨርሲቲ 	
105	የስራ ሁኔታ	<ol style="list-style-type: none"> 1. በስራ ላይ ያለ/ያለች ወታደር 2. ጡረታ ወይም በርድ የወጣ/የወጣች 3. ሲቪል ሰራተኛ 4. ሌላ ካለ ይገለጽ 	
106	የኑሮ ሁኔታ	<ol style="list-style-type: none"> 1. ለብቻ 2. ከጋደኛ ጋር 3. ከቤተሰብ ጋር 4. ሌላ ካለ ይገለጽ 	
107	የወር ገቢ ምን ያህል ነው	<ol style="list-style-type: none"> 1. ከ 750 ብር በታች 2. ከ 751 – 3000 ብር 3. ከ 3001 – 5000 ብር 4. ከ 5000 ብር በላይ 	

ክፍል ሁለት-- ስለማህበራዊ አኗኗር ግንኙነት ጥያቄ የሚከተሉት ሶስት ጥያቄዎች አጠቃላይ

ስለማህበራዊ አኗኗርና ግንኙነት በተመለከተ ይሆናል።

ተራ ቁጥር	ጥያቄዎች	አማራጭ መልስ	ኮድ
201	በዕርስዎ ላይ ችግር ቢደርሱብዎ በቅርበት ሊያገኙት የሚችሉት ሰው	<ol style="list-style-type: none"> 1. ምንም የለም 2. 1 ወይም 2 	

	በቁጥር ስንት ይሆናሉ (አንዱን ይምረጡ)	3. ከ 3-5 4. ከአምስት በላይ	
202	በሚያደርጉት ነገር ስለ እርስዎ ምን ያህል ሰዎች ይጨነቃሉ (ያስባሉ)	1. ማንም ሰው አያስብም ወይም አይጨነቅም 2. በጥቂቱ ይጨነቃሉ ወይም ያስባሉ 3. አይታወቅም 4. በሚገባ 5. በጣም	
203	እርዳታ በሚፈልጉበት ጊዜ ከወዳጅዎ ወይም ከአጋርዎ እርዳታ ለማግኘት ምን ያህል ቀላል ነው ለእርሶዎ /አንዱን ይምረጡ/	5. በጣም ቀላል 4. ቀላል 3. ይቻላል 2. አስቸጋሪ ነው 1. በጣም አስቸጋሪ ነው	

ክፍል ሶስት :- በሱስ አጠቃቀም ዙሪያ ጥያቄዎች

ተ.ቁ	ጥያቄዎች	አዎ	አይደለም
301	ከሚከተሉት ሱስ አምጪ ነገሮች ውስጥ በህይወትዎ አንድግዜ ብቻ የተጠቀሙት / ከህክምና ጥቅም ውጭ/ 1. ሲጋራ 2. የአልኮል መጠጦች (ቢራ፣ አረቄ፣ ወይን-----) 3. ጫት 4. ካናቢስ 5. ኮኬይን 6. አሃዮድ 7. ቤንዘ ዲያሜፒን 8. ሌሎች ካሉ ይግለጹ		
302	ከሚመለከቱት ሱስ አምጪ ነገሮች ከባለፉት ሶስት ወራት ውስጥ እስከ አሁን ግዜ ድረስ የሚጠቀሙት /ከህክምና ጥቅም ውጭ ብቻ/		

	<ol style="list-style-type: none"> 1. ሲጋራ 2. የአልኮል መጠች (ቢራ፣ አረቄ፣ ወይን-----) 3. ጫት 4. ካናቢስ 5. ኮኬይን 6. አሃዮድ 7. ቤንዘ ዲያኬቲን 8. ሌሎች ካሉ ይግለጹ 		
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