

CHAPTER 5

SUMMARY, CONCLUSIONS, IMPLICATIONS AND RECOMMENDATIONS FOR FURTHER STUDIES

5.0 Introduction

This chapter is represented in four sections. The first section contributes to an overall summary of the study, followed by the summary of the findings and their conclusions. Subsequent to this are the implications of the study and followed by recommendations for future research.

5.1 Summary of the Study

Motivation and self-efficacy are two psychological constructs closely related to drug behaviour and addiction. This study aims to get more understanding of the relationship between motivation and self-efficacy during rehabilitation, especially in prison-based therapeutic communities. Hereby there are five research questions as listed as follows:

RQ1: What was the level of circumstances, motivation, and readiness according to CMR scales among inmates at the prison?

RQ2: What was the level of self-efficacy according to DASES scales among inmates at the prison?

RQ3: What was the relationship between CMR (motivation) score and DASES (self-efficacy) score among inmates at the prison?

RQ4: What was the relationship between CMR subscales and the DASES scale among inmates at the prison?

Research Question 1 identified the level of circumstances, motivation and readiness which construct the CMR scale among inmates at the prison. The value help

researcher identifies the determination of inmates to engage with the rehabilitation programme and later create awareness to change their addiction lifestyle. Besides that, the CMR score determined level stages of changes among inmates. This was aligned with the Transtheoretical Model (TTM) proposed by *Prochaska and DiClemente (1983)*.

Research Question 2 explores the level of self-efficacy among inmates at the prison through the DASES scale, which is considered a vital factor in human behavioural engagement and performance. DASES assesses inmates' efficacy when facing high-risk situations that may trigger the urge to initiate drug use.

Research Question 3 examines the relationship between the CMR and DASES scores. The correlation between this two construct psychometrics will help researchers determine whether they are related to each other or can stand independently. In this study, Therapeutic Community (TC) acted as a mediating variable, CMR was the independent variable, and DASES was the dependent variable.

In addition, Research Question 4 evaluates the relationship between CMR subscales and the DASES scale. The relationship will briefly explain the connection between subscales in CMR toward the DASES scale. Each CMR subscale represents various variables in determining extrinsic and intrinsic factors and readiness to make changes.

5.2 Summary of Findings

All the research questions pointed out in this study have been well explored and answered. This study involves 170 respondents representing 296 inmates in the therapeutic community rehabilitation programmes, enabling the data and results to generalise to this population. Although data distribution is not normally distributed since certain variables have a little skew and kurtosis, parametric statistical tests like Pearson correlation are still conducted. Minor deviations from the normal distribution of continuous data do not affect parametric tests (Öztuna et al., 2006; Wadgave & Khairnar, 2019). Hence, in most other situations, parametric tests are more powerful in analysing non-normally distributed continuous data.

Research Question 1 finds that most respondents show low to moderate high CMR scores. The three subscales in CMR, which are circumstances, motivation and readiness, also show the same result, which lies between low to moderately high scores. A higher score on the CMR scale indicates a higher commitment and ability to make changes toward self. Respondents with higher scores of CMR are more capable of making changes in their lifestyle, having positive integration with rehabilitation programmes, and some become role models for other inmates.

The CMR scale was developed to measure substance abusers' motivation and readiness for treatment and to predict treatment retention (De Leon et al., 1994). External and internal motivation are the two primary categories (Vallerand, Robert, 2000). Thus, motivation and preparedness are essential indicators for rehabilitation officers to predict client retention and engagement, as they will impact post-treatment outcomes (Melnick et al., 1997 ; Ali et. Al, 2017).

Circumstances, known as external pressure or external motivation, refer to a situation which leads to the possibility for residents in a rehabilitation programme to remain or leave. A lower level of circumstances shows that residents are not ready to fully engage in rehabilitation treatment because their minds and souls are still outside, thinking things behind the bar. For the therapeutic community in prison based, each resident is compulsory to join this module, thus, treatment retention or early dropout does not become an issue, unlike certain rehabilitation centres, which usually occur drop out.

Motivation refers to internal recognition of the need to change behaviour. It is about what makes a person want to change on the inside. These reasons can be either good or bad. Positive reasons include wanting a new way of life, having more good things in life, growing as a person, and having better relationships with others. As mentioned above, the respondents' averages are grouped from low to moderately high motivation levels. A higher level of motivation acknowledges the need to make changes if they do not start changes soon after, it will negatively impact their lifestyle. For low motivation, they are in denial stages where they reject the demand to become an ideal self.

Anxiety, loneliness, positive and negative social influences, and depression are all risk factors for relapse, as reported by Gorski et al. (1994). People who have spent time behind bars, or even under strict community supervision and custody, may experience a wide range of emotions upon their release. Patients in recovery must rely on their inner resources, self-awareness, and coping abilities, as well as the support of

their friends and family, to avoid recurrence. Rehabilitating prisoners becomes more challenging as the number of offenders with numerous and chronic psychological disorders rises.

Over time, recovery is a process of growth and transformation. The Developmental Model of Recovery (DMR) was created to assist people in recovery and treatment professionals in developing effective plans for recovery, establishing treatment objectives, and monitoring progress. This plan divides recovery into six stages: transition, stabilisation, early recovery, middle recovery, late recovery, and management (Gorski et al., 1994). Relapse was considered a normal part of the treatment process. This is due to the fact that each individual has their own set of triggers, high-risk situations, and friends that cause them to gradually begin using drugs again.

According to DMR, inmates who are currently participating in a drug rehabilitation treatment are regarded to be in the early stages of recovery. The phases of recovery can be interchanged depending on how far along the inmate is in their rehabilitation. Early recovery is characterised by the requirement to live a lifestyle free of the use of any chemicals. Addicts have a responsibility to educate themselves on addiction as well as the treatment process. They have to put some distance between themselves and their fellow students who are addicted to drugs and focus on cultivating relationships that will aid in their long-term rehabilitation. In addition, convicted individuals are required to learn how to construct values, ideas, emotions, and behaviours that are centred on recovery. These values, which will replace values developed in addiction as well as any antisocial attitudes formed previous to addiction,

must replace values formed in addiction. In order for this programme to be successful, significant intervention is required in the form of teaching these skills to the inmates. In most cases, the early healing phase lasts for somewhere between one and two years. According to Gorski (2009) and Melemis (2015), the lack of good social and recovery skills to develop a support system is the leading cause of relapse during the early periods of treatment for substance use disorders.

A person's level of motivation was one of the most influential factors in determining whether or not they could remain sober throughout the treatment process. According to Volkow et al. (2011), addiction disrupts the neuronal pathways necessary for insight, the sense of reward, the capacity to be motivated, and social behaviours. This functional overlap causes addicted individuals to make poor decisions despite being aware of the negative consequences; it explains why previously rewarding life situations and the threat of judicial punishment are ineffective in preventing drug use; and it explains why a medical approach is more effective than a criminal approach in preventing addiction.

Researchers McIntosh and McKeganey (2001) came to the conclusion that those who abstained from drug use did so for two key reasons: (1) the need to heal a damaged sense of self, and (2) the hope for a brighter future. Many people who deal with addiction eventually reach a point in their lives when they take stock of all that has transpired, recognise that they are unhappy with the person they have become, and decide to make a change as a result. This turning point occurs when the addict is faced with an alternative future and eventually comes to the realisation of how far down the rabbit hole they have fallen. Before the decision was made to put an end to them, it was

clear that many of these enlightening meetings and exchanges had already been going on for some time. It would appear that elements such as the user's status in their work and how these inputs are processed in connection to the addict's sense of self play a role in the choice to stop using drugs. They are versatile and open to making adjustments as necessary. This turning point is typically preceded by a catastrophe or another experience that compels the person to confront the fallibilities inherent in their own humanity.

McBride et al. (1994) studied drug users' motivation to abstain from marijuana and cocaine by having them fill out a modified version of the Reason for Quitting Questionnaire (RFQ). They concluded that health, self-control, social influence, and legal issues are the four main drivers of abstinence. Due to the lack of differentiation between internal and extrinsic elements, the study was unable to draw any firm conclusions on which dimensions contribute and affect the most. More research is needed to quantify it in broader populations, according to the study. The study's author concluded that drug users had far higher levels of motivation linked to self-control, while tobacco smokers have much lower levels of motivation linked to health to abstain from using tobacco products. The author also found that the degree of health-related versus social-impact motivators was not a reliable indicator of abstinence effectiveness. The authors used this technique to get a rough idea of the participants' ratio of intrinsic to extrinsic motivation.

Downey et al. (2001) implement the RFQ to a larger sample size in order to study the determinants that contribute to drug-free lifestyles. This advice was made by McBride et al. (1994). We found positive connections between the difference score and

intrinsic motivation, negative correlations between immediate reinforcement and social influence, and positive correlations between intrinsic and extrinsic motivation. Positive correlations were also found between the two types of motivation. The findings of this study offer preliminary support for the utility of the 20-item modified RFQ for assessing abstinence motivation among individuals who require treatment for addiction and who are also presented with major detrimental consequences. Concerns about one's own identity served as this group's major impetus for abstinence, followed by external pressures imposed by the law and society. It has been discovered that intrinsic motivation is far more successful than extrinsic motivation in achieving one's goals. The use of logistic regression models that were adjusted for total motivation allowed for the examination of the relationships between extrinsic and intrinsic drive at the beginning of the study, as well as the difference between the two, and success in maintaining abstinence during the course of the follow-up period. The findings of this study were very similar to those found by McBride et al. (1994).

When it comes to deciding treatment adherence, engagement, and behavioural change, motivation plays a critical role. Cahill et al. (2003) study the influence of motivation throughout the therapeutic process as well as the relationship between motivation and anxiousness or despair. The research looked at how motivation shifts during therapy, as well as how mental health conditions like anxiety and depression can have an effect on motivation. The Treatment Motivation Questionnaire (TMQ) was established to examine four areas of motivation: interpersonal help-seeking, lack of trust in treatment, perceived internal locus of causality, and perceived external locus of causality. The TMQ was piloted in the United Kingdom and has since been translated into several other languages. After therapy, the only aspect of the patient's motivation

that altered was a decrease in their level of external motivation; all of the other aspects of motivation stayed at the high levels seen before treatment. Depression, as measured by the Beck Depression Inventory (BDI), was substantially linked with three of the four motivational dimensions, whereas anxiety, as measured by the Spielberger State-Trait Anxiety Inventory (STAI), was significantly associated only with internal motivation. According to the findings of the research, the effects of anxiety and depression on one's internal and external sources of motivation may be distinct.

The authors of the study by DiClemente et al. (1999) highlight the distinction between motivation for treatment and motivation for behavioural change. When someone is coerced into receiving treatment, there is a greater chance that they may be unmotivated, hesitant, or indifferent about making genuine changes to their conduct. A person must be motivated to participate in treatment in order to sustain treatment compliance and achieve a favourable outcome. Given that therapy is helpful in lowering and/or eliminating substance use, it follows that a person must be motivated to participate in therapy. As a consequence of this, it would appear that treatment motivation is a condition that is necessary but not sufficient for causing long-term behavioural modifications and beneficial outcomes. In addition, DiClemente et al. (1999) note that the majority of therapy programmes presuppose an individual's motivation to change their conduct as a prerequisite for participation. If programmes do not incorporate tactics for inspiring individuals who are devoid of it, there is a lower likelihood that the programmes will be successful.

Kelly and Greene (2014) found that the degree to which an individual believes they are capable of abstaining from substance use is correlated with their level of

motivation to be sober. Patients who had high levels of both self-efficacy and motivation had the best outcomes, whereas patients who had high levels of self-efficacy but low levels of drive had significantly poorer outcomes. The findings of the study also showed that patients who had low self-efficacy as well as low motivation had the worst outcomes, whereas patients who had low self-efficacy but high motivation had somewhat improved outcomes. Patients who are extremely motivated may be able to maintain high levels of abstinence, in spite of the obvious disadvantage posed by a lack of faith in their ability to refrain from using drugs or alcohol. Although it has been suggested that individuals are unlikely to engage in a course of action unless they believe they are capable of achieving it (e.g., Bandura, 1997), the findings of this study suggest that despite low confidence in one's ability to achieve an outcome (such as future abstinence from alcohol and other drugs), it can still be attempted and achieved by leveraging strong intrinsic motivational drives. For example, future abstinence from alcohol and other drugs is an example of such an outcome.

Readiness is a person's own thoughts, plans, commitments, and reasons for doing certain things (Rapp et al., 2007). Joe et al. (1998) looked at how ready offenders were to change their behaviour after getting help. So, this subscale compares treatment to self-reliance and outside help (like church, friends, moving in with family, or going somewhere else). This test finds out if someone is ready for rehab and if they need sober care. Respondents who were very ready knew that they needed to go to a recovery centre to change and become more capable. Motivational preparation is a way to predict how people will act in the future. General psychological reasons for motivation include humanism, the incentive and arousal theory, and the drive reduction theory. Motivation is a key part of treatment and recovery for people who use drugs or alcohol because it

leads to change and action. Some people (Miller, 1983) say that bad motivational structures are to blame for addiction and its difficulty in changing adaptive behaviour. Motivation (Prochaska and DiClemente, 1984) backs up the steps of change paradigm. The phases of change paradigm (Prochaska and DiClemente, 1984) and motivational interviewing (Miller, 1998), one of the most successful ways to treat addiction, are based on motivation. Collins et al. (2012) found that the present desire to stop using drugs is not a good predictor of future drug use because it is sensitive to signals, situations, and circumstances in the environment. So, motivation has to do with how important change and effort are (Rollnick, Mason, and Butler, 1999).

Stages of change can be identified and measured, are linked to recruitment and treatment participation, and foretell changes in drug use and abstinence, as stated by Carlo DiClemente's transtheoretical model of behaviour change. The stages of transformation denote a progression that starts before treatment begins, continues during treatment, and continues after treatment ends. It's crucial to keep in mind that transitions between stages of change are rarely linear. When a person relapses, they start over at the beginning of the process.

According to DiClemente, motivation is context dependent. So, wanting to stop using drugs is not the same as wanting to attend treatment. Change occurs in stages, and it is vital to evaluate those stages so that effective treatments can be implemented. The specific drug-using behaviours or constellation of behaviours, the regularity and duration of behavioural patterns, the individual's consideration and intention to change, and prior experiences with the initiation of change related to this drug-using behaviour are all crucial elements for assessing stages of change. Patients entering treatment, or any other major life change, tend to fall into one of several types depicted by the model.

The model can be thought of as a gradient along which one can progress towards enduring transformation. According to this paradigm, which was developed by Prochaska and DiClemente in 1982, there are three levels of change commitment: precontemplation, contemplation, and action.

When someone is in the precontemplation stage, they do not have much of a desire to change their existing pattern of behaviour in the near future. During precontemplation, one does not experience any incentive to change their behaviour in any way. Either the person has not yet understood the gravity of the situation or they believe the potential gains will outweigh the potential losses. Patients, while they are at the contemplation stage of the change process, weigh the pros and cons of continuing on with their current course of action against making a change. People who are at the stage of the change process known as contemplation are open to the concept of changing their conduct, but they are still gathering additional information before making a decision about whether or not to actually make the change. When a patient enrolls in therapy or implements another component of the plan to improve their behaviour, this is considered to be the patient "taking action," which is the next stage in the procedure. In order to take action, an individual must first modify the problematic behaviour (such as sustained abstinence, increased participation in therapy, or voluntary attendance at self-help meetings) and then acquire new tools to prevent relapse (such as seeking assistance, working with a sponsor in a 12-step programme, or being honest about cravings).

The TTM has been supported by empirical evidence (e.g., Kristeller, Rossi, Ockene, Goldberg, and Prochaska, 1992). For instance, DiClemente, Prochaska, Fairhurst, Velicier, Velasquez, and Rossi (1991) discovered that smokers in the

preparation stage exhibited more change processes than smokers in the contemplation stage, who had higher ratings on the change processes than smokers in the pre-contemplation stage. Moreover, pre-contemplation stage smokers had higher ratings than preparation stage smokers. In addition to providing a conceptual framework for work, one of the most important contributions of this model is that it has inspired research into the development of instruments for assessing the phases of change. This is an extremely significant contribution. It is conceivable that the TTM's popularity is attributable in part to the fact that it emphasises change in general rather than treatment in particular. Although a person's desire for treatment and reason for change are frequently intertwined, these two motivations are distinct (DiClemente, 1999). According to Jordan and Oei (1989), substance abusers who are endeavouring to change their addictive behaviours frequently seek professional treatment only after their previous attempts to change have failed. In fact, the "Action" and "Maintenance" portions of the TTM can be broken down into more specific components, such as therapy motivation and treatment events.

There is a consensus among experts on the significance that treatment motivation plays in predicting treatment response, despite the fact that several techniques have been used to conceptualise and quantify motivation for treatment. Its significance can be seen more easily when viewed in the context of the treatment process model proposed by Simpson (2001, forthcoming). According to this concept, the outcomes of treatment (such as abstinence and a reduction in the number of arrests) are the result of a series of therapeutic experiences that mutually impact one another. Within the framework of this paradigm, the characteristics of the client that are assessed during the intake process have an effect on the early engagement in treatment that is

demonstrated by the client's participation in the programme and the development of a therapeutic relationship with the counsellor. In turn, these engagement experiences lead to "early recovery," which includes changes in drug use and behaviours connected to drug use as well as improvements in one's psychological well-being (Rao, 2004). Modifications to one's way of life, such as these, can help one remain in therapy for a longer period of time. Therefore, a patient's motivation for therapy affects both their susceptibility to treatment and their early participation in treatment. At the time of admission, patients with higher levels of treatment motivation are more likely to engage in the process and have successful outcomes.

Motivated clients, for instance, exhibit greater engagement in treatment. In other words, these clients tend to attend more counselling sessions (Simpson, Joe, Rowan-Szal, & Greene, 1995). Greater treatment motivation is also predictive of a more beneficial therapeutic relationship with one's counsellor. Specifically, treatment preparedness was found to be positively correlated with counsellor rapport, client confidence ratings in treatment, and therapeutic engagement (Joe, Simpson, & Broome, 1998).

Treatment readiness was found to be a significant measure of intrinsic desire that predicted retention and engagement by Joe et al. (1998). Motivation as a predictor of staying in treatment and engaging in therapy across all treatment settings was the focus of the third national drug abuse treatment outcome study (DATOS) undertaken in the United States. Treatment preparedness is significantly correlated with early therapy in both long-term residential (LTR) and outpatient methadone (OMT).

Rapp et al., (2007) used a pre-treatment population of substance abusers who were evaluated at a centralised intake unit in Dayton, Ohio, for their study to expand understanding of treatment readiness in this group of substance abusers. The study was conducted in 2007. The Pre-Treatment Readiness Scale, sometimes known as the PRS, is reexamined in this study using a larger sample of substance abusers who had recently been evaluated but who had not yet started treatment. The factor structure of the PRS, as well as the ways in which the components interact with one another, were investigated with the help of structural equation modelling (SEM). The possible influence of three different sets of predictor variables on both the individual aspects of preparedness and the preparation process as a whole was investigated through the use of testing. As a consequence of this finding, Problem Recognition was discovered to have an impact on Treatment Readiness, albeit via an other mediating variable known as Desire for Change as opposed to Desire for Help. The desire for change factor had an impact on a fourth component as well, which was referred to as treatment reluctance. Both inhibitory characteristics and fixed features, such as age and gender, had very little of an impact on readiness variables. Fixed characteristics such as age and gender also had very little of an impact. The characteristics of the illness, such as the intensity of the drug and the perceived obstacles to treatment, had a more profound impact on the preparedness criteria.

Opsal et al. (2019) conducted a study to compare the stages of readiness to change (motivation) between SUD patients who entered treatment voluntarily and those who entered treatment involuntarily, and to determine whether the stages of patient readiness to seek assistance changed during the treatment period. Additionally, the authors wanted to find out whether the stages of patient readiness to seek assistance

changed during the treatment period. In addition, the patient's willingness to change was explored, along with the experience of being involuntarily admitted to the hospital and the factors related with the ability to manage substance use at the 6-month follow-up. The emphasis was placed on the patient's willingness to change. The research indicated that patients who were forced admitted were significantly less motivated to improve than patients who were voluntarily admitted at the time of admission (39% vs. 59% motivation). The majority of patients who were admitted, regardless of whether they did so voluntarily or involuntarily, were already in the most advanced stage (preparation) of readiness to get care when they were admitted, and they remained in this condition when they were discharged. It was not possible to predict abstinence at follow-up based on the stage of readiness to change at the time of admission. The severity of SUD at the time of assessment was the only factor that proved to be significantly predictive of persistent substance use after six months. The majority of patients who were involuntarily admitted scored well on the measurement of their level of motivation to continue with their therapy. The patients' levels of motivation stayed consistent at a relatively high level throughout their hospital stays, and in some cases, it even grew. As a consequence of this, they were getting close to a level of motivation that was comparable to that of voluntarily admitted patients who were getting close to being released.

Research Objective 2 investigate the level of self-efficacy among respondents. The result shows that most respondents are categorised into moderately high levels of self-efficacy. Perceived Self-efficacy is a key factor in how people behave and how well they do. Self-efficacy is a useful clinical concept that focuses on the person's beliefs about being able to do certain things or stick with things even when they are hard or

change. According to the self-efficacy theory, these beliefs, not expected outcomes, explain future behaviour and are, therefore, very important from a clinical point of view. A higher level of the DASES scale indicates respondents become more resistant to unfavourable conditions or when facing high risks. DASES examine how respondents react when facing the environments which will trigger drug use. Besides that, self-efficacy usually becomes a key finding in determining the effectiveness of rehabilitation treatment.

Bandura (1977) was the first researcher to propose the idea of self-efficacy beliefs serving as the final common pathway that mediates changes in conduct. Because of this, the self-efficacy theory was able to confirm that the behavioural changes brought on by the diverse types of treatment are brought about by a single cognitive mechanism known as "efficacy expectancy." Nevertheless, self-efficacy has a close relationship with the anticipation of being able to deal with multiple high-risk scenarios when they emerge one after another. Expectancy is made up of two different parts: (i) cognitive (informational) components, which are connected to what a person "knows" or anticipates will happen as a result of engaging in significant behaviour, and (ii) motivational (incentive) components, which are connected to the "reinforcement values" of the specific outcomes or effects. A feeling of assurance in one's capacity to successfully manage high-risk circumstances contributes to an increase in one's level of self-efficacy.

Self-efficacy and relapse were closely linked in people. There are many models of return, but the psychological and psychobiological models are the most important ones. Marlatt (1996) and Marlatt and Gordon (1985) say that the cognitive-behavioral method is the most interesting psychological model. During this time, there were two

main types of high-risk events that came to be known. Intrapersonal environmental determinants are relapse episodes in which the main reaction is psychological, physical, or to events in the environment. This group includes negative emotions (NE), physical discomforts (PD), urges and temptations (UT), positive emotions (PE), and testing your own control (TPC). The second group is made up of social forces. It shows up when other people have a big effect on relapse events. It includes problems with other people (CO), social pressures (SP), and good times with other people (PT). Marlatt and Gordon (1985) say that 35% of relapses happen in the Northeast, 16% in Colorado, and 20% in the Southwest. In 1996, Lowman, Allen, and Stout found that between 62 and 73% of relapse events were NE and SP. Bradley, Gossop, Brewin, Philips, and Green (1989) and Heather, Stallard, and Debbutt (1991) found that SP determinants are not the only important factors in relapse. Cravings, temptations, and drug indicators can also lead to relapse. Some study shows that negative feelings and a lack of social support are the main reasons why heroin addicts relapse. Along with social isolation and family issues, mood state was more likely to be a high-risk factor for return in the future. Connors, Maistro, and Zywiak (1996) said that bad things that happened in life and being in high-risk situations had nothing to do with the chance of return. Also, cognitive evaluation and self-expectation are linked to relapse predictors in another way.

Marlatt and Gordon (1985) proposed the idea that a person's construction of a strong expectancy, in this case that the use of alcohol would have a favourable and desirable effect, is related with the high-risk situation that might lead to relapse. In other words, the person anticipates favourable results from alcohol consumption. According to Sanchez-Craig (1976), even after an apparently favourable assessment, a recurrence is always possible. Annis and Martin's (1985) inventory of drug-taking situations

(IDTS) was based on Marlatt and Gordon's (1985) taxonomy of high-risk environments. This instrument examines the client's heavy substance use throughout the previous years and takes into account the context in which that use occurred. It's a multi-dimensional assessment that can pick up on changes in someone's drug use habits. Heather et al. (1991) argued that multidimensional evaluation provides a more sensitive way for assessing lapse precipitants than the category methodology used by Marlatt. Marlatt used the categorical approach to calculate the quantity of lapse precipitants.

ElSheikh and Bashir's (2004) investigation into the differences between alcoholics and heroin addicts in terms of relapse dimensions and self-efficacy found that heroin addicts have significantly higher mean IDTS scores compared with the alcoholics sample, while alcoholics have significantly higher mean SCQ scores than did their heroin counterpart. Once again, the alcohol group had much lower admission and relapse rates than the heroin group. Negative emotions (NE), testing personal control (TPC), social pressure (SP), and desire and temptations (UT) were also found to be the most high-risk scenarios for relapse.

Self-efficacy was one of the most important goals of care for people with substance use disorder (SUD). In a trial of mindfulness-based relapse prevention (MBRP), cognitive-behavioral relapse prevention (RP), and treatment as usual (TAU) in 2012, Moniz-Lewis et al. looked to see if self-efficacy was linked to treatment results. They found that self-efficacy was linked to how well treatment worked. Greater self-efficacy at the end of treatment and rising self-efficacy over time predicted a much higher chance of not using drugs or drinking too much for a year. Greater self-efficacy at the end of treatment was also linked to a lot fewer days of heavy drinking among people who did drink, and it helped explain the link between treatment condition and

the chance of not using drugs and fewer days of heavy drinking at the 12-month follow-up. Those who got MBRP had the best self-efficacy after treatment, which meant they were more likely to stop using drugs and had fewer days of heavy drinking. These results show that self-efficacy may be one way that MBRP works.

Mindfulness-based relapse prevention led to statistically significant improvements in attendance and abstinence, according to Uhlig's (2009) study. The ability to provide more effective alternatives for the treatment of alcohol and substance addiction has implications for social change. The purpose of this study is to determine whether the addition of Mindfulness-Based Relapse Prevention to a standard programme, such as the matrix model, could significantly alter client outcomes. Sixty-six people in the early stages of recovery participated in the study conducted at a substance abuse clinic in a prominent American city. As the independent variable, the Mindfulness Based Relapse Prevention programme was utilised. The Alcohol Abuse Coping Response Inventory measured coping skills, motivation was measured by the Stages of Change Scale, attendance was measured by attendance records, and abstinence was measured by toxicology results from client charts.

Hyde et al. (2008) found ten papers that looked at self-efficacy before and after treatment for smoking, drinking, or using other addictive substances. Even though seven of the ten studies showed positive effects on self-efficacy, these effects were caused by many different types of treatments. This meant that the authors couldn't complete their original goal of finding the best way to improve self-efficacy. Also, even though self-efficacy was improved, only two of the studies showed a significant change in addictive

behaviours, and those studies didn't look into whether the change in addictive behaviours was caused by self-efficacy.

It was found by Stephens and colleagues (1995) that relapse prevention treatment led to a bigger gain in self-efficacy than social support (see also Allsop and colleagues' research from the year 2000). Brown et al. (2002) found that whereas relapse prevention aftercare treatment led to an increase in confidence in high-risk settings while the patient was participating in a 10-week aftercare programme, this confidence did not last after the programme was finished. It was reported by DiClemente et al. (2001) that in the aftercare arm of Project MATCH, alcoholic clients who received Cognitive-Behavioral Therapy (CBT) demonstrated greater improvements in self-efficacy than clients who received Motivational Enhancement Therapy (MET), regardless of their baseline levels of self-efficacy. This suggests that the potential value of CBT's coping skills training for enhancing self-efficacy may lie in the fact that it teaches clients how to deal with stressful situations. Researchers Finney, Noyes, Coutts, and Moos (1998) found that cognitive behavioural therapy (CBT) and 12-step programmes both led to increased levels of self-efficacy.

In 1994, Borrelli and Mermelstein discovered that smokers who achieved more behavioural objectives had greater self-efficacy, which suggested they would not smoke at the follow-up. Similarly, Lozano and Stephens (2010) discovered that individuals who actively set objectives felt more confident in their ability to achieve them. Ilgen, McKellar, and Moos (2007) discovered that greater participation in skill-building tasks (such as coping skills and stress management) during treatment was associated with greater self-efficacy, and that self-efficacy was strongly associated with treatment

outcome. Walton et al. (2003) discovered a significant correlation between the frequency and efficacy of coping strategies and self-efficacy. Majer, Jason, Ferrari, Olson, and North (2003) discovered that self-efficacy could be enhanced by employing active rather than inert coping strategies. In the study conducted by Kadden et al. (2007) and Litt et al. (2008), the use of coping skills during treatment was strongly correlated with self-efficacy after treatment ($r=.255$; $p.01$). This supports the notion that more frequent use of coping skills is likely to contribute to an increase in self-efficacy. Several researchers have found that teaching clients additional problem-solving strategies is one method to increase their self-efficacy. In fact, according to Roffman and Stephens (2005), the best method to prevent people from relapsing with drug use is to teach them stress management skills and boost their confidence in their ability to do so.

LaChance et al. (2009) found that, of five potential mediators studied (readiness to change, self-efficacy, perceived risk, norm estimates, and positive drinking expectancies), only self-efficacy mediated the effects of treatment on drinking outcomes. This conclusion was based on a full test of mediation: (1) group motivational enhancement therapy (GMET) reduced problem drinking and its consequences (more than two other interventions); (2) GMET enhanced self-efficacy; and (3) improvements in self-efficacy were associated with reduced problem drinking. Brown et al. (2002) reported that self-efficacy mediated the effectiveness of CBT on drug use outcomes, and Allsop et al. (2000) found that relapse prevention treatment was related to outcome through the intervening variable of posttreatment self-efficacy. Borrelli and Mermelstein (1994) reported that the achievement of subgoals affected outcome through self-efficacy.

Researchers Ilgen et.al, (2005) found that among alcohol and drug dependent patients in residential treatment, a high degree of abstinence self-efficacy at treatment discharge was the biggest predictor of one year abstinence. This was the case even though the patients had been in treatment for a period of time. Based on these data, it seems that cultivating a high level of abstinence self-efficacy is something that should be prioritised in clinical practise.

Greater self-efficacy (as well as less reliance on avoidance coping) predicted remission from drinking after as long as 3 years, whereas persons with less self-efficacy were more likely to relapse after stopping drinking. According to the findings of Moos and Moos (2006), the correlation between self-efficacy and abstinence from drinking is a substantial one. A study that was done by Ramo, Anderson, Tate, and Brown (2005) on teens who struggled with both substance misuse and psychiatric diseases discovered that self-efficacy in coping played a protective role against relapse.

The study was conducted on teenagers who had both a substance abuse problem and a psychiatric ailment. Gwaltney, Shiffman, Balabanis, and Paty (2005) conducted daily assessments of abstinence self-efficacy among smokers who were attempting to stop the habit. These smokers were in the process of quitting smoking. They arrived to the conclusion that abstinence led to an increase in one's sense of self-efficacy and that this was the most important benefit. In addition to this, they came to the conclusion that declines in daily self-efficacy accurately predicted relapses into the smoking habit. According to the findings of this study, an individual's view of their own level of self-

efficacy can change throughout the course of their lifetime, and these changes can accurately predict their day-to-day behaviour.

Research Objective 3 shows a significant, moderate, positive relationship between CMR and DASES scales. The relationship between these two constructs indicates they mutually influence each other. Although the main purpose of the CMR scale is to predict treatment retention and engagement, it contributes to the treatment outcome to some extent. A higher level of CMR score will result in a higher DASES score. Respondents ready to make changes will engage positively with the treatment and soon have higher self-efficacy to help them cope with high risks situations.

Research Objective 4 examine the relationship between each subscale in CMR and DASES. Circumstances subscales show a significant, weak and negative relationship toward DASES. Respondents who have low scores of circumstances will show a higher level of self-efficacy. The same goes for the readiness subscales and DASES, which is a significant, weak and positive relationship. A higher readiness score will make a higher score on the DASES scale. A significant, moderate and positive relationship formed between motivation and readiness. Respondents with a higher motivation score will have higher scores on the DASES scale. Although there are relationships ranging from weak to moderate between these subscales and DASES, further study on how these items influence each other. The study finds that each subscale in the CMR scale indicated how far the respondents realise and are ready to make changes toward their addiction.

Both CMR and DASES measured significant psychological constructs in shaping people's actions. CMR assesses readiness to treatment (motivation for

treatment) by measuring both inner and extrinsic elements of motivation. The purpose of the DASES is to assess a person's level of self-efficacy by seeing how they deal with potentially drug-initiating situations of high risk. Therefore, the likelihood of a person being drug-free was highly dependent on the connection between motivation and self-efficacy.

It has been proven that abstinence-related self-efficacy and action-oriented motivation to alter addictive behaviours are important predictors of post-treatment drinking. Other significant predictors are abstinence-related motivation and action-oriented motivation. Self-efficacy and motivation are associated in boosting long-term abstinence and percent days of abstinence (PDA) during residential treatment, and they may play a key role in AUD recovery, as was determined by Muller et al. (2019) in their study.

Greenfield et.al, (2012) and Kadden and Litt (2011) show that self-efficacy is an important part of both general health habit change models and models that focus on addiction. But a person's motivation or dedication to a future activity may change how well a self-efficacy number can predict that activity. Kelly and Greene (2014) looked at how self-efficacy for abstinence and motivation for sobriety affect drug use outcomes in a large clinical group. The results showed that abstinence self-efficacy (SE) and motivation for sobriety (MS) had main effects over time, but a significant interaction showed that SE affected PDA based on MS. Further research showed that for people with high SE, MS had a small but significant effect on PDA, but for people with low SE, MS had a big effect, so their outlook was the same as for people with high SE.

Findings show how complicated SE theory is and that a patient may have a good

outcome even if they don't have a lot of confidence in their ability to stay sober if they have a strong recovery drive. In the same way as Majer et al. (2015), desire to change is linked to self-efficacy for abstinence during drug treatment. When someone leaves inpatient treatment for a substance use problem, their motivation, readiness for treatment, and belief in their own ability to stay sober are all looked at. Self-efficacy for abstinence decreased motivation, while being ready for treatment and using drugs boosted it. Self-efficacy in staying sober did not predict ready for treatment. Self-efficacy for abstinence might encourage people with drug use disorders to make changes.

Lu et al. (2017) conducted a study to determine whether self-concept is related to drug addicts' desire to cease using drugs and self-efficacy. The structural equation model (SEM) analysis, which examined both total and individual categories of childhood maltreatment, revealed that maltreatment was associated with diminished self-concept, self-efficacy, and motivation to avoid drugs. Self-efficacy and abstinence motivation were positively associated with self-concept. In contrast, there was no significant correlation between self-efficacy and the desire to cease using drugs. An indirect study revealed that self-concept mediates the relationship between childhood maltreatment and self-efficacy. Critically, self-concept was the link between childhood maltreatment and the desire to quit using narcotics. Even when the total scores of maltreatment were substituted with the scores of specific categories of maltreatment, the indirect effect of self-concept on the relationship between childhood maltreatment and the desire to stop using drugs remained. The conclusion of the study is that the self-concept of a drug addict is essential to comprehending the relationship between childhood abuse and the desire to cease using drugs, as well as self-efficacy.

5.3 Conclusions

After conducting this study examines the relationship between motivation, readiness and self-efficacy among inmates who undergo therapeutic community as a part of the rehabilitation programme. The conclusions are as stated below:

- a) The CMR scale is constructed based on Stages of Change (SOC) to identify stages of change in respondents. Conceptually, circumstances and motivation subscales correspond to the stages of the Change model's pre-contemplation, contemplation, and preparation stages, and readiness corresponds to the action and maintenance stages. Each of these subscales has a different degree of weight influencing respondents' changes.
- b) The three constructs in this scale, circumstances, motivation and readiness, are highly significant and correlated, suited to predicting substance abuse treatment retention and engagement. Previous studies have supported this finding.
- c) The study generalises that most of the respondents are grouped into moderately high scores on the CMR scale. It indicates that the respondents are in contemplation and action stages based on the TTM model. So, it is expected that positive engagement during the rehabilitation programme.
- d) The Drug Avoidance Self-Efficacy Scale (DASES) was created as an alternative psychometric test to assess the ability of multiple drug users to avoid substance use. Previous research indicates that the majority of self-efficacy assessment tools can evaluate one's level of self-efficacy in relation to the use of drugs; however, the administration of the scale needs to be repeated for each consumed drug.

- e) This study shows that most of the respondents moderate highly self-efficacy after entering rehabilitation. This picture is a good image of the acceptance of the rehabilitation programme. However, a continuous study needs to be conducted to validate the findings.
- f) CMR and DASES scales have a moderate positive relationship, indicating that these instruments influence each other. The result concluded that CMR not only influences treatment engagement and retention but also influences treatment output. Self-efficacy is measured as an indicator of the treatment module.
- g) Indirectly, the effectiveness of the treatment module can be evaluated. Each treatment facility aims to build individuals with higher coping skills and the ability to react positively in high-risk situations. This may delay relapse and makes residents sober.

5.4 Implications of the Study

Based on the results of this study, we now know that an addict's motivation and self-efficacy are two separate but equally important factors in regulating his or her behaviour and drug use. This research shows that drug offenders who are in excellent situations, have high motivation, and are open to treatment have a better chance of participating in substance abuse treatment programmes. Individuals undergoing treatment for substance misuse have access to treatments designed to keep them actively involved in their care and improve their chances of success. It is possible to measure convicts' self-efficacy as a therapeutic outcome by observing their behaviour in potentially dangerous situations. They will be able to refuse the temptation to start using drugs because of their high levels of self-efficacy.

CMR provides an alternative method for assessing the development of inmates, notably in terms of their substance abuse. In the past, the extent of change was determined using both the Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES) and the University of Rhode Island Change Assessment Scale (URICA). Regularly evaluating CMR levels in inmates based on each patient's Stage of Change, as defined by the Stages of Change model (DiClemente, 2005), could be advantageous for substance abuse treatment programmes and, in this case, prison departments. DiClemente established the Stages of Change model. It has been found that counselling in the form of motivational interviewing, or MI, improves outcomes for individuals with low CMR who enter treatment for substance abuse (Allen & Olson, 2016; Carroll et al., 2006). The acronym MI stands for motivational interviewing.

The findings also assist the rehabilitation centre in attaining a general grasp of how the patients behave and react to the treatment method that is provided by the rehabilitation institution. Residents who participate actively and positively in their treatment program are better able to respond constructively when presented with adverse or high-risk circumstances. Residents who do not participate actively and positively in their treatment program are less likely to be able to respond constructively. Every rehabilitation clinic develops its own one-of-a-kind program to assist in the rehabilitation of addicts and to equip them with the coping mechanisms and life skills essential for them to become more resistant to the negative effects of drug addiction. This is done in order to help addicts recover from their addiction. The ongoing administration of this assessment instrument will be of assistance to the administration in the process of establishing or revising their rehabilitation module, which will be most

effective in rehabilitating people who are addicted and lowering the likelihood that they will relapse. As residents continue their participation in rehabilitation programmes, they will often experience a rise in both their level of self-efficacy and the number of treatment options at their disposal. On the other hand, an individual's impression of their level of self-efficacy is not significantly affected by involvement in therapy or continuous attendance at sessions.

Researchers may find that the findings contribute to the expanding corpus of knowledge on determining the relationship between self-efficacy and motivation. Although they are closely related, self-efficacy and motivation are two distinct concepts. Self-efficacy and motivation are, however, closely related. Self-efficacy can be contrasted with motivation in that the former refers to a person's belief in their own capabilities, whereas the latter refers to what motivates a person to pursue those capabilities. On the other hand, motivation is defined as an individual's determination to achieve their objectives. Previous research (Muller et al., 2019; (Kelly & Greene, 2014) demonstrates a range of correlations between motivation and self-efficacy, from strong to moderate correlations. Both the self-efficacy model and the motivation model imply that there is a complex interaction between them, with reciprocal links and indirect outcomes. In order to increase their self-efficacy, it is probable that patients must experience success in overcoming barriers to changing their alcohol use patterns by taking steps towards behavioural change (DiClemente et al., 1999; Witkiewitz & Marlatt, 2009). This is due to the fact that patients who overcome obstacles successfully are more likely to believe they are capable of achieving their objectives (DiClemente et al., 1999). This finding suggests that sustained post-treatment abstinence may be associated with higher levels of self-efficacy.

5.5 Recommendations for Further Studies

This study has contributed to understanding two psychological contracts, which are important in behavioural change toward addiction. As the study progressed, a few areas surfaced as suggested areas for future studies. The recommendations are as follows:

- a) A longitudinal study should be implemented since it is understandable that relapse can occur during each stage of change. A longitudinal study should help the researcher understand better the relationship between motivation and self-efficacy.
- b) Because of limited time, this study only involves respondents actively involved in the therapeutic community programme. This makes the result only can be generalised to this population only. Under HDP developed by the prison department, the therapeutic community programme is another rehabilitation programme besides the vocational and orientation phase. Thus, a sample from this phase must also be chosen to make the result more accurate and generalised.
- c) Other than finding a relationship, another analysis could be implemented, such as regression or factorial analysis. It will help the researcher and rehabilitation centre to predict the rehabilitation outcome and the importance of these two psychological constructs.
- d) Although both instruments have higher validity across multicultural, comparing validated instruments should be administered to get reliable and constant results. Compared to other instruments, CMR and DASES are more specific to recognising and evaluating drug addiction.

5.6 Overall Summary

Attempting to alter an individual's conduct, especially that of an addict, is challenging due to the complexity of the issues involved. Initiating and maintaining the dynamic process of any behaviour change requires a motivating factor, which can take the shape of cognitive commitments or stages. The procedure of treating substance addiction relies heavily on this factor. Internal and external factors both have an impact on one's level of motivation. Addicts' intrinsic dimension includes things like their own personal drive to change. The extrinsic component, on the other hand, involves considerations beyond one's control, such as the threat of legal action or the opinions of one's loved ones. By delving into these two facets of motivation, researchers can better understand why a patient is undergoing treatment and gauge the treatment's efficacy. There is evidence that both internal and external drives are important in the recovery process from substance abuse. Recuperation relies heavily on intrinsic motivation; nevertheless, there are situations when external motivation is more useful. Therefore, motivation must be continuously evaluated throughout the course of treatment.

There is substantial scientific support for the notion that an individual's perception of competence is essential to comprehending human behaviour. One definition of efficacy expectation is the belief that one can perform the actions necessary to achieve a desired outcome effectively. In contrast, the latter belief does not include confidence in one's ability to complete the necessary steps to achieve the desired outcome. Self-efficacy was found to be a strong predictor of coping practises,

performance, and perseverance in the face of challenging problems. In addition, it was discovered that efficacy perceptions had a substantial impact on the relationship between preceding performance and subsequent performance. Efficacy beliefs are essential for initiating and sustaining coping strategies. Thus, self-efficacy can influence behaviours independent of prior activity, and multiple studies have shown that self-efficacy perceptions are more accurate predictors of behaviour than actual self-efficacy.

Two crucial psychological concepts that allow us to foresee shifts in human behaviour are motivation and self-efficacy. Motivation in drug addiction is linked to the phases of change required to achieve sober, whereas self-efficacy is associated with the results of therapy. By shifting their focus to these concepts, researchers may uncover novel approaches to lowering the current rate of drug addiction.