RELATIONSHIP BETWEEN HEALTH BELIEFS AND THE COMPLETION OF TREATMENT PROCESS AMONG METHAMPHETAMINE DEPENDENT PATIENTS : CASE STUDY AT THANYARAK INSTITUTE

RABIAB TOKAEW

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ABSTRACT

This research was a cross-sectional study. The objectives of the study were 1) to explore health beliefs of methamphetamine dependent patients and 2) to examine factors related to the completion of the treatment process. The samples of this study were 452 patients receiving treatment at Thanyarak Institute. Questionnaires and medical records review were used in the data collection process.

The average score on perceived susceptibility was 13.28 (total 7-21), while the average score on perceived severity was 24.99 (total 10-30) , the average score of perceived treatment benefit was 13.63 (total 6-18) and the average score of perceived treatment barrier and cost was 14.09 (total 7-21). The average score in treatment motivation was the highest at 17.14 (total 6-18). The research result indicated that 63.7% of the samples were classified as having completed the treatment process.

The results from multivariate analysis showed that sex, occupation, history of incarceration, amount of methamphetamine used per day, system of treatment, and methods of treatment were significantly related to completion of the treatment process. Males were less likely than females to complete the treatment process (OR =0.42,P=0.010). Government officers and company employee were also less likely than the unemployed and general workers to complete the treatment process (OR =0.37, P=0.018). Patients who had a history of incarceration due to other problems were less likely than those without a history of incarceration to complete the treatment process (OR =0.18, P<0.001). The patients who used a greater amount of methamphetamine per day were less likely to complete the treatment process, as compared to those who used lesser amount (OR =0.93, P=0.014). Regarding systems of treatment, it was found that those who were being treated compulsorily were more likely to complete the treatment than those who were being treated voluntarily (OR = 4.77, P=0.007) and those who were in the admission treatment phase of rehabilitation were more likely to complete the treatment than those who were in the detoxification phase (OR = 6.36, P=0.007).

Health beliefs and family support did not have a relationship to completion of the treatment process. On the other hand, compulsion with control system should be employed in the treatment process. More attention should be given to males and those who have a history of incarceration or high amount of methamphetamine used per day.

KEY WORDS: METHAMPHETAMINE / HEALTH BELIEF / COMPLETION / TREATMENT PROCESS

120 pages

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ความสัมพันธ์ระหว่างความเชื่อด้านสุขภาพ และ การบำบัดรักษาครบตามเกณฑ์ในผู้เสพติดยาบ้า: กรณีศึกษาสถาบันธัญญารักษ์

RELATIONSHIP BETWEEN HEALTH BELIEFS AND THE COMPLETION OF TREATMENT PROCESS AMONG METHAMPHETAMINE DEPENDENT PATIENTS: CASE STUDY AT THANYARAK INSTITUTE

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บทคัดย่อ

การศึกษาครั้งนี้เป็นการวิจัยแบบภาคตัดขวาง โดยมีวัตถุประสงค์เพื่อศึกษาความเชื่อด้านสุขภาพ และ ปัจจัยที่มีอิทธิพลต่อกระบวนการบำบัดรักษาครบตามเกณฑ์ในผู้เสพติดยาบ้า การศึกษาครั้งนี้ทำการเก็บข้อมูลจากผู้ป่วยที่เข้ารับการบำบัดรักษาการเสพติดยาบ้าในสถาบันธัญญารักษ์ จำนวนทั้งสิ้น 452 คน เก็บรวบรวมข้อมูลโดยใช้แบบสอบถามที่ได้รับการพัฒนาขึ้น และ การทบทวนเวชระเบียนหลังการจำหน่ายผู้ป่วย

ผลการศึกษาพบว่าคะแนนเฉลี่ยของการรับรู้ความเสี่ยงมีค่า13.28 (จากทั้งหมด 7-21) ในขณะที่คะแนนการรับรู้ความรุนแรงมีค่า 24.99 (จากทั้งหมด 10-30) และ คะแนนการรับรู้ประโยชน์ของการบำบัดรักษามีค่า 13.63 (จากทั้งหมด 6-18) คะแนนแรงจูงใจมีค่าเฉลี่ยค่อนข้างสูงคือ 17.14 (จากทั้งหมด 6-18) นอกจากนี้ยังพบว่าร้อยละ 63.7 ของกลุ่มตัวอย่างรับการบำบัดรักษาครบกำหนดตามเกณฑ์

ผลการวิเคราะห์พบว่า เพศ อาชีพ ประวัติการถูกจำคุก ปริมาณยาบ้าที่ใช้ต่อวัน ระบบการรักษา และ ขั้นตอนการรักษาแรกรับ มีความสัมพันธ์กับการรับการบำบัดรักษาครบตามเกณฑ์ โดยพบว่า เพศชายมีโอกาสรับการบำบัดรักษาครบตามเกณฑ์น้อยกว่าเพศหญิง (OR=0.42,P=0.010) ผู้ที่มีอาชีพประจำได้แก่ ข้าราชการหรือพนักงานบริษัท มีโอกาสบำบัดครบตามเกณฑ์น้อยกว่า ผู้ว่างงานหรือรับจ้างทั่วไป (OR= 0.37, P=0.018) ผู้ที่เคยถูกจำคุกด้วยคดีอาญามีโอกาสรับการบำบัดรักษาครบตามเกณฑ์น้อยกว่าผู้ที่ไม่เคยถูกจำคุกมาก่อน (OR=0.18,P<0.001) ผู้ที่ใช้ยาบ้าต่อวันมากมีโอกาสครบตามเกณฑ์น้อยกว่าผู้ที่ใช้ยาบ้าต่อวันน้อยกว่า (OR =0.93, P=0.014) ผู้ป่วยบังคับบำบัดแบบควบคุมตัวมีโอกาสบำบัดครบตามเกณฑ์มากกว่าผู้ป่วยในระบบสมัครใจ (OR = 4.77, P=0.007) และผู้ที่เข้ารักษาแรกรับขั้นฟื้นฟูสมรรถภาพมีโอกาสบำบัดรักษาครบตามเกณฑ์มากกว่าผู้ที่เข้ารับการรักษาแรกรับในขั้นบำบัดด้วยยา (OR = 6.36, P=0.007)

ความเชื่อทางสุขภาพและแรงสนับสนุนจากครอบครัวไม่มีความสัมพันธ์อย่างมีนัยสำคัญทางสถิติกับการบำบัดรักษาครบตามเกณฑ์ในผู้เสพติดยาบ้า ทั้งนี้เพื่อให้อัตราการรักษาจนครบตามเกณฑ์มีสูงขึ้นควรใช้ระบบบังคับบำบัดแบบควบคุมตัวในผู้เสพติดยาบ้า และควรให้ความสนใจเป็นพิเศษในผู้ป่วยที่เคยมีประวัติถูกจำคุกด้วยคดีอาญาและผู้ป่วยที่ใช้ยาบ้าเป็นปริมาณสูงต่อวัน

120 หน้า.

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CHAPTER I
INTRODUCTION

1. Background and Significance of the Study

Drug dependence and abuse is one of the most serious and complex social problems globally. It affects all levels of society including individuals, families, and communities. In Thailand, drug problem has become a substantial social and public health issue for a long time. In addition, the collateral problems associated with drug dependence and abuse (violent, crime, morbidity and mortality) became a major national concern that need to be solved urgently. Currently, the most common illegal drug dependence with the fastest spreading one in Thailand is methamphetamine. As a stimulant (1), it was originally called “YAMA” because it causes a user to become more active and energetic (2). However, due to its harmful effects which causing the permanent damage of brain and methamphetamine-induced mental disorder, it was renamed as “YABA” in 1996 and was ranged the first category (same range with heroin) in the Narcotics Act, B.E. 2522 as one of the most harmful narcotic substance. Nevertheless, the problem regarding methamphetamine dependence and abuse has become more severe and wider spread. Large national budgets were spent on solving these problems: 1,021.46 million Baht, 1,628.77 million Baht and 2,006.09 million Baht during 1999 – 2001(3), respectively. In 2003, the Thai government set the drug problems in the first priority of national agenda and also declared an irrevocable policy widely known as “war on drugs”. This policy was implemented under the concept of “treating addicts, punishing dealers”. Not only that treatment of drug dependence were considered as significant strategies to solve the problem (4), it also encourage the patient to live in the society happily and drug-independently. As the result, several methods and strategies were employed to force and promote the treatment among the drug-dependences. Since the declaration of war on drug to

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November 2004, it was reported that 60.5% of methamphetamine addicts (213,918) were treated (5).

It was believed that the best methods of ending drug independence were treatment and rehabilitation. Based on the Narcotics Act, B.E. 2522 (6), treatment cover 4 stages: 1) Pre-Admission, 2) Detoxification by taking medications for physically drug independence which may take 7-14 days, 3) Rehabilitation which is a significant 4-to-18-month stage highlighting physical, mental, social and occupational rehabilitations to prevent re-addiction, and 4) After-Care which takes a year. The effective treatment must cover all these four stages and takes at least over a year (7). Due to several difficulties and the long period of treatments, many problems have existed among treated-drug addicts. Most of drug-dependent patients are unwilling to be treated. Some of them receive incomplete treatments (i.e. ignore the stage of rehabilitation after being detoxified). According to a study of the effectiveness of Thanyarak Institute's FAST Model rehabilitative program in 2003, it was discovered that 86.06% of the patients who had received complete treatments could stop using drugs after 1-year follow-ups. However, it was found that only 14.10% of all patients were reported receiving complete treatments (8). Similarly, a study of the Northeast Khon Kaen (cite in Suniya Yoddum et. al) (9), Drug Dependence Treatment Center, in 2001 indicated that only 75 of 4,741 drug addicts participated in the rehabilitation stage of treatments. After following up on 1,500 treated addicts, it was found that only 18 ones (1.2%) could stop taking drugs for 1-2 years. The majority of them (1,122 patients = 74.8%) had their returns to use drugs again within 30 days. Thus, the evidence indicated that encouragement of the patients to receive complete 4 stage-treatments could reduce the re-addiction. In addition, the completion of treatment process was determined to be an indicator of drug treatment complete (4).

The Health Beliefs Model (HBM) is a psychological model that attempts to explain and predict health behavior by focusing on the attitudes and beliefs of individuals (10). The HBM can be used to predict an individual's health behavior in his/her disease prevention and illness behavior. The model can explain that the appearance of the individual's health behavior depends on his/her perceived susceptibility, perceived severity, perceived treatment benefit, perceived treatment barrier and cost and health motivations as contributing factors (11). Similarly, a public

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health concept believes that the main factor in an individual's required behavior is a beliefs. Thus, in order to have the individual have appropriate illness behavior, it is necessary to create appropriate beliefs, attitudes and values (12). The Health Beliefs Model has been widely used to explain patients' behavior on disease prevention, treatment participations, following treatment advice and keeping appointments both in various general and chronic diseases, for example, children's vaccination(13)., behavior in prevention of chronic diabetic wounds(14). For drug dependence and abuse, it is widely accepted that an addict is a patient, so methamphetamine addiction is an illness. However, drug dependence patients are different from other patients since many of them are willing and happy to take the drugs and also it was very difficult to end the drug-dependence due to the strong narcotic effect of substances. Additionally, based on working experience, most drug-dependent patients would not like to receive treatments. From the literature review, there has never been a study explaining the relationship between Health Beliefs Model and the completion of treatment process in drug dependent patients before, it had each study selected 1 or 2 component in health beliefs to explaining cooperation in treatment process or relating of re-addiction e.g. perceived susceptibility or perceived severity.

As stated above, the author is interested to explore the health beliefs of the methamphetamine in dependent patients and its relationship with the completion of treatment process. The findings of this study will help the medical personals to understand beliefs and attitude of the methamphetamine dependents better. The extent of their perceived susceptibility, perceived severity, perceived treatment benefit and perceived treatment barrier and treatment motivation will be revealed. The relationship between health beliefs, family support and other factors affecting the completion of treatment process will be identified. As the result, the findings can be used to guide public health personnel and other related organization to better design and develop more effective approaches of treating methamphetamine dependent patients that can help them reduce re-addiction, have better physical well-being, be able to live happily in the society, and finally become powerful national human resources.

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2. Objective of the Study

Objectives of the study are;

2.1 To explain the health beliefs of methamphetamine dependent patients who receive treatments.

2.2 To examine the relationships between their Health Beliefs and the completion of treatment process.

2.3 To examine the relationships between socio-demographic factors, addiction and treatment factors, and family support factors and the completion of treatment process.

3. Scope of the Study

This research is cross-sectional study examining the relationships between the Health Beliefs Model and the completion of treatment process among methamphetamine dependent patients who received detoxification and rehabilitation treatments at the Thanyarak Institute of Department of Medical Services of the Ministry of Public Health.

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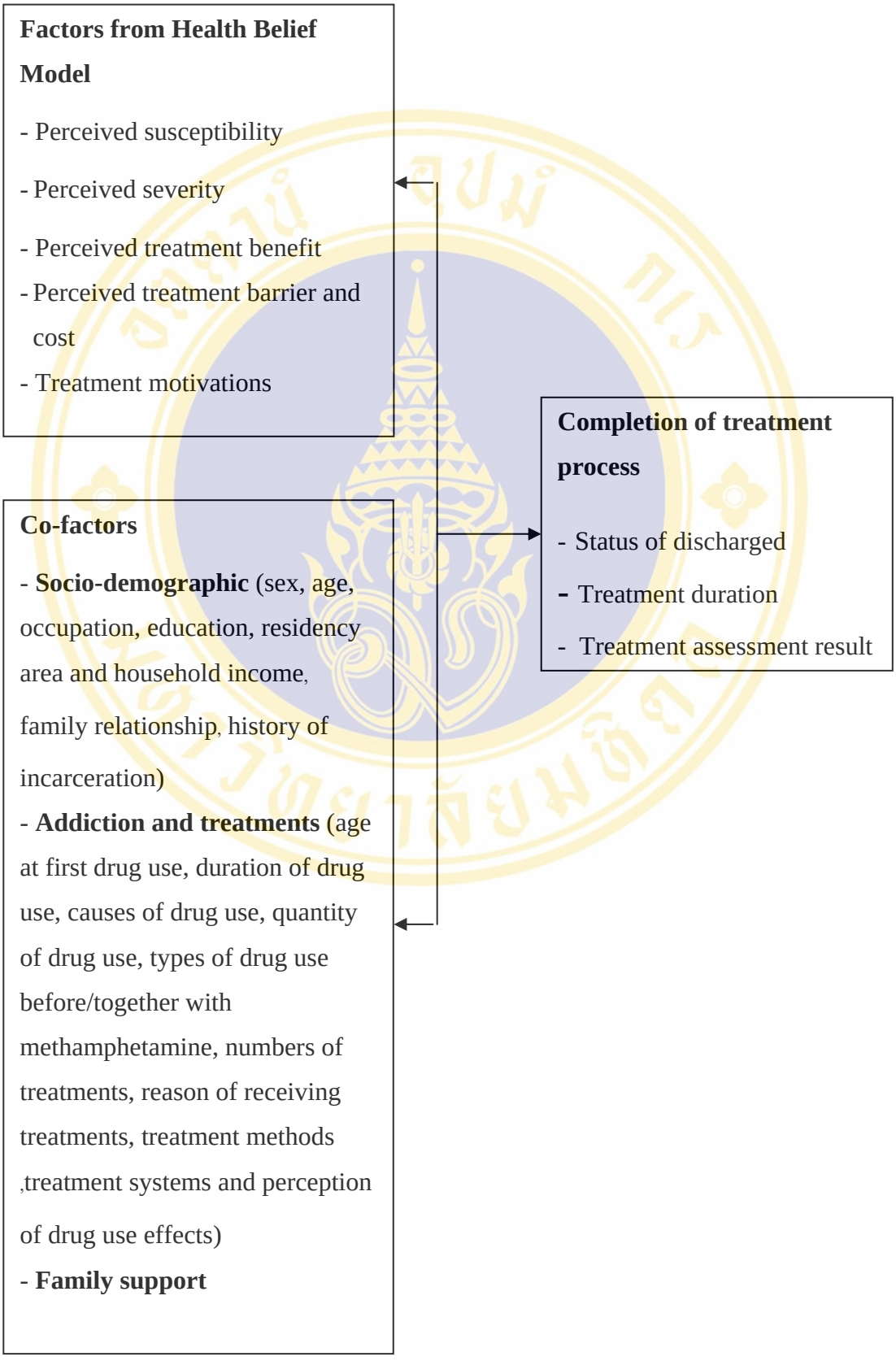
4. Research Conceptual Framework



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The inclusion of variables included in the conceptual framework was determined from the concept of the Health Beliefs Model and the literature review. According to the developed conceptual framework, variables included in the study are demographic, social and economic factors, addiction and treatment factors, family support and the Health Beliefs Model. Completion of treatment process are composed of the status of discharged and the treatment duration. In this study, if a patient is in the rehabilitation stage of treatments fore more than 90 days without any escape or seriously violate the rules, he/she would be considered as having good cooperation behavior. For being complete in treatment process, the at least 120-day of treatment duration with the good assessment result in the rehabilitation stage (get minimum score of 60 out of 100) are used as the indicator of complete of treatment process.

5. Variables and measurement level

Variable	Level of Measurement
Independent variables	
Health Beliefs Model	Interval scale
Co-factors	
- Sex	Nominal scale
- Age	Ratio scale
- Occupation	Nominal scale
- Education	Ordinal scale
- Residency area	Nominal scale
- Household income	Ratio scale
- Family relationship	Nominal scale
- History of incarceration	Nominal scale
- Age at first drug use	Ratio scale
- Duration of drug use	Ratio scale
- Causes of drug use	Nominal scale
- Quantity of drug use	Ratio scale

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Variable	Level of Measurement
- Types of drug use before/together with methamphetamine	Nominal scale
- Numbers of treatments	Ratio scale
- Reasons of receiving treatments	Nominal scale
- Treatment methods	Nominal scale
- Treatment system	Nominal scale
- Perception of drug use effects	Nominal scale
Family support	Interval scale
Dependent variables	
Complete of treatment process	
- Status of discharged	Nominal scale
- Treatment duration	Ratio scale
- Treatment assessment results	Nominal scale

6. Research Hypothesis

6.1 The Health Beliefs Model can be used to predict the completion of treatment process among methamphetamine dependent patients.

- Perceived susceptibility has positive relationship with the completion of treatment process.

- Perceived severity of methamphetamine addiction has positive relationship with the completion of treatment process.

- Perceived treatment benefits has positive relationship with the completion of treatment process.

- Perceived treatment barrier and cost has negative relationship with the completion of treatment process

- Treatment motivations has positive relationship with the completion of treatment process

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6.2 Socio-demographic factors has the relationship with the completion of treatment process.

6.3 Addiction and treatment factors has the relationship with the completion of treatment process.

6.4 Family support factors has the relationship with the completion of treatment process.

7. Operation Definitions

7.1 Methamphetamine dependent patients means drug addicts who mainly use methamphetamine and are required to be treated for their methamphetamine addictions.

7.2 Age at first drug use means the age when a patient began to use any illegal drugs.

7.3 Duration of drug use means a period of months or years from the first methamphetamine use to the treatment.

7.4 Number of treatments means all numbers of all treatments for drug addiction from both public and private detoxification centers.

7.5 Treatment systems means the system of treatment for drug addiction under the policy of caring for drug addicts who are accepted to be treated by the Thanyarak Institute which are voluntary system, non-controlled compulsory system and controlled compulsory system.

7.6 Causes of used means origins considered by the addicts their causes of their drug used and addictions including being deceived, for responding to physical needs, for responding to mental needs, joining drug-using friends, drug-using family members and living in an area of a drug epidemic.

7.7 Perception of drug used effects means experiences or physical health, mental health, family and social effects of methamphetamine use acknowledged by addicts.

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7.8 Reasons of receiving treatment means reasons for addicts' treatments in the Thanyarak Institute including by themselves, by their families, by social measures and by laws.

7.9 Family support means patients' perception of emotional, information, material, financial and time supports from their family members during their periods of treatments.

7.10 Perceived susceptibility of methamphetamine addiction means methamphetamine addicts' perception of, beliefs in and opinions on risks of chronic methamphetamine addiction, secondary diseases, physical, mental, social and economic effects from methamphetamine addiction and relapse to them after treatments.

7.11 Perceived severity of methamphetamine addiction means methamphetamine addicts' perception of, beliefs in and opinions on severity of physical, mental, social and economic effects from being methamphetamine addicts.

7.12 Perceived treatment benefits means methamphetamine addicts' perception of, beliefs in and opinions on advantages of treatments for methamphetamine addiction, following rules and regulations and advice, receiving complete treatments of a term according to the specified treatment system and acceptance of continuous follow-ups of at least a year.

7.13 Perceived barrier and cost means methamphetamine addicts' perception of, beliefs in and opinions on obstacles, difficulties, waste of time and property, adjustments during treatments, physical, mental, social and economic disadvantages both to themselves and their families during the period of treatments.

7.14 Treatment motivations means methamphetamine addicts' general interests in their health, intention to receive treatments, following advice, receiving complete treatments of a term and motivations and expectation for treatment results.

7.15 Discharged status means methamphetamine addicted patients' causes, types or conditions when ceasing treatments or being discharge from the treatments.

7.16 Treatment duration means numbers of days from the first day of admission to the treatments to the day of discharge from the treatments.

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7.17 Complete of treatment process means achievements in giving treatments to methamphetamine dependent patients in which they must be treated until the completion of rehabilitation stage with a treatment period of 90 days up and assessed to pass the criteria.

8. Expected Outcome and Uses

8.1 To better understand health beliefs of methamphetamine dependent patients in the aspects of perceived susceptibility, perceived severity of methamphetamine addiction, perceived treatment benefit, perceived treatment barrier and cost and treatment motivations.

8.2 To know the factors (Health beliefs, socio-demographic, addiction and treatment, family support) affecting complete of treatment process among methamphetamine dependent patients.

8.3 To guide public health personnel and other related organization to better design and develop more effective approaches of treating methamphetamine dependent patients

8.5 To guide further study in other aspects relevant to the Health Beliefs Model and treatment effectiveness among drug abusers.

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CHAPTER II
LITERATURE REVIEW

From the cross sectional study on relationship between health beliefs and the completion of treatment process among methamphetamine dependent patients at Thanyarak Institute. Therefore, we should make clear understanding in relevant details of this study as summarized in brief as follow:

1. Knowledge of Drug Addicts and Addiction
2. Knowledge of methamphetamine
3. Standard of Drug Dependence Treatment and Rehabilitation
4. Theory of health beliefs model
5. Concept of Social Support
6. About of Thanyarak Institute
7. Related Researches

1. Knowledge of Drug Addicts and Addiction

1.1 Definition of drug addicts and addiction

Narcotics mean any substance both natural and synthetic that input to the body in any ways and effect to the mind and body into the drug dependence such as tolerance syndrome , withdrawal syndrome , whatever actions to get the drug taking , Bad-effect to oneself, other, family, social, and nation.

The meaning of drug issued by section of the Narcotics Act, B.E. 2522 (15) declared any chemical or material that taking into the body by eat, inhalation, injection, or any and effect to the mind and body such as want to higher quantity, withdrawal syndrome when stop taking, all time needs violently both body and mind and finally deterioration of health. Including the chemical for the narcotics produce.

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World Health Organization (WHO) (15) defined drug addiction as a state of periodic or chronic intoxication produced by the repeated consumption of a drug. Its characteristics include:

1) An overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means.

2) A tendency to increase the dose.

3) A psychic (psychological) and generally a physical dependence on the effects of the drug.

4) An effect detrimental to he individual and to the society.

Conclusion, narcotics means any substances that input to the body and so create the habit syndrome in both body and mind, important of characteristics of drug action effect to drug dependence include 4 characteristics.

1) A desire (but not a compulsion) to continue taking the drug for the sense of improved well being that it engenders.

2) Little or no tendency to increase the dose.

3) Some degree of psychic dependence and, hence, no abstinence syndrome.

4) A detrimental effect, if any, primarily on the individual.

1.2 Types of drug dependence

Drug can be categorized by: (15)

1.2.1 Distinguishing by source classifies drug dependence into 2 following type

1) Nature extracts from plant or plan e.g. Cannabis

2) Synthesis with the chemical method e.g. Morphine, Heroin, Methadone, Pethidine, Methamphetamine, Thinner

1.2.2 Drug dependence substances considered harmful to the body are classified into five categories.

1) Category 1 = Very harmful drug dependence such as Heroine, and YABA (Methamphetamine), Met methamphetamine, LSD or Ecstasy or MDMA

2) Category 2 = General drug dependence such as morphine, cocaine, codeine, medicinal opium and Methadone, etc.

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3) Category 3 = Drug dependence which has mixtures of harmful substances such as codeine cough syrup, Dephenoxylate with opium Cocaine as mixtures.

4) Category 4 = Chemical which are used to produce drug dependence category 1 and 2 such as acetic anhydride and acetic chloride.

5) Category 5 = Harmful drug dependence which weren't included in category 1 such as marijuana and madder leaves.

1.2.3 Distinguishing by the affect against the central nerves is classified into 4 kinds.

1) Depressants, e.g. opium, heroin, sleeping, pill, nerve ecstasies, all type of alcoholic drinks including evaporates e.g. thinner, benzene, lacquer, and glue

2) Stimulants, e.g. methamphetamine, madder leave, cocaine, etc.

3) Hallucinogenic drug, e.g. L.S.D., D.M.T., S.T.P. and Mescaline

4) Multi-effect (depress or Stimulate or Hallucinate) e.g. marijuana

1.3 Symptoms of drug addict

Narcotics all effect to bad mind and body of drug addict. Drug addiction is difficult to Observation of drug addict, if drug addict who use any or use short period he has normal body, don't sure to observation. It does depend on type of drug, some of that show slow action but some show quick and severe, different of severity. However symptoms of drug addict can be classified into 2 symptoms as follow (16):

1.3.1 Dependence that show all symptoms of mind, body and behavior. For observation, drug addict is weakness, shapeless, yellow eyes ball, dark green lip, low body weight, unstable emotion, brain damage, dementia, uncontrollable emotion, problem in work and learn, lie etc.

1.3.2 Withdrawal drug-addicts that don't want to get treatment or drug-addicts that want to use drug but cannot get drug so they have symptoms (Withdrawal) these symptoms will show up to type of drug use, the symptoms will be adverse to drug use for example methamphetamine-addict will be sleepy, exhausted and pupil reduce, heroin-addicts will be painful, fidgety, yawn, goose bump, pupil dilate, muscle

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pain, stomach ache, snow-blind, vomit, diarrhea, sleepless, hyperventilate, delirium, someone convulsed coma and death.

1.4 Cause of drug used

1. Motivation of peer group who uses drug, that show of 50 percentage of drug addict (17) and research of Kurab Ratanasutjatum (18) show of 36.06 percentage of youth.

2. Experiment or Learning by doing , wrong beliefs, think that not easy to addict, but he uses drug he become to drug addict, some one uses drug for release illness and plain e.g. asthmatic, that used one time become to drug addict as such as heroin user. (17)

3. Unknown, users unknown what they take is compound drug because of its shape as cigarette or toffee.

4. Body illness e.g. post operated , head age ,malignant tumor that need drug to release plain (19) 2.04 percentage cause of drug use in youth from body illness

5. Psychological problems e.g. unhappiness, family and social problems, separated or divorce family, 90 percentage of cause of drug addict in youth from separate or unhappiness family (19)

6. Habit risk to drug addict e.g. abnormal personality, unstable, anxiety and think of using drug not able to drug addict.

Conclusion, cause of drug addict is multiple factors. However, cause of drug addict is bio-psycho-social problems as 3 factors as individual factor, agent factor and supportive circumstantial factor. 3 factors are related all as follow: (19)

1. Individual factor

1.1 Biological factor. Health case of sick user consecutive to body and treatment of chemical. Example hillier use opium for alleviate pain, the doctor use morphine for alleviate pain from tumor, broken bomb or after operate is the effect for take drug.

1.2 Psychological factor. Mine and personality tend of personal has used e.g. inadequate personality, emotion unstable personality, passive aggressive personality, Antisocial personality and psychopathic personality. Almost they lack the love of parent, related to drug addict and healthy.

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So that addicts likely have psychology problems of having separated or divorce family and happiness. These things can drive children from home to associate with friends and being persuaded to experiment the narcotics. Foster the children, no time advise when they meet problems.

2. Factors of drug for epidemiology

Agent is drug and effect of it. When use drug for longtime, the body was once of it, system of body was under of it. When the boy none received, the boy was suddenly change or we call racking drug. It will be want drug very much. They will be finding drug for release racking for system of body was normally. Increase study chemistry or drug well be effect to nerve have opportunity for take it all.

3. Social factor

Environment which brings about drug dependency e.g. environment under pressure, important of that is family problems, separated or divorce family. Members don't have counselor and helper, unhappiness. These thongs can drive children from homes to associate with friends and persuaded to experiment the narcotics. In other that occupation problems, economic crisis, social labeling, bad environments, quantitative drug in social, changing circumstantial, dishonest, attitude and tradition of members in social, these related of drug problems.

Conclusion, cause of drug used from many factor, a lot of them answer that they want to try of drug , its normally , one or more of them can cut of drug but if who has illness, family problems, stress, psychological problems and want drug to decrease body and mind illness he become to drug addict certainly.

2. Knowledge of methamphetamine

Generic's name of "YA-BA" is methamphetamine. For Thailand; the proceeded of methamphetamines controls in 1955 at first under the Ministry of Public Health in regard to the Dangerous Drugs by the Drugs Sold Act 1950. At first we know it's name is "YAMA", active drug, anti sleeping drug, strong drug, these show methamphetamine is support to strong body, can works hard. A large number of methamphetamine used appeared among the world war 2 because it could generated the courage of the army and also get set to the war anytime., after that used in exercise

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organization and horse drive racing. In medical organization used for decreases body weight or anti pain**.** The day after, YAMA is spread over all because of we known positive effect than negative of it. Effect to economic and social crisis. In1996 on 16 October, Minister of Interior at that time declared that changed the methamphetamines from “YAMA” into “YA-BA” because he wanted to understanding the peoples known its effected into the mental disorder and classified YABA is Type 1 or Violence narcotics**,** very harmful drug dependence such as Heroin, LSD or Ecstasy or MDMA. (20). However, now YABA is spread over than any drug, spread in to every high risk group. In the further YABA is very harmful drug dependence and severe problem in Thailand.

2.1 Background of methamphetamine

It firstly synthetic at 1887 (20) as “Methamphetamine sulfate ”, by a German scientist’s name Edelma, that contained the nervous stimulate effected as called “nervous stimulate drugs”. Subsequently at 1919 by a Japan scientist A.Ogata can generated it derivative of methamphetamine as “Methamphetamine” and eventually at 1928 discovered that its formula was similar to ephedrine that had the properties to relief the catarrh due to its effects of trachea expanded and also asthma treated by Dr. Gordon A. Alles. Methamphetamine available firstly in drugs for traded at 1932 called benzedrine, as smelling salt contained 250 milligrams that equal to currently methamphetamine 25-50 tablets.At 1936 the drugs company could produce the tablet benzedrine and it’s propagandized in upon 39 diseases treated properties such as mental disorder, depression headache, hypotension, seasick, and also pregnant disease. It affects created dexterity, strengthen, active, and was a home medicine subsequently due to the popular of methamphetamine as well.In 1937, according to the studied of Minnesota University, USA discovered that the majority of youth widespread used the methamphetamine in the wrong purposes.In 1938, the Food and Drug Administration of USA declared the benzedrine used must attached directly to the prescription and not used as a home medicine any more, hence, the benzedrine drugs had out of the market so far.

For Thailand, the proceeded of methamphetamines controls in 1955 at first under the Ministry of Public Health in regard to the Dangerous Drugs by the Drugs

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Sold Act 1950. The declaration specified that all synthetic medulla stimulant drugs were dangerous and this section has been in forced since 30 April 1955. All this could control the methamphetamines as a dangerous drugs, but however, could stopped the spread of methamphetamines as far as a first wave in the period of 1958-1967.Then methamphetamines came to the rare products so the look-alike drug, which as same appearances, were occurred in 1980-1988 but contained other nervous stimulants ingredients as a second wave of Thailand such as caffeine, ephedrine, etc.

2.2 Characteristic, compound and taking method of methamphetamine

YABA is chemical or material from synthetic. Characteristic is white crystals, smell less and a few bitter. In Thailand; a lot of YABA is tablet and various in sizes, diameter as 6-8 mms and the thick as 3 mms, a tablet weight as 70-110 milligrams, it's color provided in white, orange, brown, yellow, and spotted line. The most signs found are MY, 44, M, 99, London and head of horse at center of the tablet etc. while the injection methamphetamine is provided in the tube or mixed with the foods or beverages. The shape of methamphetamine provided as follow as powder, capsule, tablet, pill and solution. Important compound agent in YABA is methamphetamine, ephedrine, caffeine, fenylthyline, phemoline,dexamphetamine methamphetamine, theophylline, starch,fenpropcrex.. For taking of methamphetamine by eat, smoke or vapor, solute and drink, inhale by nose and injected to muscle or venous (20).

2.3 Action or Pharmacology Effects of Methamphetamine

The methamphetamine and it's derivatives are pharmacology effects as adrenaline or epinephrine, these as normal body agent, these are effects as following:

2.3.1 Pharmacological effect as following :

Effects to the central nervous system; methamphetamines provided the central nervous system stimulants, sleepless, merriment, tireless, and happy. In case of overdosed generated the panic and psychosis.

Effects to the cardiovascular system; it stimulate the heart and generated the tachycardia, headache, blood circulation failure, and chest pains.

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Effects to the gastrointestinal tract; dry mouth, hungry less, squeamishness, diarrhea, cramp in the stomach, and also the sex feeling changed. Effects to the gender and urinary tract system; diuretic, less of sexual behavior and increase uremia.

2.3.2 Tolerance syndrome and depend on methamphetamine means have to taking the in higher quantity for the same, natural and synthetic that input to the body in any ways and effect to the mind and body into the drug dependence, that symptoms as weakness, coma, severe hungry during to 3-4 days, when stop to used he has rebound phenomena. and if taking the drug for every day or many times per day

2.3.3 Possible effects: alert, excited, fancifully, hypertension, sleepless, and hungry less.

2.3.4 Withdrawal symptom: there are the symptoms after the effected of drugs as negligence, long term sleep, angry fully, depressed, and environment careless.

2.4 Methamphetamine Problems and Effects

Immediate taking high dose of methamphetamine results in a high fever, a stroke in the brain, shocking and death. Long-term repeated use of methamphetamine always brings about greater physical effects than short-term taking as the following:

2.4.1. Physical effects: The various physical effects of methamphetamine include decreased sleepiness, insomnia, increased energy, increased sweating, decrease in appetite (anorexia), increased heart rate, headaches, increased blood pressure and contemporary sexual inability.

2.4.2. The psychological effects of methamphetamine include euphoria, dysphoria, increased attention, increased alertness, excessive talking, rapid speech, irritability, nervousness, anxiety, paranoia, delusions of grandeur, panic, aggressive and sometimes violent behavior, severe depression, suicidal tendencies, hyperactivity and excitability, increased sense of well-being, and emotional liability. Occasionally excessive and/or chronic use of methamphetamine can lead to methamphetamine psychosis, with side effects such as hallucinations, paranoid, delusions, and thought disorder.

2.4.3 Accidents: With thought disorder, hallucinations during taking methamphetamine, a person shows strange behaviors such as climbing up. On the

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other hand, sleepiness and drowsiness with inactive effects of the drug, a road or working accident can occur.

2.4.4 AIDS and other infectious diseases: Use of shared and unsterilized needles produces risks of transmission of infectious diseases, especially AIDS, hepatitis and blood-borne infectious diseases. Additionally, taking drugs in a flock causes users to engage in unsafe sexual activities which consequently result in AIDS or other sexually transmitted diseases.

2.4.5 Use of other drugs: methamphetamine users have always been found taking other drugs in order to prevent them from unneeded methamphetamine effects. In case of insomnia, for example, they may use central nervous system depressants, such as alcohol heroin, benzodiazepines and sleeping pills.

2.4.6 Side effects: As methamphetamine causes less appetite, needed vitamin deficiency can happen to users and they consequently become weak and subject to illness. Additionally, it causes unusual heartbeats, cardiovascular diseases and death, in some cases, from brain stroke and heart attack.

2.4.7 Illegal abuse: Drug users' behavior is always related to crime committing. They attempt every approach to access to drugs. They are accordingly found guilty: theft, drug possession or sub-distribution and murders, etc.

Other effects include, for example, dismissal, worse academic performance, removal from school and family conflicts.

3. Standard of Drug Dependence Treatment and Rehabilitation

The Ministry of Public Health plays great roles in solving problems of drug users and drug-dependence patients and consistent development of drug dependence treatment and rehabilitation. Previously, there were various treatment and rehabilitation methods, other than standard procedures. With declaration of the war-on-drug policy in 2003(4), the Ministry has been assigned to cooperation in relevant authorities in development of standards for effective and efficient drug independence treatment and rehabilitation system in order to transmit it to regional authorities to deal with drug dependent patients in their areas, which finally helps them return to the society happily. Standard procedures are performed without separating patients of

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different drugs. Treatment and rehabilitation stages are not different in types of drugs but in an individual as to necessary. The general procedures are as follows:

3.1 Diagnosis or characteristic of Abuse and Dependence

Diagnosis of Substance Abuse and Dependence before treatment is important, because care team can give true treatment program for different.

Criteria for Substance Abuse (2):

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 – month period:

(1) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home.

(2) Recurrent substance use in situations in which it is physically hazardous

(3) Recurrent substance – related legal problems.

(4) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

Criteria for Substance Dependence:

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at anytime in the same 12 – month period:

(1) Tolerance, as defined by either need for markedly increased amounts of the substance to achieve intoxication or desired effect.

(2) Withdrawal, as manifested by either of The characteristic withdrawal syndrome for the substance, the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.

(3) The substance is often taken in larger amounts or over a longer period than was intended.

(4) There is a persistent desire or unsuccessful efforts to cut down or control substance use.

(5) A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

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(6) Important social, occupational, or recreational activities are given up or reduced because of substance use.

(7) The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

3.2 Treatment for Drug Dependence

According to the resolution of drug dependence treatment passed in the first national seminar on drug dependence treatment during July 26-28, 1977 at the conference room of the Priest Hospital, attended by the Director of the Department of the Medical Services, WHO representatives, the United Nations Fund for Drug Abuse Control (UNFDC) representatives and doctors from both public and private hospitals, it was concluded that drug dependence treatment requires 4 procedures covering pre-admission, detoxification (physical treatment), rehabilitation (mental treatment) and after-care(21).

3.2.1 Pre-admission

1. Registration: A drug-dependent person registers to be a patient of the hospital by presentation of his/her identity card and being present together with his/her relative. The medical record of each patient is used to prevent disguise. Filling in the application form is followed by lung x-ray, blood test, urine test, photographing, inquiry into drug-use background and information of his/her family members and registration of the patient and the relative, respectively.

2. Assessment and Interview: The patient and his/her relative is interviewed in order to investigate all aspects of problem, given initiation into treatment methods, stages and results, convinced to be treated attentively, suggested on physical and mental preparation and introduced to admission or making an appointment for admission to treatment for an unready patient. This stage takes about 7 days; however, as subject to change and unwilling to be treated, he/she is admitted to the hospital immediately on that day, as to agreement of his/her relative, doctors and nurses.

3.2.2 Detoxification: This stage is divided into two services:

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1. Out - patient Service: The patient is not required to stay over in the hospital. He/she is detoxified as an out-patient, physically treated and given medicine to relief physical suffering. For example, a heroin-dependent patient has to take a daily dose of methadone for 21 days. Almost Bangkok's public health centers, such as the Thart Tong Temple and Dindang centers, are open for drug-dependent out-patients who will be received a daily dose of methadone for 45 days. The hospitals in Bangkok open for such out-patients include Rajvithi Hospital, Vachira Hospital, Pramongkut Hospital, etc. In other provinces, this service is available at central hospital and general hospital with psychiatric department, such as Prapokklao Hospital, Anant Mahidol Hospital, Nakorn Sawan Hospital and Songkhla Hospital.

2. In-patient Service: Patients of this service must be treated in the hospital. They are detoxified, received symptomatic treatment and cure for complications, provided with initiation to available services of the hospital and convinced to be treated attentively. Psychotropic medication and group and individual therapies are provided. There are also various availabilities including telephone, postal services, money order and proper utensils and meals, recreations, sports, music, etc. the services also include motivation enhancement therapy and psycho-education for patients and their families, specifically in heroin and morphine dependent ones who are detoxified by methadone for 14 days. All patients of different drug dependence are required to be treated for 21 or until disappearance of physical symptoms then they can return home. They can also continue their treatments in the rehabilitation stage at the Thanyarak Institute, 5 Regional Drug Dependence Treatment Centers under the Department of Medical Services in Chiangmai, Mae Hong Sorn, Khon Kaen, Songkhla Pattani, Pramongkut Hospital, Songkhla Hospital, etc.

3.2.3 Rehabilitation

This stage is also very significant because it is a mental therapy so that the patients can return to their society happily. It takes 4 months – 1 year as the following details.

1. Rehabilitation Activities: They include initiation into treatment stages and results and attentive treatment, routines activity, psychotropic medication through group or individual therapy, occupational training, psycho-education,

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meditation, yoga, recreations, occupational therapy, facilities, physical therapy, group and individual studies. They are also encouraged by their families.

2. Job: Patients who need to leave the rehabilitation center will be provided with occupational training or jobs for about two weeks.

3. Half-way House: It covers group activities, recreations, routines, facilities, psychotherapy with the support and cooperation of relatives. They will be trained to work jobs in the center.

3.2.4 After-care: By this stage, patients are supported and followed continuously so that they can be definitely drug-independent. Activities in this stage include making appointments, recommendations and problem resolution assistance, following drug withdrawal, urine tests, inspirational encouragement, building strong psychic health, establishment of treated drug-independence club, etc. For general detoxification centers, it is provided that patients' after-care results must be followed for 1 year: 2 weeks, 1 month, 2 months, 3 months, 6 months, 9 months and 12 months respectively for after care. For Tanyarak institute, patients who received complete treatment program, they will receive after care for 1 year everybody.

3.3 Determination of specifics of the rehabilitation

Method of the rehabilitation consists of two systems covering drug users and drug addicts according to the standard of drug dependence treatment of the Ministry of Public Health as the following (4):

3.3.1 Drug Users

1. Behavioral Changing Camp

Conduct of resolution to drug problems previously specifically concentrated on patients and ignored consideration of system. Many academicians consider such conduct greatly significant. The perfect conduct should consist of three important aspects: biological, psychological and social, which institute the so-called bio-psycho-social approach. This is extremely significant in caring patients with the assistance of the system theory in the best ground for critical thinking. The theory is composed of multi sub-systems, rather than unitary system, with reactions to many other systems. An individual well-being is produced from complex relations among systems which react to each other. Behavioral modification is required to think of

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concurrently such systems as a whole. The drug user treatment via the approach of behavioral changing camp determines their targets as drug users and their families. Adolescents are informed with the purpose of changing their behavior and developing drug users' capability in order to be society's good and happy member with required behavior. Accordingly, application of the principle of emotional quotient development to the conduct can help to fulfill the objective because the emotional quotient development is, in principle, compose of 5 main components including self-awareness, self-understanding, emotional management and inspiration for achieving the target, sympathy with other and social skills. Additionally, their families are reinforced to perform their duties perfectly, understand their adolescents and society and support their youth properly and duly through the camp rehabilitation of 9-15 days.

2. Clinic Kai Jai Ni Chumchon

It is a system of drug user rehabilitation appropriate for using in a community public health center so that it is easily accessible to receive rehabilitation service from a local instructor and practice self development in order to be drug-independent. Participatory learning activities for drug users and their families are conducted for 2 months, once a week; totally 8 times.

3. Psycho-Social Therapy Program at school and in the community

The program was developed from the Matrix Intensive Outpatient Program in order to be appropriate to school contexts. This program is conducted through by a teacher for drug user students with less complex use and shorter time. Learning group activities are set up, in which a group of 8-12 early-stage drug user students participate for 1-2 hour, twice a week at total of 17 times in 9 weeks, of which at least three times are required to be jointly participated in by their parents.

4. Psycho-Social Therapy Program at Public Health Center

This 16-weeks program, developed from the Matrix program, is applicable to a large group of drug users. The officials of the community public health center organize activities, of which procedures are the same of the Matrix program, to be participated in for an hour once, twice a week.

3.3.2 Drug Addicts

1. Modified Matrix Program, developed from the 16-weeks Matrix Intensive Outpatient Program of UCLA University in the USA, specifically used as

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approach for stimulant cocaine abuse treatment and later improved in order to be also applicable to other drug abuse: heroin, alcohol and methamphetamine (Matrix Institute, 2000). With efficiency and low cost, the program highlights providing necessary knowledge inserted into each step of the rehabilitation through group therapy to patients and their families. In Thailand, after a period of application of this 16-week program, the team preparing the handbook of the Matrix Program modifies each activity to be completed appropriately within 12 weeks with 1-year follow-ups, specifically to methamphetamine patients (4).

- Individual Counseling or Individual Session and Conjoint Session, it's a first of treatment program for the patient and family learning about process and cooperation.

- Early Recovery Skill Groups, patient learning about symptom of withdrawal syndrome and received information to after process in self help group, duration of these process is 8 times that two times in one week.

- Relapse Prevention Skill Groups, in these process drug addicted learning about knowledge and skill to prevented relapsing, it is important process and duration is 24 times that two times in one week.

- Family Education Group. For these process patients and their family leaning about family support to cut off drugs, these process is 6 times, one time in every two weeks though of total process.

- Self Help Group. For these group, drug addict who stop using and chair experience to protect relapsing by learning group.

- Social Support. For these group, drug addict learning about life skill to lived without drugs.

2. Inpatient program

The Rehabilitation of drug addict Act 2002 of drug addicts' treatment has many kinds etc; Therapeutic community in Banpichitjai, Jirasa Model, PMK Model.For Thanyarak Institute, the treatment of addiction has four sequential stages (4) such as pre-admission, treatment or detoxification, rehabilitation, and follow-up or after-care stages, in the parted duration of treatment in the rehabilitation stage is 1 year and 6 month. Almost of patients are heroin dependent. In 2001,

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Thanyarak Institute used the FAST Model in the rehabilitation stage. The aims of the FAST Model are used the combination of family involvement, alternative treatment activities, self-help, and therapeutic community in rehabilitation, importance in patient focus and reduce the times in the rehabilitation stage to 4 months – 1 year. The Components of FAST Model are as follow as:

F: Family, Families take part in treatment at first and also take care together with living in their families, societies and communities as the real condition.

A: Alternative Treatment Activity, It is to choose appropriate alternatives in treatment as the reality of patients.

S: Self – Help, Patients experience and cure their physical, mental and social. They will have the strong mental by adjusting their behavior, attitude, emotion and relationship so that they can survive happily without drugs.

T: Therapeutic community consists of many therapeutic groups including the morning meeting, the background inquiry, the seminar, the psychiatric therapy, the understanding remake group, the recreation, the sanitary education, the friends' help and the exercising. The program aims to encourage patients to be confident, learn and change their behavior for self acceptance and acceptance of others' views, responsibility and ability to work with others in the patients. They are awarded by promotion of their responsibilities and warned when doing wrong. Their behavior is evaluated periodically: early admission, on therapy and post-therapy, in order to make appropriate improvements in patient caring plans.

To summarize, the new concentrated treatment, FAST Model is the process for curing drug addicts. Patients and their families will get benefits from learning treatment, which gives them to choose their appropriate alternative. It is possible to do and continuously pursue. More importantly, to pursue the curing will succeed if patients can execute the self-help process continually and all of process patients received of behavior evaluation for developed of difference treatment.

3.4 Criteria of evaluation of patients' treatment achievement

3.4.1 Physical and mental aspects: strong/weak, healthy/ill, happy/sad, friendly/separated or aggressive; no drug use found.

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3.4.2 Behavioral aspect: responsible to action and assignments, self discipline, social skills, confidence and appropriate facing and solving problems.

3.4.3 Family/community aspect: participation of family/community during treatment stages: detoxification, rehabilitation and development (career and educational planning).

The Thanyarak Institute assesses their patients periodically by using an assessment form with 20 evaluation lists of 100 points at total. A patient to achieve treatment is required to get over 60 points up, otherwise, he/she will be referred to other public health service until passing the assessment criteria and continuous care in after care stage (8).

3.5 Principles of effective drug addiction treatment

For effectiveness of drug addiction treatment, complete treatment program is important from first stage to end stage, especially stage of rehabilitation and after care. Treatment program must to treat total of bio-psycho-mine and social. Principles of effective drug addiction treatment is very kinds. The scientific research have yielded a set of fundamental principles that characterize effective drug abuse treatment. These 13 principles are (22):

1) No single treatment is appropriate for all individuals. Matching treatment settings, interventions, and services to each patient's problems and needs is critical.

2) Treatment needs to be readily available. Treatment applicants can be lost if treatment is not immediately available or readily accessible.

3) Effective treatment attends to multiple needs of the individual, not just his or her drug use. Treatment must address the individual's drug use and associated medical, psychological, social, vocational, and legal problems.

4) Treatment needs to be flexible and to provide ongoing assessments of patient needs, which may change during the course of treatment.

5) Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The time depends on an individual's needs. For most patients, the threshold of significant improvement is reached at about 3 months in

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treatment. Additional treatment can produce further progress. Programs should include strategies to prevent patients from leaving treatment prematurely.

6) Individual and/or group counseling and other behavioral therapies are critical components of effective treatment for addiction. In therapy, patients address motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding non drug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationship.

7) Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.

8) Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way. Because these disorders often occur in the same individual, patients presenting for one condition should be assessed and treated for the other.

9) Medical detoxification is only the first stage of addiction treatment and by itself does little to change lone-term drug use. Medical detoxification manages the acute physical symptoms of withdrawal. For some individuals it is a precursor to effective drug addiction treatment.

10) Treatment does not need to be voluntary to be effective. Sanctions or enticements in the family, employment setting, or criminal justice system can significantly increase treatment entry, retention, and success.

11) Possible drug use during treatment must be monitored continuously. Monitoring through urinalysis can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that treatment can be adjusted.

12) Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases.

13) Recovery from drug addiction can be a long term process and frequently requires multiple episodes of treatment. Participation in self-help support programs during and following treatment often helps maintain abstinence.

It can be seen that drug dependent treatment is not easy to conduct. It takes at least one year to complete it. It found that drug addicts rarely received treatment, some only detoxified and returned home, and some could achieve all four stages of

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treatment but was found repeating drug dependence. It was reported that a patient got the 49th treatment due to such repeat (9). However, it is glad to discover that many hundred thousand drug dependent patients can well achieve their purpose to be fully independent from drugs. Accordingly, efficient treatment system and great attempt to make patients receive complete treatment system can be a good way to solve drug problems. Most of the rehabilitation process has similar components including revival of good value, social reconnection or reintegration, social skill development, living peacefully with others, caring of necessary livelihood, which are called competence rehabilitation conducted concurrently with prevention of drug use repeat. There are 8 indicators of a competency rehabilitated person as follows (7):

1) Ex-addiction: A person is independently from all kinds of drug which also include alcohol and cigarette which tend to lead one to other more serious drugs. He/she is reformed how to minimize arousing factors and prevent and be patient with withdrawal symptoms.

2) Commitment: A person strictly keeps agreements.

3) Life goals: A person has a life goal to inspire him to achieve his commitments.

4) Social reconnection or reintegration: A person change his habits, ways of life and behavior in order to make social relationships without drug and confidently. He is not afraid of speaking about his bad experience of drug use and present his value.

5) Happy revival: A person is happy with his new life, enjoys his daily activities and can seek delights like others.

6) Self-control: A person can restrain himself on return to drugs despite persuaded by a friend or aroused by anything. One who has experience in being trained to self manage and control can fight against withdrawal symptoms better than an untrained one. He concurrently knows to make mental confidence.

7) Self acceptance: This means that a person knows well his virtuous and evils characteristics, strengths and weakness, understand his some limitations and accept conditions to find methods of adjustable ways of life independently from drugs and without self-contrasting and conflicts with others.

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8) Spiritual development: It is power of seeking for virtue in order to live happily and peacefully and developing thinking process to be strong mental immunity for new life in a new society.

A person who passes complete rehabilitation system is required to achieve the first seven indicators, while the last, though necessary, needs forever practice.

3.6 Treatment Effectiveness Assessment Forms and Methods

Assessment theorists propose different assessment forms and methods. Each form is designed for a specific purpose with distinct virtues and inferiorities and based on the principle that a program is a systematic activity aiming to determined achievement with the purpose to utilize the assessment results for management of program and external surroundings relating to the system. A successful program requires conforming components covering contexts, basic factors, performances and results. Appropriateness of results is based on contextual appropriateness. Effectiveness and efficiency are two key indicators in assessment of appropriateness of results. Effectiveness highlights outputs consistent with required targets or objectives. On the other hand, efficiency emphasizes comparison of direct costs for a unit of output. In this research, the health beliefs model of methamphetamine users which related to the effectiveness of treatment is used for indication. From the literature review on the effectiveness of treatment, Wimol Lakkanapichonchat et al studying on the FAST Model of the Thanyarak Institute determine 6 indicators of treatment effectiveness (8).

1. Percentage of members' satisfaction to the FAST Model.
2. Percentage of members who do not use drugs during treatment.
3. Percentage of members whose families participate in family participatory activities.
4. Percentage of members who have better relationships with their families after treatment.
5. Percentage of members who received complete the treatment program (in a due period and passing the assessment criteria)
6. Percentage of members who received complete the treatment program and without repeat of drug-dependence in a year

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In this research, variables of methamphetamine dependence treatment effectiveness indicator include treatment duration, type of discharge and treatment evaluation (pass/fail).

4. Theory of health beliefs model

Health beliefs model is pattern or model that developed from psycho social theory for discus of personal healthy and illness behavior. In the first time to predicted of prevention health behavior, in the after to predicted of illness behavior and sick-role behavior. Health beliefs model is feeling cognitive and perception about personal healthy, illness and treatment, that true or fault and show as different action or behavior. (10), so that: healthy behavior is related of health beliefs, illness and sick-role behavior and selected of treatment (23).

4.1 Developed of health beliefs model

For five decades, the Health Beliefs Model (HBM) has been one of the most widely used conceptual frameworks in health behavior. The HBM has been used both to explain change and maintenance of health-related behaviors and as a guiding framework for health behavior interventions. The HBM has been expanded, broken down into components, compared to other frameworks, and analyzed using a wide of multivariate analytic techniques. Over the past two decades, more research has been conducted to specify measures of health beliefs and relationships between these beliefs. The HBM that remains vital. We also examine other psychosocial constructs that further explain relationships within the HBM. Earlier reviews of HBM research findings provide historical context. Recent HBM research continues to emphasize individual health beliefs

The Health Beliefs Model was developed initially in the 1950s by a group of social psychologists in the U.S Health Service to explain the widespread failure of people to participate in programs to prevent and detect disease (24). Later the model was extended to people’s responses to symptoms (25) and to their behaviors in response to diagnosed illness, particularly adherence to medical regimens.

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The HBM is a value-expectancy theory. When value-expectancy concepts were gradually reformulated in the context of health-related behaviors, the interpretations were as follows: (1) the desire to avoid illness or to get well (value) and (2) the beliefs that a specific health action available to a person would prevent or ameliorate (illness expectation). The expectancy was further delineated in terms of the individual's estimate of personal susceptibility to and severity of an illness, and of the likelihood of being able to reduce that threat through personal action.

The development of the HBM grew out of practical concerns with the limited success of various programs of the U.S. Public Health Service in the 1950s. One such early example was the failure of large numbers of eligible adults to participate in tuberculosis screening programs provided at no charge in mobile X-ray units conveniently located in various neighborhoods. The concern of the program operators was with explaining people's behavior by illuminating those factors that facilitated or inhibited positive responses.

Beginning in 1952, Hochbaum (24) studied probability samples of more than twelve hundred adults to understand their readiness to obtain X- rays, which included their beliefs that they were susceptible to tuberculosis and their beliefs in the personal benefits of early detection. Among individuals who exhibited both beliefs in their own susceptibility to tuberculosis and the beliefs that overall benefits would accrue from early detection, 82 percent had at least one voluntary chest X- ray during a specified period preceding the interview. Of the group exhibiting neither of these beliefs, only 21 percent had obtained voluntary X- rays during the criterion period, see detail in figure 1.

The basic components of the HBM are derived from the work of Kurt Le win (26), a social psychologist, who conceptualized that the life space in which an individual exists is composed of regions, some having negative valence (negative valued), some having positive valence (positively valued), and others being relatively neutral. Illness is conceived to be regions of negative valence that can be expected to exert a force moving the person away from the positive valence region. Preventive behaviors are strategies for avoiding the negative valued regions of illness and disease, (25) see detail in figure 2.

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These components examine the value placed by an individual on a particular outcome and the individual's estimation of the likelihood that a given action will achieve that outcome (27). The HBM describes individual health behavior to take action to avoid disease then he would need to perceive that: (a) he was personally risk of the disease (susceptibility); (b) the occurrence of the disease would have at least moderate severity on his life (severity); and (c) taking a particular action would be beneficial in reducing his susceptibility to or the severity of the condition (benefits). Also, the action would not entail overcoming important psychological barriers such as cost, pain and embarrassment (barriers) (10). Modifying factors and cues to action that refer to the other variables that indirectly influence the health-related behavior were introduced to the model by Becker and other in 1975 to improve the explanation of preventive behaviors (11) , see detail in figure 3.

4.2 The components of health beliefs model

4.2.1 Perceived Susceptibility**;** Individuals vary widely in their feeling of personal vulnerability to a condition (in the case of medically-established illness, this dimension has been reformulated to include such question as estimates of susceptibility, beliefs in the diagnosis, and susceptibility to disease in general) (28). Thus, this dimension refers to individuals' subjective perception of his or her risk of contacting a disease.

4.2.2 Perceived severity; Feelings concerning the seriousness of contracting a disease or leaving a disease untreated also vary from person to person. This dimension includes evaluation of both medical/ clinical consequences (e.g., death, disability, and pain) and possible social consequences (e.g., effects of the conditions on work, family life, and social relation). The combination of perceived susceptibility and severity have been described as perceived threat (11)

4.2.3 Perceived benefits; The direction that the action taken was thought to be influenced by beliefs regarding the relative effectiveness of available alternatives in reducing the disease threat to which the individual feel subjected. An alternative is likely to be seen as beneficial if it relates subjectively to the reduction of one's susceptibility or severity of an illness. People behavioral decisions are related to readiness of and the way chosen should be useful and have less barrier (28)

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4.2.4 Perceived barriers and cost; The potentially negative aspects of particular health action, the perceived barriers, may act as impediments to undertaking the recommended behaviors. A kind of cost-benefit analysis is thought to occur where in the individual weighs the action's effectiveness against perceptions that may be expensive, unpleasant (e.g., painful, difficult, and upsetting), inconvenient, time-consuming, and so forth. Thus, as Rosenstock noted, "The combined levels of susceptibility provided the energy or force to act and the perception of benefits (less barriers) provided a preferred path of action" (10).

4.2.5 Cues to action; are other variables that might be internal (e.g., symptoms) or external (e.g., mass media communications, interpersonal interactions, or reminder postcards from health care providers) frequently associated with the HBM. A cue or trigger to action appears to be necessary for an individual to undertake the health-related behavior. The intensity of cues needed to trigger preventive actions given a certain level of readiness to engage in such activities is unknown The general assumption is made that the higher the level of readiness to act, the lower the intensity of the cue needed to trigger behavior. In other words a negative relationship is postulated between intensity of cue and level of readiness to engage in preventive actions. Cues to action may ultimately prove to be important, but they have not been systematically studied (10)

4.2.6. Modifying factors; modifying factors contributes to or block disease preventive actions or following advice on disease treatment. The modifying factors consist of demographic variables (age, gender, race), constructional variables (complexity and side effects of treatment, difficulty level in following the service's instructions), reaction variables (type, quality, continuity and consistency of relationships between a service provider and a service receiver), supporting variables which are internal (illness, pains, exhaustion) and external (campaigns or news from the media, suggestions from officials, friends and others, source of advice, appointment card or post, warning card, family's members' illness, social pressure or support, etc). Inducing agents or arousers must occur in accordance with behavior. Intensity of such inducing agents or arousers to appropriate behavior varies from a person's mental readiness to show his/her behavior. That is, low readiness needs highly intensive inducing agents or arousers, vice versa.

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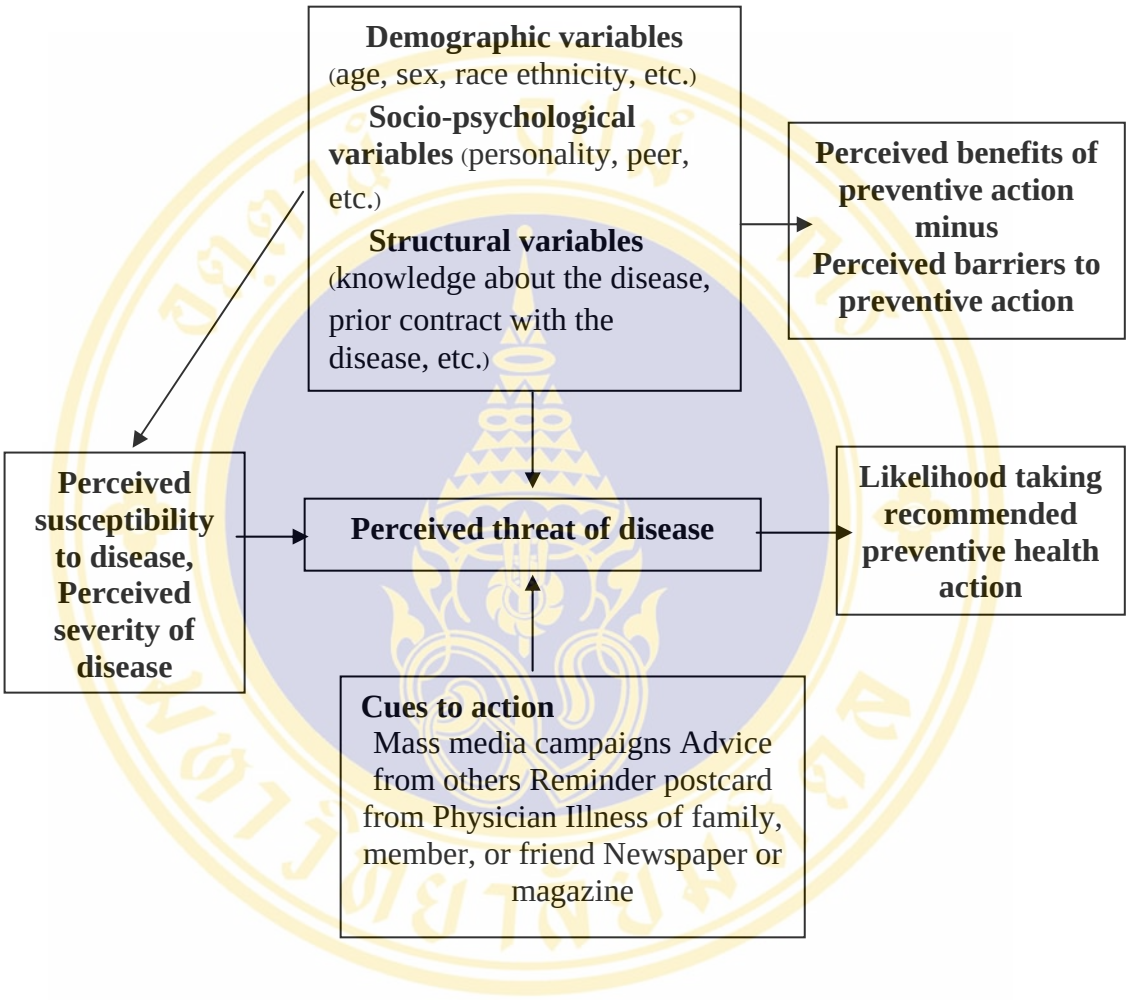

Figure 1; The Health Beliefs Model as predictor of preventive health behavior (Rosenstock, 1974)

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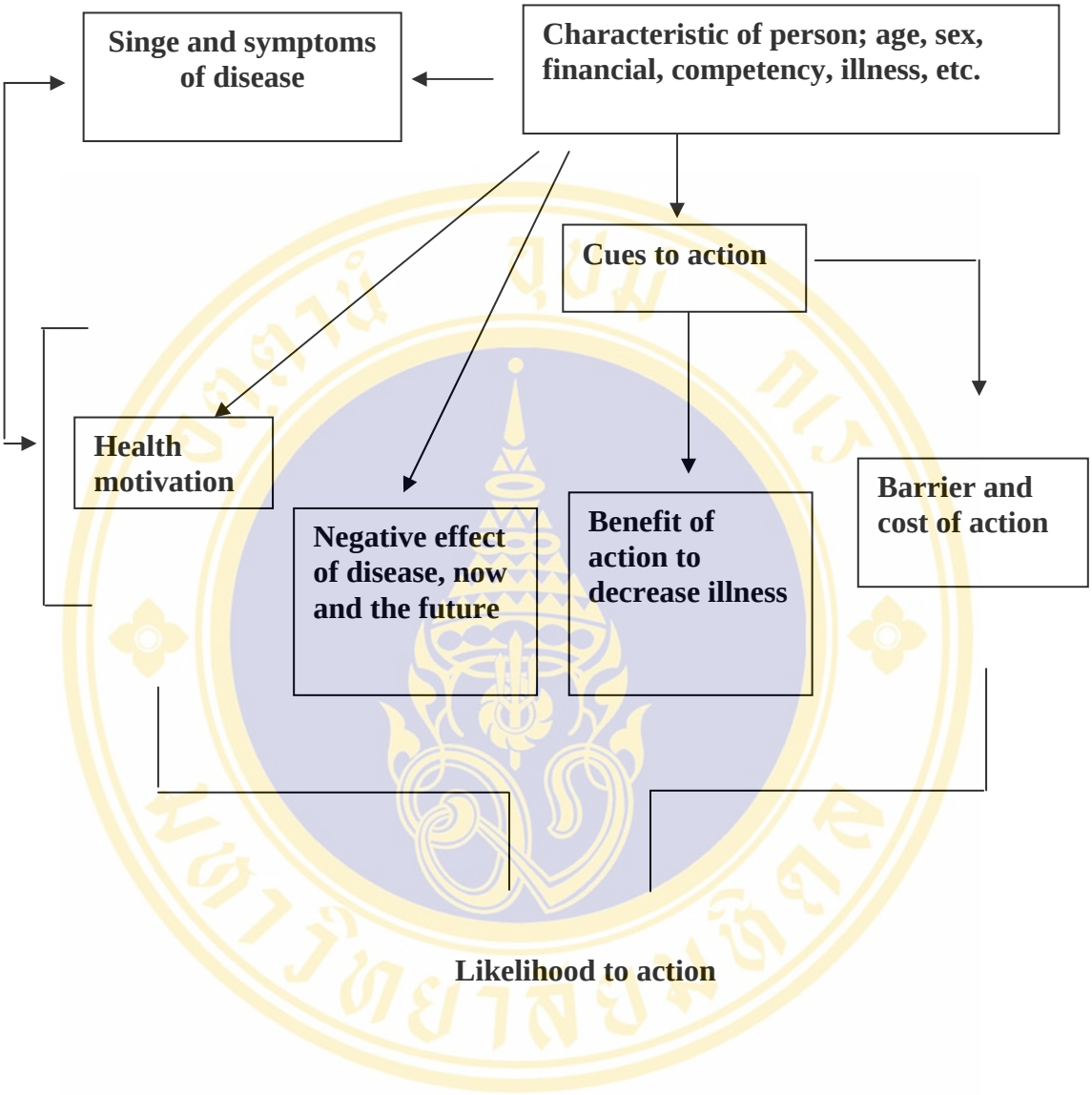

Figure 2；Kirscht and John . (1974) . "The Health Beliefs Model and Illness Behavior Health Education Monographs".

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Ready to action **Modify Factor** **Cooperation behavior**

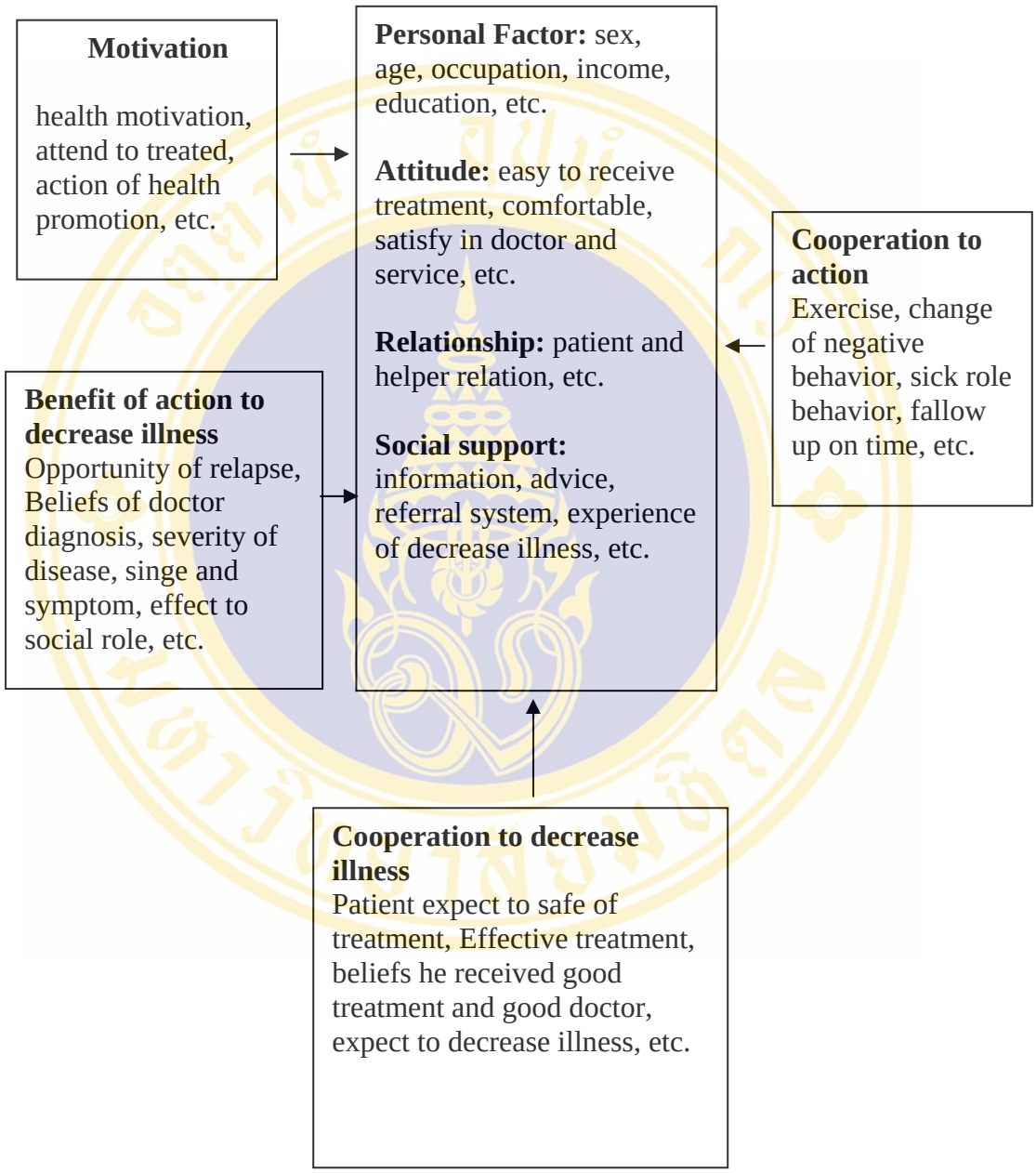

Figure 3; Becker,et al. "The Health Beliefs Model and cooperation Behavior"Strategies for Enhancing Patient Compliance" Journal of Community Health.

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The concept of health beliefs model explains in brief a person behavior of prevention and treatment for diseases that the person has to be informed disease risks and severity. This information causes him/her to avoid a threatening condition by behaving in the way he/she considers the best. Such consideration is made by comparing benefits, disadvantages, costs and obstacles of health practices. Additionally, health motives and other modifying factors as demography, structures, reactions and induction are considered contributing to his/her practices of health behavior.

According to the above concept, this research investigates the health beliefs model used for prediction and explanation of behavior in drug-dependent treatment which is a significant factor to treatment effectiveness. The independent variables include modifying factors: age, gender, education, occupation, household income, age at first use, period of use, cause of use, amount of use, numbers of treatment, cause of treatment, treatment program/service, treatment procedures, experiences in effects of drug use; and the health beliefs model: perceived risks of complications and repeat drug dependence, perceived severity of drug dependence, perceived benefits of treatment, perceived barrier and costs and general health motivation in treatment.

5. Concept of Social Support

5.1 Definition of Social Support

The think about social support is based on the theory, derived from the result of learning in social psychology. The learning in social psychology discovered that main decision of a person depends on the influence of another person, who is always of great importance and more powerful than the first person. Information form several book, journals and research, showed that the social support relate behavior of person in both direct and non-directional. The social support has an effect on behavior of person in both physical and mental (29). Therefore, social support in necessary for every drug addict. In this research social support is family support. Many meaning of social support are defined by many people as follow:

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Weiss (30) defined that the social support means persons feel to like social attachment, social integration, opportunity for nurturance, reassurance of worth, reliable alliance and assistance or guidance.

Cobb (31) defined that the social support means the information, that are receive marking him to be live that he get love, care, respect, and he is a part of society.

Kahn (32) defined that the social support relates positively and objective, between a person to another person. Furthermore, the social support means insisting or confirming or in agreement with behavior of others, as well as helping each other with money and kinds.

Thoists (33) defined that the social support means emotional, social, material, and information support among persons in society.

Kaplan (34) defined that the social support in aspects:

1) The social support means appreciation in basic social need, such as: being love and respect, being a part and secured though relation with others.

2) The social support means person's relation, which is maintained or is lost from importance person of that person.

House (35) defined that the social support is relation between person, which consist of: affection, care, trust, love, relation, support in money, labor, information, feedback, as well as an information, for individual assessment.

Bunjhaim tagunwong (cite in Prapapen Suwan) (36) said that social support mean the persons had received advise information, materials and concern and emotional support from person and group the social interaction and be able to estimate the receiving and responding in terms of information, materials and concern which made the patients feel valuable and being the part of the society. The persons who were supported by the society could encounter their problems and tension including adjust or change their behavior in the better way.

For this study the researcher concluded the meaning of social support according to the meaning of family support. In terms of the persons who were family members respond their needs and advise to treated abut methamphetamine dependent,

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5.2 Social support level

Gottieb (37) has categorized social support into 3 levels which are:

1) Macro level is the consideration of collaboration or participation in society, which could be measured by relationship with social institutions or groups and life style in society.

2) Mezzo level is the view of the structure and responsibility of the social network, measured by specific group that have consistent relationship such as group of friends. This level of social support is to give advice, materials, friendship and emotional support.

3) Micro level is the consideration of the relationship with people who are most intimate, be living that quality of the relationship is more importance than the quantity such as number or frequency. The sources of social support are partner, children and members in the family who are considered the most intimate one in the emotional aspect.

Pender (38) divided the social support into 5 systems as follows;

1) Natural support system, i.e. relatives who were the persons' important support resource because it was the transferring source of beliefs, value, pattern of behavior and various experiences.

2) Peer group support system; this was the support received from other experience and skill persons and able to adjust themselves to the situations that were critical in their lives.

3) Religion organization or denominations; it was the source which helped the persons meet and exchange their beliefs, attitude, instruction about way of life, customs and tradition from the persons who practiced the dharma, monk and priest.

4) Health professional support system; it was the source of patient's support which was important when they received their help but not sufficiently from their family and friends.

5) Organized support system not directed by health professionals; it is supported from voluntary organization and being medium group to let the persons change their behaviors.

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5.3 Types of social support

Kahn (32) divided the type of social support into 3 parts as follows;

1) Affection; it was the positively emotional expression of the persons expressed in the form of love, relationship, acceptance and respect.

2) Affirmation; it was the expression of acceptance or agreement in appropriate behavior in terms of action and ideas

3) Aid; it was the interaction towards other persons in giving things or helping directly.

Kaplan (34) divided the social support to be 2 types as follows;

1) Tangible support such as economic support or financial or physical assistance which Kaplan gave the additional meaning that was the behavior which gave to the persons directly such as physical help, materials, financial help and treatment.

2) Intangible support which was in the form of encouragement, giving love, emotional warmth and information giving. Kaplan called this kind of support was psychological support which were commendation and encouragement.

Schaefer, et al. (39) divided the social support into 3 types and each type are independence off all that as follows;

1) Emotional support; the support in terms of love giving, concern, admiration, respect, reliance, encouragement and obedience.

2) Instrumental support directly towards the essential of persons in terms of financial, time, labor as well as sacrifice in order to help or support in various activities.

3) Information support; recommendation, suggestion, warning, consulting and giving information which could apply for solving problems happening.

5.4 Effect of social support on health condition

The social support has effects on the health condition in three forms including practice for health condition promotion, encouragement of an individual’s realization of life goal and contribution to health promotion behavior. The findings indicate that a lower mortality from, example, hypertension, smoking and blood fat level, is found in people’s with great social participation and a higher rate in socially

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isolated people. There is also discovery that social support contributes to skills of facing problems, increased pride, higher self-control and self-confidence, decreased lifelessness and tragedy, and acceptance and understanding occurring stress. According to Pender (38), social support is composed of 3 of significance.

1. Retention of health conditions: Social support helps to provide appropriate surroundings by reducing stress conditions.

2. Promotion of health conditions: Social support helps to provide surroundings contributing to development and growth.

3. Prevention of illness conditions: Social support helps to have review on adjustment in stress conditions and helps an individual behave in a way that minimizes stress.

Academicians attempt to explain mechanism or effects of social support on health and illness conditions but there is currently no resolution that can give a clear explanation of social support mechanism. However, it can be concluded into two following aspects.

1. Direct effects on health conditions: Social support has a positive effect on life happiness because it causes satisfaction which is a basic social need. This direct effect works as initial prevention, as like as immunity. Social participation relates to physical and mental health and functions of the nervous system, the endocrine system and the immune system. In contrast, without social support, there will be suppression of immunity which fails to function and consequently affects health conditions. According to the research of Graydon and Rose on social support and functionality of immunity in patients with the chronic obstructive pulmonary disease, it was found that high social supported ones have good mental conditions together with decreased signs and symptoms for the disease. In addition, many studies discover that social support positively relates to life quality and self-care in patients with chronic diseases (40).

2. Preventive or absorbent agent: Social support prevents an individual from stress conditions and helps to be able to alter and modify the method of facing problems appropriately. It works as a bumper reducing effects from bad life situations and contributing to good ones. It is believed that a strong social supported individual is able to face a great and important change in his/her life properly. Black, Nair and Harington (40) discovered that social support contributes to less stress and suppression

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in HIV-infected mothers and helps them be able to adjust. This resulted in good infatuation with their babies. Japanese students, Ju and Fukada, investigating on stress and social support and physical and mental health in 1999, found that social support helps to prevent stress in a person with physical illness.

In this study, social support mean family support is selected as a modifying factor contributing to the completion of treatment process among methamphetamine dependent patients. Selected primary sources of social support cover parents, father/sister, and husband/wife and family members. They are determined as mental or emotional support, information and advice support, material, financial and time support in patients' treatment.

6. About of Thanyarak institute

6.1 History of Thanyarak institute

Thanyarak Institute, Medical Service Department, Ministry of Public Health, Thailand takes responsibility in the drug addict's treatment at tertiary level. State of Thanyarak Institute is 504/1 Wipavadeerungsit road, Patumtanee province. Thanyarak Institute is academic resource for solving drug problem in Thailand, develops treatment models to suit situations, cover all territories. Treatment models run on both voluntary basis and probation basis. The institute facilitate treatment network which can refer any clients for their best benefit (41).

Thanyarak Hospital has been in operation for upper 50 years (1th January 1959). In first time it's name is ."Sathansongkaukontidphin" and change to Thanyarak Institute in 2004.That serviced here is 770 beds and about 7,500 cases per year. For past decades, almost all in-patient clients at Thanyarak Institute are intravenous heroin inject clients. Thanyarak Institute adopted Therapeutic Community model (TC, from USA) for years. The model is useful to help clients learning the model's concepts and shape their behavior but it takes long times to fulfill the TC program.

For last decade, drug problem has changed, more than half of all in-patient clients at Thanyarak Institute are methamphetamine abusers and average age of client lower to teenage. So Thanyarak Institute director has developed TC model to FAST model. The aims of the FAST Model are to use the combination of family

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involvement, alternative treatment activities, self-help and therapeutic community in rehabilitation, importance in patient focus and reduce the times in the rehabilitation stage to 4 months – 1 year. Service by Thanyarak Institute are complete 4 state of classical treatment as follow as:

Pre-admission service for patients who plan to stay in the institute. They will get personnel interview, family counseling and orientation.

Detoxification services for patients who need medical detoxification by substitution method. Usually, methadone is prescribed for detoxification for heavy heroin addict patients and other medical treatments are for non-opiate dependent cases.

Rehabilitation services for patients who do not need medical detoxification anymore. Rehabilitation includes psychotherapy, occupational therapy and vocational therapy.

After-care services for patients who finish our treatment program. They will get our follow up program. Follow up program may be mailing the questionnaires to them, making the appointments for some times or home visits.

6.2 Function of Thanyarak institute (41)

6.2.1 Providing treatment and rehabilitation for drug dependent people both as out - patient and in-patient 770 beds on most of the patients are voluntary commits and basis 4 stages of services include of treatment.

6.2.2 Serve as the authorized center for identification of suspected drug dependent consumption cases of the Ministry of Public Health.

6.2.3 Serve as a diagnostic center and a treatment center for drug dependent persons with HIV positive.

6.2.4 Encourage all and every cases released from our treatment programmers to render themselves under an active After-Care programmers in order to protect them from relapsing to drug abuse.

6.2.5 Offer rehabilitation, including vocational training, to our clients that will enable them to live a productive life in the society by Therapeutic community approach.

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6.2.6 Thanyarak Institute serves as the center for training medical paramedical personals, researching in prevention, treatment and rehabilitation in drug dependence.

6.2.7 Licensing any drug treatment clinics

6.3 Statistic data of drug dependence treatment in Thanyarak Institute

1. Numbers of in-patient and out- patient serviced by Thanyarak Institute per year classified by sex (42).

Years	2547	2548	2549	2550
Male	3,505	6,034	4,631	4,971
Female	941	1,301	907	1,101

2. Numbers of in-patient and out- patient serviced by Thanyarak Institute per year classified by cause of use

Year	2547	2548	2549	2550
Want to try	1,887	2,296	1,978	2,472
Influence by friend	1,291	2,510	2,312	2,531
To happiness	567	479	605	570
Illness	17	13	20	9
Problem in life	174	335	368	262
To work hard	74	213	220	194
Other	391	1,392	0	7
Non classify	45	97	35	27
Total	4,446	7,335	5,538	6,072

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3. Numbers of in-patient and out- patient serviced by Thanyarak Institute per year classified by type of drugs

type of drugs	2547	2548	2549	2550
Heroin	201	97	90	69
Opium	13	12	8	11
Marihuana	175	192	160	254
Kratom	63	62	90	64
Benzodiazepine group	6	4	4	4
Methamphetamine	1,949	3,084	2,763	3,369
Total	4,446	7,335	5,538	6,072

4. Percentage of in-patient and out- patient serviced who can complete the treatment program by Thanyarak Institute classified by system of treatment

Year	2548			2549			2550		
System/ Types	Voluntary	compulsory	total	Voluntary	compulsory	total	Voluntary	compulsory	total
inhalant	27.4	20	27.2	32.4	0	32.2	25.2	0	25.2
alcohol	56.4	66.7	56.4	52.7	0	52.6	54.3	0	54.3
methamphetamine	24.2	51.1	41.5	21.4	60.5	44.6	24.4	61.6	47.0
heroin	22.0	38.5	24.0	14.6	20	10.9	12.3	100	12.3
other	82.6	83.8	52.1	24.6	80.8	28.3	24.7	61.4	30.1
total	56.0	52.1	54.9	36.6	60.6	44.7	36.6	61.6	46.1

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7. Related Researches

Different genders, Thai cultures and child rearing preferences can affect opinions, practical behavior, including drug addict behavior. According to JIraporn Suthisanon cited Prapapen Suwan(36), who studied drug perception among Lower Secondary School students under the supervision of Bangkok Metropolitan Administration. It was found that female students recognized drug problems and learned about its harmful effects, including taking preventive measure better than male students. This finding is consistent with the study of Nion and Preecha Klinrut cited Vatcharee Meesilp (43), who had discovered that more female students at Northeast Teaching College resisted drug temptation better than male students.

Regarding age, people at different age would receive dissimilar knowledge and experiences. Age thus became another influenced factor toward differences in ideas, problems and actions which is consistent with the studies of Duangduen Punmanavin , Premsuree Iaemthong , and Tanomsri Inthanon cited Prapapen Suwan,(36) that suggested health problems among adolescents quite different from other ages. In other words, Adolescents must cope with emotional and social changes, at the same time, adapt to the surrounding problems. According to Dumrong Sakornvimol, his study mentioned the correlations between age of transportation truck driver and knowledge in methamphetamine's harm and danger.

As for occupation, individual occupation is correlated with his income, knowledge, beliefs, attitude, including different characteristic in each occupation influenced drug use decision. As being seen from the study of Prapapen Suwan (36), that most methamphetamine addicts were truck drivers, taxi drivers, laborers, night workers, and a group of students. Moreover, the study of Office of the Narcotics Control Board in drug problems in the industrial sector had suggested the use of methamphetamine spreading mostly in woods and metals processing businesses from the need of drug users to increase their agility while working without feeling tired or sleepy.

Income is the determinant of individual's purchasing power to acquire consumption goods and search for the opportunity to perceive news and information. Furthermore, this is being the social status indicator of an individual which coincided

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with the study of Chirawat Nitnaed and Umporn Otrakul cited Vatcharee Meesilp (43). Findings from the study had suggested that a person at low economic level tended to worry more than a person at high economic or moderate levels, the study of Jiraporn Suthisanon cited Vatcharee Meesilp (43), has suggested that families at different economic levels showed no differences in knowledge.

Vacharee Meesilp (43) had studied selective factors related to receiving treatment during heroin detoxification by studying 120 drug addicts during the treatment. Findings samples with self-beliefs, expected results from own actions, family support and treatment behavior at medium level whereas self-beliefs, family's support and officer's support were positively related to following treatment rules.

Eison , et al. Kohakon Sommong (44) , arranged the test program in Health Education to prevent premature pregnancies among teenagers by making them and their sex partners aware of the risk of getting pregnant. Also, finding advantages and disadvantages of getting premature pregnancy at the early teen, including benefits received from stop having sexual relationship or using effective birth control and reducing adolescents' perception in barriers to birth control. Findings after the test suggest that Adolescents' perceptions had increased in all aspects. As a result, controlling behavior and pregnancy also increased whereas 2 out of 3 adolescents refused to act the same in sexual relationship and used more birth control from 34 percent to 50 percent.

Bungorn Boonruksasut (45) studied factors effecting drug addicts' decisions for not participating in rehabilitation at Thanyarak Hospital, Pathum Thani province by studying 163 involuntary male patients at the dormitory with medical treatment. Findings indicated that 73.62 percent of patients made own decisions for not participating in rehabilitation and 11.04 percent referred to family's decisions. Moreover, unwanted feeling came from the hospital's surroundings, hospital treatments and other hospital activities.

Sudjit Jonnoppakarn (cited Bongon Bunragsasut,) (45) had monitored the treatment of 113 drug addicts. Findings indicate that 72.73 percent required the treatment, 52.23 completed the treatment. Meanwhile, 13.59 percent mentioned that treatment could be done from individual's strong determination to quit drug and 42.73 percent admitted in effective treatment from being force into it.

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Supak Vanichsaenee (46) studied the correlations between being employed, amount of drugs use before the treatment and results from treating drug addicts at Health Clinic 6 of Bangkok Metropolis by randomly selected 95 drug-free patients released during April and May 2525 for 142 times . Conclusions show that amount of drugs taken; individual employment is strongly correlated with unsuccessful treatment where unemployed heavy drug failed to attend full treatment.

Orapen Nakvachara and Sasri Puttamapun (47) studied social and psychological factors threatening treatment and rehabilitation of drug addicts in Chiang Mai province to learn about their intentions to receive treatment, reasons for not completing the treatment and relapse, including different types of treatments to stop drug use by interviewing 368 patients undergone the treatment at Chiang Mai Treatment Center for Drug Addicts and Psychological Clinic. It was found that most drug addicts came to the treatment center when they had no access to the drugs, not from pure intention to quit taking drugs completely, but rather stopping the body from craving for drugs. Most of times, they only stayed for short treatment.

Kurab Ruttanasajjathum et.al. (18) studied family relationship, drug problems and sexual behaviors of Vocational Students in the eastern region by studying the relationship between family members and their behaviors and overall relationships which indicated positive correlation at low level with statistical significance at <0.01 with perception of risk in using drugs and the intensity of drug addiction, knowledge in benefits and obstacles from drugs prevention. As for child rearing by parents or guardian, it had been correlated positively at low level , having statistical significance < 0.01 with risk perception in drug use and perception in drug use with overall drugs prevention.

Adisak Sripenrut (cited Bongon Bunragsasut,(45) studied factors related to 58 repeated drug offenders in Ubol Ratchathani Central Prison by dividing factors into 3 major areas as follows:

1. Demographic factors related to age which ranked from 18-25 years with Primary School education and maximum income of 1,500 baht monthly.

2. The social structure revealed that the drug offenders were growing without proper child rearing, but most parents stayed together. While most family

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members were living in harmony in the uncrowned home and surrounding. Most of them lived in the rural area with parents.

3. Factors related to social process of 58 prisoners, having 32 prisoners as friends of previous offenders while 51.7 percent of prisoners regarding such offensive actions as copying others.

Hanucharurnkul (cited Kohakon Sommong (44) studied social support, certain factors, self-care and quality of life in the cancer patients received X-ray treatment from 70 cervical cancer patients, 42 patients with head and throat cancer. Findings indicated that social support for cancer patients received X-ray treatment had positive correlation with self-care best whereas social support correlated positively with life quality of cancer patient received X-ray treatment.

Miller (cited Wason Karwsaga), (48) studied family characteristics and the use of drugs by colleting data from 7,722 adolescents aged 15-16 years old in England. Findings indicated that children who lived with both mother and father were the least likely to become drug addicts, especially among young girls. As for children who lived with single parent or being orphans, using drugs depending on their own behaviors such as, enjoy going out and break the laws.

Kwanruthai Rongcooptavanich (49) studied social support toward quitting drugs or relapsing by studying drug addicts undergone the treatment at Thanyarak Hospital. Findings indicated that social support whether being social or data supports should protect individual from crisis and increase individual's ability to quit drugs.

John A.O , Donnell and John C.Ball (cited Sunaiya Yoddum and Janjira Rodsong (9) wrote the book in Narcotic Addiction under the topic of Treatment of the Addict stated in one section that, " Important concept of treatment deals with individual after receiving rehabilitation when fully understand about drugs problems and achieve the purpose in all steps of treatment would be easy to persuade such person to quit drugs. As we all know that drug addict usually started to get hook on the drugs when he was about 17 to 20 years old without warnings and understanding life experiences thoroughly. When he received treatment he would be entitled for proper care and receive training to get rid fear and tension until able to quit drugs eventually. Building proper social attitude for the patient, include trying different treatment

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suitable for each patient may be successful approach to motivate drug addicts to receive treatment for their own well-being subsequently.

Sunaiya Yoddum and Janjira Rodsong (9) studied conditions which could cause patient's denial for rehabilitation by conducting Quantitative research among 10 patients during detoxification period and those who refuse to participated in rehabilitation at Songkla Drugs Treatment Center. Findings indicated 4 factors as follows 1.Deciding to accept treatment to satisfy the parents or the parents forcing the children to enter treatment 2. Having adapted to the treatment 3. Ambiguous treatment data 4. Patents refused the treatment because the desire to look after the family, back to school and wanted to be free.

Paipun Pityanon et al. (50) studied factors influenced the effectiveness and accomplishment of the rehabilitation at Thanyaruk Hospital. Findings indicated that both patients and officers felt positively about the current approach. One few suggested some improvements in some activities that proved ineffective which resulted from patients' conditions and insufficient number of hospital's staffs to are for patients. They had recommended adding more procedures to prepare patients before entering hospital's treatment as well as having patients' request for more measures for treating complication, including lifting the ban on smoking during detoxification to avoid sneaking to smoke and use other drugs in the hospital.

Nisanat Chokerd (51) studied health beliefs and practicing to quit drinking liquor among 40 alcoholic patients at Lumpoon Hospital. Findings indicated that overall health beliefs were rather high and associated with practicing to quit drinking. As for perception of risk infection and perception of disease intensity were rather high and also associated with practicing to quit drinking. The perception of benefits had remained at high level and not associated with practicing to quit drinking. Besides, it was found that perception of obstacles in practicing to quit drinking had not associated with practicing to quit drinking.

Bunjongjit Panthong (52) studied factors effecting behavior in quit drinking among 80 alcoholic patients at Thanyaruk Insitutte, Phathum Thani province. Findings indicated that chemical factors in educational level and income correlated with quit drinking by having statistical significance 0.05. As for age, marriage status, occupation, live-in acquaintances, family income had not correlated with quit

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drinking. Regarding knowledge in alcoholic beverages, attitude toward drinking, risk perception and intensity of sickness for alcohol had not correlated with quit drinking.

Police Major Songprod Sirisuki (53) studied factors effecting the rehabilitation among drug addicts as being the community treatment: case study the Treatment and Rehabilitation Center at Ang Thong province through informal interview and observation of activities within the Treatment Center. Findings indicated that proper location, knowledge of officers, budget, members' willingness to accept treatment and family support are contributed to program efficiency.

Vipavadee Saengpetch (54) found factors associated with drug treatment by continue being out-patient until having completed Matrix Program in Thanyarak Institute by collecting data from 129 samples. Findings 71.90 percent received support from families, therapies, friends already received treatment, and attitude and occupation could predict behavior of out-patients who attended full Matrix treatment at Thanyarak Institute. The most powerful predictable factor was family support which could be used jointly to predict drug treatment for out-patients until the completion of the Matrix program at 47.50 percent.

Jintana Yiemchaiphum (55) studied the motivation for quitting drugs by studying 36 patients who had completed the treatment and working as member assistants at Thanyarak Institute. Findings indicated few motivation factors related to danger from using drugs and the desire to look after family. Some drug addicts had no real intention to quit using drugs, but rather quitting because of the difficulty in finding drugs and being afraid of getting caught or families forcing or pleading with them to receive treatment. After brief period, they started to see benefits from the treatment.

Prasart Tagan (56) studied service development of chronic patients in primary care unit. the study examining medical record of high blood pressure patients from Wang Ta Pa Hospital, Nan province suggested that in the year 2004, there were 1, 266 patients and later increased to 1,518 patients in the year 2005. Each patient voluntarily received and completed the medical treatment. According to the data from patients' treatment assessment during 2005, findings indicated that 54.84 percent forgot to take medicine, 40.86 percent failed to take medicine as prescribed by the

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doctor. Moreover, 11.88 percent had their blood pressure increased drastically so that they must be sent to the doctor to change medication regimen.

Apiradee and Virairut (57) who had studied the support for amphetamine-dependent patients to receive treatment at Thanyaruk Hospital. It was found that amphetamine-dependent patients received well support from relatives in all areas, especially on encouraging patients to stay with the treatment showed the highest mean.

Sobat Magun (58) studied factors affecting the acceptance of rehabilitation process and the assessment of rehabilitation effectiveness in drug addicts.The sample groups were the persons attended the rehabilitation processed, compulsory system and control but not strict type in Thanyarak institute, amounting to 112 persons. Findings the correlation analysis that adoption in the rehabilitation process is not related to evaluation results after rehabilitation process with significant level of 0.01.

Jumrieng Rungmak (59) studied self-care behavior of alcohol drinkers received treatment at Thanyarak Institute as out-patients. The finding indicated health beliefs among samples were rather high while self-care behavior remained at moderate level.

Irene Schofield MSc, et al, (60) studied An exploration of the smoking-related health beliefs of older people with chronic obstructive pulmonary disease. After interviewing former smokers, current smokers and the patients with chronic obstructive pulmonary, it was found that 2 out of 3 people from these groups, mostly known about health-care but cited many obstacles in quitting smoking. Even with their strong determination to quit smoking, it was useless effort since external factors aroused more urge for smoking than knowing smoking as the cause of diseases.

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CHAPTER III
MATERIALS AND METHODS

This is cross sectional study aims to explore the health Beliefs of methamphetamine dependent patients and to examine the factors relationship between the completion of treatment process among patients receiving treatments at the Thanyarak Institute, Department of Medical Services of the Ministry of Public Health. The research methodology is described as follows;

1. Population and Samples

The research populations are methamphetamine addicts who are receiving treatments. The samples include both inpatient and outpatient methamphetamine-addicted patients receiving care at Thanyarak Institute during the study period who met the eligibility criteria, as specified below;

Inclusion criteria

1. Diagnosed as having methamphetamine dependence.

2. Receiving in-patients care in the stage of detoxification or receiving in-patient or out-patient care in the stage of rehabilitation.

3. No hearing impairment, hallucination or any psychological symptoms while filling in the questionnaire.

4. Willing to participate in the study.

Exclusion criteria

1. Refuse to participate in the study

2. Have difficulty in communication

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2. Sample Size

Determination of the sample size is done according to the formula of Lemeshow S. (61) which specifies that the population size must not be smaller than 30 times of independent variables. As there are 15 independent variables in this research, the population size becomes 450. So data are to be collected from eligible 452 samples who have been receiving treatments at the Thanyarak Institute since October 2006.

3. Research Instrument

Questionnaire was used as the research instrument. The developed questionnaire is divided into 4 main parts. The first three parts are 1) socio-demographic information and addiction and treatment factors, 2) Family support and 3) health beliefs. The last part of the questionnaire is the assessment form of treatment results acquired from the patient's medical record after treatment completion. The following are detailed each part of the questionnaire;

3.1 Part 1: It consists of 21 questions asking about socio-demographic and addiction and treatment information. The questions cover the respondent's personal information including sex, age, residency area, education, occupation, household income, age at first drug use, duration of drug use, types of drug use before/together with methamphetamine, daily doses, criminal records, numbers of treatments, treatment methods, treatment systems, family relationships, people whom the patient living together, causes of drug use, reasons of receiving treatments, and experience in effects of methamphetamine use.

3.2 Part 2: This set of questionnaire is to test the respondent's family supports. It consists of 15 questions asking about family members' helps and encouragements during his or her drug addiction and treatments. This part consisted of 6 questions about emotional encouragement, 4 questions about information and advice support, and 5 questions about financial and material support (1 negative questionnaire in item 15). The answers are in three point likert- scales as the following:

High (3): referring to a great amount of what stated in the message which the respondent receives from his or her family.

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Medium (2): referring to a medium amount of what stated in the message which the respondent receives from his or her family.

Low (1): referring to a small amount of what stated in the message which the respondent receives from his or her family.

In negative questionnaire, the answers are in three point likert- scales are opposite above.

3.3 Part 3: This part of the questionnaire asking about the Health Beliefs Model. It covers 36 questions about the respondent's opinions on, beliefs in and perception of 5 aspects of the Health Beliefs Model. They include 7 questions about the perceived susceptibility (2 negative questionnaires in item 6, 7), 10 questions about the perceived severity of methamphetamine addiction consequences (1 negative questionnaire in item 14), 6 questions about the perceived treatment benefits (2 negative questionnaires in item 22,23), 7 questions about the perceived barrier and cost, 6 questions about treatment motivations. The answers are in three point likert-scales ranging from agree (3) to uncertain (2), and disagree (1) and the answers in negative questionnaire in three point from agree (1) to uncertain (2), and disagree (3). As the result, the highest score indicate having strong belief in the domain.

3.4 Part 4: This part is the assessment of cooperate behavior and the completion of treatment process which will be completed at the end of treatment process. Three types of information including the discharge status, duration of treatment, and treatment assessment result were collected from individual patient's record.

4. Instrument examination

4.1 Validity

Face validity and content validity were assessed by 3 experts before the data collection process.

4.2 Reliability

Pilot testing was conducted among 30 involuntary methamphetamine-dependent patients receiving treatment at Thanyarak Institute. Reliability of the questionnaires was assessed through Cronbach's Coefficent of Alpha.

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The results of the reliability were as follow:

List	Reliability
Overall score of whole questionnaire of family supports	0.89
Score of questionnaire of emotion supports	0.91
Score of questionnaire of information and advice	0.85
Score of questionnaire of financial and material supports	0.81
Overall score of whole questionnaire of Health Belief Model	0.87
Score of questionnaire of perceived susceptibility	0.83
Score of questionnaire of perceived severity	0.79
Score of questionnaire of perceived treatment benefits	0.86
Score of questionnaire of perceived barrier and cost	0.84
Score of questionnaire of treatment motivations	0.88

5. Data Collection

Data collection was done by face-to-face interview using developed questionnaire. Data on treatment results will be acquired from their patient's records. Data collection will be performed in two phases. The first phase is during the first three days of being admitted to treatments by considering the readiness of the patients. During the first phase, information on parts 1-3 will be gathered. On the other hand, information on part 4 will be collected at the second phase of data collection which is the end of the treatment process.

Data Collection will be performed in the following steps:

5.1 Developed research instrument.

5.2 Sending an official letter, with the purpose of asking for permission for data collection, from the Graduate School of Mahidol University to the chief of the Thanyarak Institute under the Department of Medical Services of the Ministry of Public Health.

5.3 Informing the head of the patient building and the staff of the detoxification center and the rehabilitation center about the data collection and making an appointment to do so.

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5.4 The research author introducing himself/herself to a respondent and asking him/her for permission to be interviewed with protection of privacy, then having him/her sign in the permission form.

5.5 Making an interview and having the interviewee read and answer the questionnaire, taking about 15-20 minutes.

5.6 Following treatment results from the patient record on completion of the treatment**.**

6. Data Analysis

After data collection was completed, data examination for accuracy will be performed, followed by data analysis using the Statistics Package for Social Science (SPSS) program.

The following are statistics used in the data analysis.

6.1 Descriptive Statistics: Percentage, mean and standard deviation are to be used to describe data.

6.2 Univariate Analysis: Simple logistic regression will be performed to examine the relationship between interested factors and the completion of treatment process.

6.3 Multivariate analysis: Multiple logistic regression will be performed to examine the relationship between interested factors and the completion of treatment process after adjusted for other co-variate. In this step, only significant factors from univariate analysis will be included in the model.

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CHAPTER IV
RESULTS

The results of this study were divided into two main parts as follows;

1. Descriptive analysis
    1.1 Socio-demographic factors
    1.2 Addiction and treatment factors
    1.3 Family support factors
    1.4 Health beliefs model factors
    1.5 Completion of treatment process
2. Factors affecting completion of treatment process

1. Descriptive analysis

1.1 Socio-demographic factors

Socio-demographic information (i.e. sex, age, occupation, education level, residency area, household incomes, family relationship, and history of incarceration) of all 452 patients included in the study was shown in table 1 and 2.

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Table 1 Socio-demographic characteristic of the patients (Category variables)

Factors	Number	Percentage (%)
Sex	N= 452	
Male	324	71.7
Female	128	28.3
Residency area	N= 449	
Bangkok	227	50.6
Perimeter area	81	18.0
Others	141	31.4
Education Level	N= 448	
Primary school or lower	194	43.3
Lower secondary school	171	38.2
Upper secondary school	69	15.4
Vocational education	6	1.3
Bachelor's degree (University) or higher	8	1.8
Occupation	N= 444	
Unemployed	101	22.7
Student	14	3.2
General workers	203	45.7
Agriculture worker	20	4.5
Government officer	3	0.7
Merchant/ Own account business	62	14.0
Private company employee	39	8.8
Actor/Actress	2	0.5

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According to table 1, majority of the patients are male (71.7%), living in Bangkok (50.6%), had primary school or lower education (43.3%), and work as general workers (45.7%).

Table 2 Socio-demographic characteristic of the patients (Continuous variables)

Factors	Min	Max	$\overline{X}$	SD	Number	Percentage (%)
Age (year) N= 451	15	54	25.9	7.18		
15 - 24					218	48.3
25 - 34					180	39.9
35 - 44					48	10.6
45 - 54					5	1.1
Household Income (Baht per month) N= 452	500	110,000	15,394	16,859		
< 5,000					120	26.5
5,000 – 35,000					290	64.2
35,001 – 65,000					33	7.3
65,001 – 95,000					6	1.3
> 95,000					3	0.7

From table 2, the lowest age is 15 years old while the highest is 54 years old. Mean age of the respondents was 25.9 (S.D. 7.18) years old. Household income per month of the sample group ranged between 500 Baht to 110,000 Baht, with the mean income of 15,394 Baht (S.D. 16,859)

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Table 3 Family information and history of incarceration

Factors	Number	Percentage (%)
Family relationship	N= 451	
Warm relation	313	69.4
Lived together but unrelated	54	12.0
Lived separately	84	18.6
Person whom the patients lived	N= 451	
Father	28	6.2
Mother	105	23.3
Father and Mother	140	31.0
Husband or Wife	74	16.4
Couple	58	12.9
Friend	20	4.4
None	26	5.7
History of incarceration	N= 452	
None	257	56.8
Incarceration due to drug problems	162	35.8
Incarceration due to other problems	33	7.3

According to table 3, concerning family relationship, most of the patients indicated having warm relationship with their families (69.4%). About 31% of the patients lived with father and mother, while 23.3% lived mother only, and 16.4% lived with husband or wife. For history of incarceration, most of the patients (56.8%) have never been in prison while 35.8% and 7.3% had history of incarceration due to drug problems and other problems, respectively.

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1.2 Addiction and treatment factors

Addiction and treatment factors were displayed in table 4-7. According to table 4, age at first time drug use ranged between 8 years old and 42 years old. The mean age at first time drug use was 19 years old (SD 5.7). For duration of drug use before treatment, the data showed that it ranged between 1 month and 27 years. Mean duration of drug use before treatment was 4.23 years (SD 3.76)

Table 4 Age at first time drug use and duration of drug use before treatment

Factors	Min	Max	$\overline{X}$	SD	Number	Percentage (%)
Age at first time drug use (N= 452)	8	42	19	5.7		
< 10 yrs					3	0.7
10 – 15 yrs					143	31.6
16 – 20 yrs					194	42.9
21 – 25 yrs					49	10.8
26 – 30 yrs					34	7.5
31 – 35 yrs					18	4.0
36 – 40 yrs					8	1.8
> 40 yrs					3	0.7
Duration of drug use before treatment (N= 452)	1 mo	27 yrs	4.23	3.76		
< 6 month					60	13.3
1 – 5 years					259	57.3
6 – 10 years					109	24.1
11 – 15 years					16	3.5
6 – 20 years					5	1.1
> 20 years					3	0.7

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According to table 5, number of treatment ranged 1 to 20 with the mean of 1.45 (S.D. 1.53) times. For number of treatment period more than 3 months, it was found that about 91.6 % of the patients indicated never had treatment period more than 3 months. Concerning the number of drug use per day, it ranged between ¼ tablet to 30 tablets with the mean of 3.57 tablets (S.D. 4.92)

Table 5 Number of treatments, number of treatment period more than 3 months and quantity of drug use per day

Factors	min	max	$\overline{X}$	SD	Number	Percentage (%)
Number of treatments (N= 452)	1	20	1.45	1.53		
1 time					330	73
2 – 4 times					110	24.3
5 – 7 times					6	1.3
8 – 10 times					5	1.1
20 times					1	0.2
Number of treatment period more than 3 months (N= 452)						
None					414	91.6
1 time					27	6.0
2 times					6	1.3
3 times					1	0.2
4 times					3	0.7
7 times					1	0.2

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Amount of drug use per day	1/4	30	3.57	4.92		
¼	tab				5	1.1
½	tab				38	8.4
1 – 5	tabs				341	75.4
6 – 14	tabs				38	8.4
11 – 15	tabs				11	2.4
16 – 20	tabs				14	3.1
> 20	tabs				5	1.1

Table 6 displayed type of drug use before and together with methamphetamine. It was found that most of them (approximately 75%) had never used any drug before methamphetamine. In addition, it was found that most of the patients did not use other drug together with methamphetamine (78.5%).

Table 6 Type of drug use before and together with methamphetamine

Factors	Number	Percentage (%)
Type of drug use before methamphetamine	N= 451	
None	340	75.2
Marijuana	42	9.3
Heroin	25	5.5
Inhalants	40	8.8
More than 1 drug	4	0.8
Type of drug use together with methamphetamine	N= 451	
None	354	78.5
Marijuana	55	12.2
Heroin	5	1.1
Inhalants	7	1.6
Sedative drug	13	2.9
ICE	13	2.9
More than 1 drug	4	0.9

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Table 7 Cause of methamphetamine use, perceived effects of methamphetamine use, reason of receiving treatment, treatment methods and treatment systems

Factors	Number	Percentage (%)
Cause of methamphetamine use (can selected more than one item)	N= 452	
Unknown	10	2.2
Wanted to try	372	82.3
Peer group influence	237	52.4
Being lived in drug abuse community	89	19.7
To replace other drugs	17	3.8
To loss body weight	58	12.8
To relief illness	16	3.5
To be able to work hard	61	13.5
For happiness	176	38.9
To decrease stress	110	24.3
Had drug abusers in family	14	3.1
Had family problem	75	16.6
Perceived effects of methamphetamine use (can selected more than one item)	N= 452	
Biological illness	341	75.4
Accident	50	11.1
Think or action to suicide	24	5.3
Working or learning problem	104	23.0
Arrested by policeman	152	33.6
Illness from violent	46	10.2
Hallucinate	114	25.2
Get treated in psychiatric hospital	13	2.9
Family problem	161	35.6

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Reason of receiving treatments (can selected more than one item)	N= 452	
To temporarily stop	23	5.1
Referred by family	110	24.3
Concern to be arrested	45	10
Hard to buy or high price	11	2.4
Wanted to cut off drugs	234	51.8
Referred by work office or school	2	0.4
Ordered by court	340	75.2
Treatment methods	N= 452	
In patient detoxification treatment	58	12.8
In patient rehabilitation treatment	380	84.1
Out patient rehabilitation treatment	14	3.1
Treatment systems	N= 452	
Voluntary system	81	17.9
Compulsory without control	11	2.4
Compulsory with control	360	79.6

According to table 7, it was found that the first 3 causes of methamphetamine use were wanted to try (82.3%) followed by peer group influence (52.4%), and for happiness (38.9%), respectively.

For perceived effects of used methamphetamine; data showed that 341 samples (75.4%) perceived having biological illness from methamphetamine used, 161 samples (35.6%) had family problem, 152 samples (33.6%) were arrested, 114 samples (25.2%) were hallucinate and 13 samples (2.9 %) were received treatment in psychiatric hospital.

For reason of receiving treatments; data showed that 340 (75.2%) were ordered by court, 234 (15.8%) wanted to cut off drugs, 110 (24.3%) were referred by

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family, 45 (10%) were concern to be arrested, and 23 (5.1%) wanted to temporarily stop, respectively.

For treatment methods, data showed that majority of treatment method were in- patient rehabilitation treatment (84.1%), followed by in - patient detoxification treatment (12.8%), and out- patient rehabilitation treatment (3.1%), respectively.

For treatment systems, data showed that majority of treatment system were compulsory with control (79.6%), followed by voluntary system (17.9%), and compulsory without control (2.4%), respectively.

1.3 Family Support factors

Family support factors including emotional support, information support and instrumental support were described in table 8.

For emotional support; the data showed that the highest level were in item "Family members are always accepted and gave samples second chance to improve them self" ($\bar{x}$= 2.77, S.D.= 0.51), followed by "Family members make samples feel warm, secure and safe" ($\bar{x}$= 2.63, S.D.= 0.59), and "Close acquaintances made samples feel useful and needed " ($\bar{x}$= 2.52, S.D.= 0.62), respectively. On the other hand, the lowest level were found in item "When samples had encountered problems, there is always someone listening to their problems and comforting them" ($\bar{x}$= 2.17, S.D.= 0.69) respectively.

For information support; the data showed that the highest level were in item "Family members had made the suggestions for them to stay in and complete the treatment program as required by the hospital" ($\bar{x}$= 2.66, S.D.= 0.64), followed by "Family members have presented you with new guidelines and modern methods to help you stop drugs dependent" ($\bar{x}$= 2.49, S.D.= 0.6), and "Family members have given you the advice to seek the drug dependent treatment" ($\bar{x}$= 2.48, S.D.= 0.72), respectively.

For instrumental support; the data showed that the highest level were in item "Close family members are prompted to provide money and necessities when they really needed at present" ($\bar{x}$= 2.36, S.D.= 0.70). On the other hand, the lowest level were found in item as "Samples still had many concerned responsibilities that needed to be done not so different from pre-drug dependent treatment" ($\bar{x}$= 1.63, S.D.= 0.70), and "Family members have helped to relieve burdens on housework,

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office works or school works while you were undergone the drug dependent treatment"($\bar{X}$ = 2.19, S.D.= 0.75), respectively.

Table 8 Family support of the patients

Emotional support	High (3)	medium (2)	Low (1)	$\bar{X}$	S.D.
1. Family members make you feel warm, secure and safe.	311 (69.1%)	112 (24.9%)	27 (6.0%)	2.63	0.59
2. When you have encountered problems, there is always someone listening to your problems and comforting you.	151 (33.7%)	221 (49%)	76 (17.0%)	2.17	0.69
3. Close acquaintances have never made you feel deserted or lonely.	249 (55.2%)	153 (33.9%)	49 (10.9%)	2.44	0.68
4. Family members always accepted and give you second chance to improve yourself.	355 (80.7%)	68 (15.5%)	17 (3.9%)	2.77	0.51
5. Close acquaintances made you feel useful and needed.	266 (59.1%)	153 (34.0%)	31 (6.9%)	2.52	0.62
6. Family members understand and sympathize with your battling against drugs during the drug rehabilitation.	224 (49.6%)	162 (35.8%)	66 (14.6%)	2.35	0.72
Total of emotional support	(6-18	point)		14.89	2.59

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Information support	High (3)	medium (2)	Low (1)	$\overline{X}$	S.D.
7. Family members have given you the advice to seek the drug dependent treatment.	272 (61.3%)	113 (25.5%)	59 (13.3%)	2.48	0.72
8. Family members have presented you with new guidelines and modern methods to help you stop drugs dependent.	257 (57.1%)	156 (34.7%)	37 (8.2%)	2.49	0.64
9. Family members have assisted you with information and guided you to follow the advices of doctors, nurses and treatment staffs.	251 (55.5%)	147 (32.5%)	54 (11.9%)	2.44	0.7
10. Family members have made the suggestions for you to stay in and complete the treatment program as required by the hospital.	327 (72.7%)	92 (20.4%)	31 (6.9%)	2.66	0.6
Total of information support (4-12 point)				10.06	1.98
Instrumental support	High (3)	medium (2)	Low (1)	$\overline{X}$	S.D.
11. Family members are gladly sacrificed time to take you to the hospital or regularly pay for your hospital visits.	170 (37.7%)	202 (44.8%)	79 (17.5%)	2.20	0.72
12. Close family members are gladly assisted you with the expenses while undergone the drug dependent treatment.	170 (37.6%)	203 (44.9%)	79 (17.5%)	2.20	0.72
13. Close family members are prompted to provide money and necessities when you really needed.	221 (49.0%)	173 (38.4%)	57 (12.6%)	2.36	0.7

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Instrumental support	High (3)	medium (2)	Low (1)	$\overline{X}$	S.D.
14. Family members have helped to relieve burdens on housework, office works or school works while you are undergone the drug dependent treatment.	178 (39.5%)	179 (39.7%)	94 (20.8%)	2.19	0.75
15. At present, you still have many concerned responsibilities that needed to be done not so different from pre-drug dependent treatment.	57 (12.6%)	169 (37.4%)	226 (50.0%)	1.63	0.70
Total of instrumental support (5-15 point)				10.58	2.24

As found in table 9, the summary score were high with the average of 35.5 and the standard deviation 5.58 (total possible point ranged between 15-45). The average score of family support on emotional support were 14.89 (S.D. 2.59) followed by information support with an average of 10.07 (S.D. 2.31), and instrumental support wit an average of 10.58 (S.D. 2.31), respectively.

Table 9 Summary score for family support factors

Family support factor	N	$\overline{X}$	SD
Emotional support (point is 6-18)	431	14.89	2.59
Information support (point is 4-12)	440	10.07	2.31
Instrumental support (point is 5-15)	449	10.58	2.31
Total (point 15-45)		35.5	5.58

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1.4 Health beliefs model factors

Health beliefs model factors including perceived susceptibility, perceived severity, perceived treatment benefit, perceived treatment barrier and cost and treatment motivations were described in table 10 -14.

Table 10 Perceived susceptibility of the samples

Message	High (3)	medium (2)	Low (1)	$\overline{X}$	S.D.
1. To date, you are unable to stop methamphetamine dependent by yourself.	85 (18.8%)	126 (27.9%)	241 (53.3%)	1.65	0.78
2. Prolong use of methamphetamine increases drug addiction and difficult to stop drug dependent.	224 (49.6%)	115 (25.4%)	113 (25.0%)	2.25	0.83
3. You have high probability of becoming chronic addict from taking methamphetamine repeatedly without the drug dependent treatment.	200 (44.6%)	112 (25.0%)	136 (30.4%)	2.14	0.86
4. You are taking risk of using stronger drugs with methamphetamine.	135 (30.1%)	96 (21.4%)	217 (48.4%)	1.82	0.87
5. When you do not take methamphetamine as needed it, you feel restless and craving for drug.	159 (35.3%)	93 (20.6%)	199 (44.1%)	1.91	0.89
6. The doctor diagnosis that you are addicted to drug is rather harsh diagnosis.	151 (33.8%)	163 (36.5%)	133 (29.8%)	2.04	0.80
7. You have taken methamphetamine occasionally for fun, but not enough to make you methamphetamine dependent.	55 (12.2%)	109 (24.2%)	287 (63.6%)	1.49	0.70
Total perceived susceptibility	(7-21 point)			**13.28**	3.23

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Table 10 showed result of analysis in perceived susceptibility of the sample. The data showed that in total perceived susceptibility were moderate ($\bar{x}$= 13.28, S.D.= 3.23). The highest level was found in item "Prolong used of methamphetamine increases drug addiction and difficult to stop drug dependent" ($\bar{x}$= 2.25, S.D.= 0.83). On the other hand, the lowest level was found in "Sample had taken methamphetamine occasionally for fun, but not enough to make them methamphetamine dependent."($\bar{x}$= 1.49, S.D.= 0.70), "To date, samples are unable to stop methamphetamine dependent by them self ($\bar{x}$= 1.65, S.D.= 0.78), and "Sample are taking risk of using harder drugs with methamphetamine"($\bar{x}$= 1.82, S.D.= 0.87), respectively.

Table 11 Perceived severity of the samples

Message	High (3)	medium (2)	Low (1)	$\bar{X}$	S.D.
8. Methamphetamine is the dangerous drug that severely damaged health of drug dependent.	368 (81.4%)	57 (12.6%)	27 (6%)	2.75	0.55
9. Prolong use of methamphetamine can create dimly ear, hallucination and brain deterioration as well as making the drug addict permanently insane until committing suicide.	269 (59.6%)	130 (28.8%)	52 (11.5%)	2.48	0.69
10. Taking methamphetamine has made you lost a large amount of money and assets.	404 (89.6%)	29 (6.4%)	18 (4.0%)	2.86	0.45
11. Prolong use of drugs can cause problems in learning or working and eventually being fired from work.	374 (82.7%)	60 (13.3%)	18 (4.0%)	2.79	0.50
12. Methamphetamine dependent can create conflicts between you and family members and close acquaintances.	277 (61.3%)	93 (20.6%)	82 (18.1%)	2.43	0.78

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Message	High (3)	medium (2)	Low (1)	$\overline{X}$	S.D.
13. Methamphetamine dependent makes you break laws, for examples, burglary, quarreling and fighting, injury to others or being drugs dealer.	232 (51.3%)	85 (18.8%)	135 (29.9%)	2.21	0.88
14. Even using methamphetamine is punishable, but it makes you feel more vigorous, happy and fun.	108 (23.9%)	146 (32.3%)	198 (43.8%)	1.80	0.80
15. Using methamphetamine is illegal, increases risk of being arrested, and gets life penalty from being drugs dealer.	389 (86.1%)	43 (9.5%)	20 (4.4%)	2.82	0.49
16. Using methamphetamine increases your risk for getting accidents.	275 (61.2%)	126 (28.1%)	48 (10.7%)	2.51	0.68
17. Using methamphetamine makes you prone to contact diseases or become more addicted to other drugs.	234 (51.8%)	130 (28.8%)	88 (19.5%)	2.32	0.78
Total of perceived severity (10-30 point)				24.99	3.53

Table 11 showed result of analysis in health beliefs about perceived severity. The data showed that in total perceived severity were high ($\overline{X}$= 24.99, S.D.= 3.53) from total were 10-30. The highest average was found in item "Taking methamphetamine had made them lost a large amount of money and assets" ($\overline{X}$= 2.86, S.D.= 0.45), followed by " Using methamphetamine is illegal, increase risk of being arrested, and gets life penalty for being drugs dealer" ($\overline{X}$= 2.82, S.D.= 0.49), respectively.

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Table 12 Perceived treatment benefit of the samples

Message	High (3)	medium (2)	Low (1)	$\overline{X}$	S.D.
18. In hospital- methamphetamine dependent treatment can make you stop taking methamphetamine permanently.	300 (66.4%)	129 (28.5%)	23 (5.1%)	2.61	0.58
19. Strictly following the advices of doctors, nurses and treatment staffs can make you stop taking methamphetamine permanently.	317 (70.4%)	113 (25.1%)	20 (4.4%)	2.66	0.58
20. Receiving complete drugs dependent treatment in the specified time is crucial for you to stop methamphetamine dependent.	291 (64.4%)	128 (28.3%)	33 (7.3%)	2.57	0.63
21. Best methamphetamine dependent treatment required rehabilitation in both body and mind which necessary for a drug dependent to spend enough time in the treatment.	268 (59.4%)	136 (30.2%)	47 (10.4%)	2.49	0.68
22. Stop taking methamphetamine is depended on a person determination. There is a beliefs that without hospital treatment, a person can quit taking methamphetamine.	33 (7.3%)	123 (27.3%)	294 (65.3%)	1.42	0.63
23. The detoxification in the methamphetamine dependent treatment is enough for a drug dependent to quit taking methamphetamine.	81 (18.0%)	218 (48.3%)	152 (33.7%)	1.84	0.70
Total of treatment benefit	(6-18 point)			13.63	2.18

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Table 12 showed result of analysis in health beliefs about perceived treatment benefit of the samples. The data showed that in total perceived treatment benefit were in moderate level ($\bar{X}$= 13.63, S.D.= 2.18) from total of 6-18. The highest average was found in item “Strictly following the advices of doctors, nurses and treatment staffs can make you stop taking methamphetamine permanently” ($\bar{X}$= 2.66, S.D.= 0.58), and “Methamphetamine Dependent Treatment based on the hospital drugs treatment plan can make you stop taking methamphetamine permanently” ($\bar{X}$= 2.61, S.D.= 0.58), respectively. On the contrary, the lowest average was found in items “Stop taking methamphetamine is depended on a person determination. There is a beliefs that without hospital treatment, a person can quit taking methamphetamine” ($\bar{X}$= 1.42, S.D.= 0.63) and “The detoxification in the methamphetamine dependent treatment is enough for a drug dependent to quit taking methamphetamine” ($\bar{X}$= 1.84, S.D.= 0.70), respectively.

Table 13 Result of analysis all items in health beliefs about perceived treatment barrier and costs of the samples

Message	High (3)	medium (2)	Low (1)	$\bar{X}$	S.D.
24. Full methamphetamine dependent treatment has consumed most of your times.	197 (43.6%)	122 (27.0%)	133 (29.4%)	2.14	0.84
25. Receiving full methamphetamine dependent treatment has made you pay huge expenses in the treatment.	115 (25.6%)	163 (36.3%)	171 (38.1%)	1.88	0.79
26. Full methamphetamine dependent treatment has caused problems at work or school.	183 (40.5%)	144 (31.9%)	125 (27.7%)	2.13	0.82

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Message	High (3)	medium (2)	Low (1)	$\overline{X}$	S.D.
27. Full methamphetamine dependent treatment has inconvenience and becoming burdens for family members.	212 (46.9%)	120 (26.5%)	120 (26.5%)	2.20	0.83
28. Receiving methamphetamine dependent treatment has difficult steps for you to follow.	134 (29.8%)	164 (36.4%)	152 (33.8%)	1.96	0.80
29. Hospital rules and regulations during the treatment have made you feel tense and uneasy.	147 (32.5%)	157 (34.7%)	148 (32.7%)	2.00	0.81
30. Receiving full methamphetamine dependent treatment has made you feel worry if other people knowing about your treatment.	111 (24.6%)	218 (28.3%)	213 (47.1%)	1.77	0.82
Total of perceived treatment barrier and cost		(7-21 point)		14.09	3.87

Table 13 showed result of analysis in health beliefs about perceived treatment barrier and cost. The data showed that in total perceived treatment was in moderate level($\overline{X}$ = 14.09, S.D.= 3.87). The high average was found in item "Full methamphetamine dependent treatment has inconvenience and becoming burdens for family members" ($\overline{X}$ = 2.20, S.D.= 0.83) while the lowest average was found in item **"**Receiving full methamphetamine dependent treatment has made you feel worry if other people knowing about your treatment" ($\overline{X}$ = 1.77, S.D.= 0.82), respectively.

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Table 14 Treatment motivations of the samples

Message	High (3)	medium (2)	Low (1)	$\overline{X}$	S.D.
31. You are firmly determined to quit taking methamphetamine or stronger drugs	387 (86.2%)	51 (11.4%)	11 (2.4%)	2.84	0.43
32. You believe that you can go back to work or study after receiving completefully complete drug dependent treatment.	379 (83.8%)	63 (13.9%)	10 (2.2%)	2.82	0.44
33. You believe that your future will be definitely better after receiving completefully complete drug dependent treatment.	398 (88.1%)	49 (10.8%)	5 (1.1%)	2.87	0.37
34. You believe that your body and mind will be stronger after receiving completefully complete drug dependent treatment.	406 (89.8%)	44 (9.7%)	2 (0.4%)	2.89	0.32
35. You believe that in the future you will be accepted by family members and society after receiving completefully drug dependent treatment.	386 (85.4%)	58 (12.8%)	8 (1.8%)	2.84	0.42
36. You are willing to receive full drug dependent treatment as a gift to the love ones.	408 (90.3%)	38 (8.4%)	6 (1.3%)	2.89	0.35
Total of treatment motivations(6-18 point)				**17.14**	**1.49**

From table 14 showed result of analysis in health beliefs about treatment motivations; the data showed treatment motivation were in the high level ($\overline{X}$= 17.14, S.D.= 1.49) from possible range of 6-18. The highest average was found in item

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"samples are willing to receive full drug dependent treatment as a gift to the love ones" ($\bar{X}$= 2.89, S.D.= 0.35), "You believe that your body and mind will be stronger after receiving completefully complete drug dependent treatment" ($\bar{X}$= 2.89, S.D.= 0.32), and "Samples believe that your future will be definitely better after receiving completefully complete drug dependent treatment" ($\bar{X}$= 2.87, S.D.= 0.37), respectively

Table 15 Summary score of health beliefs model factors

Health beliefs Factors	N	$\bar{X}$	SD
Perceived susceptibility (point is 7-21)	440	13.28	3.23
Perceived severity (point is 10-30)	447	24.99	3.54
Perceived treatment benefit (point is 6-18)	446	13.63	2.18
Perceived treatment barrier and cost (point is 7-21)	447	14.09	3.87
Treatment motivation (point is 6-18)	449	17.14	1.49

From table 15 showed the analysis results of health beliefs model factors, which were categorized by perceived susceptibility, perceived susceptibility, perceived treatment benefit, perceived treatment barrier and cost and motivated of treatment. It found out that the level of health beliefs each category were in moderate to high level. The average score on perceived susceptibility is 13.28 (total 7-21) with standard aviation of 3.23, while the average score on perceived severity is 24.99 (total 10-30) with standard deviation of 3.54, and the average score of perceived treatment benefit is 13.63 (total 6-18) with standard deviation of 2.18. The average score in treatment motivation seemed to be the highest with an average of 17.14 (total 6-18) and standard deviation of 1.49

1.5 Completion of treatment process

Completion of treatment process were described in table 16. According to table 16, it was found that majority of sample received treatment 91-120 days (63.4%). 14.2% of them received treatment less than 15 days while 9.3%, and 8.2% received treatment about 15-30 days, and 31-60 days, respectively. Only 1.5% of them received

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treatment more than 120 days. For status of discharged, the data showed that most of them discharged after completion of rehabilitation state (63.7%) while 17.3% escaped, and 13.1% discharged after completion of detoxification state, respectively.

For the completion of treatment process, data from the analysis showed that most samples (63.7%) were completed in treatment process (i.e. complete treatment program in rehabilitation state) while 36.3% were not complete (uncompleted treatment program in rehabilitation state), respectively.

Table 16 Treatment duration, status of discharged and complete of treatment process

Factor	Min	Max	$\overline{X}$	SD	Number	**Percentage (%)**
Treatment duration	2	185	86.8	46.4		
N=452						
< 15 days					64	14.2
15 - 30 days					42	9.3
31 - 60 days					37	8.2
61 - 90 days					16	3.5
91 - 120 days					286	63.3
> 120 days					7	1.5
Status of discharged						
Completed rehab state					288	63.7
Completed detoxify state					59	13.1
Escape					78	17.3
Not to be volunteer					5	1.1
Faulty behavior					15	3.3
Stop by patient					7	1.5
Complete of treatment process						
Complete Treatment					288	63.7
Non Complete Treatment					164	36.3

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4.2 Factors affecting the completion of treatment process

For factors affecting the completion of treatment process can be explanation by simple logistic regression, factors of socio-demographic, addiction and treatment factors showed in table 17 and 18. For health beliefs and family support factor showed in table 19 and multivariate analysis of the factors affecting completion of treatment process (Multiple logistic regression) showed in table 20.

Table 17 displayed summary of the relationship between personal factors and the completion of treatment process by simple logistic regression. According to the result, it was found that sex, education, occupation, and history of incarceration are significant factors affecting complete of treatment process.

Table 18 presents the summary of the relationship between addiction/treatment factors and the completion of treatment process. The result revealed that duration of drug use, amount of methamphetamine use per day, other drug dependence before and together with methamphetamine use, number of treatment, system of treatment, and method of treatment were significantly associated with complete of treatment process.

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Table 17 Summary of the relationship between personal factors and the completion of treatment process (Univariate; logistic regression)

Factor	Detail of socio-demographic factors	OR	P- value
Sex	Male vs. Female	0.32	<0.001 **
Age		0.99	0.527
Occupation	-Own business/agriculture vs. unemployed/ general workers	0.89	0.674
	-Government officer/ company employee vs. unemployed/ general workers	0.41	0.007*
	-Student vs. unemployed/ general workers	0.39	0.071
Education	-Secondary school vs. primary school and lower	0.53	0.002*
	-Upper secondary school vs. primary school and under	0.39	0.088
Residency area	Bangkok and perimeter area vs. other	0.82	0.342
Household incomes		0.45	0.051
Family relationship	Good vs. non good	0.89	0.503
History of incarceration	Incarceration due to drug problem vs. none	1.435	0.095
	Incarceration due to other problems vs. none	0.29	0.002*

** Significant at $p < 0.01$

* Significant at $p < 0.05$

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Table 18 Summary of the relationship between addiction and treatment factors and the completion of treatment process (Univariate; logistic regression)

Factor	Detail of addiction and treatment factors	OR	P- value
Age at first drug use		0.26	0.552
Duration of drug use	Less than 6 month vs. upper than 6 month	2.04	0.027*
Amount of methamphetamine use per day		0.93	0.001*
Other drug dependence before methamphetamine use	Heroin vs. non	0.33	0.009*
	Marijuana vs. non	0.59	0.116
	Inhalant vs. non	0.67	0.230
Other drug dependence together with methamphetamine use	Heroin vs. non	0.69	0.692
	Marijuana vs. non	0.55	0.045*
	Inhalant vs. Non	0.18	0.046*
	Ice vs. non	0.14	0.033*
	Sedative drug vs. non	0.14	0.003*
Numbers of treatment	First time receiving treatment vs. had ever received treatment before	1.66	0.019*
System of treatment	Compulsory with control vs. Voluntary system	15.68	<0.001 **
	Compulsory with non control vs. Voluntary system	4.36	0.030*
Method of treatment	In -patient rehabilitation vs. inpatient detoxification	0.40	<0.001 **

** Significant at $p < 0.01$

* Significant at $p < 0.05$

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Table 19 showed the summary of the relationship between family support and health beliefs factors and complete of treatment process. According to the table, it was found that only perceived susceptibility were significant predictors of complete of treatment process.

Table 19 Summary of the relationship between family support& health beliefs model factors and the completion of treatment process (Univariate; logistic regression)

Factors	OR	P -value
Family support		
Emotional support	1.072	0.069
Informational support	1.086	0.095
Instrumental support	0.953	0.263
Total family support	1.018	0.334
Health beliefs		
Perceived susceptibility	0.936	0.033 *
Perceived severity	0.973	0.326
Perceived treatment benefit	0981	0.674
Perceived treatment barrier and cost	1.015	0.569
Treatment motivation	1.018	0.122

Factors affecting complete of treatment process from multivariate analysis were shown in table 20. According to the analysis, it was found that sex, occupation, history of incarceration, other drug dependence together with methamphetamine use, system of treatment, and methods of treatment were significantly associated with complete of treatment process. It was found that male were 58% less likely than female to get complete of treatment process. Being government officers and employee were 63% less likely than unemployed/not study/general workers to get complete of treatment process. The patients who had history of incarceration due to other problems were 82% less likely than those without history of incarceration to get complete of treatment process. The patients who used more than amount of used per day were 7%

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less likely to get complete of treatment process, as compared to those who were used less than. Regarding systems of treatment, it was found that those who were in compulsory with control were 4.77 times more likely than those who were in voluntary system to get complete in treatment process. Finally, for methods of treatment, it was found that those who were in in-patient rehabilitation methods were 6.36 times more likely than those who were in in-patient detoxification to get complete in treatment process.

Table 20 Multivariate analysis of the factors affecting complete of treatment process (Multiple logistic regression)

Factor	Detail	OR	P- value
Sex	Male vs. Female	0.42	0.010*
Occupation	Own business/agriculture vs. unemployed/ general workers	0.91	0.767
	Government officer/ company employee vs. unemployed/ general workers	0.37	0.018*
	Student vs. unemployed/ general workers	0.49	0.394
Education	Secondary school vs. primary school and lower	1.38	0.676
	Upper secondary school vs. primary school and under	0.71	0.231
History of incarceration	Incarceration due to drug problem vs. none	0.75	0.339
	Incarceration due to other problems vs. none	0.18	<0.001 **
Duration of drug use	Less than 6 month vs. upper than 6 month	0.47	0.812
Amount of methamphetamine use per day		0.93	0.014*

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Factor	Detail	OR	P- value
Other drug dependence before methamphetamine use	Heroin vs. non	0.47	0.246
	Marijuana vs. non	0.97	0.955
	Inhalant vs. non	0.71	0.441
Other drug dependence together with methamphetamine use	Heroin vs. non	1.31	0.835
	Marijuana vs. non	1.30	0.512
	Inhalant vs. Non	1.09	0.948
	Ice vs. non	0.27	0.781
	Sedative drug vs. non	0.53	0.469
Numbers of treatment	First time receiving treatment vs. had ever received treatment before	1.20	0.564
System of treatment	Compulsory with control vs. Voluntary system	4.77	0.007*
	Compulsory with non control vs. Voluntary system	0.19	0.213
Method of treatment	In -patient rehabilitation vs. inpatient detoxification	6.36	0.007*
Health beliefs	Perceived of Risk from methamphetamine used	1.003	0.942

* Significant at $p < 0.05$

** Significant at $p < 0.001$

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CHAPTER V
DISCUSSION

This study examined the relationship of health beliefs and complete of treatment process among methamphetamine-dependent patients. The effects of socio-demographic factors, addiction and treatment factors, and family support were also examined. Research results are discussed in 4 parts as follows;

1. Completion of treatment process among methamphetamine-dependent patients
2. Family support for drugs treatments
3. Health beliefs of the methamphetamine-dependent patients
4. Factors affecting complete of treatment process among-methamphetamine-dependent patient

1. Completion of treatment process among methamphetamine-dependent patients

According to the cooperation behavior data of methamphetamine-dependent patient based on the patients' discharge record, it was found that 64.8 percent of methamphetamine dependents received treatment for 3 months or longer. Considering discharge channels, findings indicated that 13.1 percent of methamphetamine-dependent patients received complete treatment with medication or detoxification state while 63.7% met the assessment standard criteria for rehabilitation. Only few 17.3% escaped from the treatment center whereas 3.3% were discharged because they broke the rules, 1.5 percent missed appointment, and 1.1 % discontinued treatment, respectively. In the assessment of complete of treatment process, patients must pass all 4 phases of treatment, starting from pre-admission, detoxification, and rehabilitation

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and after care. In this study, outcomes were assessed as soon as the patients had received the required treatment more than 3 months and met the rehabilitation assessment criteria as well as being normally discharged from the Drug Treatment Center as soon as he completed the treatment. Data revealed that only 63.7 percent of methamphetamine dependents completed the treatment or were considered as having complete of treatment process. The rest 36.3 percent did not complete the treatment. This findings was consistent with the treatment statistic of methamphetamine dependents at Thanyarak Institute (42), which indicated that in the year 2006, 2007 and 2008, the percentage of methamphetamine dependents completed the treatment were 44.6 percent, 47.0 percent and 57.7 percent, respectively. After considering 78 methamphetamine dependents or patients who had been escaped from treatment, findings revealed that methamphetamine dependents escaped most during the first 14 days (43.6%), while 21.8 % escaped during the first 15 to 30 days. Another 21.8 % escaped during 31 to 60 days. The reasons for non completion of treatment may be due to the fact that these patients were not ready for the treatment or unable to adjust to new environment in the treatment center or unable to tolerate the withdrawal symptoms. This reason is somewhat different from the treatment of other chronic diseases. For example, the study of Prasart Tagun (56) on the innovation of preliminary servicing the chronic patients that examined the medical record of high blood pressure patients from Wang Ta Pa Hospital, Nan province suggested total 1,266 patients in 2004, and subsequently increased to 1,518 patients in 2005. Each patient voluntarily received and completed the medical treatment. According to the data from patients' treatment assessment during 2005, findings indicated that 54.84 percent forgot to take medicine, 40.86 percent failed to take medicine as prescribed by the doctor. Moreover, 11.88 percent had their blood pressure increased drastically so that they must be sent to the doctor to change medication regimen. .

In summary, even though the methamphetamine dependents were classified as the patients who required treatment and must complete all 4 phases of treatment, however, the treatment of methamphetamine dependents revealed both differences and similarities as the treatment for other chronic diseases. It is different in the readiness, the patient's willingness to receive treatment, the difficulty in adjusting him/herself during the treatment, as well as the physical, spiritual, conceptual and intellectual

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conditions that may be affected from methamphetamine use. In this case, many patients involuntarily received treatment and failed to complete the treatment. As for complete of treatment process, it went in the same direction. Therefore, the treatment team in charge of treatment for methamphetamine dependents, including policies-makers must understand the nature of each disease thoroughly in order to administer proper treatment for these patients. This finding was consistent with the concept in the drug treatment of National Institute on Drug Abuse(22), which indicated that treatment should not only focus on drug dependent itself but also should consider other problems in patients' lives. No single treatment alone suitable for everyone. Staying with the whole treatment process is essential for treatment complete. Since most patients could better adjusted themselves after completing the treatment for 3 months, then treatment providers should put much emphasis on caring methamphetamine dependents, especially during the first 14 days to reduce patients' anxiety and examined patient's concern before the treatment as to reduce tension and suffering from withdrawal which may help them to stay and complete the treatment. It might be due to the fact that this step during Pre-admission was reduced so that many patients were unwillingly to receive the treatment. When the patients showed up at the treatment center, the doctor or nurse usually admitted those patients in the same day without advance preparation. This finding was similar to the study of Paipun Pttayanon et. al (50), on influenced factors towards effectiveness and accomplishment during rehabilitation of drug dependents at Thanyarak Hospital, which revealed that patients and officers had positive attitudes towards the treatment, only few patients suggested improvement and more attentions to patient's preparation before admitting for treatment. Then, the pre-admission procedures at the hospital should be amended.

2. Family Support for Drug Treatments

The survey was done among samples by asking them to select item showing family support in receiving drug treatment and determine score in each item from 1-3 points. The highest scores showed high level of family support. From data collection and analysis, overall family support remained at high level with mean scores at 35.5 (full scores 15-45). When considering each area of family support, Emotion support

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had the highest scores, with average scores 14.89 (full scores 6-18). When considering each question, it was found that most of the patients indicated that family accepted and gave them opportunity to improve him/herself (80.7%) and that family members make them feel warm, secure and safe (69.1%). This finding is consistent with the fact that most samples answered that their families stayed together peacefully and also consistent with the studies of Apiradee and Virairut (57) who had studied the support for amphetamine-dependent patients to receive treatment at Thanyaruk Hospital. It was found that amphetamine-dependent patients received well support from relatives in all areas, especially on encouraging patients to stay with the treatment showed the highest mean. As for information support, it showed the second highest core with the total mean core at 10.07(full scores 4-12). After considering each item, it was found that most of the sample answered that family members have made the suggestions for them to stay in and complete the treatment program as required by the hospital (73%), which indicated that family paid an important role in providing information support to methamphetamine dependents to enter and complete the treatment. This finding is consistent with the author's work experiences when the relatives of methamphetamine dependent expressed their desires for the methamphetamine dependent to stay for treatment as long as him/her needed. When the methamphetamine dependent refused the treatment, the family may notice some changes in methamphetamine dependent's behavior. This methamphetamine dependent is being categorized as drug dependence rather than being drug abuse because his/her brain and perception constantly changed, including withdrawal symptoms which made him/her refused the treatment.

As for Instrumental support, it seemed to be the least as compared to other support. Only half of the patients indicated that close family members were prompted to provide money and necessities when he/she really need while less than half of them indicated that their family provided instrumental support for them. In addition, half of them indicated that they worried or concerned about their responsibilities and tasks that needed to be completed. Therefore, the treatment center should pay more attention in helping the methamphetamine dependent to prepare for the treatment or pre-treatment in order to reduce anxiety from unfinished businesses and also increase the methamphetamine's readiness with more compassion and willingness to accept and listen to the problems of methamphetamine dependents, including family suggestions to properly help them.

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This finding is similar to that of Vacharee Meesilp (43), on factors related to behavior during the treatment of heroin dependents during the detoxification phase. Findings indicated that samples were full of self-confidence and expected good outcomes, having family support and behavior during the treatment at moderate level.

3. Health Beliefs of Methamphetamine Dependents

The questionnaire survey was done by asking samples to choose statement showing perceptions based on Health Beliefs pattern in 5 areas and identify scores in each item, given 1-3 points by assigning high scores for high perception in each area (negative questions with high perception scores refers to samples disagreement with such statement, on the contrary low perception scores indicated samples agreement). According to the result, it was found that treatment motivation seemed to be the highest among other believes with the mean score of 17.14 (full scores 6-18).

After considering questions regarding perception in risk and severity from taking methamphetamine, findings indicated that methamphetamine dependents know and aware of problems and impacts from taking methamphetamine. It was easier for them to perceive notice able damages such as body deterioration, losing assets, and being at risk of breaking the laws. Nonetheless, many incorrect perception still exist as the result found that 63.6% believed that taking methamphetamine occasionally for fun won't make them addicted to the drug, 53.3% believed that to date they can to stop methamphetamine dependent by them self, 48.4% believed that they are not taking risk of using stronger drugs with methamphetamine, about 43.8% indicated that although taking methamphetamine may be punished but it gives a person more energy, happiness and fun, while about 51.8% indicated that using methamphetamine made them prone to contact diseases or become more addicted to other drugs. As for perceived benefits and barriers in methamphetamine treatment, findings suggested that most samples believed that strictly following the advice of doctor, nurse and treatment staffs and the hospital approach for methamphetamine treatment helped them stop taking methamphetamine. However, about 35% of the samples still believed that stop taking methamphetamine is depended on a person determination; therefore, a person can quit taking methamphetamine without hospital treatment. In addition, about 70% believed that the

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detoxification in the methamphetamine dependent treatment is enough for a drug dependent to quit taking methamphetamine. Moreover, 73% of the samples indicated that full methamphetamine dependent treatment was inconvenience and becoming burdens for family members. About 70% of the sample indicated that full methamphetamine dependent treatment has consumed most of your times and that full methamphetamine dependent treatment has caused problems at work or school. As for treatment motivation, more than 80% of the sample indicated having strong motivation to get complete in treatment. It was found that about 90% of the sample indicated that they are willing to receive full drug dependent treatment as a gift to the love ones and that their body and mind will be stronger after receiving complete fully complete drug dependent treatment.

From the above result, several misbelieves need to be corrected by the practitioners and providers. According to the study of Jintana Yiemchiphum (55), on the motivation to quit drugs, it was found that the reason for quitting was the awareness of harm and danger from taking drugs. However, this study found that some methamphetamine dependents had no real intention to quit drugs, but doing so because it was difficult to find drugs and afraid of being arrested while few were forced into the drug treatment by the family. After certain period of treatment, they started to see the positive results of the treatment. Moreover, the study of Bangorn Boonraksasut(45), on factors affecting patient' decision for not receiving the treatment in rehabilitation phase at Thanyarak Hospital suggested that it was the patient's own decision (73.62%) and the family's decision (11.04%). Furthermore, hospital environment, hospital; treatments and other activities inside the hospital were all contributed factors to this patient's decisions. Furthermore, finding from data analysis indicated that the patients had high hope or expectation that their lives would be better after stop taking drugs. This information should be useful in the treatment of methamphetamine dependents as the advice or caring model for the methamphetamine dependents to understand the benefits from the treatment, including building concrete motivation to change into correct thinking and beliefs as well as improving drugs behaviors among drugs dependents and risky groups for being the good model to encourage their cooperation in completing all steps of the treatment.

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4. Factors affecting complete of treatment process

The result from logistic regression indicated that gender, occupation, imprisonment history, amount of methamphetamine used per day, treatment method in admission and treatment system significantly associated with complete of treatment process.

Regarding gender, males had less chance (58%) to complete the treatment , it may be due to the fact that there was a difference in child rearing process between boys and girls, which is consistent with the study of Jiraporn Suthisanon cited Vacharee Meesilp (43), on drugs perception among the Lower Secondary School students under Bangkok Metropolitan Administration. It was found that female students could understand and learn about the danger of drugs as well as being able to protect themselves against drugs better than male students. Most samples received treatment in the control system which made them unable to stop the treatment unless they escaped from the treatment center. Because of their gender, female samples had less chance to escape than male samples. Furthermore, the dormitory that female patients lived in has close door to prevent them from escaping, while the male dormitory arranged as treatment community, which is quite easy to leave. After considering drug users by gender, it was found that males used more drug than females which quite contrary with the drug treatment record among females proved higher successful treatment than males. Perhaps this had been resulted from rearing male offspring with freedom and accepting their drug behaviors more than female offspring. Therefore, the treatment provider should give more attention to different in gender and opportunity that may facilitate effective treatment process.

As for occupation, methamphetamine dependents that held steady job in the controlling position such as corporate or State Enterprise’s employees and government officers had less chance (63%) to complete the treatment than unemployed methamphetamine dependents or general workers. No significant difference was found among self-employed methamphetamine dependents, vendors or students. It may be explained that because of time consuming treatment process those with stable job and responsibilities might worried that missing work for long period of time might make them become fired. Therefore, in setting up guidelines, much attention should be

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given to the impacts on work and study. All divisions should provide knowledge that would allow patients' participation and opportunity to receive standard treatment or adapt treatment plan suitable for each patient in accordance to the treatment concept of NIDA (22) that required continuous assessment in treatment plan for each patient and adapting to suit each patient as needed such as changing treatment plan for in-patient and out-patient treatments or treatments beyond regular office hours.

For imprisonment history, findings indicated that methamphetamine dependents with previous imprisonment history in non-drugs charge had less chance (82%) of complete the treatment than those who had no imprisonment history. As for methamphetamine dependents who had been imprisoned due to drug charge before the treatment, they had similar treatment results as those without imprisonment which is consistent with the government policies in problems-solving process for drugs dependents that required the classification of patients before the treatment and divided the treatment on voluntarily, controlled and penalty systems. Some drugs dependents may have criminal records such as committed crimes, robberies, murders, and stealing which may be difficult to treat with drugs treatment alone. Therefore, the treatment provider must check the patient's history thoroughly for proper treatment plan.

Regarding numbers of methamphetamine usage daily, it was found that patients used large numbers of methamphetamine while receiving treatment at Thanyaruk Institute had less chance (7%) of complete the treatment than who used less amount of drugs daily, because methamphetamine created tolerance, patients who used large numbers of methamphetamine he had high depend on it and high withdrawal symptoms when he stop taking, that which made those patients suffered more from quitting drugs which may result in unable to complete the treatment. By knowing the patient's history of addiction, the treatment provider could predict the patient's symptoms ahead of time and would be able to administer proper treatment. This should help relieve patient' suffering from quitting drugs and increase the completion of treatment with medication and proceed to rehabilitation phase.

For treatment system, findings indicated that methamphetamine dependents who received the controlled treatment had better chance to complete the treatment than those received voluntarily treatment 4.77 times, whereas the patients received treatment in the non-controlled system had similar treatment results as those

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voluntarily patients which is consistent with the principle criteria for drugs treatment of NIDA which mentioned that motivation, penalties or forcing treatment by family, work place or the court contributed to complete drugs treatment. This finding is also consistent with the thought of drug dependent patients as law breakers that should be forced into the treatment by laws together with voluntarily drug treatment (4). This recommendation could present to the treatment center or policies makers for solving drugs problems to understand and use as control measures legally and socially. Beside, the control measures on facilities such as, surrounding, fencing and security measures could help patients to stay and complete of drug treatment process.

Regarding treatment model for fist admission, it was done as received in - patient rehabilitation treatment which allows patients to complete the drugs treatment 6.36 times more than those received treatment as in-patients detoxification. This finding was consistent with the study of Orapen Nakvachara and Sari Puttamapun (47) on social and psychological factors as barriers to treatment and rehabilitation of drugs dependents in Chiang Mai. It was found that most drug dependents came to the treatment center because they could not get the drug, not because they really wanted to quit. Asking for treatment was only way to ease the suffering and they usually stayed for short period of treatment. This finding was confirmed by the treatment at Thanyarak Institute that divided treatment into different steps. First, the patient must pass the treatment in detoxification. Then, the patient would be moved to other building for rehabilitation on voluntarily basis. Most of the time, the patient refused to enter rehabilitation phase which is required. Therefore, treatment provider need explain treatment procedures and provide continuous treatment and educated patients of the importance of each treatment steps.

Furthermore, health beliefs had no influence towards complete of treatment process, perhaps it may be due to the fact that these believes were measured during the first three days of admission. However, when the patient tried to stop taking drug, he/she would develop the drug craving and feeling depress so severe that he may commit suicide and methamphetamine affected to cognitive, psycho motor function and behavior. These may be strongly affected the complete treatment more than earlier beliefs. Literatures reviews indicated that this study is consistent with the beliefs of drug dependents as being seen in the work of Jumrieng Rungmak (59) who studied

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self-care behavior of alcohol drinkers received treatment at Thanyarak Institute as out-patients. The finding indicated health beliefs among samples were rather high while self-care behavior remained at moderate level, studied of Jintna Yiemchiphum (55), on the motivation to quit drugs, it was found that the reason for quitting was the awareness of harm and danger from taking drugs., some methamphetamine dependents had no real intention to quit drugs, but doing so because it was difficult to find drugs and afraid of being arrested while few were forced into the drug treatment by the family. After certain period of treatment, they started to see the positive results of the treatment. which is consistent with the study of Irene Schofield MSc et al, (60) in An exploration of the smoking-related health beliefs of older people with chronic obstructive pulmonary disease. After interviewing former smokers, current smokers and the patients with chronic obstructive pulmonary, it was found that 2 out of 3 people from these groups, mostly known about health-care but cited many obstacles in quitting smoking. Even with their strong determination to quit smoking, it was useless effort since external factors aroused more urge for smoking than knowing smoking as the cause of diseases and finding is consistent with the study of Banjongjit Punthong (52) who studied factor affecting complete of treatment of alcoholics at Thanyarak Institute. It was found that complete of treatment involved with biochemistry factors while age, and marriage status, persons living with, family incomes, liquor knowledge, and attitude towards alcohol drinking were not affect the complete of treatment. However, the study by Sombat Makun (58), regarding the correlations between accepting rehabilitation and assessment results after rehabilitation in accordance with the Drug Dependents Rehabilitation Act 2545 B.E, 2002 (4), indicated that patients' accepting treatment was not correlated with assessment after rehabilitation.But this study is different to study of Vipavadee Saengpetch (54) found factors associated with drug treatment by continue being out-patient until having completed Matrix Program in Thanyarak Institute by collecting data from 129 samples. Findings 71.90 percent received support from families, therapies, friends already received treatment, attitude and occupation could predict behavior of out-patients who attended full Matrix treatment at Thanyarak Institute. The most powerful predictable factor was family support which could be used jointly to predict drug treatment for out-patients until the completion of the Matrix program at

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47.50 percent, because most sample of this study receive in- patient treatment method but Matrix Program is out patient treatment, family support and attitude are important to cooperation in treatment behavior.

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CHAPTER VI
CONCLUSION

The cross-sectional study examined the relationships between health beliefs and the completion of treatment process among methamphetamine dependent patients receiving care at Thanyarak Institute, Medical Department, Ministry of Public Health. Face-to-face interview was carried out to collect data among 452 voluntary patients who met all eligibility criteria of the study. Data collection process began in October 2006. Eligible patients were interviewed within the first three day after admission. Factors predicting complete of treatment process were analyzed with Logistic Regression. Research results and recommendations are presented as follows,

1. Research Conclusions

1.1 Socio demographic factors

Among 452 methamphetamine users or samples who had undergone drug treatment, majorities were males (71.7%), aged between 15 to 24 years old (48.3%). Most of them lived in Bangkok (50.6%), complete secondary educations (53.6%) and primary educations (43.3%) . As for occupations, findings indicated that most of them were general worker (45.7%) while some were unemployed (22.7%). Most of them had average family income between 5,000-35,000 baht per month (64.2%). As for family relationship, most samples indicated having good family interaction (69.4%) And for imprisonment record, it was discovered that approximately half of samples had never been imprisoned before (56.8%) while 35.8% had been imprisoned with drugs charge and 7.3% with other charges such as robbery, murder and stealing.

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1.2 Addiction and treatment

According to the analysis, it was found that age at first drug use of most of the samples were 16-20 years old (42.9%). Most of them indicated that the duration of drug use before receiving treatment on average ranged between 1-5 years (57.3 %). Regarding treatment history, findings indicated that most samples (73 %) received first treatment. As for history of staying in the treatment longer than 3 months, most samples as high as 91.6% had never stayed in the treatment longer than 3 months. For amount of methamphetamine used daily, findings indicated that majorities used methamphetamine at daily average of 1-5 tablets per day (75.4%). Out of total samples, 75.2 percent used methamphetamine as the first illegal drug while 21.5 % used methamphetamine together with other drugs.

Most samples gave many reasons for using methamphetamine, 82.3 % stated that they wanted to try. Their reasons for entering the treatments were: 75.2 % from court order, followed by they want to cut off using methamphetamine (51.8 %). Regarding perception effect of methamphetamine use, findings indicated that 75.4 % of the samples answered that they had biological illness while 35.6 percent mentioned that they had family problems.

Regarding treatment method of admission , most samples (84.1%) entered the treatment as in - patient rehabilitation. Concerning treatment system, 79.6% were in compulsory with control system in accordance with the Rehabilitation Act 2545 B.E (2002) while 17.9 % entered the treatment voluntary.

1.3 Complete of treatment process

Information on this part was collected from medical record after the sample had been discharged. The results found that most samples spent time in the treatment on average 87 days. Majorities of them spent time between 91-120 days (63.3%) and approximately ¼ of samples received treatment less than 30 days. After considering type of patient discharged, findings indicated that patients who had been discharged as receiving complete treatment or passed rehabilitation process were only 63.7 percent. The rest were discharge before completing the treatment, as being shown 17.3 percent had escaped from the treatment center and 13.1% only passed detoxification stage.

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1.4 Family Support

Findings from the analysis indicated that overall family support remained at high level with the mean scores of 35.5 (possible scores 15-45 points), having the highest scores in Emotion Support with the mean scores of 14.89 (possible scores 6-18 points), followed by Information support with the mean scores of 10.07 (possible scores 4-12 points) and Instrumental support with the mean scores of 10.58 (possible scores 5-15). After considering each item separately, findings indicated that the patients received most family support in family acceptance and providing chance for the patient to improve himself (Mean =2.77), followed by family advice for the patient to complete the treatment as required by the hospital (Mean=2.66). Finding 50% The patients received the least family support concerning their responsibilities that need to be done (Mean= 1.63).

1.5 Health Belief Model

Findings from analysis found that the highest health belief pattern among the samples was treatment motivation, followed by perceived severity. As for beliefs in perceived susceptibility, perceived treatment benefit and perceived treatment barrier and cost were at moderate level. The indication for high treatment motivation was the sample's intention to complete the treatment as the gift for the love one (Mean=2.89), followed by their beliefs in health recovery both physical and mental health after this treatment (Mean =2.89) and their expectation that they will have good future if the treatment was successful (Mean =2.87). As for perceived severity, findings indicated that the samples realized that taking methamphetamine caused huge loss of money and assets (Mean = 2.86). Moreover, using methamphetamine is illegal; at risk being arrested and get death penalty for drug traders (Mean=2.82). Prolonged use of methamphetamine may cause problems in learning, working and may be fired from work (Mean= 2.79) whereas drug users' health can be deteriorated rapidly (Mean= 2.75)

Regarding perceived treatment benefit and perceived treatment barrier and cost, findings indicated that the samples believed that if they had followed the advice of doctor, nurse and treatment officer diligently, they could stop using methamphetamine (Mean=2.66). As for false beliefs which may become treatment

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barriers are as followed; belief that taking methamphetamine occasionally for fun would not make a person become a drug dependent (Mean=1.49), a person could stop taking methamphetamine if he wanted to (Mean = 1.65), using methamphetamine may pose danger but it gave a person more energy, happiness and joy (Mean= 1.80), stop taking methamphetamine depending on a person's strong will, no need to get treatment at the hospital (Mean=1.42) and methamphetamine treatment after detoxification is considered quite enough to make a person quit methamphetamine (Mean=1.84).

1.6 Factors affecting complete in treatment process

Results from the analysis of factors influencing complete in treatment process among methamphetamine dependents patients using Multiple Logistic Regression is summarized as follows:

For demographic factors, findings indicated that gender, incarceration history and occupation had significant effect on complete in treatment process among methamphetamine-dependents patients. Findings indicated that male had 58% less chance of completing drug treatment process, as compared to female, those with history of imprisonment due to non-drugs charges had 82% less chance of completing treatment process, as compared to those without imprisonment history. Methamphetamine users with regular jobs such as government officers and company employee had 63% less chance of completing drug treatment process, as compared to general worker and unemployed. As for age, educational level, residency area, family incomes, family relationship had no influence on complete in treatment process. As for addiction and treatment factors, findings indicated that age at the first time using drug, duration of methamphetamine used before treatment, patients who used any other drug used before or used together with methamphetamine and number of treatment were not associated with complete of treatment process. On the contrary, amount of meth-amphetamine used per day, system of treatment and method of treatment in admission are significantly relationship with complete of treatment process.

In another words, methamphetamine users who used more amount per day had 7% less chance of completing drug treatment process, as compared to

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methamphetamine users who used less amount per day , patients who received treatment under compulsory with control system had 4.77 folds better chance of completing the treatment, as compared to those who received treatment under voluntary system. Moreover, the patients who received first treatment as In- patient rehabilitation had 6.36 folds better chance of completing treatment, as compared to those with In- patient detoxification.

On the other hand, family support and health belief of the samples did not significantly affect the complete of treatment process among methamphetamine-dependent patients.

2. Recommendations

2.1 When treating methamphetamine-dependents patients, admission assessment should be conducted to identified useful information that significantly affect the complete of treatment process, such as amount of methamphetamine used per day, history of imprisonment, and particular problem of each patient which may become a barrier for drug treatment. In addition, problems from work absenteeism or their worried about other unfinished businesses before receiving drug treatment could be relieved by giving full attention, giving counseling during pre-admission, and administering medication to reduce suffering from withdrawal. Also, providing them with suggestions to reduce tension during the adjustment phase, including strictly looked out to prevent patients' escape so that patients could receive full benefits from completing the treatment.

2.2 Treatment team should listen to problems and pay attention to the patient's discomfort, as well as encouraging family to detect patient's discomfort and fully participate in the treatment and resolve patent's earlier problems and regularly pay visit to the patient for psychological support until the completion of the treatment without making patient feel as if he or she is becoming the family burden.

2.3 In addition, the priority should be given to the treatment process together with strict control measures such as legal measures, strict social control from family, supervisor, and school, including safety measures to prevent escaping from the Treatment Center.

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3. Recommendations for Further Researches

3.1 This study only focused on socio-demographic factors, addiction and treatment factors, family support factors, and health belief factors, nevertheless, several other factors may affect the complete of treatment process. So future researchwill be need to identify the influences of those factors on the complete of treatment process, for example officers' support in helping patients to prepare for the treatment, treatment environment, self-efficacy, and the withdrawal symptoms during the preliminary phase of treatment.

3.2 Study examining the reason of the methamphetamine-dependents patients to escape the drug treatment is also important for developing guideline for prevention and encouragement of patients to stay with the treatment.

3.3. This study only examined health belief of the patients during the first three day after admission; therefore, further study may need to address the health belief of the patients after receiving treatment for such a period of time. Health belief during admission and after could then be compared. Also, relationship between health beliefs after receiving treatment and complete of treatment process could also be examined.

3.4. Further study with the aims to develop model or supporting activities during the preparation phase so that patients can be ready for drug treatment, learn the benefits from such treatment as well as improve motivation to complete the drug treatment should also be conducted.

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APPENDIX

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เอกสารคำชี้แจงแก่อาสาสมัคร/ผู้เข้าร่วมการวิจัย

เรียน ผู้เข้าร่วมตอบแบบสอบถามงานวิจัยทุกท่าน

ด้วยดิฉันนางระเบียบ โตแก้ว นักศึกษาระดับปริญญาโท สาขาวิชาวิทยาการเสพติด (โครงการร่วม) บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล จะทำการศึกษาวิทยานิพนธ์ เรื่องความสัมพันธ์ระหว่างความเชื่อด้านสุขภาพ และการบำบัดรักษาครบตามเกณฑ์ในผู้เสพติดยาบ้าใน สถาบันธัญญารักษ์ กรมการแพทย์ กระทรวงสาธารณสุข โดยขอความสมัครใจในการตอบแบบสอบถามจากผู้เข้ารับการบำบัดรักษาการเสพติดยาบ้าทุกท่านเข้าร่วมโครงการวิจัย ซึ่งมีรายละเอียดดังนี้

วัตถุประสงค์เพื่อศึกษาถึง ความคิด ความเชื่อของผู้เสพติดยาบ้าเพื่อนำผลการศึกษาไปพัฒนากระบวนการบำบัดรักษาฟื้นฟูและการดูแลผู้เสพติดยาบ้า ให้ได้รับการบำบัดรักษาฟื้นฟูอย่างมีคุณภาพ ตามมาตรฐาน ส่งผลให้ผู้ติดยาเสพติดกลับไปใช้ชีวิตในสังคมอย่างปกติ โดยไม่พึ่งพายาเสพติด โดยข้อมูลต่างๆ ที่รวบรวมไว้ จะเก็บเป็นความลับและนำเสนอในเชิงวิชาการเท่านั้น ในการตอบแบบสอบถามเพื่อเก็บรวบรวมข้อมูล จะไม่มีการลงชื่อผู้ตอบแบบสอบถาม ผู้วิจัยจะใช้การลงหมายเลขเอกสารเท่านั้น จะไม่ระบุว่าเป็นข้อมูลของผู้ใด เมื่อวิเคราะห์ข้อมูลแล้วจะเก็บไว้เป็นความลับและนำเสนอในภาพรวมเท่านั้น

การเข้าร่วมตอบแบบสอบถามในครั้งนี้จะเป็นไปด้วยความสมัครใจ ท่านจะบอกเลิกเมื่อใดก็ได้ โดยไม่มีผลกระทบใด ๆ ต่อการบำบัดรักษาของท่าน หากท่านยินดีที่จะเข้าร่วมวิจัย ขอความกรุณาให้ท่านลงนามในแบบฟอร์มใบยินดีเข้าร่วมวิจัยตามที่แนบมาพร้อมนี้ ขอขอบคุณที่ท่านให้ความร่วมมือในการวิจัยครั้งนี้ หากท่านมีคำถามเกี่ยวกับแบบสอบถามหรือรายละเอียดในการวิจัยครั้งนี้ ท่านสามารถติดต่อกับผู้ศึกษาวิจัย คือ นางระเบียบ โตแก้ว สถาบันธัญญารักษ์
โทร. 02-9989177, 083-1301467 โทรสาร 02-9989177

ลงชื่อ.....

(นางระเบียบ โตแก้ว)

วันที่ให้ข้อมูล.....

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ใบยินยอมของผู้เข้าร่วมโครงการวิจัย (Consent form)

โครงการวิจัยเรื่อง เรื่องความสัมพันธ์ระหว่างความเชื่อด้านสุขภาพและการบำบัดรักษาครบตามเกณฑ์ในผู้เสพติดยาบ้า: กรณีศึกษาสถาบันธัญญารักษ์

วันที่ให้คำยินยอม วันที่.....เดือน..... พ.ศ. .....

ก่อนที่จะลงนามในใบยินยอมให้ทำการวิจัยครั้งนี้ ดิฉัน/กระผมได้รับการอธิบายจากผู้วิจัยถึงวัตถุประสงค์ของการวิจัย วิธีวิจัย อันตรายที่อาจเกิดขึ้นจากการวิจัย รวมทั้งประโยชน์ที่จะได้รับจากการวิจัยอย่างละเอียด และมีความเข้าใจดีแล้ว ซึ่งผู้วิจัยได้ตอบคำถามต่าง ๆ ที่สงสัยด้วยความเต็มใจ ไม่ปิดบัง ซ่อนเร้น จนดิฉัน/กระผมพอใจและเข้าร่วมโครงการนี้ด้วยความสมัครใจ และดิฉัน/กระผมมีสิทธิ์ที่จะบอกเลิกการเข้าร่วมการวิจัยนี้เมื่อใดก็ได้ถ้าปรารถนาโดยไม่เสียค่าใช้จ่ายใด ๆ ที่จะเกิดขึ้นตามมา ทั้งนี้ผู้วิจัยรับรองว่าจะเก็บข้อมูลเฉพาะที่เกี่ยวข้องกับตัวดิฉัน/กระผมเป็นความลับ โดยจะเปิดเผยได้เฉพาะในรูปแบบที่เป็นสรุปผลการวิจัยในภาพรวม (หรือดิฉัน/กระผมอนุญาตให้ผู้วิจัยเปิดเผยข้อมูลต่อหน่วยงานต่างๆ ที่เกี่ยวข้องได้ตามที่เห็นสมควรซึ่งกระทำได้เฉพาะกรณีจำเป็นด้วยเหตุผลทางวิชาการเท่านั้น) ผู้วิจัยรับรองว่าหากเกิดอันตรายใด ๆ ที่มีสาเหตุจากการวิจัยดังกล่าว ดิฉัน/กระผมจะได้รับการพิทักษ์สิทธิ์โดยไม่คิดมูลค่า โดยผู้รับผิดชอบการวิจัยนี้ คือนางระเบียบ โตแก้ว หมายเลขโทรศัพท์ 083-130-1467

ดิฉัน/กระผมได้อ่านข้อความข้างต้นแล้ว และมีความเข้าใจดีทุกประการ และได้ลงนามในใบยินยอมนี้ด้วยความเต็มใจ

ลงนาม.....ผู้ยินยอม

(.....)

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แบบสอบถาม
(QUESTIONNAIRES)

งานวิจัยเรื่อง ความสัมพันธ์ระหว่างความเชื่อด้านสุขภาพและการบำบัดรักษาครบตามเกณฑ์ในผู้เสพติดยาบ้า: กรณีศึกษาสถาบันธัญญารักษ์

คำชี้แจง **:** แบบสอบถามมี 4 ตอน คือ

ตอนที่ 1 แบบสอบถามข้อมูลส่วนบุคคล การเสพติดและการรักษา มี 21 ข้อ

ตอนที่ 2 แบบสอบถามแรงสนับสนุนของครอบครัวต่อการบำบัดรักษา 15 ข้อ

ตอนที่ 3 เป็นแบบสอบถามความเชื่อด้านสุขภาพมี 36 ข้อ

ตอนที่ 4 แบบเก็บข้อมูลประเมินผลการบำบัดรักษา 3 ข้อ (สำหรับผู้วิจัย)

ตอนที่ 1 ข้อมูลส่วนบุคคล

คำชี้แจง : ใส่เครื่องหมาย ✓ ในช่อง ☐ ของแต่ละข้อ และเติมข้อความลงในช่องว่าง โดยในแต่ละข้อตอบได้ 1 คำตอบ

1. ท่านรับการบำบัดรักษาที่ตึก……

2. เพศ ☐ ชาย ☐ หญิง

3. ท่านมีอายุ……ปี

4. ที่อยู่อาศัยก่อนเข้ารับการรักษาจังหวัด ☐ กรุงเทพฯ ☐ ปริมณฑล ☐ จังหวัดอื่น ๆ

5. ลักษณะที่อยู่อาศัย ☐ชนบท / ชานเมือง ☐ ชุมชนเมือง ☐ ชุมชนแออัด

6. ระดับการศึกษา ☐ประถมศึกษา หรือต่ำกว่า ☐มัธยมศึกษาตอนต้น
☐มัธยมศึกษาตอนปลาย หรือ ป.ว.ช. ☐อนุปริญญา หรือเทียบเท่า
☐ปริญญาตรี ☐ สูงกว่าปริญญาตรี

7. อาชีพ ☐ ว่างงาน/ ไม่ได้เรียน ☐นักเรียน / นักศึกษา
☐ เกษตรกรรม ☐ รับราชการ /รัฐวิสาหกิจ
☐พนักงานบริษัท / ห้าง /ร้าน ☐ ธุรกิจส่วนตัว / ค้าขาย
☐รับจ้าง(ระบุ)……. ☐ อื่น ๆ ระบุ…….

8.รายได้รวมของท่านและครอบครัวเฉลี่ย .... บาทต่อเดือน

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9.อายุที่ใช้ยาเสพติดที่ผิดกฎหมายครั้งแรก.....ปี

10. ก่อนเสพติดยาบ้าท่านเคยเสพติดสารเสพติดอื่นมาก่อนหรือไม่ ☐ ไม่เคย ☐ เคย คือ.....

11. ก่อนเข้ารับการรักษาครั้งนี้ท่านเคยได้รับโทษจำคุกหรือไม่ ☐ ไม่เคย ☐ เคย คดี.....

12. ระยะเวลาที่ใช้ยาบ้าจนถึงเข้ารับการรักษาครั้งนี้……ปี.....เดือน

13. จำนวนยาบ้าที่ใช้เฉลี่ยต่อวัน (ช่วง 1 เดือนที่ผ่านมา).....เม็ด

14. ยาเสพติดที่ใช้ร่วมหรือสลับกับยาบ้า ☐ ไม่มี ☐ ฝิ่น ☐ เฮโรอีน ☐ กัญชา
☐ ยานอนหลับ ☐ อื่น ๆ ระบุ.....

15.จำนวนครั้งที่เข้ารับการบำบัดรักษาทั้งของรัฐและเอกชน……ครั้ง (รวมครั้งนี้)
เคยรักษาเกิน 3 เดือน.....ครั้ง

16. สัมพันธภาพในครอบครัว ☐ อยู่ร่วมกันอย่างดี ☐ อยู่ร่วมกันแบบต่างคนต่างอยู่
☐ แยกกันอยู่

17.บุคคลที่ท่านอาศัยอยู่ด้วย ☐ บิดา ☐ มารดา ☐ บิดาและมารดา
☐สามีหรือภรรยา ☐ ญาติพี่น้อง ☐ เพื่อน ☐ อยู่คนเดียว

18. ระบบการรักษา ☐สมัครใจ ☐ บังคับบำบัดแบบไม่ควบคุมตัว ☐บังคับบำบัดแบบควบคุมตัว

19. สาเหตุสำคัญที่ท่านใช้ยาบ้า (ตอบได้มากกว่า 1ข้อ)

☐ ถูกบังคับ หรือ โดนหลอก ☐ ร่างกายไม่แข็งแรงหรือเจ็บป่วย
☐ อยากทดลอง ☐ อยากทำงานหรืออ่านหนังสือได้มาก ๆ
☐ อยู่ในกลุ่มเพื่อนที่ใช้ยา ☐ เพื่อความสนุกสนาน
☐ อยู่ในแหล่งจำหน่ายยาเสพติด ☐ เครียดหรือเบื่อหน่ายชีวิต
☐ใช้เพื่อทดแทนยาเสพติดตัวอื่น ☐ มีคนในครอบครัวใช้ยาเสพติด
☐ อยากผอม ☐ มีปัญหาในครอบครัว
☐ อื่น ๆ ระบุ.....

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20. เหตุผลสำคัญที่มารับการบำบัดรักษา (ตอบได้มากกว่า 1 ข้อ)

☐ พักเครื่อง/หยุดใช้ยาชั่วคราว ☐ ต้องการเลิกอย่างเด็ดขาด
☐ ครอบครัวขอร้อง/บังคับให้มารักษา ☐ ที่ทำงานหรือโรงเรียนส่งมารักษา
☐ กลัวถูกจับ ☐ ศาลสั่งให้มารักษา
☐ หายายาก/ราคาแพง ☐ อื่น ๆ ระบุ.....

21. ผลเสียที่เคยได้รับเนื่องจากการใช้ยาบ้า (ตอบได้มากกว่า 1 ข้อ)

☐ ร่างกายทรุดโทรม เจ็บป่วย ☐ บาดเจ็บจากการทะเลาะวิวาท
☐ ประสบอุบัติเหตุ ☐ หูแว่ว/เห็นภาพหลอน
☐ เคยคิดหรือพยายามฆ่าตัวตาย ☐ รักษาโรงพยาบาลจิตเวช
☐ มีปัญหาด้านการงาน หรือการเรียน ☐ มีปัญหากับครอบครัว
☐ ถูกจับดำเนินคดีเช่น ลักขโมย คดีเสพ คดีจำหน่าย
☐ อื่น ๆ .....

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ตอนที่ 2 แบบวัดการสนับสนุนของครอบครัว

คำชี้แจง โปรดใส่เครื่องหมาย ✓ลงในช่องที่ตรงกับการช่วยเหลือ และประคับประคองที่ท่านได้รับจากบุคคลต่าง ๆ ในครอบครัว เครือญาติ โดยเลือกตอบเพียงข้อเดียว

ข้อ	ข้อความ	มาก	ปานกลาง	น้อย
1.	คนในครอบครัวทำให้ท่านรู้สึกอบอุ่น มั่นใจ และปลอดภัย			
2.	เมื่อมีปัญหาท่านมีคนให้ความสนใจ รับฟังปัญหา และความรู้สึกไม่สบายใจของท่าน			
3.	บุคคลใกล้ชิดทำให้ท่านรู้สึกว่าไม่ได้ถูกทอดทิ้งหรืออยู่อย่างโดดเดี่ยว			
4.	บุคคลในครอบครัวยอมรับและให้โอกาสแก่ท่านได้แก้ไขตนเองเสมอ			
5.	บุคคลใกล้ชิดแสดงให้ท่านรู้ว่า ท่านเป็นคนมีประโยชน์และเป็นที่ต้องการของเขา			
6.	บุคคลในครอบครัวเข้าใจ เห็นใจที่ท่านต้องอดทนต่อสู้กับอาการอยากยาในช่วงที่เลิกยา			
7.	บุคคลในครอบครัวแนะนำให้ท่านมารับการรักษาเพื่อให้เลิกยาเสพติด			
8.	บุคคลในครอบครัวเสนอแนวทาง และ วิธีการใหม่ ๆ เพื่อช่วยให้ท่าน เลิกยาเสพติดให้ได้			
9.	บุคคลในครอบครัวช่วยให้ข้อมูล และชี้แนะให้ท่านปฏิบัติตามคำแนะนำของแพทย์ พยาบาล และเจ้าหน้าที่ที่ให้การบำบัดรักษา			
10.	บุคคลในครอบครัวแนะนำท่านให้อยู่รับการบำบัดรักษาจนครบกำหนด ตามขั้นตอนที่โรงพยาบาลกำหนด			
11.	บุคคลในครอบครัวยินดีสละเวลาพาท่านมาโรงพยาบาล หรือมาเยี่ยมท่านสม่ำเสมอ			
12.	คนในครอบครัวยินดีช่วยเหลือในเรื่องค่าใช้จ่ายในระหว่างที่ท่านรับการบำบัดรักษา			

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ข้อ	ข้อความ (ต่อ)	มาก	ปานกลาง	น้อย
13.	คนในครอบครัวพร้อมที่จะให้ เงินทอง ของใช้ และสิ่งจำเป็นต่าง ๆ เมื่อท่านขาดแคลน			
14.	บุคคลในครอบครัวช่วยแบ่งเบาภาระหน้าที่เกี่ยวกับงานบ้าน งานที่ทำงาน หรือโรงเรียน ในระหว่างที่ท่านมารับการรักษา			
15.	ปัจจุบันท่านยังคงมีภาระหน้าที่ต่าง ๆ ที่เป็นห่วงและจะต้องทำไม่ต่างจากก่อนเข้ารับการบำบัดรักษา			

ตอนที่ 3 แบบสอบถามด้านแบบแผนความเชื่อทางสุขภาพ

คำชี้แจง โปรดใส่เครื่องหมาย ✓ ในช่องที่ตรงกับความคิด ความรู้สึกของท่านมากที่สุดโดยให้เลือกตอบเพียงข้อเดียว

ข้อ	ข้อความ	เห็นด้วย	ไม่แน่ใจ	ไม่เห็นด้วย
1.	ปัจจุบันท่านไม่สามารถเลิกยาบ้าได้ด้วยตนเองแล้ว			
2.	การใช้ยาบ้ายิ่งนานจะยิ่งทำให้ติดยา และเลิกยากมากขึ้น			
3.	ท่านมีโอกาสใช้ยาบ้าซ้ำจนติดเรื้อรังมากขึ้นหากยังไม่มารับการรักษา			
4.	ท่านมีโอกาสเสี่ยงต่อการใช้ยาเสพติดอื่นที่รุนแรง ร่วมด้วยเมื่อใช้ยาบ้า			
5.	เมื่อท่านมีความต้องการยาบ้าแล้วไม่ได้เสพจะเกิดอาการหงุดหงิด กระวนกระวาย และอยากยา			
6.	การที่แพทย์วินิจฉัยว่าท่านเป็นผู้ติดยาบ้านั้นเป็นการวินิจฉัยที่รุนแรงเกินไป			
7.	ท่านเสพยาบ้าเพื่อความสนุกสนานชั่วคราวเท่านั้น ไม่ถึงกับติดยาบ้า			

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ข้อ	ข้อความ	เห็นด้วย	ไม่แน่ใจ	ไม่เห็นด้วย
8.	ยาบ้าเป็นยาเสพติดที่อันตราย และทำให้ผู้เสพมีสุขภาพร่างกายทรุดโทรมอย่างมาก			
9.	การใช้ยาบ้าเป็นเวลานาน จะทำให้เกิดอาการหูแว่ว เห็นภาพหลอนสมองเสื่อม ผู้ติดยาบ้านาน ๆ อาจเป็นบ้าถาวร และอาจถึงขั้นฆ่าตัวตายได้			
10.	การใช้ยาบ้าทำให้ท่านเสียเงินทอง และทรัพย์สินเป็นจำนวนมาก			
11.	การใช้ยาบ้านาน ๆ จะทำให้มีปัญหาด้านการเรียน หรือการงาน และอาจถึงขั้นถูกไล่ออกได้			
12.	การติดยาบ้าจะทำให้ท่านเกิดปัญหาขัดแย้งรุนแรงกับคนในครอบครัว และคนใกล้ชิด			
13.	การติดยาบ้าจะทำให้ท่านกระทำความผิดอื่น ๆ มากขึ้น เช่น ลักขโมย ทะเลาะวิวาท ทำร้ายร่างกายผู้อื่น หรือ ต้องเป็นผู้ค้ายาเสพติด			
14.	การใช้ยาบ้าแม้จะมีโทษ แต่ก็ทำให้ท่านกระปี้กระเปร่า เกิดความสุข และความสนุกสนานมากกว่า			
15.	การใช้ยาบ้าเป็นการทำผิดกฎหมายบ้านเมือง เสี่ยงต่อการถูกจับกุม และหากเป็นผู้ค้าจะมีโทษถึงประหารชีวิต			
16.	การใช้ยาบ้าจะทำให้ท่านมีโอกาสเสี่ยงที่จะประสบอุบัติเหตุที่ร้ายแรง มากขึ้น			
17.	การใช้ยาบ้าจะทำให้ท่านมีโอกาสติดโรค หรือสารเสพติดชนิดอื่น ๆ ได้มากขึ้น			
18.	วิธีการบำบัดรักษาการติดยาบ้าตามขั้นตอนของโรงพยาบาลจะทำให้ท่านเลิกยาบ้าได้			
19.	การปฏิบัติตามคำแนะนำของแพทย์ พยาบาล และเจ้าหน้าที่ผู้ให้การบำบัดรักษาอย่างเคร่งครัดจะทำให้ท่านเลิกยาบ้าได้			
20.	การรับการบำบัดรักษาครบขั้นตอน ตามระยะเวลาที่กำหนดเป็นสิ่งสำคัญที่จะทำให้ท่านเลิกยาบ้าได้			

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ข้อ	ข้อความ	เห็นด้วย	ไม่แน่ใจ	ไม่เห็นด้วย
21.	การรักษายาบ้าที่ดีต้องมีการฟื้นฟูสภาพทั้งด้านร่างกาย และจิตใจ จึงจำเป็นต้องใช้ระยะเวลาในการรักษามากเพียงพอ			
22.	การเลิกยาบ้าอยู่ที่ใจ ไม่จำเป็นต้องรักษาที่โรงพยาบาลก็สามารถเลิกยาบ้าได้			
23.	การรักษายาบ้าเมื่อหมดอาการถอนพิษยาแล้วก็ถือว่าเพียงพอ และสามารถทำให้เลิกยาบ้าได้แล้ว			
24.	การเข้ารับการรักษายาบ้าจนครบขั้นตอนทำให้เสียเวลาของท่านอย่างมาก			
25.	การเข้ารับการรักษาจนครบขั้นตอนทำให้ท่านต้องเสียค่าใช้จ่ายจำนวนมาก			
26.	การรับการบำบัดรักษาจนครบขั้นตอนทำให้ท่านเกิดปัญหากับที่ทำงาน หรือ โรงเรียน			
27.	การรับการบำบัดรักษาจนครบขั้นตอนทำให้เกิดความยุ่งยากและเป็นภาระต่อคนในครอบครัว			
28.	การเข้ารับการบำบัดรักษามีขั้นตอนการปฏิบัติตัวที่ยุ่งยากมากสำหรับท่าน			
29.	กฎระเบียบ ข้อบังคับของโรงพยาบาลขณะบำบัดรักษา ทำให้ท่านรู้สึกเครียด และอึดอัด			
30.	การเข้ารับการบำบัดรักษาจนครบตามขั้นตอนทำให้ท่านต้องคอยกังวลว่าผู้อื่นจะรู้ว่าท่านมารักษาการติดยาเสพติด			
31.	ท่านมีความตั้งใจที่จะเลิกยาบ้า หรือยาเสพติดอย่างเด็ดขาด			
32.	ท่านเชื่อว่า ท่านจะสามารถกลับไปทำงาน หรือเรียนหนังสือได้ตามปกติภายหลังจากได้รับการบำบัดรักษาจนสำเร็จในครั้งนี้			
33.	ท่านเชื่อว่าชีวิตในอนาคตของท่านจะดีขึ้นอย่างแน่นอนภายหลังจากได้รับการรักษาจนสำเร็จในครั้งนี้			

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ข้อ	ข้อความ	เห็นด้วย	ไม่แน่ใจ	ไม่เห็นด้วย
34.	ท่านเชื่อว่าสุขภาพร่างกาย และจิตใจของท่านจะแข็งแรงสมบูรณ์ขึ้นภายหลังจากได้รับการรักษาจนสำเร็จในครั้งนี้			
35.	ท่านเชื่อว่าภายหลังจากได้รับการรักษาจนสำเร็จจะทำให้ท่านได้รับการยอมรับจากครอบครัว และสังคม			
36.	ท่านตั้งใจรับการบำบัดรักษาจนสำเร็จเพื่อเป็นของขวัญแก่คนที่ท่านรัก			

ตอนที่ 4 แบบประเมินผลการบำบัดรักษา (สำหรับผู้วิจัยประเมินจากเวชระเบียนผู้ป่วย)

1. ระยะเวลาที่รับการบำบัดรักษา……...วัน
2. ประเภทของการจำหน่าย

☐ครบกำหนดผ่านเกณฑ์ขั้นฟื้นฟูสมรรถภาพ
☐ครบกำหนดผ่านเกณฑ์ขั้นบำบัดด้วยยา
☐หลบหนี
☐ไม่สมัครใจรักษา
☐จำหน่ายเนื่องจากทำผิดกฎระเบียบ
☐ขาดการรักษา
☐อื่น ๆ

3. สรุปผลการจำหน่าย

☐ครบกำหนดตามเกณฑ์
☐ไม่ครบกำหนดตามเกณฑ์

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BIOGRAPHY

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