THE ACHIEVEMENT OF FAST-MODEL TREATMENT AND THAI TRADITIONAL TREATMENT IN METHAMPHETAMINE ADDICT REHABILITATION

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OF THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF ARTS (ADDICTIONOLOGY)
FACULTY OF GRADUATE STUDIES
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THE ACHIEVEMENT OF FAST-MODEL TREATMENT AND
THAI TRADITIONAL TREATMENT IN METHAMPHETAMINE
ADDICT REHABILITATION

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Thipchanok Saengthongdee

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THE ACHIEVEMENT OF FAST-MODEL TREATMENT AND THAI TRADITIONAL TREATMENT IN METHAMPHETAMINE ADDICT REHABILITATION

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ABSTRACT

The purposes of this research was to study the achievement of treatment in methamphetamine addict, includes causes, effect and factor, which's involved in attitude of addict's rehabilitation. Researcher needs to search for the method in effective rehabilitation. Data was collected by conducting surveys from addict's rehabilitation in Fast-model and Thai traditional treatment area all, 200 cases, were analyzed by using SPSS program.

Result of the study can be concluded as follow: personal data, general data and the chronicle data used methamphetamine to the treating of addict's rehabilitation related with attitude influence toward achievement of Fast-model treatment and Thai traditional treatment. Attitude of addicts Fast-model rehabilitation were different more than addict's Thai traditional rehabilitation. Addict's rehabilitation had not assured in achievement of both treatments. Therefore, addict's rehabilitation was not confident of achievement of Fast-model and Thai tradition rehabilitation was not high.

It can be concluded that the government should identify steps in the rehabilitation process of each method, for improvement of rehabilitation, support and continue to promote various countries approved of Thai traditional treatment, and protect and suppress the spread of methamphetamine and consistently be careful of youths returning to use of the drug again, in the future.

KEY WORDS: REHABILITATION/ METAMPHETAMINE/ TREATMENT

143 P.

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ผลสัมฤทธิ์ของการบำบัดฟื้นฟูผู้ติดเมทแอมเฟตามีนโดยวิธีการเข้มข้นทางสายใหม่และการแพทย์แผนไทย (THE ACHIEVEMENT OF FAST-MODEL TREATMENT AND THAI TRADITIONAL TREATMENT IN METHAMPHETAMINE ADDICT REHABILITATION)

ทิพย์ชนก แสงทองดี 4737833 GRAD/M

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บทคัดย่อ

การวิจัยนี้มีวัตถุประสงค์เพื่อศึกษาถึงผลสัมฤทธิ์ของการบำบัดรักษาฟื้นฟูผู้ติดเมทแอมเฟตามีนหรือยาบ้า รวมถึงสาเหตุผลและปัจจัยต่างๆที่มีต่อความคิดเห็นของผู้เข้ารับการบำบัดที่มีต่อผลการบำบัด รักษาโดยวิธีการแผนปัจจุบันและวิธีการแผนไทย ผู้วิจัยต้องการหาแนวทางในการบำบัดที่มีประสิทธิภาพมากยิ่งขึ้น โดยเก็บข้อมูลโดยวิธีแบบสอบถามจากผู้เข้ารับการบำบัดรักษายาบ้าในสถานบำบัดแผนปัจจุบันและแผนไทย รวมทั้งสิ้น 200 ราย ประมวลผลโดยการวิเคราะห์ผลทางสถิติ สรุปผลการวิจัยได้ดังนี้

ข้อมูลส่วนตัว, ข้อมูลทั่วไป และข้อมูลประวัติการใช้ยาบ้าของผู้เข้ารับการบำบัดมีผลถึงความคิดเห็นที่มีต่อผลสัมฤทธิ์ของการบำบัดวิธีแผนปัจจุบันและแผนไทย ผู้เข้ารับการบำบัดรักษาแผนปัจจุบัน มีความคิดเห็นที่แตกต่างกันมากกว่าผู้เข้ารับการบำบัดแผนไทย และผู้เข้ารับการบำบัดรักษาส่วนใหญ่ มีความคิดเห็นไม่แน่ใจกับผลการบำบัดรักษาทั้งสองวิธี ชี้ให้เห็นว่า ผู้เข้ารับการบำบัดไม่มั่นใจกับผลการบำบัดทั้งวิธีการแผนปัจจุบันและแผนไทย

ผู้วิจัยเสนอแนะดังต่อไปนี้

1. รัฐบาลควรให้ความสนใจ และให้ความสำคัญต่อกระบวนการบำบัดรักษาแต่ละประเภทเพื่อบำบัดผู้ติดยาเสพติดและการติดตามผลอย่างต่อเนื่อง

2. การบำบัดรักษาโดยการแพทย์แผนไทย ควรได้รับการสนับสนุนและประชาสัมพันธ์อย่างต่อเนื่องจากรัฐบาล เพื่อเป็นการส่งเสริมภูมิปัญญาการแพทย์แผนไทยให้เป็นที่ยอมรับจากนานาชาติ

3. รัฐบาลควรมีการป้องกันและปราบปรามยาบ้าอย่างสม่ำเสมอ การเฝ้าระวังการกลับมาของยาบ้าอีกในอนาคต

143 หน้า

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CONTENTS

		Pages
ACKNOWLEDGEMENTS		**iii**
ABSTRACT		**iv**
LIST OF TABLES		**ix**
CHAPTER 1	**INTRODUCTION**	**1**
	1.1 Background and Significance of the Research	1
	1.2 Objective of the Research	3
	1.3 Scope of the Research	3
	1.4 Research Methodology	4
	1.5 Variables of the Research	5
	1.6 Definition of Terms	6
	1.7 Hypothesis of Research	8
	1.8 Expected Benefits	8
CHAPTER 2	**LITERATURE REVIEW**	**9**
	2.1 Drug Abuse	9
	2.2 Drug addiction	21
	2.3 Roadmap of drug surveillance and establishment of sustainable victory over drug 2006-2008	31
	2.4 Treatment	41
	2.5 Matrix Model	49
	2.6 FAST Model	52
	2.7 Jirasa	55
	2.8 Thanyarak Institute	56
	2.9 Wat Thamkrabok : a Buddhist drug rehabilitation program in Thailand	59
	2.10 Related Research	60

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CONTENTS (Conts.)

		Pages
CHAPTER 3	**RESEARCH METHODOLOGY**	**64**
	3.1 Target Population	64
	3.2 Research Instrument	64
	3.3 Data Collection	65
	3.4 Data Analyses	65
CHAPTER 4	**RESULT**	**66**
	4.1 Personal and general data of sample group	66
	4.2 The chronicle data used drug abuse of sample group	73
	4.3 Analysis of relation between addict's rehabilitation and the attitude influence toward FAST-model rehabilitation	78
	4.4 Analysis of relation between addict's rehabilitation and the attitude influence toward Thai traditional rehabilitation	79
	4.5 Analysis of variance (ANOVA) of the attitude influence toward FAST-model rehabilitation	100
	4.6 Analysis of variance (ANOVA) of the attitude influence toward Thai traditional rehabilitation	111
CHAPTER 5	**DISCUSSION**	**119**
	5.1 Recommendation of addict's rehabilitation, influence towards achievement of FAST-model treatment	120
	5.2 The attitude of addict's rehabilitation influence towards achievement of Thai traditional rehabilitation	121

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CONTENTS (Conts.)

		Pages
CHAPTER 6	**CONCLUSION AND RECOMMENDATION**	**124**
	6.1 Conclusion	124
	6.2 Recommendation	125
BIBLIOGRAPHY		**127**
APPENDIX		**131**
BIOGRAPHY		**143**

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LIST OF TABLES

		Pages
Table 2-1	Show means of taking Methadone for Addict's heroin	40
Table 4-1	Demographics of the Key Informants	69
Table 4-2	Numbers and percentage of sample group as classified by the chronicle data used methamphetamine	75
Table 4-3	Relation between ages and attitude influence toward FAST-model rehabilitation	78
Table 4-4	Relation between marital status and attitude influence toward FAST-model rehabilitation	79
Table 4-5	Relation between religion and attitude influence toward FAST-model rehabilitation	80
Table 4-6	Relation between education and attitude influence toward FAST-model rehabilitation	81
Table 4-7	Relation between Occupation and attitude influence toward FAST-model rehabilitation	82
Table 4-8	Relation between age of first time drug abuse and attitude influence toward FAST-model rehabilitation	83
Table 4-9	Relation between institute of first time rehabilitation and attitude influence toward FAST-model rehabilitation	84
Table 4-10	Relation between reason of first time rehabilitation and attitude influence toward FAST-model rehabilitation	85
Table 4-11	Relation between reason of the period of stop drug and attitude affected to FAST-model rehabilitation	86

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LIST OF TABLES (Conts.)

		Pages
Table 4-12	Relation between frequency of visiting of their family and attitude affected to FAST-model rehabilitation	87
Table 4-13	Relation between neighbors of community and attitude influence toward FAST-model rehabilitation	88
Table 4-14	Relation between age and attitude influence toward Thai traditional rehabilitation	89
Table 4-15	Relation between marital status and attitude influence toward Thai traditional rehabilitation	90
Table 4-16	Relation between religion and attitude influence toward Thai Traditional rehabilitation	91
Table 4-17	Relation between education and attitude influence toward Thai Traditional rehabilitation	92
Table 4-18	Relation between Occupation and attitude influence toward Thai traditional rehabilitation	93
Table 4-19	Relation between age of first time drug abuse and attitude influence toward Thai traditional rehabilitation	94
Table 4-20	Relation between institute of first time rehabilitation and attitude influence toward Thai traditional rehabilitation	95
Table 4-21	Relation between reason of first time rehabilitation and attitude influence toward Thai traditional rehabilitation	96
Table 4-22	Relation between reason of the period of stop drug and attitude influence toward Thai traditional rehabilitation	97

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LIST OF TABLES (Conts.)

		Pages
Table 4-23	Relation between frequency of visiting of their family and attitude influence toward Thai traditional rehabilitation	98
Table 4-24	Relation between neighbors of community and attitude influence toward Thai traditional rehabilitation	99
Table 4-25	Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential age.	100
Table 4-26	The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential ages each couple by Sheffe method.	101
Table 4-27	Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential marital status.	101
Table 4-28	Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential religion.	102
Table 4-29	The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential religion each couple by Sheffe method.	102
Table 4-30	Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential education.	103

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LIST OF TABLES (Conts.)

		Pages
Table 4-31	The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential education each couple by Sheffe method.	103
Table 4-32	Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential occupation.	104
Table 4-33	The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential occupation each couple by Sheffe method.	104
Table 4-34	Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential of Acceptance of family as treatment.	105
Table 4-35	The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential of Acceptance of family as treatment, each couple by Sheffe method.	105
Table 4-36	Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was difference of acceptance of family undergoing rehabilitation.	106
Table 4-37	Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential's neighbors of community.	106
Table 4-38	The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was difference of neighbors of community each couple by Sheffe method	107

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LIST OF TABLES (Conts.)

		Pages
Table 4-39	Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was different attitude of reason to consume drug for the first time.	108
Table 4-40	The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was difference of reason to consume drug for the first time each couple by Sheffe method.	108
Table 4-41	Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential attitude of age to consume drug for the first time.	109
Table 4-42	The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential of age to consume drug for the first time each couple by Sheffe method.	110
Table 4-43	Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential age.	111
Table 4-44	Analysis of variance (ANOVA) of the attitude influence towards Thai tradition rehabilitation was differential marital status.	111
Table 4-45	Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential religion.	112
Table 4-46	The differential of the attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential religion each couple by Sheffe method.	112

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LIST OF TABLES (Conts.)

		Pages
Table 4-47	Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential education.	113
Table 4-48	Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential occupation.	113
Table 4-49	The difference of attitude influence towards achievement of Thai traditional treatment in addict's rehabilitation was differential occupation each couple by Sheffe method.	114
Table 4-50	Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential of Acceptance of family as treatment.	114
Table 4-51	Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential of acceptance of family undergoing rehabilitation.	115
Table 4-52	The difference of attitude influence towards achievement of Thai traditional treatment in addict's rehabilitation who had acceptance of family undergoing rehabilitation were differential each couple by Sheffe method	115
Table 4-53	Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential's neighbors of community.	116
Table 4-54	Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential attitude of reason to consume drug for the first time.	117

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LIST OF TABLES (Conts.)

		Pages
Table 4-55	Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential attitude of age to consume drug for the first time.	117
Table 4-56	The difference of attitude influence towards achievement of Thai traditional treatment in addict's rehabilitation was differential of age to consume drug for the first time each couple by Sheffe method.	118

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CHAPTER 1
INTRODUCTION

1.1 Background and Significance of the Research

Human resource is significant most. Human is civilization maker and all culture but, now a low quality human being by drug abuse. In Thai social, has solved drug problem, which one of policy's parliaments every period. Drug abuse has been an ongoing problem in Thailand, its infrastructure of problem has three performances; production problem, trade problem and spreading out problem of drug abuse. The majority of drug is found in Thailand for example heroine, marijuana, amphetamine, and a substance evaporates. From these structures and the character of drug, affects toward AIDS problem, accident and a crime. Drug abuse has been a significant problem in society, its effect wide reaching towards the community and the countryside. Besides, its effects are especially detrimental on children and youth in the school. A kind of drug that tends to increase, such as amphetamine and a substance evaporates.

"Drug dependence" refer to any substances that may be naturally-derived or synthetic, which, when taken continuously into the body over a long periods of time by any method, will cause the body to deteriorate and become overpowered or fall victim to that substance. There will be an increasing desire to take in more of the drug, due the fact that after a certain period using the drug, a resistance will occur where an original amount of the drug will not produce the desired effect.

For amphetamine group, drug user will buy it from a drugstore and all stores in the format of the medicine to eat for effectiveness in using, which's wrong medical objective. The government had been managing the first control in 1955, by

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Ministry of Public Health had gone out ministry notice, about specify the poison in act of sale medicine legislation 1953, in April 13, 1955. Specify, Synthetic Medulla Stimulant Drugs, the every kind was the poison, which effected to the amphetamine was controlled is the dangerous, people still bought it at the drugstore to mistake using, and then, spreading out problem of drug in amphetamine group during 1958 – 1967 (Suchart Louwborriphat, 1999: 12). Later a drug of amphetamine group and methamphetamine were controlled are the material activate of kinds the second follow act of material legislation that activate to build the mind and the nerve. Those drugs prohibited not have the production, import, and sell in a kingdom anyway. The dissemination of these drugs by a store then quietly disappears, the stealing smuggles to reach the country could do difficultly. Therefore, the amphetamines that have the amphetamine or methamphetamine is formed important medicine then is the thing that gets difficult in the market, and later have meeting amphetamine for the first time in Thailand, 1979 that the Udon Thani but still can not can prove that, make in Thailand (Payon Pansri, 1922 : 6). From the study, found Methamphetamine is used in pill form, Street names for the drug include "speed,"

There are various methods in Rehabilitation for addict's methamphetamine group, especially the modern treatment, for example the Community therapy method, FAST-model method, Matrix program, Jirasa method, Fresh model or Modify matrix etc., There are also using many kinds of Thai herbals such as three roots medicine (Loadtanongdang, Hung Houn, taro eel), has the properties makes to vomit and transfer , Thunbergia laurifolia has the properties eradicates the poison etc., For Thai traditional treatment.

The both method is good the level. The researcher, whose student in master of art, addict science filed, thinks that the achievement of FAST-model treatment and Thai traditional treatment in methamphetamine addict's rehabilitation could be an academic data and developed model of addict's treatment the next time, particularity, the FAST-model treatment at Thanyarak institute and the Thai traditional treatment at tham-krabok temple.

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1.2 Objective of the Research

1.2.1 To study model of FAST-model treatment and Thai traditional treatment in methamphetamine addict's rehabilitation

1.2.2 To study achievement of FAST-model treatment and Thai traditional treatment about the opinion, confidence, and turning over rate goes to take repeated of drug user.

1.3 Scope of the Research

Researcher specifics the target group, to study from addict's amphetamine who's treated with FAST-model treatment and Thai traditional treatment at Thanyarak Institute and Wat Thamkrabok, all of 200 peoples.

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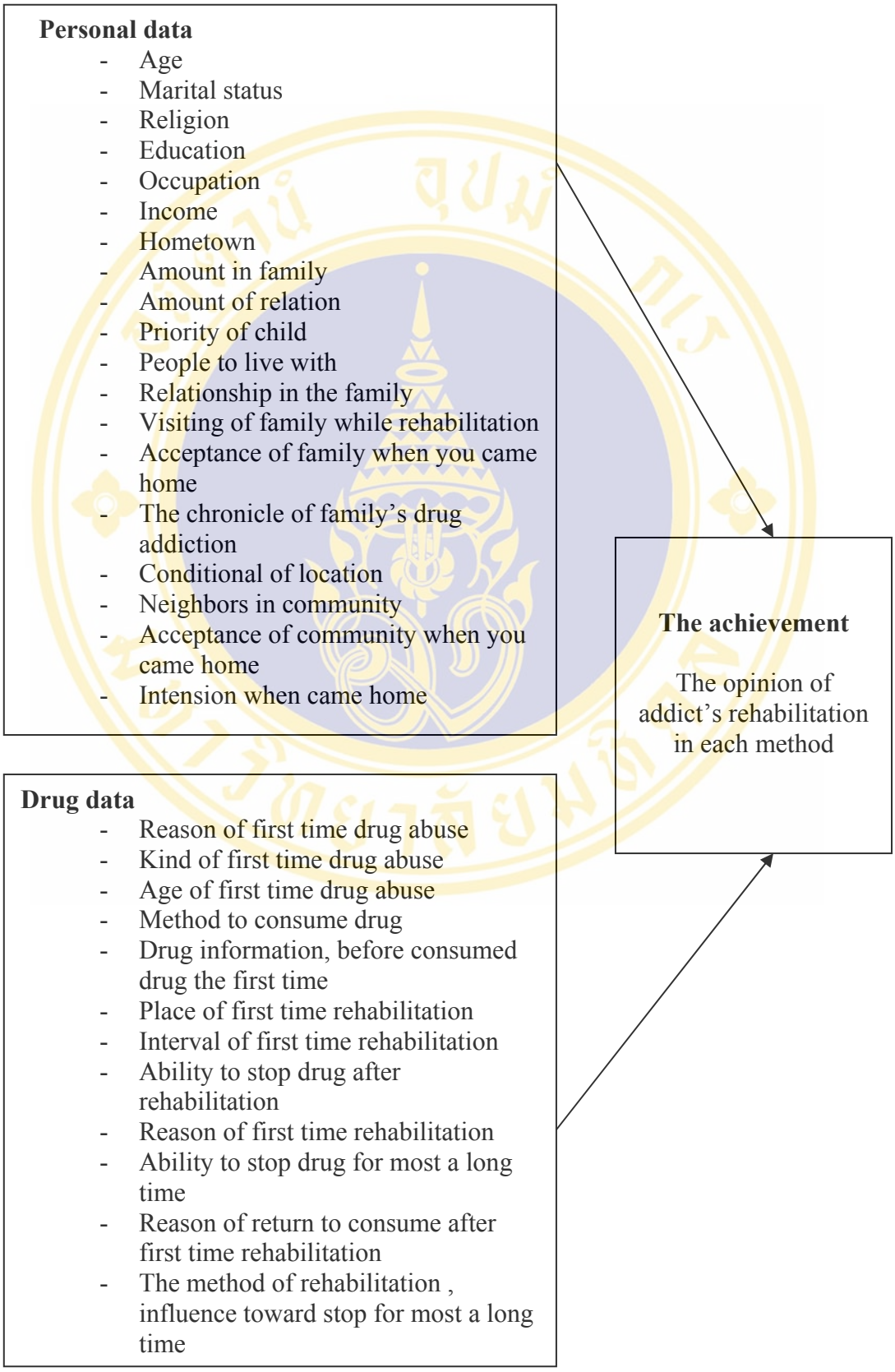
1.4 Research Methodology



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1.5 Variables of the Research

1.5.1 Dependent variable of personal data:

- Age
- Marital status
- Religion
- Education
- Occupation
- Income
- Hometown
- Amount in family
- Amount of relation
- Priority of child
- People to live with
- Relationship in the family
- Visiting of family while rehabilitation
- Acceptance of family when you came home
- The chronicle of family's drug addiction
- Conditional of location
- Neighbors in community
- Acceptance of community when you came home
- Intension when came home

1.5.2 Dependent variable of drug data:

- Reason of first time drug abuse
- Kind of first time drug abuse
- Age of first time drug abuse
- Method to consume drug
- Drug information, before consumed drug the first time
- Place of first time rehabilitation
- Interval of first time rehabilitation

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- Ability to stop drug after rehabilitation
- Reason of first time rehabilitation
- Ability to stop drug for most a long time
- Reason of return to consume after first time rehabilitation
- The method of rehabilitation , influence toward stop for most a long time

1.5.3 Independent variable:

- The opinion of addict's rehabilitation in each method

1.6 Definition of Terms

1.6.1 The addict's rehabilitation mean to treat for addict's rehabilitation both of physical and mind, by purpose for the addict's person can live in the social happiness. The treatment by holistic is method to treat addict's person will be successful, for contribute addict's person has the development in every part. Now, there are many kinds, method or various activities which differential upon addict's rehabilitation.

1.6.2 Narcotics in "Narcotics Control Act, B.E. 2519" as follow:

"Narcotics" means narcotics under the law on narcotics, psychotropic substances under the law on psychotropic substances and volatile substances under the law on controlling the use of volatile substances.

1.6.3 Narcotic act B.E. 2522 as follow:

"Narcotics" means any form of chemicals or substances, which, upon being consumed whether by taking orally, inhaling, smoking, injecting or by whatever means, causes physiological or mental effect in a significant manner such as:

1. Need of taking continuously and seeking these drugs any way

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2. Need of continual increase of dosage

3. To become enslaved to the drugs physically and psychologically and having withdrawal symptoms when deprived of drug

4. The health in general being deteriorated

Also includes plant or parts of plants, which are, give product as narcotics, or may be used to produce narcotics and chemicals used for the production of such narcotics as notified by the Minister in the Government Gazette, but excludes certain formula of household medicine under the law on drugs, which contain narcotic ingredients. This research includes psychotropic, tranquilizer, amphetamine and drug affect to nerve such as marijuana, opium, heroine, liquor is dry, a substance evaporates, thinner, gasoline, lacquer etc.,

1.6.4 "Addict people" means who must take this substance continuously, having withdrawal symptoms when deprived of drug

1.6.5 "Drug use" means to send drugs into the body by any way for example taking orally, inhaling, smoking, injecting, eating, smelling, keeping, rubbing and tucking

1.6.6 "Withdrawal or Tolerance" means the condition that the addict no takes or stop taking a substance such, make feel like do drugs, more and more continually until have the symptoms torments physical appear, the symptoms withdraws drug often is born very in the distance just 2 – 3 day then, softly decrease respectively.

1.6.7 "Tolerance" means the condition that the addict has to take that substance in the quantity for more and more then will do give get the supernatural power follows to want.

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1.7 Hypothesis of Research

1.7.1 Individual data and general data of different sample think build the cure heals of person stick amphetamine different fat

1.7.2 The data about the chronicle uses the narcotic of different sample, have something, comment build the cure heals of person addict amphetamine

1.8 Expected Benefits

1.8.1 To be lead of the education has that to go to analyses seek cure trend heals that effective more and more

1.8.2 Supporting and encourage Thai intellect in herbs local lead come to use to the advantage by treat drug habit-forming addict

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CHAPTER 2
LITERATURE REVIEW

The study of the achievement of FAST-model and Thai traditional treatment in methamphetamine addict rehabilitation. The researcher had reviewed the literature documents and related. The content had been categorizes as follows;

2.1 Drug Abuse
2.2 Drug addiction
2.3 Roadmap of drug surveillance and establishment of sustainable victory over drug 2006-2008
2.4 Treatment
2.5 Matrix Model
2.6 FAST Model
2.7 Jirasa
2.8 Thanyarak Institute
2.9 Wat Thamkrabok : a Buddhist drug rehabilitation program in Thailand
2.10 Related Research

2.1 Drug Abuse (From Wikipedia, the free encyclopedia)

Drug abuse has a wide range of definitions, all of them relating either to the misuse or overuse of a psychoactive drug or performance enhancing drug for a non-therapeutic or non-medical effect, or referring to any use of illegal drug in the absence of a required, yet practically impossible to get, license from a government authority (e.g., in the U.S. this is the DEA). Some of the most commonly abused drugs include alcohol, amphetamines, barbiturates, caffeine, cannabis, cocaine, methaqualone, nicotine, opium alkaloids, and minor tranquilizers. Use of these drugs

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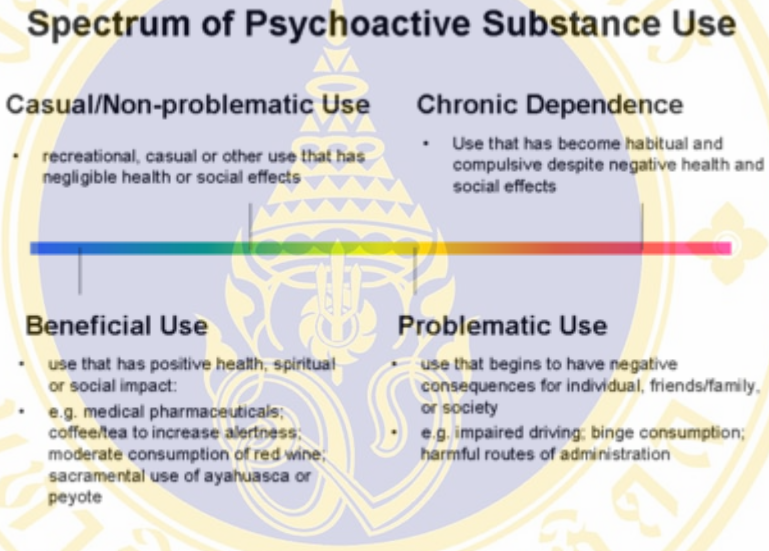
may lead to criminal penalty in addition to possible physical, social, and psychological harm, both strongly depending on local jurisdiction. Other definitions of drug abuse fall into four main categories: public health definitions, mass communication and vernacular usage, medical definitions, and political and criminal justice definitions.

2.1.1 Public health definitions



Source: A Public Health Approach to Drug Control in Canada, Health Officers Council of British Columbia, 2005

In recent decades, public health practitioners have attempted to look at drug abuse from a broader perspective than the individual, emphasising the role of society, culture and availability. Rather than accepting the loaded terms alcohol or drug "abuse," many public health professionals have adopted phrases such as "alcohol and drug problems" or "harmful/problematic use" of drugs.

The Health Officers Council of British Columbia — in their 2005 policy discussion paper, *A Public Health Approach to Drug Control in Canada* — has adopted a public health model of psychoactive substance use that challenges the

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simplistic black-and-white construction of the binary (or complementary) antonyms "use" vs. "abuse". This model explicitly recognizes a spectrum of use, ranging from beneficial use to chronic dependence (see diagram to the right).

Mass communication and vernacular usage.

The term "drug abuse" may be used in newspapers, television, etc. in an ambiguous, catch-all sense[2] rather than as a medical or legal term, sometimes disapprovingly to refer to any drug use at all, particularly of illicit drugs

Medical definitions

In the modern medical profession, the two most used diagnostic tools in the world, the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) and the World Health Organization's International Statistical Classification of Diseases and Related Health Problems (ICD), no longer recognise 'drug abuse' as a current medical diagnosis. Instead, they have adopted *substance abuse* as a blanket term to include drug abuse and other things. However, other definitions differ; they may entail psychological or physical *dependence*, and may focus on treatment and prevention in terms of the social consequences of substance use.

Historical positions of the American Psychiatric Association

In the early 1950s, the first edition of the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* referred to both alcohol and drug abuse as part of Sociopathic Personality Disturbances, which were thought to be symptoms of deeper psychological disorders or moral weakness . By the third edition, in the 1980s, drug abuse was grouped into 'substance abuse'.

In 1972, the American Psychiatric Association created a definition that used legality, social acceptability, and even cultural familiarity as qualifying factors:

...as a general rule, we reserve the term drug abuse to apply to the illegal, nonmedical use of a limited number of substances, most of them drugs, which have

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properties of altering the mental state in ways that are considered by social norms and defined by statute to be inappropriate, undesirable, harmful, threatening, or, at minimum, culture-alien.

Historical positions of the American Medical Association

In 1966, the American Medical Association's Committee on Alcoholism and Addiction defined abuse of stimulants (amphetamines, primarily) in terms of "medical supervision":

..."use" refers to the proper place of stimulants in medical practice; "misuse" applies to the physician's role in initiating a potentially dangerous course of therapy; and "abuse" refers to self-administration of these drugs without medical supervision and particularly in large doses that may lead to psychological dependency, tolerance and abnormal behavior.

Handbook on Drug and Alcohol Abuse

The *Handbook on Drug and Alcohol Abuse* defines drug abuse as "*nonmedical use of drugs, both drugs that have and those that do not have generally accepted medical value*"

Political and criminal justice definitions

Most countries have legislation designed to criminalise some drug use. Usually however the legislative process is self-referential, defining abuse in terms of what is made illegal. The legislation concerns lists of drugs specified by the legislation. These drugs are often called *illegal drugs* but, generally, what is illegal is their unlicensed production, supply and possession. The drugs are also called *controlled drugs* or *controlled substances*.

World Health Organization

The World Health Organization (WHO), a public health agency comprised of delegates appointed by the governments of member nations, is considered by many to be a medical authority. Definitions found in WHO reports are often used as the

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basis for legislation at national, regional and local levels. The WHO also produces the *ICD*, a major diagnostic resource used by medical professionals worldwide.

Although it consists largely of public health professionals, the WHO is an arm of the United Nations political body, and is therefore responsive to the needs of, demands from, and prevailing views among the UN member states that appoint WHO delegates. The manner in which the WHO has recognized and dealt with 'drug abuse' over the years reflects a continuing struggle to reconcile conflicting historical, political, social, cultural, and medical viewpoints.

In its early reports, the WHO Expert Committee on Addiction-Producing Drugs used the terms 'abuse' and 'addiction' interchangeably. Beginning in 1950s, attempts were made to distinguish between scientific and emotionally-charged terminology. However, the term 'abuse' was still inserted into definitions of addiction and dependency.

In 1957, while not explicitly saying that 'drug abuse' was synonymous with 'addiction', the committee first attempted to clarify existing definitions of addiction and habituation as had been in common parlance since at least 1931:

Drug addiction is a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: (i) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; (ii) a tendency to increase the dose; (iii) a psychic (psychological) and generally a physical dependence on the effects of the drug; and (iv) detrimental effects on the individual and on society.

Drug habituation (habit) is a condition resulting from the repeated consumption of a drug. Its characteristics include (i) a desire (but not a compulsion) to continue taking the drug for the sense of improved well-being which it engenders; (ii) little or no tendency to increase the dose; (iii) some degree of psychic dependence on the effect of the drug, but absence of physical dependence and hence of an

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abstinence syndrome [withdrawal], and (iv) detrimental effects, if any, primarily on the individual.

In 1964, a new WHO committee found these definitions to be inadequate, and suggested using the blanket term 'drug dependence':

The definition of addiction gained some acceptance, but confusion in the use of the terms addiction and habituation and misuse of the former continued. Further, the list of drugs ***abused*** *increased in number and diversity. These difficulties have become increasingly apparent and various attempts have been made to find a term that could be applied to* ***drug abuse*** *generally. The component in common appears to be dependence, whether psychic or physical or both. Hence, use of the term 'drug dependence', with a modifying phase linking it to a particular drug type in order to differentiate one class of drugs from another, had been given most careful consideration. The Expert Committee recommends substitution of the term 'drug dependence' for the terms 'drug addiction' and 'drug habituation'.*

The committee did not clearly define dependence, but did go on to clarify that there was a distinction between physical and psychological ('psychic') dependence. It said that drug abuse was "*a state of psychic dependence or physical dependence, or both, on a drug, arising in a person following administration of that drug on a periodic or continued basis.*" Psychic dependence was defined as a state in which "*there is a feeling of satisfaction and psychic drive that requires periodic or continuous administration of the drug to produce pleasure or to avoid discomfort*" and all drugs were said to be capable of producing this state:

There is scarcely any agent which can be taken into the body to which some individuals will not get a reaction satisfactory or pleasurable to them, persuading them to continue its use even to ***the point of abuse*** *— that is, to excessive or persistent use beyond medical need.*

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This is believed to be the first reference to "medical need" as a factor in the distinction between use and abuse.

In 1965, the same WHO committee commented further now providing a specific definition of abuse:

Drug abuse is the consumption of a drug apart from medical need or in unnecessary quantities. Its nature and significance may be considered from two points of view: one relates to the interaction between the drug and the individual, the other to the interaction between drug abuse and society. The first viewpoint is concerned with drug dependence and the interplay between the pharmacodynamic actions of the drug and the physiological and psychological status of the individual. The second — the interaction between drug abuse and society — is concerned with the interplay of a wide range of conditions, environmental, sociological, and economic.

Individuals may become dependent upon a wide variety of chemical substances that produce central nervous system effects ranging from stimulation to depression. All of these drugs have one effect in common: they are capable of creating, in certain individuals, a particular state of mind that is termed "psychic dependence ".

Some drugs… induce physical dependence, which is an adaptive state that manifests itself by intense physical disturbances when the administration of the drug is suspended or when its action is affected by the administration of a specific antagonist.

The committee offered several disclaimers of its definitions:

It must be emphasized that drug dependence and drug abuse, as used by the Committee, are general terms and carry no connotation of the degree of risk to public health or of the need for drug control or for a particular type of drug control. The Committee would point out again that the recommendation for the use of the terms drug abuse and drug dependence of this or that type must not be regarded as a re-definition; rather, these terms are intended as descriptive expressions for

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clarification in scientific reference, interdisciplinary discussions, and national and international procedures.

The 1969 edition of the WHO's International Statistical Classification of Diseases and Related Health Problems (ICD) manual defined drug abuse as "*persistent or sporadic excessive drug use inconsistent with or unrelated to acceptable medical practice*", modern editions have not used the term because of its ambiguity, preferring instead to refer to the cluster of symptoms previously called 'drug abuse' as 'substance abuse'.

In 1973, these statements and recent legislation based upon the term "dependence" rather than "addiction" or "abuse" were praised by President Richard M. Nixon's National Commission on Marihuana and Drug Abuse in its final report:

The Commission applauds the much-belated attempt by the scientific community to sever its conceptual apparatus from the vocabulary of politics and emotion. "Addiction," like "narcotics" and "drug abuse," has a general connotation of evil, suggesting illicit ecstasy, guilt and sin. Because the public image is conditioned more by cultural perceptions than by medical ones, medically-precise meanings simply cannot be harmonized with common parlance.

And in 1975, the WHO further distanced itself from the term 'drug abuse':

"Drug abuse" is a term in need of some clarification. ...The term is really a convenient, but not very precise, way of indicating that (1) an unspecified drug is being used in an unspecified manner and amount ... and (2) such use has been judged by some person or group to be wrong (illegal or immoral) and/or harmful to the user or society, or both. What might be called "drug abuse" by some would not necessarily be considered so by other ... For these reasons, the term "drug abuse" is avoided here

The World Health Organization presently prefers to use the terms *harmful use* and *hazardous use* (of drugs), in order to distinguish between the health effects of

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drug abuse rather than the social consequences. Another preferred term is *drug misuse*, defined as the "*use of a substance for a purpose not consistent with legal or medical guidelines, as in the non-medical use of prescription medications.*" According to WHO, the term misuse is preferred by some in the belief that it is less judgmental.

However, the 1957 and 1964–1965 WHO definitions of addiction, dependence and drug abuse persist to the present day in medical literature and have become entrenched in global legislation, despite the disclaimers and reliance on contentious assumptions. The WHO itself continues to use 'drug abuse' in its publications, and uses the term 'abuse' consistently and exclusively when discussing the control and consumption of illegal substances. This is in keeping with guidelines issued by the WHO's parent organization, the United Nations, which discourages any recognition of "recreational" or "responsible" use of drugs.

Researchers may take note that somewhat less contentious definitions of addiction, dependence, and tolerance (with no speculation as to their roles in the definition of drug abuse) were jointly issued in 2001 by the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine in the publication "Definitions Related to the Use of Opioids for the Treatment of Pain".

The US National Institute on Drug Abuse defines drug abuse as "*The use of illegal drugs or the inappropriate use of legal drugs. The repeated use of drugs to produce pleasure, to alleviate stress, or to alter or avoid reality (or all three)*."

Nixon Administration

In 1975, psychiatrist Jerome H. Jaffe (in his role as Drug Policy Director in the Nixon Administration) defined drug abuse as "*the use, usually by self-administration, of any drug in a manner that deviates from the approved medical or social patterns within a given culture*". According to Jaffe, the term "*conveys the notion of social disapproval, and it is not necessarily descriptive of any particular pattern of drug use or its potential adverse consequences*".

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2.1.2 Abuse potential

Some of the most commonly abused drugs are alcohol, anabolic steroids, amphetamines, analgesics, barbiturates, benzodiazepines, caffeine, cannabis, cocaine, laxatives, methaqualone, opiates, and tobacco. Depending on the actual compound, drug abuse may lead to health problems, social problems, physical dependence, or psychological addiction.

Some drugs that are subject to abuse have central nervous system (CNS) effects, which produce changes in mood, levels of awareness or perceptions and sensations. Most of these drugs also alter systems other than the CNS. But, not all centrally acting drugs are subject to abuse, which suggests that altering consciousness is not sufficient for a drug to have abuse potential. Among drugs that are abused, some appear to be more likely to lead to uncontrolled use than others, suggesting a possible hierarchy of drug-induced effects relative to abuse potential.

Approaches to managing drug abuse

Attempts by government-sponsored drug control policy to interdict drug supply and eliminate drug abuse have been largely unsuccessful. In the United States, the number of nonviolent drug offenders in prison exceeds by 100,000 the total incarcerated population in the EU, despite the fact that the EU has 100 million more citizens. In spite of the huge efforts by the U.S., drug supply and purity has reached an all time high, with the vast majority of resources spent on interdiction and law enforcement instead of public health.

In addition to being a major public health problem, some consider drug abuse to be a social problem with far-reaching implications. Stress, poverty, domestic and societal violence, and various diseases (i.e., injecting drug users as a source for HIV/AIDS) are sometimes thought to be spread by drug use. Studies have also shown that individuals dependent on illicit drugs experience higher rates of comorbid psychiatric syndromes.

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Harm reduction

*Main article: **Harm reduction***

One alternative involves replacing failed law enforcement policies with harm-reduction strategies, which focus on reducing the societal costs of drug abuse and other drug use. Techniques include education to avoid overdose, needle exchange programs to reduce the spread of blood-borne diseases, and opioid substitution therapy to reduce crime related to the procurement of drugs. This pragmatic approach is known as the harm reduction paradigm. Harm reduction also addresses special populations, such as drug-using parents, pregnant drug users and users with psychiatric comorbidity. The philosophy of harm reduction accepts that drug use is part of the community, but that it must be addressed as a public health issue rather than a criminal one.

Harm-reduction measures are at odds with the prevailing framework of international drug control, which rests on law enforcement and the criminalization of behaviors related to illicit drug use. However, harm-reduction has had a notable impact and is slowly gaining popularity. In Brazil alone, a comprehensive harm-reduction and drug-access program successfully reduced AIDS mortality among injection drug users by 50%.

Abstinence-Based

Abstinence-based approaches set as a goal complete abstinence from all addictive substances, including both licit and illicit, prescribed and unprescribed. While the harm-reduction approach has been demonstrated to work well with opioids, the abstinence-based approach is the medical community standard of care for sedative (including alcohol) dependence.

Medical treatment

Beyond the sociological issues, many drugs of abuse can lead to addiction, chemical dependency, or adverse health effects, such as lung cancer or emphysema from cigarette smoking.

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Medical treatment therefore centers on two aspects: 1) breaking the addiction, 2) treating the health problems.

Most countries have health facilities that specialize in the treatment of drug abuse, although access may be limited to larger population centers and the social taboos regarding drug use may make those who need the medical treatment reluctant to take advantage of it. For example, it is estimated that only fifteen percent of injection drug abusers thought to be in need are receiving treatment.[15] Patients may require acute and long-term maintenance treatment and relapse prevention, complemented by suitable rehabilitation.

Pharmacotherapy

The development of pharmacotherapies for drug dependency treatment are currently in progress. New immunotherapies that prevent drugs like cocaine, methamphetamine, phencyclidine, nicotine, and opioids from reaching the brain are in the early stages of testing as is ibogaine, an alkaloid found in the Tabernanthe iboga plant of West Central Africa. Medications such as Buprenorphine, which block the drugs active site in the brain are another new option for the treatment of opioid addiction. Depot forms of medications, which require only weekly or monthly dosing, are also under investigation.

Traditionally, new pharmacotherapies are quickly adopted in primary care settings, however, drugs for substance abuse treatment have faced many barriers . Naltrexone, a drug originally marketed under the name "ReVia," and now marketed in intramuscular formulation as "Vivitrol" or in oral formulation as a generic, is a medication approved for the treatment of alcohol dependence. This drug has reached very few patients. This may be due to a number of factors, including resistance by Addiction Medicine specialists and lack of resources.

Legal treatment

Related articles: Prohibition (drugs), Arguments for and against drug prohibition. Most countries have legislation designed to criminalise drug abuse.

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Usually however this is limited to drugs specified by the legislation. These drugs are often called *illegal drugs* but, generally, what is illegal is their unlicensed production, supply and possession. The drugs are also called *controlled substances*. Legal punishments, even for simple possession, can be quite severe (including the death penalty in some countries). Legal regimes vary across countries, and even within them, and have fluctuated widely throughout history.

Despite (and perhaps because of) the legislation many large, organized criminal drug cartels operate world-wide. Advocates of decriminalization argue that it is the legislation which makes drug dealing such a lucrative business, and leads to much of the associated criminal activity.

2.2 Drug Addiction (From Wikipedia the free encyclopedia)

Drug addiction, **substance dependence** or **chemical dependency** is the compulsive use of psychoactive drugs, to the point where the user has no effective choice but to continue use. The phenomenon of drug addiction has occurred to some degree throughout recorded history (see "opium"), though modern agricultural practices, improvements in access to drugs, and advancements in biochemistry have exacerbated the problem significantly in the 20th century with the introduction of purified forms of active biological agents, and with the synthesis of hitherto unknown substances, such as methamphetamine.

The alleged addictive nature of drugs varies from substance to substance, and from individual to individual. Drugs such as codeine or alcohol, for instance, typically require many more exposures to addict their users than drugs such as heroin or cocaine. Likewise, a person who is psychologically or genetically predisposed to addiction is much more likely to suffer from it.

Although dependency on hallucinogens like LSD otherwise known as "acid" and psilocybin is listed as Substance-Related Disorder in the DSM-IV, most

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psychologists do not classify them as addictive drugs. Experts on addiction say that the use of LSD and psilocybin causes neither psychological nor physical dependency Many users report feeling less desire to use these drugs after every use

There is anecdotal evidence which emerges of psychological addiction to recreational psychedelics such as MDMA (Ecstasy) and Ketamine. Because of the tendency for pills sold on the street as "ecstacy" to contain other drugs such as cocaine or speed, this can make the drug significantly more addictive if it is snorted through the nose

Drug addiction has two components: physical dependency, and psychological dependency. Physical dependency occurs when a drug has been used habitually and the body has become accustomed to its effects. The person must then continue to use the drug in order to feel normal, or its absence will trigger the symptoms of withdrawal. Psychological dependency occurs when a drug has been used habitually and the mind has become emotionally reliant on its effects, either to elicit pleasure or relieve pain, and does not feel capable of functioning without it. Its absence produces intense cravings, which are often brought on or magnified by stress. A dependent person may have either aspects of dependency, but often has both. "Chipping" is also a term used to describe a pattern of drug use in which the user is not physically dependent and sustains 'controlled use' of a drug. This is done by avoiding influences that reinforce dependence, such that the drug is used for relaxation and not for escape.

2.2.1 The basis for addiction

Scientists have long accepted that there is a biological basis for drug addiction, though the exact mechanisms responsible are only now being identified. It is believed that addictive substances create dependence in the user by changing the brain's reward functions, located in the mesolimbic dopamine system—the part of the brain that reinforces certain behaviors such as eating, sexual intercourse, exercise, and social interaction. Addictive substances, through various means and to different

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degrees, cause the synapses of this system to flood with excessive amounts of dopamine, creating a brief rush of euphoria more commonly called a "high".

Although the high may last only a few minutes, it also produces more longer-lasting effects in the brain. Dopamine signals occurring normally in the reward system (traveling from the ventral tegmental area to the nucleus accumbens) lead to the activation of proteins designed to calm the initial reaction and foster a continued desire to pursue the behavior responsible. Addictive substances create a greater than normal dopamine release, and the subsequent reactions of the brain are greatly exaggerated as well. The amygdala, hippocampus, and frontal cortex associate the use of the drug with intense pleasure and well-being; an association that is strengthened with each exposure, and which over time comes to dominate normal thoughts and desires. When cravings for the drug are no longer controllable, the user is considered addicted. (For a contrary view of drug addiction, see Rat Park.)'

There seems to be a genetic component to addiction Pankaj Sah of Australian National University believes that chronic marijuana users are self medicating for anxiety problems. In addition Dr. Lonny Shavelson, in his book "Hooked," has reported that 70% of female heroin addicts were sexually abused as children.

2.2.2 Evolutionary psychology view of addiction

It is obvious that genes for addiction would not be directly selected. Since evolution theory claims that every physical and behavioral trait is a direct or side effect of selection, then the capacity to be addicted to drugs must be a side effect of something that was selected.

A number of writers including Keith Henson have suggested that the capacity to be addicted to drugs is a side effect of social attention rewards. It is easy to understand how sensitivity to social rewards would evolve in social primates. For example, Jane Goodall's observation that chimpanzees who hunt get additional mating

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opportunities. The proposed evolved mechanism for social rewards is that attention causes the release of endorphins and dopamine into the brain's reward circuits.

It seems that addictive drugs activate brain reward circuits that are normally activated by attention, without the need to kill a large, dangerous animal and drag it back to camp (or modern equivalents.)

In this view, the relative success of 12 step and related programs is due to the more natural social attention-rewards replacing drug-rewards.

2.2.3 The chemicals responsible

The CREB protein, a transcription factor activated by cyclic adenosine monophosphate (cAMP) immediately after a high, triggers genes that produce proteins such as dynorphin, which cuts off dopamine release and temporarily inhibits the reward circuit. In chronic drug users, a sustained activation of CREB leaves the user feeling depressed and dissatisfied, and unable to find pleasure in previously enjoyable activities, often leading to a return to the drug for an additional "fix". It also leads to a short term tolerance of the substance, necessitating that a greater amount be taken in order to reach the same high.

Another transcription factor, known as delta FosB, is thought to activate genes that, counter to the effects of CREB, actually increase the user's sensitivity to the effects of the substance. Delta FosB slowly builds up with each exposure to the drug and remains activated for weeks after the last exposure—long after the effects of CREB have faded. The hypersensitivity that it causes is thought to be responsible for the intense cravings associated with drug addiction, and is often extended to even the peripheral cues of drug use, such as related behaviors or the sight of drug paraphernalia. There is some evidence that delta FosB even causes structural changes within the nuclear accumbens, which presumably helps to perpetuate the cravings, and may be responsible for the high incidence of relapse that occur in treated drug addicts.

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Regulator of G-protein Signaling 9-2 (RGS 9-2) has recently been the subject of several animal knockout studies. Animals lacking RGS 9-2 appear to have increased sensitivity to dopamine receptor agonists such as cocaine and amphetamines; over-expression of RGS 9-2 causes a lack of responsiveness to these same agonists. RGS 9-2 is believed to catalyze inactivation of the G-protein coupled D2 receptor by enhancing the rate of GTP hydrolysis of the G alpha subunit which transmits signals into the interior of the cell.

2.2.4 Mechanisms of effect

The mechanisms by which different substances activate the reward system vary among drug classes. Depressants such as alcohol and benzodiazepines work by increasing concentrations of GABA in the brain. Narcotics such as morphine and methadone, work by mimicking endorphins—chemicals produced naturally by the body which have effects similar to dopamine—or by disabling the neurons that normally inhibit the release of dopamine. These substances (sometimes called "downers") typically facilitate relaxation and pain-relief.

Stimulants such as amphetamines, nicotine and cocaine increase dopamine signaling, either by directly stimulating its release, or by blocking its absorption (see "reuptake"). These substances (sometimes called "uppers") typically cause heightened alertness and energy.

The most common drug addictions are to legal substances such as:

- Alcohol
- Nicotine in the form of tobacco, particularly cigarettes
- Caffeine in the form of tea, coffee, and caffeinated sodas

Many prescription or over the counter drugs can become addictive if abused. Steroidal medications, for example, are extremely addictive. In addition, a large number of other substances are currently considered to have no medical value and are not available over the counter or by prescription. Depending on the

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jurisdiction, these drugs may be legal only as part of a government sponsored study, illegal to use for any purpose, illegal to sell, or even illegal to merely possess.

In 1972, United States President Richard Nixon declared a war on illegal drugs in an attempt to control the growing problem of drug addiction and drug-related crime. It is unclear, though, whether laws against drugs do anything to stem usage and dependency. In jurisdictions where addictive drugs are illegal, they are generally supplied by drug dealers, who are often involved with organized crime. Even though the cost of producing most illegal addictive substances is very low, their illegality combined with the addict's need permits the seller to command a premium price, often hundreds of times the production cost. As a result, the addict sometimes turns to crime to support their habit.

2.2.5 Recovery from drug addiction

Methods of recovery from addiction to drugs vary widely according to the types of drugs involved, amount of drugs used, duration of the drug addiction, medical complications and the social needs of the individual. Treatment is just as important for the addicted individual as for the significant others in the addicted individuals sphere of contact.

One of many recovery methods is the 12 Step recovery program, with prominent examples including Alcoholics Anonymous and Narcotics Anonymous. They are commonly known and used for a variety of addictions for the individual addicted and the family of the individual. Substance-abuse rehabilitation (or "rehab") centers frequently offer a residential treatment program for the seriously addicted in order to isolate the patient from drugs and interactions with other users and dealers. Outpatient clinics usually offer a combination of individual counseling and group counseling. Frequently a physician or psychiatrist will assist with prescriptions to assist with the side effects of the addiction (the most common side effect that the medications can help is anxiety). People interested in not using drugs to detoxify from drugs should consider acupuncture detoxification.

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12 Step programs are the most common and well-known, but there are many other types of treatment programs. These other programs may use Cognitive-Behavioral Therapy, Rational-Emotive Therapy, or other types of psychological behavior modification methods. Other forms of treatment involve replacement drugs such as methadone. Although methadone is itself addictive, opium dependency is often so strong that the gradual tapering of a less-addictive substance is the only way to reliably treat the user. Other treatments, such as acupuncture, may be used to help alleviate symptoms as well. Determining the best type of recovery program for an addicted person depends on a number of factors, including: personality, drug(s) of addiction, concept of spirituality or religion, mental or physical illness, and local availability and affordability of programs.

Many different ideas circulate regarding what is considered a "successful" outcome in the recovery from addiction. It has widely been established that abstinence from addictive substances is generally accepted as a "successful" outcome.

2.2.6 Medical definitions

The 1957 World Health Organization (WHO) Expert Committee on Addiction-Producing Drugs defined addiction and habituation as components of drug abuse:

Drug addiction is a state of periodic or chronic intoxication produced by the repeated consumption of a drug (natural or synthetic). Its characteristics include: (i) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means; (ii) a tendency to increase the dose; (iii) a psychic (psychological) and generally a physical dependence on the effects of the drug; and (iv) detrimental effects on the individual and on society.

Drug habituation (habit) is a condition resulting from the repeated consumption of a drug. Its characteristics include (i) a desire (but not a compulsion) to continue taking the drug for the sense of improved well-being which it engenders; (ii) little or no tendency to increase the dose; (iii) some degree of psychic dependence

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on the effect of the drug, but absence of physical dependence and hence of an abstinence syndrome [withdrawal], and (iv) detrimental effects, if any, primarily on the individual.

In 1964, a new WHO committee found these definitions to be inadequate, and suggested using the blanket term 'drug dependence':

The definition of addiction gained some acceptance, but confusion in the use of the terms addiction and habituation and misuse of the former continued. Further, the list of drugs abused increased in number and diversity. These difficulties have become increasingly apparent and various attempts have been made to find a term that could be applied to drug abuse generally. The component in common appears to be dependence, whether psychic or physical or both. Hence, use of the term 'drug dependence', with a modifying phase linking it to a particular drug type in order to differentiate one class of drugs from another, had been given most careful consideration. The Expert Committee recommends substitution of the term 'drug dependence' for the terms 'drug addiction' and 'drug habituation'.

The committee did not clearly define dependence, but did go on to clarify that there was a distinction between physical and psychological ('psychic') dependence. It said that drug abuse was "*a state of psychic dependence or physical dependence, or both, on a drug, arising in a person following administration of that drug on a periodic or continued basis.*" Psychic dependence was defined as a state in which "*there is a feeling of satisfaction and psychic drive that requires periodic or continuous administration of the drug to produce pleasure or to avoid discomfort*" and all drugs were said to be capable of producing this state:

There is scarcely any agent which can be taken into the body to which some individuals will not get a reaction satisfactory or pleasurable to them, persuading them to continue its use even to the point of abuse — that is, to excessive or persistent use beyond medical need.

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The 1957 and 1964 definitions of addiction, dependence and abuse persist to the present day in medical literature. It should be noted that at this time (2006) the Diagnostic Statistical Manual (DSM IVR) now spells out specific criteria for defining abuse and dependence.

In 2001, the American Academy of Pain Medicine, the American Pain Society, and the American Society of Addiction Medicine jointly issued "Definitions Related to the Use of Opioids for the Treatment of Pain," which defined the following terms:

Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving.

Physical dependence is a state of adaptation that is manifested by a drug class specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.

Tolerance is the body's physical adaptation to a drug: greater amounts of the drug are required over time to achieve the initial effect as the body "gets used to" and adapts to the intake.

Pseudoaddiction is a term which has been used to describe patient behaviors that may occur when pain is undertreated. Patients with unrelieved pain may become focused on obtaining medications, may "clock watch," and may otherwise seem inappropriately "drug seeking." Even such behaviors as illicit drug use and deception can occur in the patient's efforts to obtain relief. Pseudoaddiction can be distinguished from true addiction in that the behaviors resolve when pain is effectively treated.

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2.2.7 Drugs considered to be addictive (Some may be debatable)

- Adderall
- Alcohol
- Analgesics
- Barbiturates
- Buprenorphine
- Butorphanol
- Caffeine
- Chloral hydrate, trichloroethanol and derivatives
- Cocaine
- Codeine
- Dextropropoxyphene
- Dextromethorphan
- Ethchlorvynol
- Fentanyl and its analogs
- Gamma-hydroxybutyrate (GHB)
- Glutethimide
- Heroin (Diacetylmorphine)
- Hydrocodone
- Hydromorphone (Dilaudid®)
- Ketamine
- Laxatives
- Levo-alpha-acetylmethadol (LAAM)
- Meperidine
- Meprobamate
- Methamphetamine and other Amphetamines
- Methaqualone and related sedative-hypnotics
- Methadone
- Methcathinone
- Morphine
- Nicotine
- Oxycodone

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- Opium
- Synthetic opioid agonists and partial agonists not considered here
- Semi-synthetic opiates not considered here
- Xanax and other benzodiazepines
- Paraldehyde (Paral®)
- Phencyclidine (PCP)
- Flunitrazepam (Rohypnol®)

2.2.8 Addiction and drug control legislation

Most countries have legislation which brings various drugs and drug-like substances under the control of licensing systems. Typically this legislation covers any or all of the opiates, canaboids, cocaine, barbiturates, hallucinogenics and a variety of more modern synthetic drugs, and unlicensed production, supply or possession is a criminal offence.

Usually, however, drug classification under such legislation is not related simply to addictiveness. The substances covered often have very different addictive properties. Some are highly prone to cause physical dependency, whilst others rarely cause any form of compulsive need whatsoever. Also, under legislation specifically about drugs, alcohol is not usually included.

Although the legislation may be justifiable on moral or public health grounds, it can make addiction or dependency a much more serious issue for the individual: reliable supplies of a drug become difficult to secure, and the individual becomes vulnerable to both criminal abuse and legal punishment.

2.3 Roadmap of Drug Surveillance and Establishment of Sustainable Victory over Drugs 2006-2008

Since the rapid expansion of drug problems have become a threatening situation deteriorating peacefulness of all Thai societies. This critical issue has

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invoked public awareness on the exigent needs of the effective countermeasures against drugs. Especially, at present, H.E. Pol. Lt. Col. Thaksin Shinanwatra's administration has proclaimed drug control policy as the urgent policy of the nation with an immediate action. As to share a common brainstorm, the first national workshop on the strategy to overcome drug has been held in Chiang Rai during March 10 – 11, 2001. As a result, the Prime Minister's Order No. 119/2544 and 120/2544 (issue dated May 31, 2001) on the guideline on the Strength of the Nation to Overcome Drug have been imposed. In addition, the 9th National Economic and Social Development Plan B.E. 2545 - 2549 (2002 - 2006) has been deliberately designed to facilitate and mobilize all drug control measures in correspondingly.

Government Policy

Being one of the top most urgent government's policy, drug prevention and suppression policies have been classified as a high priority action under the concepts, "Prevention before Suppression," "Drug addicts must be treated," "Drug traffickers must be punished." In order to achieve its objectives, the following measures will be complied:

Stringently enforce the law and create a special process to control and suppress traffickers and all those involved in the manufacturing and trafficking of drugs in a strict, swift and just manner. Amend the law to increase the highest degree of punishment for political and government officials who are involved in drug trafficking. Provide rewards and special protection for public officials and citizens who cooperate with the Government in drug suppression.

Strictly control the importation of chemicals, which may be used in the production of drugs. Strengthen the mechanisms of the public sector as well as legal measures so that they may be able to keep up with the evolution in technology involved in the production of drugs.

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Foster cooperation with international organizations and the international community in order to control and eradicate drug production bases as well as transnational networks for the distribution of drugs.

Amend and revise laws that pose an obstacle to the obtainment of medical treatment as well as the physical and mental rehabilitation of drug addicts. Such addicts must be able to receive medical treatment and rehabilitation as soon as possible facing any legal charges. In addition, the Government will set up a system that will provide services for the treatment, rehabilitation, vocational training and acclimatization of drug addicts in order that they may be able to return to the mainstream of society.

Chiang Rai Guidance

As a result of the Brainstorming Workshop for Initiating a National Strategy to Overcome Drugs held in Chiang Rai Province on March 10 - 11, 2001. Three implementation guidances have been formulated:

Implementation

Control all substances or chemicals and precursors, which could be part of narcotic productions. Control abuse of drug and substitution-drug through suppression and interception of smuggling drugs from abroad by focusing major drug trafficking.

Keep drug addicts away from drug chain by using all appropriate means of treatment and rehabilitation to the particular groups. Available military camps and government units that have potential to turn to be drug treatment centers must be utilized. All concerned laws and legislation will be amended and enacted in order to facilitate the above-mention measures, accordingly.

Prevent drug abuse by invoking public awareness on “Strength of the Nation” to overcome drugs. Target villages will be assigned. Villages/communities will be strengthened, morale will be raised, and public relations will be intensively campaigned. Moreover, the promotion of alternative activities, preventive education

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among the youth, and harm reduction approaches will be complied in order to reach those target groups.

Competent Authorities

The control of narcotic substances, drug treatment and rehabilitation, and drug prevention have been assigned to all relevant existing competent authorities. The Office of the National Economic and Social Development Board and the Bureau of the Budget have been assigned to make an adjustment and/or amendment on the master plan of 9th Narcotics Control Plan and make a budget preparation in order to support all narcotics control operations and measures in corresponding to the Chiang Rai Guidance, respectively. In addition, the Prime Minister's advisory team on drug matters is subjected to be formulated in order to monitor and evaluate the overall national drug control operations.

Prime Minister's Order No. 119/2544 and 120/2544

Prime Minister's Order No.119/B.E.2544, issued 31 May 2001, on The Concerted Effort of the Nation to Overcome Drugs:

Mobilizing the National Effort and Setting Up the Drug Prevention Plan

The Government will raise public awareness about great dangers of drugs that have threatened the country as a whole for many years. It will convince the public that combating drugs is not only a responsibility of an individual or an institution but it is also a responsibility of all Thai people and all concerned institutions. All available resources in Thai society will be integrated to be a national effort to combat drugs and eventually overcome them as quickly as possible. The drug prevention measure will be given by the Government as the first priority and the drug suppression measure will be given as the second priority. Drug immunity will be developed by the Government to protect people, especially children, youth, and various risk groups, from drug abuse. Primary social institutions will be strengthened by starting at the lowest level; i.e., family. Further more, villages near border areas will be vigorously secured and protected since they are sensitive areas for drug trafficking and drug abuse.

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Narcotics and Chemical Precursors Control

Chemicals and precursors as well as equipment used for producing narcotic drugs will be strictly controlled to prevent them from being shifted to drug producing areas both inside and outside the country. Besides, other drugs or substances that can be used as narcotics will be strictly controlled as well.

Drug Suppression

Personnel development for drug suppression will be carried out together with technology and method development. Current legislative measures will be used to interdict and wipe out drug traffickers and their networks including corrupt government officials who get involved with drug business.

Treatment and Rehabilitation

Causes and factors of the drug abuse problem will be terminated by taking drug addicts into treatment and rehabilitation by using both voluntary and compulsory systems. Besides, follow-up and assistance process will be implemented to help drug patients for their reintegration, and meanwhile various treatment and rehabilitation centres run either by GO and NGO will be developed to provide a complete service for treating all kinds of drug addicts.

Intelligence

Intelligence agencies will be developed by organizing their work such as intelligence exchange, intelligence management, and intelligence operation to be a system that can support drug suppression effectively. This will focuss on intercepting illicit chemicals and precursors imports & exports, suppressing drug trafficking networks, and searching for corrupt officials who get involved with drug business.

Direction and Coordination Task

The task of direction and coordination will be developed to be most effective for a collaboration among all concerned agencies including all sectors of Thai society in dealing with the drug problem. All problems and obstacles that hamper coordination and cooperation among concerned agencies to fight against drugs will be

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eliminated. Target areas around the country will be identified by the Government with a great concern about their environments and conditions.

Improvement of Legislation and Justice Systems

Laws, regulations, provisions, and justice systems will be improved and corrected to support drug control operations. Besides, the justice system will be improved and strengthened so that drug offenders will be punished strongly, quickly, and fairly. This will also facilitate the new Government's policy on treating drug addicts as patients.

International Cooperation

International cooperation on drug control must be supported and extended by the Government to push forward various drug control collaborations which in turn will be a significant means to solve the drug problem in all levels ;namely, national, regional, and international. This will focus exclusively on seeking international cooperation and assistance to support drug control operations in Thailand and in its neighboring countries as well as in this region.

Research, Development, and Evaluation

Research, follow-up, and evaluation on drug control plans and programmes will be conducted and supported to develop drug control guidelines, which are based on facts and systematic reliable information.

In order to pursue all the mentioned measures in an effective way, the task delegations will be assigned to the following bodies:

All parts of the responsible bureaucracy and local concerned organizations as well as public enterprises are required by the Government to take the drug problem control as their first priority; therefore, it is a responsibility of them to solve this problem together to reach a national goal in eliminating illicit drugs.

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The Bureau of Budget is assigned to take a full responsibility of preparing all budgets required for the implementation of such policy.

During the period that there has not been an order to set up roles, responsibilities, and authorities of all local concerned agencies, the Bangkok Narcotics Prevention and Suppression Centre and Provincial Narcotics Prevention and Suppression Centres together with District Narcotics Prevention and suppression Centres all over the country will keep on doing their tasks until there is a change in order.

Prime Minister's Order No.120/2544 on the establishment of the Concerted Effort of the Nation to Overcome Drugs Committee (issued 31 May 2001)

Being responsible to pursue the national efforts to overcome drugs effectively with unity without any obstacle due to bureaucratic system and obtain tangible outcomes in timely manner, the Concerted Effort of the Nation to Overcome Drugs Committee is established, accordingly. The Committee is composed of 27 persons. The Prime Minister is the president to the Committee, Deputy Prime Minister (General Chavalit Yongchaiyudth) is vice-president to the Committee, and the Secretary-General of the Office of the Narcotics Control Board is the member and secretary to the Committee. The Committee has authorities to:

Direct, command, coordinate, control, supervise, and follow-up all concerned agencies' tasks in line with the Integrated Effort of the Nation to Overcome Drugs Policy.

Set up the action plan to overcome drugs to match the current situation. Carry out personnel development for successfully implementing all action plans to overcome drugs by making its comments on that matter to the Prime Minister as the following:

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Transfer of public officials or government staff who are not appropriate for their positions out of the target areas.

Special promotions that will be given to any government official or people who perform a task of drug control well.

Protection of government officials and people who perform a task of drug control.

Recruitment of potential government officials to deal with the drug control plan's implementation.

Appoint or propose for appointments of sub-committee, working task force, and advisory committee to be responsible for solving the drug problem for each particular case or particular area. The appointed committee is supposed to do their assignments strictly and quickly.

Do other tasks which are assigned by the Prime Minister.

Drug control strategy under the 9th National Economic and Social Development Plan B.E. 2545 - 2549 (2002 - 2006)

The 9th National Economic and Social Development Plan B.E. 2545 - 2549 (2002 - 2006) has included the drug control strategy under the "Development Vision and Strategies" and "Consolidation of Thai Social Foundations" parts as follows:

Development Vision and Strategies

Being rapid spreading with a deeply impact over the general public, drug problems are threatening to the national economics stability and social security. Therefore, these problems must be urgently solved and be under controlled. Since, they caused an adverse effect to entire economics efficiency and lowers the public living standard that become lots of burden on the higher budget needs on prevention,

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correction, and rehabilitation programs. Moreover, drug problems also caused criminal problems jeopardizing individual's safeties and properties. Overwhelmingly, the lacks of teamwork and unity in joint drug control cooperation among the existing competent authorities are impeding the overall administrative capacities and national interests. In addition, since, there is a correlation between drug problems and transnational crimes along the boarder areas. These criteria induce more complexities to drug control works. Furthermore, international relations among the neighboring countries should be promoted and strengthened in order to gain regional concerted efforts to fight against drugs in an effective way.

Consolidation of Thai Social Foundations

As to improve drug control administrative approaches, preserve and protect individual safeties and properties, pro-active perception and implementing process are required. In addition, to promote more participation from all classes of societies in every step of drug control activities; the following strategies will be complied:

Family institute, communities' organization, local administrative organization, private sector, and mass media will be mobilized to be a part of preserving public securities as well as to stop communities' drug problems by civil society process and strong community approach. All crimes, harm indicators, narcotic activities (i.e., drug production, abuse, and selling) will be strictly monitored by them. In addition, by providing an informative drug preventive education through non-drug-user youth groups, drug immunities in the public will be strengthen and secure.

Screen out drug addicts from drug pushers for treatment and rehabilitation programs and providing comprehensive follow-up programs to offer more job opportunities and alternatives; so that, they will be able to live without drugs after their returning to civilian status.

By pursuing immediate action on drug suppression; so that, sudden, severe, and serious operations will be conducted. In addition, extensive legislation

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development and international cooperation will be more enhanced; so that, transnational drug syndicates along the borderlines will be terminated.

2.4 Treatment

2.4.1 Physical Treatment

Drug Therapy

- Narcotics Antagonists – From the study of physical of drug-defined theory that should be medicine resist effect of narcotic. From this concept, to find synthesis "Naltrexone"

- Drug Maintenance Therapy – This mean is taking drug to addict under control of the doctor such as Methadone Maintenance.

Table 2-1 : Show means of taking Methadone for Addict's heroin

1 -5 days of rehabilitation	Take Methadone 40 mg/day
6 – 8 days of rehabilitation	Take Methadone 30 mg/day
9 – 11 days of rehabilitation	Take Methadone 20 mg/day
12 – 14 days of rehabilitation	Take Methadone 10 mg/day
15 – 17 days of rehabilitation	Take Methadone 5 mg/day
18 – 21 days of rehabilitation	No taking Methadone, but to compound cold-remedy to Nam-jai

2.4.2 Psycho Therapy

1. Individual Counseling – is psycho rehabilitation for understanding oneself, to solve problem in correctly means, patient mind and live in social by none drug dependence. There are 3 objective as follow:

- Prevention: Consulting about information of drug for protect to drug problem occur in future

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- Remedial: Consulting about means to manage problem such as drug addiction

- Growth Engendering: Consulting about recognize to develop oneself

2. Group Counseling – Composing the Consult and Addict (member group), would like to adapt oneself especially drug problem, which member group have good relationship and good surrounding.

3. Family Counseling – family of addict's rehabilitation is consulting by create attitude from their family

Religious Therapy

Thailand is freedom to people about believes in religious, the religious institution then regard the institute where is significant the one institute in Thai social, be the central in mind of porch people. The majority people of Thailand respects the Buddhism, Christianity and Islam. Every religion makes a human has mental supporter and persist in goodness behavior.

- Buddhist, temple is central of the mind and helpful Buddhism who have any problem including drug abuse. Monk takes dharma doctrine principle to help discipline the mind person, reinforce way of life correctly.

- Christian, many Christendom's have come in to proceed establish and resuscitated drug addict habit-forming efficiency in Thailand go up, emphasize preservation physical, mind and spirit.

- Islam, there is zero at testify treat and resuscitate drug addict habit-forming efficiency by the morality consciousness and the morals with dharma lecture and practice the dharma always.

Occupation Therapy

1. **Work therapy**: aim to responsibility and patience and good attitude about work for addict's rehabilitation, by order work to practice

2. **Vocational Training**: to last means of therapy for created job to addict's rehabilitation could be work in their future.

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Therapeutic community

What is a therapeutic community?

The therapeutic community (TC) for the treatment of drug abuse and addiction has existed for about 40 years. In general, TCs are drug-free residential settings that use a hierarchical model with treatment stages that reflect increased levels of personal and social responsibility. Peer influence, mediated through a variety of group processes, is used to help individuals learn and assimilate social norms and develop more effective social skills.

TCs differ from other treatment approaches principally in their use of the community, comprising treatment staff and those in recovery, as key agents of change. This approach is often referred to as "community as method." TC members interact in structured and unstructured ways to influence attitudes, perceptions, and behaviors associated with drug use.

Many individuals admitted to TCs have a history of social functioning, education/vocational skills, and positive community and family ties that have been eroded by their substance abuse. For them, recovery involves rehabilitation -- relearning or re-establishing healthy functioning, skills, and values as well as regaining physical and emotional health. Other TC residents have never acquired functional life-styles. For these people, the TC is usually their first exposure to orderly living. Recovery for them involves habilitation -- learning for the first time the behavioral skills, attitudes, and values associated with socialized living.

In addition to the importance of the community as a primary agent of change, a second fundamental TC principle is "self-help." Self-help implies that the individuals in treatment are the main contributors to the change process. "Mutual self-help" means that individuals also assume partial responsibility for the recovery of their peers -- an important aspect of an individual's own treatment.

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How is treatment provided in a therapeutic community?

Stage 1 Induction and early treatment typically occurs during the first 30 days to assimilate the individual into the TC. The new resident learns TC policies and procedures; establishes trust with staff and other residents; initiates an assisted personal assessment of self, circumstances, and needs; begins to understand the nature of addiction; and should begin to commit to the recovery process.

Stage 2 Primary treatments often uses a structured model of progression through increasing levels of prosocial attitudes, behaviors, and responsibilities. The TC may use interventions to change the individual's attitudes, perceptions, and behaviors related to drug use and to address the social, educational, vocational, familial, and psychological needs of the individual.

Stage 3 Re-entry is intended to facilitate the individual's separation from the TC and successful transition to the larger society. A TC graduate leaves the program drug-free and employed or in school. Post residential aftercare services may include individual and family counseling and vocational and educational guidance. Self-help groups such as Alcoholics Anonymous and Narcotics Anonymous are often incorporated into TC treatment, and TC residents are encouraged to participate in such groups after treatment.

Can therapeutic communities treat populations with special needs?

Research shows that those with special or complex needs can be treated in TCs. For example, individuals with co-occurring mental illness and substance abuse may be treated in TC-oriented programs based in shelters, community residences, day treatment clinics, partial hospitalization settings, or on hospital wards. Community-based TC programs provide effective treatment for clients with criminal involvement, but successful TC programs for drug-involved offenders have also been established in correctional settings. Other special populations with substance abuse problems that may benefit from TC-oriented programs include adolescents, women and their children, persons with HIV/AIDS, and homeless people.

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Specialized treatment strategies and services are often incorporated as part of the TC for these populations. Support may include child care services for mothers; programs aimed at normalizing the developmental process for adolescents; access to mental health and social services for individuals with co-occurring mental illness and substance abuse; attention to changing criminal thinking and behavior for the criminal offender; and links to medical and social services for those with HIV/AIDS. Individualized treatment, including lengths of stay tailored to the person's needs, is especially important due to the complexity of possible problems. In addition, TC clinical and management activities may need to be modified in terms of disciplinary sanctions, peer interactions, and degree of confrontation in groups.

Women

Women who enter drug abuse treatment often have many serious problems. Many suffer from low self-esteem, depression, or other mental health disorders; are in abusive relationships; have little access to medical, mental health, and social services; lack marketable job skills; and have child custody concerns.

Both women-only programs and mixed-gender programs can be helpful in treating the drug problems of women. As might be expected, women-only programs and programs that serve higher percentages of women usually provide more services that women need. The evidence suggests that these services can contribute to significantly longer lengths of stay in treatment, which is related to better treatment outcomes.

Newer TC approaches for treating women with drug addictions often focus on issues related to family and children. Some model programs have found that allowing a woman's children to live with her in the TC can improve her mental health and lengthen retention. Although evidence tends to support the benefits of specialized services for women, more research is needed to determine the optimal structure of TC treatment in meeting women's needs.

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Adolescents

The closely supervised residential TC environment provides benefits for troubled youth. A study on adolescent drug treatment outcomes showed that adolescents treated in TC programs were more likely than those in outpatient drug-free programs to have prior drug abuse treatment experience, more severe problems, and a criminal justice history. Despite being more difficult to treat, however, adolescents in these programs had significantly improved outcomes in drug use, psychological adjustment, school performance, and criminal activities.

Another study compared the outcomes for adolescents referred through probation to TC treatment to outcomes for those referred to group homes with no specialized drug treatment services. The group homes were the same size and offered the same length of stay as the TC setting. The study found robust reductions in drug use, criminal behavior, and measures of psychological dysfunction at 3 months for all placements. However, after that period, those in the TC sustained or increased their improvements in problematic behaviors, while those in the group homes did not.

Several studies have examined longer-term effects for adolescents participating in TCs. For example, one study followed adolescents treated in six TCs. One year after treatment, these adolescents showed significant declines in alcohol, marijuana, and other illicit drug use, as well as reductions in criminal activity and other deviant behavior. Although the planned length of stay varied among the six participating TCs, completing treatment was significantly related to better outcomes. Reductions in drug use were also strongly related to having good relationships with counselors and to avoiding deviant peers after treatment. Posttreatment criminal activity was higher for those who associated with deviant peers.

It is often necessary to modify some of the traditional components of the TC to accommodate adolescent developmental differences and to facilitate their maturation. The modifications may include less hierarchy and confrontation and greater priority to education than work. For example, many TCs for adolescents have an onsite school. In addition, such programs offer a range of family services that

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require family participation. After formal treatment is completed, continuing care is often arranged.

Individuals with co-occurring mental health disorders

Individuals with co-occurring mental health and substance abuse disorders are among the most difficult to treat. Such individuals often have serious and complex impairments in multiple areas, in addition to drug abuse and mental illness. TCs can be adapted to treat individuals with mental disorders, including, in some cases, the use of psychotropic medications to treat serious mental illness. A recent study compared a TC for people who were homeless, mentally ill, and substance abusers to a community residence based on a traditional mental health treatment model. In the mental health model, individuals were housed within a less restrictive alternative to the psychiatric hospital by coupling a high level of personal freedom with counseling, skills training, and monitoring of medication compliance. The TC provided integrated mental health and drug abuse treatment in a highly structured, hierarchical environment that stressed mutual self-help and treatment community participation. Those in the TC showed more improvement on all measures of psychopathology than those in the community residence. In addition, the TC program retained the most impaired individuals longer than did the community residence. The investigators concluded that the increased structure provided by the TC may be a better option for this population than the less restrictive community residence model.

Another study that tested modifications to the TC to accommodate homeless drug abusers with co-occurring mental health problems included greater flexibility in program requirements, reduced duration of activities and level of confrontation, and greater responsiveness to individual needs. A second set of modifications, for a low-intensity TC, allowed residents greater freedom to leave the facility during the early stages of treatment, offered services in day treatment settings outside the residence, decreased the level of peer responsibility, and increased the amount of direct staff assistance. The modified TCs were compared to "treatment as usual," which consisted of a heterogeneous mix of alternatives often encountered after discharge from shelters or psychiatric facilities. Analyses comparing the outcomes of

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modified TC treatment to the usual options found that drug use was reduced in both groups, although participation in the modified TCs led to significantly greater improvements for criminal activity and indicators of depression.

Populations involved in the criminal justice system

As drug abuse and crime are often linked, many drug-abusing or addicted individuals also are involved with the criminal justice system. Some of the most extensive research studies on TCs have been conducted on treatment for populations involved in the criminal justice system. These studies have found benefits for prison-based TC treatment in preparing inmates to return to the community and for creating a safer, better managed prison environment. Drug-involved offenders have the best outcomes when they participate in community-based TC treatment while transitioning from incarceration to re-entry to the community.

One such study followed drug-abusing and addicted inmates in the Delaware Correctional System to determine the effectiveness of a continuum of care on relapse to drug use and recidivism to criminal activity. The continuum of care began in prison with a State-funded TC program called The Key. Inmates transitioned back into the community through a work-release program that allowed them to work in the community but required their return to a secure facility overnight. Some inmates were randomly assigned to usual work release, and some were assigned to Crest, a TC work-release program. In the third stage of treatment, some who had completed the Crest work-release TC and were living in the community continued in an aftercare program, which provided continued monitoring by TC counselors, outpatient counseling, group therapy, and family sessions.

One year after scheduled completion of work release, significantly higher percentages of inmates who had participated in Crest or in both Key and Crest were drug-free and arrest-free than those assigned to usual work release. Further, outcomes for those who participated in both Key and Crest were better than for all three other groups.

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At 3 years after work release, Crest treatment graduates and especially those who continued with aftercare had significantly better outcomes than those who dropped out in terms of avoiding both relapse to drug use and re-arrest. This study also highlights the value of continuing treatment of offenders during their transition back into the community.

2.5 Matrix Model

It's a proven effective, evidence-based protocol that has been used in the treatment of over 6,000 cocaine and 2,500 methamphetamine addicts.It's a ready-made intensive outpatient program (IOP) that any treatment center can implement. The Matrix Model is a comprehensive, multi-format program that covers six key clinical areas

1. Individual/conjoint therapy

- Early recovery
- Relapse prevention
- Family education
- Social support
- Urine testing

2. It's an integrated therapeutic model incorporating

- Cognitive behavioral
- Motivational enhancement
- Couples and family therapy
- Individual supportive/expressive psychotherapy and psycho education
- Twelve Step facilitation
- Group therapy and social support

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3. It's a federally recognized model

- Center for Substance Abuse Treatment (CSAT)
- National Institute on Drug Abuse (NIDA)
- Office of National Drug Control Policy and Department of Justice (National Synthetic Drugs Action Plan)
- Drug Strategies
- Under review by the National Registry of Effective Programs and Practices (SAMHSA)

How it helps clients

- Its instructional design helps clients understand complex cognitive-behavioral and clinical concepts and processes such as "the wall" of protracted abstinence.
- Its explicit framework lets clients know exactly what is expected of them.
- It reinforces positive behavior change.
- It provides a mechanism for corrective feedback and uses client resistance as a teaching tool.
- It uses hourly and daily scheduling to help clients eliminate unstructured time--a key contributor to relapse.
- It involves the client's family in an active role in the treatment process, leading to a greater understanding and ability to participate in the new life of recovery.
- It introduces and encourages self-help/support group participation.
- It uses urinalysis to monitor drug use and take the issue of use "off the table".

It's an optimum length 16 weeks for intensive outpatient treatment. Opportunity for successful outcome is increased when the client has a protracted engagement in treatment plan.

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The Matrix Model treatment protocol can be extended up to 12 months through continuing care/aftercare. It's structured differently than inpatient treatment, using methods proven-effective with stimulant addicts

- It's less confrontational
- Progress is gradual
- The focus is on the present
- "Core issues" are not immediately addressed
- The client's allegiance is to the therapist rather than the group
- A non-judgmental attitude is basis of client-therapist bond
- Change recommendations are based on scientific data
- Changes are incorporated immediately into lifestyle

It's more directive and behavior-focused than general therapy

- Visit frequency results in strong transference, which is encouraged and utilized
- Goal is stability versus comfort
- Focus is abstinence; bottom-line is always continued abstinence
- Therapeutic team approach is utilized
- Therapist frequently pursues less motivated clients
- Focus is on behavior rather than feelings; the behavior is more important than the reason behind it
- Family system support is encouraged
- Therapist functions as a coach/advocate

It's proven-effective. The organizing principles of the Matrix have been developed and modified over a 20 year period, using data from the treatment experience of 6,000 cocaine and 2,500 methamphetamine addicts. The Matrix Model works because it

- Creates explicit structure and expectations
- Establishes a positive, collaborative relationship with each patient
- Teaches information and cognitive-behavioral concepts

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- Positively reinforces positive behavior change
- Provides corrective feedback when necessary/roll with resistance
- Educates family regarding stimulant abuse recovery
- Introduces and encourages self-help participation
- Uses urinalysis to monitor drug use and take the issue of use "off the table"

It's evidence-based. The Matrix Model has over 20 years of research and development, and was recently tested in the CSAT Methamphetamine Project, the largest randomized clinical trial of treatment of methamphetamine addiction to date. Clients assigned to the Matrix Model:

- Attended more groups
- Stayed in treatment longer
- Provided more methamphetamine-free urine samples during treatment
- Had longer periods of methamphetamine abstinence

2.6 FAST Model

For past decades, almost all in-patient clients at Thanyarak Institute are intravenous heroin inject clients. Then 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 time to fulfill the TC program. For last decade, drug problem has changed, more than half of all in-patient clients at Thanyarak Institute are amphetamine abusers and average age of client lower to teenage.

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So Thanyarak Institute director has developed TC model to FAST model. FAST model use 'TC model' as a core, 'Family' oriented, various 'Alternative' treatment activities, and support client with 'Self-help' idea.

So FAST model give a new program to treat in-patient drug abuse clients and concentrate program course to 4-6 months.

F = Family: to participation begin therapy and careful with community and social

A = Alternative Treatment: for proper with addict's rehabilitation

S = Self Help: Create empower, adapt behavior, attitude, feeling and relationship

T = Therapeutic Community: Help to self-help, Peer Pressure, Behavior Modificaiton, Social Learning and Morality

1. Short Term Treatment Plan – 4 to 61 months

- No drug manner and willing
- Their family to join
- No interfere physical and psycho diseases
- Investigate medical
- Court accept to therapy

2. Medium Term Treatment Plan – 6 to 8 months

- There are drug manner but does not drug abuse and willing.
- Their family to join
- No interfere physical and psycho diseases
- Investigate medical
- No pass "Short Term Treatment Plan"

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3. Long Term Treatment Plan – 6 to 12 months

- There are drug manner but does not drug abuse, have to withdraw symptom toxic
- Their family and them not proper
- There are interfere physical and psycho diseases, to cured
- No pass "Medium Term Treatment Plan"

The first month

- Routine: manage oneself
- Assistance: oneself dependent procedure (draw, write)
- Social Learning: EQ, live dependent
- Adapt behaviors: therapist group, tools of changes behaviors
- Peer group: help to help, Operation Conference
- Alternative therapy activity (physical, psycho, social): my group, Yo-ka
- Education: vocational, occupation

The second month

- Routine: Assessment report in TC
- Assistance: oneself dependent procedure
- Social Learning: TA 101, Play + Learn, Just say no
- Adapt behaviors: Pull-up, Haircut, and Encounter
- Peer group: Operative Conference for help to help
- Alternative therapy activity (physical, psycho, social): my group, Yo-ka
- Education: vocational, occupation

The third month

- Routine: Assessment report in TC, for try out to live in social
- Assistance: oneself dependent procedure
- Social Learning: TA 101 (episode 3), every other week, Plan for learning life
- Adapt behaviors: Pull-up, Haircut, and Comment for reason
- Family: join to plan for way of life

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- Peer group: Operative Conference for help to help
- Alternative therapy activity (physical, psycho, social): my group, Yo-ka
- Education: vocational, occupation

The fourth month

- Routine: Assessment report in TC, for try out to live in social
- Assistance: oneself dependent procedure
- Social Learning: Try out to live in social, face to problem
- Adapt behaviors: Therapy treatment
- Family: adapt plan to life in social, home and community
- Peer group: Operative Conference for help to help
- Alternative therapy activity (physical, psycho, social): my group, Yo-ka
- Education: vocational, occupation

2.7 Jirasa

That means help each other properly. Happy practice 10 the points

1. For valuable time
2. For quality of communication
3. For appreciate the value of oneself
4. For the regulations of family
5. For responsibility
6. For skill to manage temper feeling
7. For the familiarity and the environment of a child
8. For drug knowledge to child
9. For skill to solve problem and making decided
10. For skill Anti-drug

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2.8 Thanyarak Institute

Strategies

1. Develop, transfer and evaluate drug addict treatment modalities
2. Encourage treatment research and widespread to worldwide
3. Develop treatment information technology.
4. Develop human resource's knowledge and etiquette.
5. Develop treatment network to standard level**.**

Services

Patients attending clinic of Thanyarak Institute can be categorized as following:

A. Drug dependent patients:

Outpatients: the patients take methadone at the clinic everyday or taking home other medicines.

- Methadone clinic for heroin addicts: taking methadone solution once everyday and taper dose to none for 21 days

- **Methadone Maintenance Prescription** for clients who take at least 1/2gram of Heroin per day or get treatment program more than 5 times in 3 years, the hypothesis is that if the addicts take methadone much enough they do not need to take heroine anymore. We give methadone to clients as much they can tolerate in the long time.

- **Non-methadone medicine** for other clients

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

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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.

B. General illness patients: attending outpatient clinic, this is separated from the drug addict clinic.

Thamkrabok Monk Sanctuary

Thumkrabok Monk Sanctuary is a famous place to cure drug addicts, located at the Prongprap Hill in Tambon Khunkhlon, Amphoe Phra Phutthabat, 25 kilometres from Saraburi City on Phahonyothin Road. Mother Mian Panchan founded Somnaksong Thamdrabok in 1957. After her death, Abbot Chamrun Panchan, her nephew has continued this work; he later received the Magsaysay Award on 10 September 1975.

Wat Tham Krabok is a Buddhist temple (wat) in Thailand, located in the Phra Phutthabat district of Saraburi Province.

The temple was first established as a monastery in 1958 by the Buddhist nun Mae Chee Boonruen. It was upgraded to temple status 17 years later, in 1975. The temple is majestic in its appearance, with gold pagodas marking its entrance.

Hmong refugees

Since the 1970s, the temple has hosted Hmong refugees in a camp on its grounds, mostly consisting of people who fled Laos following the end of the Vietnam War. The Hmong were United States war allies in the Secret War against the communist Pathet Lao, the Viet Cong and North Vietnam.

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When several Thailand-based Hmong refugee camps closed due to lack of financial support in the early 1990s, the refugees fled to the temple to avoid repatriation to Laos. The population at the temple quickly grew to about 16,000.

Wat Tham Krabok and its Hmong refugees drew global attention in the mid-1990s, as they became the subject of a major global political debate over their future. The United Nations, with support from the Clinton administration, sought to repatriate the Hmong at Wat Tham Krabok to Laos. Nevertheless, this effort drew significant opposition from American conservatives and human rights leaders. Michael Johns, the influential former Heritage Foundation foreign policy analyst and aide to former President George H. W. Bush, helped lead opposition to the forced repatriation, labeling it a "betrayal," since many Hmong had aided the United States during the Secret War.

While some Hmong were repatriated, most began to be resettled to the United States, with about one-third of them relocating to the U.S. state of Minnesota, though California, Wisconsin and other states also received significant numbers.

Drug rehabilitation and trafficking

Wat Tham Krabok is also well known for its heroin and opium drug rehabilitation program, which was started in 1959. Thousands of heroin and opium addicts have been treated there.

Over the years a variety of prominent Western drug addicts have been treated at Wat Tham Krabok, including British punk rock musician Pete Doherty, Irish singer Christy Dignam and American writer Patrick K. Kroupa.

However, it also has been suspected as a conduit for international heroin and opium trafficking. This led to a decision by the Thai government, in April 2003, to ring the temple with concertina wire and to establish strict controls on entering and leaving the temple.

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2.9 Wat Thamkrabok : a Buddhist drug rehabilitation program in Thailand

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Since 1959 Wat Thamkrabok, a Buddhist monastery in Thailand, has been conducting a drug addiction rehabilitation program which claims a 70% success rate. The program is known for its use of unconventional methods, such as inducing vomiting to relieve "cravings" for drugs, herbal saunas, strict discipline, an emphasis on Buddhism, and a sacred vow to never again use drugs. This is a descriptive study based on observations and interviews (mostly with foreigners) made at the monastery. While it was not possible to evaluate claims of success, there were several interesting aspects of the program which emerged. Vomiting was reported to be effective in reducing "craving," and participants seemed to have a positive regard for the program, but there were some serious concerns raised about health risks and the coercive nature of the program.

2.10 Research Documentary Related

In 1974, Sauwanit Jitpitak et.,al, tested to concentrate Buddha at Thannaburi institute since April, 1, 1874 – February, 14, 1975, by divided 2 group such as test groups 60 people and control groups (seminar) 40 people, seminar 3 level

1. To train member everyone for a months
2. To train member twice a week for 3 months
3. To train member once a week until finished project

Moreover, to follow after beyond punishment for 2 years, result of the research found that test group liked “Pawana Buddho” more than other method because practices easily. Concentrate practice affected to people to become aware.

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Recommended of the research that should be repeat experiment by concentrate with other treatment together, ordination is one best method because addict's rehabilitation live with surrounding well.

1976, Wichai Posanajinda et.,al., studied relation involved with drug abuse of defender from Thanyaburi division of an army and Woman Lad Yoa division of an army. Collected data by used questionnaire with addict for 703 people, result, found that 65% of prisoner consumed drug since less than 20 years old. The majority of prisoner graduate of elementary, to fail family, rate of divorced highly, high unemployed of 30 days before they was jail, cause of first time drug abuse was peer persuade. In additional, the researcher presented the way to solve problem of spread drug, should be solve problem of social before and depend on participation of family.

1976, Jit Sittiamorn et.,al., studied condition and problem of addict's rehabilitation of Thanyarak hospital for 500 cases. Collected data by used questionnaire with addict's opium, result, found that the majority of sample group were 15 to 29 years old and 40 to 44 years old, rate of divorced highly, graduated of elementary, secondary and university very little, most of labor but there was less illegal work and rate of unemployed in lower. Causes of firs time consumed drug, was peer persuade, curiously and depressed of mind.

1976, Dumrong Chuewsin et.,al., studied drug abuse of criminal court, special jail, Bangkok and Woman division of an army around 4,500 cases, to test by analyzed drug in urine of user drug and interview general data. Result, found that 45% of defender consumed drug every time, cause of psychic wanted, and began to use since less than 20 years old. The majority of sample group, graduated of elementary, to work for wage, could been bought everywhere and depressed of social effected to return consumed.

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Treatment of female addicts: the importance of relationships to parents, partners, and peers for the outcome.

In an intensive case study, a representative sample of female addicts (n = 13) were followed through the total program of a hierarchical TC and again 2 months later. The type of relationship to parents was repeated in partner and peer relationships, which were strongly related to outcome. All women in the nonsuccessful group entered into destructive relationships to male coresidents in the outpatient period, while none of the women in the successful group did so. Parents, partners, and peer relationships should therefore be in focus during treatment, and one should consider whether women should have separate treatment programs.

Drug users' spiritual beliefs, locus of control and the disease concept in relation to Narcotics Anonymous attendance and six-month outcomes.

Narcotics Anonymous (NA) is an important support network for drug users emerging from abstinence based treatments. However, the views of NA on 'spirituality' and the 'disease' nature of addiction could be seen as encouraging an external attribution style and have been cited as reasons for non-attendance. After 6 months ninety percent of 101 drug users in treatment were followed up. Narcotics Anonymous attendance was inversely related to drug use for those who had left residential care. We found that spiritual beliefs and disease concept beliefs were not prerequisites for attendance of NA. Spiritual beliefs were not found to cause external attributions for previous drug use or possible future lapse events. It emerged that the most powerful predictors of non-attendance were positive attitudes to the use of alcohol. Treatment implications are discussed.

This study’s purpose is to characterize human immunodeficiency virus (HIV) related risk behaviors of homeless youth ; (b) determine whether substance use is associated with risky sexual behavior in this population ; and, if so, (c) explore explanations for this relationship. A purposive sample of 327 homeless youth (ages 14-21 years) in Washington, DC, were surveyed in 1995 and 1996. Survey items were adapted from items used in a national study of adult substance use and sexual behavior and measured global (lifetime) and event-specific (most recent sexual

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encounter) behaviors. Sexual activity with many partners, "survival" sex, and substance use were common. However, needle use was rare, and consistent condom use and risky sex were statistically significant, but only a few of the event-specific correlations were significant. Marijuana use during the most recent sexual encounter was associated with nonuse of condoms, but this relationship disappeared in the multivariate model. However, crack use during the last encounter was associated with condom use ; this relationship remained significant in the multivariate model. Lack of motivation to use condoms, longer histories of sexual activity and homelessness, symptoms of drug dependency, not discussing HIV risks with partner, and being female were also associated with nonuse of condoms. Homeless youth do use condoms, even within the context of substance use and casual sex. Results suggest that prevention and targeted intervention efforts have had some positive effect on this population, but young homeless women are in need of targeted prevention. Finally, additional research is needed to investigate the observed relationship between crack use and condom use in this sample.

This research examines the role that various background, labor marker, and street lifestyle factors play in street youths' drug and alcohol use. Using a sample of 200 homeless male street youths, the researcher found that exposure to parental substance abuse increases street youths' risk of alcohol and hard-drug use. Further histories of physical abuse are related to the use of psychedelic drugs. The data also indicate that long-term homelessness influences hard-drug use, whereas drug- and alcohol-using peers influence the use of alcohol, marijuana and psychedelic drugs. Participation in property crime increases street youths' use of all types of drugs and alcohol, whereas drug distribution is linked to greater soft-drug use. Finally, job histories and depression are linked to alcohol and hard-drug use, whereas self-blame for unemployment increases alcohol use.

This study's purpose is to describe endorsement rates of substance use criteria among homeless adolescents and to evaluate the reliability of diagnostic formulations among a group of adolescent s who use more frequently and more heavily than other samples of adolescents. Substance use rates and DSM-IV abuse

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and dependence criteria were assessed among 198 (109 male) homeless youths between the ages of 13 and 19, as part of a larger study. Endorsement rates and reliability analyses were completed for diagnostic criteria assessed for alcohol, marijuana, amphetamines and heroin. Consistent with other studies of homeless youth, data revealed high rates of substance use and high rates of substance dependence. Both dependence and abuse diagnoses were associated with greater rates of use. DSM-IV criteria showed acceptable internal reliability, although variability was observed when applied to different substances. Of the drugs assessed, problems with heroin use appeared to be best, and marijuana use least, represented by dependence criteria. Criteria pertaining to continued use despite interference with role obligations and the experience of craving were consistently related to other dependence criteria.

A study shows that about half of teens in juvenile detention have two or more psychiatric disorders and substance abuse disorders. The study, conducted by from the Psycho-Legal Studies Program at the Feinberg School of Medicine at Northwestern University, also found that the most common combination was substance abuse disorders and attention deficit hyperactivity disorder (ADHD) or behavioral disorders, which affected almost a third of 1,829 teens examined. Almost half also had anxiety disorders, affective disorders or both. More than one of ten teens had a substance abuse disorder and a major mental disorder, such as psychosis, manic episode or major depressive episode. Among 305 teens with major mental disorders in the current study, more than half of girls and almost three fourths of boys also had a substance abuse disorder.

Four of every five children and teen arrestees in state juvenile justice systems are under the influence of alcohol or drugs while committing their crimes, test positive for drugs, are arrested for committing an alcohol or drug offense, admit having substance abuse and addiction problems, or share some combination of these characteristics, according to a new report released by The National Center on Addiction and Substance Abuse (CASA) at Columbia University. The 177-page report of the five-year study, Criminal Neglect : Substance Abuse, Juvenile Justice

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and the Children Left Behind, is the most comprehensive analysis ever undertaken of substance abuse and state juvenile justice systems. The report found that 1.9 million of 2.4 million juvenile arrests had substance abuse and addiction involvement and that only 68,600 juveniles receive substance abuse treatment. (http://alcoholism.about.com/od/teens/a/blcasa041007.htm).

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CHAPTER 3
RESEARCH METHODOLOGY

A study of "THE ACHIEVEMENT OF FAST-MODEL TREATMENT AND THAI TRADITIONAL TREATMENT IN METHAMPHETAMINE ADDICT REHABILITATION" the researcher used questionnaire and interview were tools of this research for addict's methamphetamine had treated in FAST-model in Thayarak Institute and Thai traditional treatment in the Wat Thamkrabok : A Buddhist Drug Rehabilitation Program in Thailand.

3.1 Target Population

The researcher identified the group target as follow:

3.1.1 Addict's methamphetamine is willing to treat in Thanyarak institute, are 100 cases.

3.1.2 Addict's methamphetamine is willing to treat in Wat Tham-Krabok temple, are 100 cases.

All target population is 200 cases.

3.2 Research Instrument

The research created the questionnaire for collective data of this study, which composed any parts as follow:

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Part 1: The personal and general data of addict's methamphetamine

Part 2: The chronicle data used drug abuse

Part 3: The attitude data of influence towards achievement of FAST-model and Thai traditional treatment

3.3 Data Collection

The researcher used questionnaire for 2 groups were of Thanyarak institute and Wat Tham-Krabok in three months. After Faculty of Graduate Studies Passed.

3.4 Data Analyses

This study, the information that was obtained from descriptive statistics and inductive statistics by SPSS as follow:

3.4.1 Descriptive Statistics was analyzed and described the information at the beginning, such as frequency, percentile, mean and standard deviation.

3.4.2 Inductive or Inferential Statistics was used to test of between independent variables and attitude, which affected to achievement the FAST-model and the Thai traditional rehabilitation by Chi square test.

3.4.3 Analysis of variance (ANOVA) was used to compare the personal data and the chronicle data used methamphetamine of addict's rehabilitation, which affected to the achievement of treatment.

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CHAPTER 4
RESULT

From the study of THE ACHIEVEMENT OF FAST-MODEL TREATMENT AND THAI TRADITIONAL TREATMENT IN METHAMPHETAMINE ADDICT REHABILITATION by used questionnaire in compared study, which the sample group was addict's methamphetamine to treat in Thayarak Institute of FAST-model rehabilitation amount 100 cases and Wat Thamkrabok amount 100 cases, all sample group 200 cases, as follow:

4.1 Personal and general data of sample group

4.2 The chronicle data used drug abuse of sample group

4.3 Analysis of relation between addict's rehabilitation and the attitude influence toward FAST-model rehabilitation

4.4 Analysis of relation between addict's rehabilitation and the attitude influence toward Thai traditional rehabilitation

4.5 Analysis of variance (ANOVA) of the attitude influence toward FAST-model rehabilitation

4.6 Analysis of variance (ANOVA) of the attitude influence toward Thai traditional rehabilitation

4.1 Personal and general data of sample group (Table 4-1)

4.1.1 Age – The majority of sample group are 26 to 35 years (49%), 14 to 25 years (39%) and 36 to 45 years (12%).

4.1.2 Marital Status – The majority of sample group are single (79%), married (17.5%), widow (3.5%) and divorce (0%).

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4.1.3 Religion – The majority of sample group are Buddhist (86.5%), Islam (9.5%) and Christian (4%).

4.1.4 Education – The majority of sample group are Elementary (52%), Secondary School (39.5%) and bachelor Degree (8.5%).

4.1.5 Occupation – The majority of sample group are Part-time (46.5%), Full-time (26.2%), student (16.2%) and unemployed (8.9%).

4.1.6 Average income per month (Baht) – The majority of sample group is lower 5,000 baht (49.2%), 5,000 to 10,000 baht (47%), and 10,000 to 20,000 baht (3.8%).

4.1.7 Hometown – The majority of sample group are provincial (59.1%) and Bangkok (40.9%).

4.1.8 Amount of member in family – The majority of sample group are 4 to 6 people (43.5%), 1 to 3 people (41%), 7 to 9 people (8.5%), 10 to 12 people (3.5%) and 13 to 15 people (3.5%).

4.1.9 Amount of relations – The majority of sample group are 2 people (26.5%), 1 people (22.5%), 4 people (18%), 3 people (12.5%), 7 people (8.5%), 9 people (7%) and 5 people (5%).

4.1.10 Priority of child – The majority of sample group are the first (58.5%), the third (14%), the second (13.5%), the fourth (7%) and the seventh (7%).

4.1.11 People to live with – The majority of sample group lived with many people together in family (56.0%).

4.1.12 Relationship in family – The majority of sample group are closely (68.5%) and none closely (31.5%).

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4.1.13 Acceptance of family as treatment – The majority of family's sample group came to visit sometime (34%), never (31.5%), often (22.5%) and other (12%).

4.1.14 Acceptance of family undergoing rehabilitation – The majority of family's sample group are most pleasant (83.5%), neglect (4.0%) and aversion (3.5%).

4.1.15 The chronicle of family's drug addiction – The majority of family's sample group anti drug and ever addict drug equally (27.0%).

4.1.16 Conditional of location – The majority of sample group are city (53.5%) and urban (27.0%).

4.1.17 Neighbors of community – The majority of neighbor's sample group are consuming and selling drug (54%), selling (18%), anti drug (15.5%) and other (12.5%).

4.1.18 Acceptance of community undergoing rehabilitation – The majority of sample group are acceptable and helpful (63.5%) and neglect (36.5%)

4.1.19 Intension of undergoing rehabilitation – The majority of sample group would not involve with methamphetamine and all drug abuse (63%), uncertainly (33.5%), other (3.5%) and nobody think about return to consume drug.

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Table 4-1 : Demographics of the Key Informants

Personal Data	Amount (200 people)	Percentage
Age (Years)		
14 – 25	39	39.0
26 - 35	98	49.0
36 – 45	24	12.0
Marital Status		
Single	158	79.0
Married	35	17.5
Widow	-	-
Divorced	7	3.5
Religion		
Buddhist	173	86.5
Christian	8	4.0
Islam	19	9.5
Education		
No education	-	-
Elementary	104	52.0
Secondary School	79	39.5
Bachelor Degree	17	8.5
Higher Bachelor Degree	-	-
Occupation		
Student	31	16.2
Full-time	50	26.2
Temporary Employee	93	46.5
Unemployed	17	8.9
No answer	(9)	-

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Table 4-1 : Demographics of the Key Informants (Continued)

Personal Data	Amount (200 people)	Percentage
Average income per month		
Under 5,000 baht	95	49.2
5,000 – 10,000 baht	83	47.0
10,000 – 20,000 baht	15	3.8
Higher 20,000 baht	-	-
No answer	(7)	
Hometown		
Bangkok	79	40.9
Province	114	59.1
No answer	(7)	-
Amount in family		
1 – 3	82	41.0
4 – 6	87	43.5
7 – 9	17	8.5
10 – 12	7	3.5
13 – 15	7	3.5
Amount of relations		
1	45	22.5
2	53	26.5
3	25	12.5
4	36	18.0
5	10	5.0
7	17	8.5
9	14	7.0

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Table 4-1 : Demographics of the Key Informants (Continued)

Personal Data	Amount (200 people)	Percentage
Priority of child		
1	117	58.5
2	27	13.5
3	28	14.0
4	14	7.0
7	14	7.0
People to live with		
Father	21	10.5
Mother	15	7.5
Cousin	7	3.5
Husband/wife	11	5.5
Child	2	1.0
Friends	21	10.5
Alone	11	5.5
Other (More than 1 choice)	112	56.0
Relationship in the family		
Closely	137	68.5
Not Closely	63	31.5
Incompatible	-	-
Other	-	-
Visiting of family while rehabilitation		
Often	45	22.5
Sometime	68	34.0
Never	63	31.5
Other	24	12.0

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Table 4-1 : Demographics of the Key Informants (Continued)

Personal Data	Amount (200 people)	Percentage
Acceptance of family when you came home		
Pleasant	167	83.5
Neglect	8	4.0
Aversion	7	3.5
Other	18	9.0
The chronicle of family's drug addiction		
Never	54	27.0
Ever	146	73.0
Conditional of location		
City	107	53.5
Urban	93	46.5
Neighbors in community		
Consuming and selling	108	54.0
Anti drug	31	15.5
Selling	36	18.0
Other	25	12.5
Acceptance of community when you came home		
Acceptable and Helpful	127	63.5
Aversion	-	-
Unacceptable	-	-
Neglect	73	36.5
Intension when came home		
Stop to involve all drug addition	126	63.0
Uncertain	67	33.5
Return to consume again	-	-
Other	7	3.5

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4.2 The chronicle data used drug abuse of sample group (Table 4-2)

4.2.1 Reason of first time drug abuse – The majority of sample group would like to consume for funny (57%), peer persuade (13%), any problem (4%).

4.2.2 Kind of first time drug abuse – The majority of sample group consumed marijuana (18.5%), volatile (18.5%) and other (6.5%).

4.2.3 Age of first time drug abuse – The majority of sample group consumed the first time since 12-21 years old (71%), 22-31 years old (25.5%), 32-41 years old (3.5%).

4.2.4 Method to consume drug – The majority of sample group inhaled (73%) and ate (27%).

4.2.5 Drug information, before first time drug abuse – The majority of sample group had drug information in moderated (40.5%), low (32%) and high (14%) and nothing (13.5%).

4.2.6 Place of first time rehabilitation – The majority of sample group treated at the institute of FAST-model rehabilitation (66.5%) and institute of Thai traditional rehabilitation (33.5%).

4.2.7 Interval of rehabilitation the first time – The majority of sample group had treated the first time since 1998-2006 (49.5%), 1988-1997 (31%), 1968-1977 (10%) and 1978 – 1987 (9.5%).

4.2.8 Ability to stop drug after rehabilitation – The majority of sample group could be stop drug for 1-10 months (41.5%), 21-30 months (22.5%), 11-20 months (13.5%), incapable stopped (11%), 31-40 months (7%), 41-50 months (4.5%).

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4.2.9 Reason of first time rehabilitation – The majority of sample group was forced or begged (53.5%), stop by oneself (24.5%), fear to be arrested (13%) and other (9%).

4.2.10 Ability to stop drug for most a long time – The majority of sample group could stop drug for 1-10 months (43%), 21-30 months (19.5%), 11-20 months (14.5%), incapable stopped (9.5%), 31-40 months (8.5%) and 41-50 months (5%).

4.2.11 Reason of return to consume after first time rehabilitation – The majority of sample group are sensitive with their family (39%), other (24%), insane (22%) and their mind to be affected (15%).

4.2.12 The method of rehabilitation, affected to stop for most a long time – The majority of sample group treated by other method (65.5%), FAST-model rehabilitation (22%) and Thai traditional rehabilitation (12.5%).

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Table 4-2: Numbers and percentage of sample group as classified by the chronicle data used methamphetamine

Data	Amount (200 people)	Percentage
Reason of first time drug abuse		
Curiousness	114	57.0
Funny	52	26.0
Persuade of peer	26	13.0
To have and problem or worried	8	4.0
Support their work	-	-
Used to cure diseases	-	-
Kind of first time drug abuse		
Methamphetamine	126	63.0
Marijuana	37	18.5
Volatile	24	12.0
Other	13	6.5
Age of first time drug abuse		
12 – 21 years old	142	71.0
22 – 31 years old	51	25.5
32 – 41 years old	7	3.5
Method to consume drug		
Inhale	146	73.0
Eat	54	27.0
Drug information, before consumed drug the first time		
High	28	14.0
Moderate	81	40.5
Low	64	32.0
Noting	27	13.5

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Table 4-2: Numbers and percentage of sample group as classified by the chronicle data used methamphetamine (Continued)

Data	Amount (200 people)	Percentage
Place of first time rehabilitation		
Institute of FAST-model rehabilitation	133	66.5
Institute of Thai traditional rehabilitation	67	33.5
Interval of first time rehabilitation		
1998 – 2006	20	10.0
1988 – 1997	19	9.5
1968 – 1977	62	31.0
1978 – 1987	99	49.5
Ability to stop drug after rehabilitation		
1 – 10 months	83	41.5
11 – 20 months	27	13.5
21 – 30 months	45	22.5
31 – 40 months	14	7.0
41 – 50 months	9	4.5
Incapable to stop	22	11.0
Reason of first time rehabilitation		
Forced or begged	107	53.5
Poor health	-	-
Fear to be arrested	26	13.0
No money for buy drug	-	-
Stop by oneself	49	24.5
Other	18	9.0

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Table 4-2: Numbers and percentage of sample group as classified by the chronicle data used methamphetamine (Continued)

Data	Amount (200 people)	Percentage
Ability to stop drug for most a long time		
1 – 10 months	86	43.0
11 – 20 months	29	14.5
21 – 30 months	39	19.5
31 – 40 months	17	8.5
41 – 50 months	10	5.0
Incapable to stop	19	9.5
Reason of return to consume after first time rehabilitation		
Sensitive with their family	78	39.0
Insane	44	22.0
their mind to be affected	30	15.0
Other	48	24.0
The method of rehabilitation, influence toward stop for most a long time		
FAST-model rehabilitation	44	22.0
Thai traditional rehabilitation	25	12.5
Other	131	65.5

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4.3 Analysis of relation between addict's rehabilitation and the attitude influence toward FAST-model rehabilitation

4.3.1 Age – It was found that age of sample group was significant to the attitude influence toward achievement of FAST-model rehabilitation (P-value = 0.000), that means the different ages affected to the attitude of FAST-model rehabilitation is differentially. From the study was found that the majority of sample group between 14 to 25 years and 36 to 45 years disagreed with achievement of FAST-model rehabilitation. Sample group between 26 to 35 years old were uncertain in achievement of FAST-model rehabilitation. Therefore, ages increasing, attitude of addict's rehabilitation was uncertain increasing about FAST-model rehabilitation because there are various treatments and spreading of drug in present. (Table 4-3)

Table 4-3: Relation between ages and attitude influence toward FAST-model rehabilitation

Age	Attitude			Total
	Agree	Uncertain	Disagree	
14 – 15 years	10 5.00	32 16.00	36 18.00	78 39.00
26 – 35 years	0 0.00	61 30.50	37 18.50	98 49.00
36 – 45 years	0 0.00	7 3.50	17 8.50	24 12.00
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-Value = .000

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4.3.2 Marital Status – It was found marital status of sample group was significant to attitude influence toward FAST-model rehabilitation (P-Value = 0.000), that means the difference of marital status affected to the difference of FAST-model rehabilitation. From this study, found that the majority of single status sample group disagreed with achievement of FAST-model rehabilitation, marriage and widow status were uncertain in achievement of FAST-model rehabilitation (Table 4-4)

Table 4-4 : Relation between marital status and attitude influence toward FAST-model rehabilitation

Marital Status	**Attitude**			**Total**
	Agree	**Uncertain**	**Disagree**	
Single	10 5.00	68 34.00	80 40.00	158 79.00
Marriage	0 0.00	25 12.50	10 5.00	35 17.50
Widow	0 0.00	7 3.50	0 0.00	7 3.50
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-Value = .000

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4.3.3 Religion - It was found religion of sample group was significant to attitude influence toward FAST-model rehabilitation (P-Value = 0.000), that means the difference of religion affected to the difference of FAST-model rehabilitation. From this study, found that the majority of sample group were Buddhists disagreed with achievement of FAST-model rehabilitation, the other were uncertain in achievement of FAST-model rehabilitation (Table 4-5)

Table 4-5 : Relation between religion and attitude influence toward FAST-model rehabilitation

Religion	**Attitude**			**Total**
	Agree	**Uncertain**	**Disagree**	
Buddhist	10 5.00	73 36.50	90 45.00	173 86.50
Christian	0 0.00	8 4.00	0 .00	8 4.00
Islam	0 0.00	19 9.50	0 0.00	19 9.50
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-Value = .000

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4.3.4 Education - It was found education of sample group was significant to attitude influence toward FAST-model rehabilitation (P-Value = 0.000), that means the difference of education affected to the difference of FAST-model rehabilitation. From this study, found that the majority of elementary were uncertain in achievement of FAST-model rehabilitation, Secondary school and bachelor degree disagreed with achievement of FAST-model rehabilitation (Table 4-6)

Table 4-6 : Relation between education and attitude influence toward FAST-model rehabilitation

Education	Attitude			Total
	Agree	Uncertain	Disagree	
Elementary	0 0.00	67 33.50	37 18.50	104 52.00
Secondary School	10 5.00	33 16.50	36 18.00	79 39.50
Bachelor Degree	0 0.00	0 0.00	17 8.50	17 8.50
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-Value = .000

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4.3.5 Occupation - It was found occupation of sample group was significant to attitude influence toward FAST-model rehabilitation (P-Value = 0.000), that means the difference of occupation affected to the difference of FAST-model rehabilitation. From this study, found that the majority of students and Full-time workers disagreed with achievement of FAST-model rehabilitation, Part-time workers were uncertain in achievement of FAST-model rehabilitation (Table 4-7)

Table 4-7 : Relation between Occupation and attitude influence toward FAST-model rehabilitation

Occupation	Attitude			Total
	Agree	Uncertain	Disagree	
Student	0 0.00	14 7.33	17 8.90	31 16.23
Full-time	0 0.00	10 5.24	40 20.94	50 26.18
Part-time	10 5.24	59 30.89	24 12.56	93 48.69
Unemployed	0 0.00	17 8.90	0 0.00	17 8.90
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-Value = .000

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4.3.6 Age of first time drug abuse - It was found age of first time drug abuse was significant to attitude influence toward FAST-model rehabilitation (P-Value = 0.000), that means age of first time drug abuse was differential, affected to the difference achievement of FAST-model rehabilitation. From this study, found that age of first time drug abuse between 12 to 21 years were uncertain in achievement of FAST-model rehabilitation and 22 to 31 years disagreed with achievement of FAST-model rehabilitation (Table 4-8)

Table 4-8 : Relation between age of first time drug abuse and attitude influence toward FAST-model rehabilitation

Age of first time drug abuse	Attitude			Total
	Agree	Uncertain	Disagree	
12 – 21 years	10 5.00	86 43.00	46 23.00	142 71.00
22 – 31 years	0 0.00	7 3.50	44 22.00	51 25.50
32 – 41 years	0 0.00	7 3.50	0 0.00	7 3.50
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-Value = .000

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4.3.7 Institute of first time rehabilitation - It was found institute of first time rehabilitation was significant to attitude influence toward FAST-model rehabilitation (P-value = 0.481), that means institute of first time rehabilitation was not differential significant. (Table 4-9)

Table 4-9 : Relation between institute of first time rehabilitation and attitude influence toward FAST-model rehabilitation

Institute of first time rehabilitation	Attitude			Total
	Agree	Uncertain	Disagree	
FAST-Model Rehabilitation	5 2.50	66 33.00	62 31.00	133 66.50
Thai tradition Rehabilitation	5 2.50	34 17.00	28 14.00	67 33.50
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-value = .000

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4.3.8 Reason of first time rehabilitation – It was found the reason of first time rehabilitation for sample group was significant to attitude influence toward FAST-model rehabilitation (P-Value = 0.000), that means the reason of first time rehabilitation of sample group was differential, affected to the difference of FAST-model rehabilitation. From this study, found that the forced sample groups were uncertain in achievement of FAST-model rehabilitation, the sample group was fear to be arrested and the sample group would like to stop by oneself disagreed with achievement of FAST-model rehabilitation (Table 4-10)

Table 4-10 : Relation between reason of first time rehabilitation and attitude influence toward FAST-model rehabilitation

Reason of first time rehabilitation	**Attitude**			**Total**
	Agree	**Uncertain**	**Disagree**	
To be forced - beg	0 0.00	82 41.00	25 12.50	107 53.50
Fear to be arrested	0 0.00	9 4.50	17 8.50	26 13.00
Stop by oneself	10 5.00	0 0.00	39 19.50	49 24.50
Other	0 0.00	9 4.50	9 4.50	18 9.00
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-value .000

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4.3.9 The period of stop drug - It was found the period of stop drug was significant to attitude influence toward FAST-model rehabilitation (P-Value = 0.000), that means the period of stop drug was differential, affected to the difference of FAST-model rehabilitation. From this study, found that the sample group incapable to stop drug disagreed with achievement of FAST-model rehabilitation. Sample group could be to stop drug for 1 to 10 months disagreed with same as for 21 to 30 months, the sample group could be to stop drug for 11 to 20 months, 31 to 40 months and 40 to 50 months, were uncertain in achievement of FAST-model rehabilitation. (Table 4-11)

Table 4-11 : Relation between reason of the period of stop drug and attitude affected to FAST-model rehabilitation

The period of stop drug	Attitude			Total
	Agree	Uncertain	Disagree	
Incapable to stop a drug	0 0.00	0 0.00	19 9.50	19 9.50
1 – 10 months	0 0.00	41 20.50	45 22.50	86 43.00
11 – 20 months	0 0.00	22 11.00	7 3.50	29 14.50
21 – 30 months	10 0.00	10 5.00	19 9.50	39 19.50
31 – 40 months	0 0.00	17 8.50	0 0.00	17 8.50
41 – 50 months	0 0.00	10 5.00	0 0.00	10 5.00
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-value .000

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4.3.10 Acceptance of family as treatment - It was found Acceptance of family as treatment**,** was significant to attitude influence toward FAST-model rehabilitation (P-Value = 0.000), that means acceptance of family was differential, affected to the difference of FAST-model rehabilitation. From this study, found that their family, who often had come to visit, was uncertain and disagreed with achievement of FAST-model rehabilitation. Their family, who sometime had come to visit, disagreed with achievement of FAST-model rehabilitation. Their family, who never had come to visit, was uncertain in achievement of FAST-model rehabilitation. (Table 4-12)

Table 4-12 : Relation between frequency of visiting of their family and attitude affected to FAST-model rehabilitation

Frequency of visiting of their family	**Attitude**			**Total**
	Agree	**Uncertain**	**Disagree**	
Often	10 5.00	18 9.00	17 8.50	45 22.50
Sometime	0 0.00	14 7.00	54 27.00	68 34.00
Never	0 0.00	53 26.50	10 5.00	63 31.50
Other	0 0.00	15 7.50	9 4.50	24 12.00
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-value .000

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4.3.11 Neighbors of community - It was found neighbors of community was significant to influence toward FAST-model rehabilitation (P-Value = 0.000), that means the difference of neighbors of community, affected to the difference of FAST-model rehabilitation. From this study, found that neighbors consumed and sold drug, disagreed with achievement of FAST-model rehabilitation, in additional the sample group was drug sale, was uncertain in achievement of FAST-model rehabilitation. (Table 4-13)

Table 4-13 : Relation between neighbors of community and attitude influence toward FAST-model rehabilitation

Neighbors of community	Attitude			Total
	Agree	Uncertain	Disagree	
Consume – sell drug	0. 0.00	42 21.00	66 33.00	108 54.00
Anti drug	0 0.00	7 3.50	24 12.00	31 15.50
Sell drug	10 5.00	26 13.00	0 0.00	36 18.00
Other	0 0.00	25 12.50	0 0.00	25 12.50
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-value .000

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4.4 Relation analysis between addict's rehabilitation and the attitude influence toward Thai traditional rehabilitation

4.4.1 Age – It was found that age of sample group was significant to the attitude influence toward to Thai traditional rehabilitation (P-value = 0.842), that means the age was not different significant. (Table 4-14)

Table 4-14 : Relation between age and attitude influence toward Thai traditional rehabilitation

Age	Attitude			Total
	Agree	Uncertain	Disagree	
14 – 15 years	1 0.50	70 35.00	7 3.50	78 39.00
26 – 35 years	2 1.00	84 42.00	12 6.00	98 49.00
36 – 45 years	1 0.50	21 10.50	2 1.00	24 12.00
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-Value = .842

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4.4.2 Marital Status – It was found that marital status of sample group was significant to the attitude influence toward Thai traditional rehabilitation (P-value = 0.972), that means the marital status was not different significant. (Table 4-15)

Table 4-15 : Relation between marital status and attitude influence toward Thai traditional rehabilitation

Marital Status	Attitude			Total
	Agree	Uncertain	Disagree	
Single	3 1.50	138 69.00	17 8.50	158 79.00
Marriage	1 0.50	31 15.50	3 1.50	35 17.50
Widow	0 0.00	6 3.00	1 0.50	7 3.50
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-Value = .972

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4.4.3 Religion - It was found that religion of sample group was significant to the attitude influence toward Thai traditional rehabilitation (P-value = 0.529), that means the religion was not different significant. (Table 4-16)

Table 4-16: Relation between religion and attitude influence toward Thai Traditional rehabilitation

Religion	Attitude			Total
	Agree	Uncertain	Disagree	
Buddhist	4 2.00	153 76.50	16 8.00	173 86.50
Christian	0 0.00	6 3.00	2 1.00	8 4.00
Islam	0 0.00	16 8.00	3 1.50	19 9.50
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-Value = .529

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4.4.4 Education - It was found that education of sample group was significant to the attitude influence toward Thai traditional rehabilitation (P-value = 0.356), that means education of sample group was not different significant. (Table 4-17)

Table 4-17 : Relation between education and attitude influence toward Thai Traditional rehabilitation

Education	Attitude			Total
	Agree	Uncertain	Disagree	
Elementary	4 2.00	88 44.00	12 6.00	104 52.00
Secondary School	0 0.00	71 35.50	8 4.00	79 39.50
Bachelor Degree	0 0.00	16 8.00	1 0.50	17 8.50
Total	4 2.00	175 87.50	21 10.50	200 100.00

P-Value = .356

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4.4.5 Occupation - It was found that occupation of sample group was significant to the attitude influence toward Thai traditional rehabilitation (P-value = 0.133), that means occupation of sample group was not different significant. (Table 4-18)

Table 4-18: Relation between Occupation and attitude influence toward Thai traditional rehabilitation

Occupation	Attitude			Total
	Agree	Uncertain	Disagree	
Student	1 0.52	29 15.19	1 0.52	31 16.23
Full-time	1 0.52	46 24.08	3 1.57	50 26.17
Part-time	2 1.05	79 41.36	12 6.28	93 48.69
Unemployed	0 0.00	12 6.28	5 2.62	17 8.90
Total	4 2.09	166 86.91	21 11.00	191 100.00

P-Value = .133

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4.4.6 Age of first time drug abuse - It was found age of first time drug abuse of sample group was significant to attitude influence toward Thai traditional rehabilitation (P-Value = 0.000), that means age of first time drug abuse was differential, affected to the difference of Thai traditional rehabilitation. From this study, found that age of first time drug abuse between 12 to 31 years were uncertain in achievement of Thai traditional rehabilitation same as the other. (Table 4-19)

Table 4-19 : Relation between age of first time drug abuse and attitude influence toward Thai traditional rehabilitation

Age of first time drug abuse	Attitude			Total
	Agree	Uncertain	Disagree	
12 – 21 years	2 1.00	121 60.50	19 9.50	142 71.00
22 – 31 years	1 0.50	48 24.00	2 1.00	51 25.50
32 – 41 years	1 0.50	6 3.00	0 0.00	7 3.50
Total	4 2.00	175 87.50	21 10.50	200 100.00

P-Value = .000

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4.4.7 Institute of first time rehabilitation - It was found institute of first time rehabilitation was significant for attitude influence toward Thai traditional rehabilitation (P-value = 0.491), that means institute of first time rehabilitation was not differential significant. (Table 4-20)

Table 4-20 : Relation between institute of first time rehabilitation and attitude influence toward Thai traditional rehabilitation

Institute of first time rehabilitation	Attitude			Total
	Agree	Uncertain	Disagree	
FAST-Model Rehabilitation	2	115	16	133
	1.00	57.50	8.00	66.50
Thai tradition Rehabilitation	2	60	5	67
	1.00	30.00	2.50	33.50
Total	4	175	21	200
	2.00	87.50	10.50	100.00

P-value .491

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4.4.8 Reason of first time rehabilitation – It was found reason of first time rehabilitation was significant for attitude influence toward Thai traditional rehabilitation (P-value = 0.410), that means reason of first time rehabilitation was not differential significant. (Table 4-21)

Table 4-21 : Relation between reason of first time rehabilitation and attitude influence toward Thai traditional rehabilitation

Reason of first time rehabilitation	Attitude			Total
	Agree	Uncertain	Disagree	
To be forced - beg	2 1.00	96 48.00	16 8.00	114 57.00
Fear to be arrested	1 0.50	46 23.00	5 2.50	52 26.00
Stop by oneself	1 0.50	25 12.50	0 0.00	26 13.00
Other	0 0.00	8 4.00	0 0.00	8 4.00
Total	4 2.00	175 87.50	21 10.50	2.00 100.00

P-value .410

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4.4.9 The period of stop drug - It was found the period of stop drug was significant for attitude influence toward Thai traditional rehabilitation (P-value = 0.757), that means of the period of stop drug was not differential significant. (Table 4-22)

Table 4-22 : Relation between reason of the period of stop drug and attitude influence toward Thai traditional rehabilitation

The period of stop drug	Attitude			Total
	Agree	Uncertain	Disagree	
Incapable to stop a drug	0 0.00	19 9.50	0 0.00	19 9.50
1 – 10 months	2 1.00	73 36.50	11 5.50	86 43.00
11 – 20 months	1 0.50	24 12.00	4 2.00	26 43.00
21 – 30 months	1 0.50	36 18.00	2 1.00	29 14.50
31 – 40 months	0 0.00	15 7.50	2 1.00	39 19.50
41 – 50 months	0 0.00	8 4.00	2 1.00	10 5.00
Total	10 5.00	100 50.00	90 45.00	200 100.00

P-value .757

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4.4.10 Acceptance of family as treatment – It was found acceptance of family as treatment was significant for attitude influence toward Thai traditional rehabilitation (P-value = 0.249), that means of acceptance of family as treatment, was not differential significant. (Table 4-23)

Table 4-23 : Relation between frequency of visiting of their family and attitude influence toward Thai traditional rehabilitation

Frequency of visiting of their family	**Attitude**			**Total**
	Agree	**Uncertain**	**Disagree**	
Often	0 0.00	40 20.00	5 2.50	45 22.50
Sometime	1 0.50	63 31.50	4 2.00	68 34.50
Never	3 1.50	50 25.00	10 5.00	63 31.50
Other	0 0.00	22 11.00	2 1.00	24 12.00
Total	4 2.00	175 87.50	21 10.50	200 100.00

P-value .249

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4.4.11 Neighbors of community - It was found neighbors of community was significant for attitude influence toward Thai traditional rehabilitation (P-value = 0.354), that means of neighbors of community was not differential significant. (Table 4-24)

Table 4-24 : Relation between neighbors of community and attitude influence toward Thai traditional rehabilitation

Neighbors of community	Attitude			Total
	Agree	Uncertain	Disagree	
Consume – sell drug	2 1.00	97 48.50	9 4.50	108 54.00
Anti drug	1 0.50	28 14.00	2 1.00	31 15.50
Sell drug	1 0.50	31 15.50	4 2.00	36 18.00
Other	0 0.00	19 9.50	6 3.00	25 12.50
Total	4 2.00	175 87.50	31 10.50	200 100.00

P-value .354

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4.5 Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation

df = degrees of freedom
SS = sum of squares
MS = mean square
F = significant of F
P = probability value

4.5.1 Age – It found that the sample group was differential age, attitude influence towards FAST-model rehabilitation was different significant, P-value= .05 (Table 4-25 – 4-26)

Table 4-25 : Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential age.

Source of Variation Age	**df**	**SS**	**MS**	**F**	**P**
Inter-group	2	493.929	246.964	5.971	.003*
Inner-group	197	8148.291	41.362		
Total	199	8642.220			

*P-value = .05

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Table 4-26 : The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential ages each couple by Sheffe method.

Age	$\bar{X}$	Age		
		1	2	3
14-25	26.81	-		
26-35	24.67	-	-	
36-45	21.88	*	-	-

Addict's rehabilitation were 14 to 25 years old, had different attitude from addict's rehabilitation were 36 to 45 years old, influence towards achievement of FAST-model rehabilitation, was significant (P-value = .05).

4.5.2 Marital Status – It found that the sample group was differential marital status, attitude influence towards FAST-model rehabilitation was not differential significant P-value = .05 (Table 4-27)

Table 4-27 : Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential marital status.

Source of Variation Marital Status	df	SS	MS	F	P
Inter-group	2	251.863	125.932	2.957	.054*
Inner-group	197	8390.357	42.591		
Total	199	8642.220			

*P-value = .05

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4.5.3 Religion - It found that the sample group was differential religion, attitude influence towards FAST-model rehabilitation was not differential significant P-value = .05 (Table 4-28)

Table 4-28 : Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential religion.

Source of Variation religion	df	SS	MS	F	P
Inter-group	2	1137.448	568.724	14.929	.000*
Inner-group	197	7504.772	38.095		
Total	199	8642.220			

*P-value = .05

Table 4-29 : The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential religion each couple by Sheffe method.

Religion	$\bar{X}$	Religion		
		(1)	(2)	(3)
Buddhist (1)	24.42	-		
Christian (2)	24.00	-	-	
Islam (3)	32.53	*	*	-

Addict's rehabilitation were Buddhist, had different attitude from addict's rehabilitation were Islam, influence towards achievement of FAST-model rehabilitation, was significant (P-value = .05). (Table 4-29)

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4.5.4 Education - It found that the sample group was differential education, attitude influence towards FAST-model rehabilitation was not differential significant P-value = .05 (Table 4-30 – 4-31)

Table 4-30 : Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential education.

Source of Variation Education	df	SS	MS	F	P
Inter-group	2	1045.410	522.705	13.555	.000*
Inner-group	197	7596.810	38.562		
Total	199	8642.220			

* P-value = .05

Table 4-31 : The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential education each couple by Sheffe method.

Education	$\bar{X}$	Education		
		(1)	(2)	(3)
Elementary (1)	25.12	-		
Secondary (2)	26.76	-	-	
Bachelor degree (3)	18.12	*	*	-

Addict's rehabilitation studied in elementary and secondary level, had different attitude from addict's rehabilitation of Bachelor degree, influence towards achievement of FAST-model rehabilitation, was significant (P-value = .05).

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4.5.5 Occupation - It found that the sample group was differential occupation, attitude influence towards FAST-model rehabilitation was not differential significant P-value = .05 (Table 4-32 – 4-33)

Table 4-32: Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential occupation.

Source of Variation Occupation	df	SS	MS	F	P
Inter-group	3	831.556	277.185	7.075	.000*
Inner-group	187	7326.182	39.177		
Total	190	8157.738			

* P-value = .05

Table 4-33 : The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential occupation each couple by Sheffe method.

Occupation	$\bar{X}$	Occupation		
		(1)	(2)	(3)
Student (1)	23.81	-		
Full Time (2)	22.80	-	-	
Part Time (3)	27.52			
Unemployed (4)	25.59	*	*	-

Addict's rehabilitation were students, had different attitude from addict's rehabilitation were Part-time jobs, influence towards achievement of FAST-model rehabilitation, was significant (P-value = .05).

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4.5.6 Acceptance of family as treatment - It found that Acceptance of their family was differential, attitude influence towards FAST-model rehabilitation was not differential significant P-value = .05 (Table 4-34 – 4-35)

Table 4-34 : Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential of Acceptance of family as treatment.

Source of Variation Acceptance of family while rehabilitation	**df**	**SS**	**MS**	**F**	**P**
Inter-group	3	1959.381	653.127	19.155	.000*
Inner-group	187	6682.839	34.096		
Total	190	8642.220			

*P-value = .05

Table 4-35 : The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential of Acceptance of family as treatment, each couple by Sheffe method.

Frequency of visiting of their family	$\bar{X}$	**Frequency of visiting of their family**		
		(1)	**(2)**	**(3)**
Often (1)	29.71	-		
Sometime (2)	21.71	-	-	
Never (3)	26.51			
Other (4)	22.67	*	*	-

Addict's rehabilitation, their family had sometime come to visit, had different attitude from their family had often come to visit, and their family had never come to visit, had different attitude from their family had often come to visit, influence towards achievement of FAST-model rehabilitation, was significant (P-value = .05).

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4.5.7 Acceptance of family undergoing rehabilitation - It found that acceptance of their family was differential, attitude influence towards FAST-model rehabilitation was not differential significant P-value = .05 (Table 4-36)

Table 4-36 : Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was difference of acceptance of family undergoing rehabilitation.

Source of Variation Acceptance of family undergoing rehabilitation	**df**	**SS**	**MS**	**F**	**P**
Inter-group	3	92.554	30.851	.707	.549
Inner-group	187	8549.666	43.621		
Total	190	8642.220			

*P-value = .05

4.5.8 Neighbors of community - It found that neighbors of community were differential, attitude influence towards FAST-model rehabilitation was not differential significant P-value = .05 (Table 4-37 – 4-38)

Table 4-37 : Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential's neighbors of community.

Source of Variation Neighbors of community	**df**	**SS**	**MS**	**F**	**P**
Inter-group	3	4385.190	1461.730	67.300	.000*
Inner-group	187	4257.030	21.720		
Total	190	8642.220			

*P-value = .05

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Table 4-38 : The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was difference of neighbors of community each couple by Sheffe method

Neighbors of community	$\bar{X}$	Neighbors of community			
		(1)	(2)	(3)	(4)
Consume – sell drug (1)	23.49	-			
Anti drug (2)	19.87	*	-		
Sell drug (3)	34.61	*	*	-	
Other (4)	25.40	-	*	*	-

Addict's rehabilitation who had neighbors of community anti drug, had different attitude from addict's rehabilitation who had neighbors of community addict drug, and addict's rehabilitation who had neighbors of community was sale drug, had different attitude from addict's rehabilitation who had neighbors of community anti drug, influence towards achievement of FAST-model rehabilitation, was significant (P-value = .05).

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4.5.9 Reason of first time drug abuse - It found that there was different attitude of first time drug abuse, influence towards FAST-model rehabilitation was not differential significant P-value = .05 (Table 4-39 – 4-40)

Table 4-39 : Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was different attitude of reason to consume drug for the first time.

Source of Variation Reason of firs time drug abuse	**df**	**SS**	**MS**	**F**	**P**
Inter-group	3	1128.337	376.112	9.811	.000*
Inner-group	187	7513.883	38.336		
Total	190	8642.220			

* P-value = .05

Table 4-40 : The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was difference of reason to consume drug for the first time each couple by Sheffe method.

Reason of first time drug abuse	$\bar{X}$	**Reason to consume drug for the first time**			
		(1)	(2)	(3)	(4)
Curiousness (1)	24.78	-			
Funny (2)	28.48	*	-		
Persuade of peer (3)	22.15	*	*	-	
To have and problem or worried (4)	19.00	-	*	*	-

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Addict's rehabilitation who consumed drug for funny, had different attitude from addict's rehabilitation who consumed drug because curiousness, and addict's rehabilitation addict's rehabilitation who consumed drug because persuade of peer and worried their any problem, had different attitude from addict's rehabilitation who consumed drug for funny, influence towards achievement of FAST-model rehabilitation, was significant (P-value = .05).

4.5.10 Age of first time drug abuse - It found that there was different attitude of age first time drug abuse, influence towards FAST-model rehabilitation was not differential significant P-value = .05 (Table 4-41 – 4-42)

Table 4-41 : Analysis of variance (ANOVA) of the attitude influence towards FAST-model rehabilitation was differential attitude of age to consume drug for the first time.

Source of Variation Age of first time drug abuse	**df**	**SS**	**MS**	**F**	**P**
Inter-group	2	1497.897	748.949	20.652	.000*
Inner-group	197	7144.323	36.266		
Total	199	8642.220			

*P-value = .05

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Table 4-42 : The difference of attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential of age to consume drug for the first time each couple by Sheffe method.

Age to consume drug for the first time	$\bar{X}$	**Age to consume drug for the first time**		
		(1)	(2)	(3)
12 – 21 years (1)	26.70	-		
22 – 31 (2)	20.51	*	-	
32 – 41 (3)	28.00	*	*	-

Addict's rehabilitation, who consumed drug for the first time since 22 to 31 years old, had different attitude from addict's rehabilitation who consumed drug for the first time since 12 to 21 years old. And addict's rehabilitation who consumed drug for the first time since 32 to 41 years old, had different attitude from addict's rehabilitation who consumed drug for the first time since 22 to 31 years old, influence towards achievement of FAST-model rehabilitation, was significant (P-value = .05).

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4.6 Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation

4.6.1 Age – It found that the sample group was differential age, attitude influence towards Thai traditional rehabilitation was not different significant P-value = .05 (Table 4-43)

Table 4-43 : Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential age.

Source of Variation Age	df	SS	MS	F	P
Inter-group	2	94.642	47.321	2.431	.091
Inner-group	197	3834.753	19.466		
Total	199	3929.395			

4.6.2 Marital Status – It found that the sample group was differential marital status, attitude influence towards Thai traditional rehabilitation was not differential significant P-value = .05 (Table 4-44)

Table 4-44 : Analysis of variance (ANOVA) of the attitude influence towards Thai tradition rehabilitation was differential marital status.

Source of Variation Marital Status	df	SS	MS	F	P
Inter-group	2	9.723	4.861	.244	.783
Inner-group	197	3919.672	19.897		
Total	199	3929.395			

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4.6.3 Religion - It found that the sample group was differential religion, attitude influence towards Thai traditional rehabilitation was differential significant P-value = .05 (Table 4-45 - 4-46)

Table 4-45 : Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential religion.

Source of Variation religion	df	SS	MS	F	P
Inter-group	2	121.032	60.516	3.130	.046
Inner-group	197	3808.363	19.332		
Total	199	3929.395			

* P-value = .05

Table 4-46 : The differential of the attitude influence towards achievement of FAST-model treatment in addict's rehabilitation was differential religion each couple by Sheffe method.

Religion	$\bar{X}$	Religion		
		(1)	(2)	(3)
Buddhist (1)	28.73	-		
Christian (2)	24.75	-	-	
Islam (3)	28.58	*	*	-

Addict's rehabilitation were Christian, had different attitude from addict's rehabilitation were Buddhist, influence towards achievement of FAST-model rehabilitation, was significant (P-value = .05).

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4.6.4 Education - It found that the sample group was differential education, attitude influence towards Thai traditional rehabilitation was not differential significant P-value = .05 (Table 4-47)

Table 4-47 : Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential education.

Source of Variation Education	df	SS	MS	F	P
Inter-group	2	50.797	25.398	1.290	.278
Inner-group	197	3878.598	19.688		
Total	199	3929.395			

4.6.5 Occupation - It found that the sample group was differential occupation, attitude influence towards Thai traditional rehabilitation was not differential significant P-value = .05 (Table 4-48 – 4-49)

Table 4-48 : Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential occupation.

Source of Variation Occupation	df	SS	MS	F	P
Inter-group	3	189.684	63.228	3.326	.021*
Inner-group	187	3555.248	19.012		
Total	190	3744.932			

* P-value = .05

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Table 4-49 : The difference of attitude influence towards achievement of Thai traditional treatment in addict's rehabilitation was differential occupation each couple by Sheffe method.

Occupation	$\bar{X}$	Occupation		
		(1)	(2)	(3)
Student (1)	30.19	-		
Full Time (2)	28.22	-	-	
Part Time (3)	28.39			
Unemployed (4)	26.12	*	*	-

Addict's rehabilitation were unemployed, had different attitude from addict's rehabilitation were students, influence towards achievement of Thai traditional rehabilitation, was significant (P-value = .05).

4.6.6 Acceptance of family as treatment - It found that Acceptance of their family was differential, attitude influence towards Thai traditional rehabilitation was not differential significant P-value = .05 (Table 4-50)

Table 4-50 : Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential of Acceptance of family as treatment.

Source of Variation Acceptance of family as treatment	df	SS	MS	F	P
Inter-group	3	14.383	4.794	.240	8.68
Inner-group	187	3915.012	19.975		
Total	190	3929.395			

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4.6.7 Acceptance of family undergoing rehabilitation - It found that acceptance of their family was differential, attitude influence towards FAST-model rehabilitation was differential significant P-value = .05 (Table 4-51 – 4-52)

Table 4-51 : Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential of acceptance of family undergoing rehabilitation.

Source of Variation Acceptance of family undergoing rehabilitation	**df**	**SS**	**MS**	**F**	**P**
Inter-group	3	273.643	91.214	4.890	.003*
Inner-group	187	3655.752	18.652		
Total	190	3929.395			

*P-value = .05

Table 4-52 : The difference of attitude influence towards achievement of Thai traditional treatment in addict's rehabilitation who had acceptance of family undergoing rehabilitation were differential each couple by Sheffe method

Acceptance of family undergoing rehabilitation	$\bar{X}$	**Acceptance of family after rehabilitation**			
		(1)	(2)	(3)	(4)
Pleasant (1)	28.51	-			
Neglect (2)	24.75	-	-		
Aversion (3)	33.29	*	*	-	
Other (4)	28.78	-	-	-	-

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Addict's rehabilitation had their family was aversion, had different attitude from addict's rehabilitation had their family was pleasant, and addict's rehabilitation had their family was aversion, had different attitude from addict's rehabilitation had neglect, influence towards achievement of Thai traditional rehabilitation, was significant (P-value = .05).

4.6.8 Neighbors of community - It found that neighbors of community were differential, attitude influence towards Thai traditional rehabilitation was not differential significant P-value = .05 (Table 4-53)

Table 4-53 : Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential's neighbors of community

Source of Variation Neighbors of community	**df**	**SS**	**MS**	**F**	**P**
Inter-group	3	121.872	40.624	2.091	.103
Inner-group	187	3807.523	19.426		
Total	190	3929.395			

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4.6.9 Reason of first time drug abuse- It found that there was differential attitude of reason to consume drug for the first time, influence towards Thai traditional rehabilitation was not differential significant P-value = .05 (Table 4-54)

Table 4-54 : Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential attitude of reason to consume drug for the first time.

Source of Variation Reason of first time drug abuse	df	SS	MS	F	P
Inter-group	3	98.123	32.708	1.673	.174
Inner-group	187	3831.272	19.547		
Total	190	39.29			

4.6.10 Age of first time drug abuse - It found that there was differential attitude of age to consume drug for the first time, influence towards Thai traditional rehabilitation was differential significant P-value = .05 (Table 4-55 – 4-56)

Table 4-55 : Analysis of variance (ANOVA) of the attitude influence towards Thai traditional rehabilitation was differential attitude of age to consume drug for the first time.

Source of Variation Age of first time drug abuse	df	SS	MS	F	P
Inter-group	2	125.668	62.834	3.254	.041*
Inner-group	197	3803.727	19.308		
Total	199	3929.395			

*P-value = .05

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Table 4-56 : The difference of attitude influence towards achievement of Thai traditional treatment in addict's rehabilitation was differential of age to consume drug for the first time each couple by Sheffe method.

Age of first time drug abuse	$\bar{X}$	**Age to consume drug for the first time**		
		(1)	(2)	(3)
12 – 21 years (1)	28.14	-		
22 – 31 years (2)	29.25	*	-	
32 – 41 years (3)	31.86	*	*	-

Addict's rehabilitation, who consumed drug for the first time since 32 to 41 years old, had different attitude from addict's rehabilitation who consumed drug for the first time since 12 to 21 years old, influence towards achievement of FAST-model rehabilitation, was significant (P-value = .05).

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CHAPTER 5
DISCUSSION

The objectives of this research were study to the achievement of rehabilitation in addict's methamphetamine, compared between FAST-model and Thai traditional treatment, involved attitude, feeling and confident of addict's rehabilitation at each institute. For the instrument of the study was the questionnaires, the sample group was addict's methamphetamine to willing from the forced system of treatment at institute of FAST-model rehabilitation. There were sample groups 100 cases of Thayarak institute and 100 cases of Wat Tham-Krobok, all 200 cases.

Result of study; found that the majority of the sample groups were 26 – 35 years old of average with single status and Buddhist. They studied in elementary level and Part-time job. Most of them had the average income per month less than 5,000 baht and 5,000 – 10,000 baht, their hometown is province, 4 to 6 people in their family, 2 people of relation in family, to be the first of child. There was more than a person live with them, closely relationship. While rehabilitation, their family had sometime come to visit, their family was pleasant and welcomed when they came back to home. Most of member in their family never addicted drug, their community was city and their neighbors consumed and sold drug. When they came back to community, everybody accepted and helped them, they will stop to involve with methamphetamine and all drug. A cause of the first consuming was curious. Methamphetamine was a kind of drug, which the first consuming. They consumed drug the first since 12 to 21 years old, the inhaled method was widely consuming.

Before the first used drug, addict's rehabilitation knew drug information in moderate level. They treated at the FAST-model institute the first time since 1998 –

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2006. After rehabilitation, addict's rehabilitation stopped drug for 1 to 10 months most a long time and reason of the first rehabilitation because they had been forced. After the first rehabilitation, they returned to consume again because they had depressed from their family. Lately, FAST-model rehabilitation was the treatment method, which had used more than Thai traditional rehabilitation.

5.1 Recommendation of addict's rehabilitation, influence towards achievement of FAST-model treatment

From the study was found that the interval of age's difference, affected to the different attitude, the majority of sample group between 14 to 25 years and 36 to 45 years, disagreed with achievement of FAST-model rehabilitation. Sample group between 26 to 35 years old was uncertain in achievement of FAST-model rehabilitation. For marital status, found that the difference of marital status affected to the difference of FAST-model rehabilitation. From this study, found that the majority of single status disagreed with achievement of FAST-model rehabilitation, marriage and widow status were uncertain in achievement of FAST-model rehabilitation. For religion, found that the difference of religion affected to the difference of FAST-model rehabilitation, that the majority of Buddhists disagreed with achievement of FAST-model rehabilitation, the others were uncertain in achievement of FAST-model rehabilitation. For education, found that the difference of education influenced towards the difference of FAST-model rehabilitation, the majority of elementary were uncertain in achievement of FAST-model rehabilitation, Secondary school and bachelor degree disagreed with achievement of FAST-model rehabilitation. For occupation, found that the difference of occupation influenced towards the difference of FAST-model rehabilitation, the majority of student and Full-time worker disagreed with achievement of FAST-model rehabilitation, Part-time worker sample group were uncertain in achievement of FAST-model rehabilitation. For age of first time drug abuse, found that age of first time drug abuse was differential, influenced towards the difference of FAST-model

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rehabilitation. The sample groups of age to consume drug for the first time between 12 to 21 years were uncertain in achievement of FAST-model rehabilitation and 22 to 31 years disagreed with achievement of FAST-model rehabilitation. For Institute of first time rehabilitation, found that institute of first time rehabilitation was not differential significant. For the reason of first time rehabilitation of sample group, found that the reason of first time rehabilitation of sample group was differential, influenced towards the difference of FAST-model rehabilitation. The forced sample groups were uncertain in achievement of FAST-model rehabilitation, the sample group was fear to be arrested and the sample group would like to stop by oneself disagreed with achievement of FAST-model rehabilitation. For the period of stop drug, found that the period of stop drug of sample group was differential, influenced towards the difference of FAST-model rehabilitation. The sample group incapable to stop drug disagreed with achievement of FAST-model rehabilitation. Sample group could be to stop drug for 1 to 10 months disagreed with the same as for 21 to 30 months, the sample group could be to stop drug for 11 to 20 months, 31 to 40 months and 40 to 50 months, were uncertain in achievement of FAST-model rehabilitation. For acceptance of family as treatment, found that acceptance of family was differential, influence towards the difference of FAST-model rehabilitation. Their family, who often had come to visit, was uncertain and disagreed with achievement of FAST-model rehabilitation. Their family, who sometime had come to visit, disagreed. Their family, who never had come to visit, was uncertain in achievement of FAST-model rehabilitation.

5.2 The attitude of addict's rehabilitation influence towards achievement of Thai traditional rehabilitation

From the study was found that the interval of age's difference, affected to the attitude was not different, the majority of sample group sample group between 26 to 35 years old was uncertain in the achievement of FAST-model rehabilitation same as 14 to 25 and 36 to 45 years old. For marital status, found that the difference of

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marital status affected to the achievement of FAST-model rehabilitation was not different, the majority of single status were uncertain in achievement of FAST-model rehabilitation same as marriage and widow status. For religion, found that the difference of religion affected to the achievement of FAST-model rehabilitation was not different, that the majority of Buddhists were uncertain in achievement of FAST-model rehabilitation same as the others. For education, found that the difference of education affected to achievement of FAST-model rehabilitation was not different, the majority of elementary sample group were uncertain in achievement of FAST-model rehabilitation same as secondary school and bachelor degree. For occupation, found that the difference of occupation affected to the achievement of FAST-model rehabilitation was not different, the majority of Part-time worker were uncertain in achievement of FAST-model rehabilitation same as the others. For age of first time drug abuse, found that age to consume drug for the first time was different, affected to the achievement of FAST-model rehabilitation was not different. The sample groups of age to consume drug for the first time between 12 to 21 years were uncertain in achievement of FAST-model rehabilitation same as between 22 to 31 years and 32 to 41 years. For Institute of first time rehabilitation, found that institute of first time rehabilitation was not differential significant. For the reason of first time rehabilitation of sample group, found that the reason of first time rehabilitation of sample group was differential, affected to the achievement of FAST-model rehabilitation was not different. The forced sample groups were uncertain in achievement of FAST-model rehabilitation same as the others. For the period of stop drug, found that the period of stop drug of sample group was differential, affected to the achievement of FAST-model rehabilitation was not different. The sample group could be to stop drug for 11 to 20 months, 21 to 30 months, 31 to 40 months and 40 to 50 months, were uncertain in achievement of FAST-model rehabilitation. For reaction of family while rehabilitation, found that reaction of family was differential, affected to the achievement of FAST-model rehabilitation was not different. Their family, who had sometime come to visit, were uncertain in the achievement of FAST-model rehabilitation same as the others. For neighbor of community, found that neighbor of community were not different, affected to the achievement of FAST-

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model rehabilitation was not different. Most of neighbor consumed and sold drug were uncertain in achievement of FAST-model rehabilitation same as the others.

From the mentioned, found that the majority of addict's FAST-model rehabilitation, had attitude influence towards achievement of rehabilitation was differential, most of sample group were uncertain and disagreement. For addict's Thai traditional rehabilitation had attitude influence towards achievement of rehabilitation was not different, most of sample group were uncertain. So addict's rehabilitation were uncertain both method but they had method of stop drug by oneself. It refers to stop drug effectiveness, depend on the intention of addict's rehabilitation. Although, method is excellence but addict's rehabilitation neglect, their rehabilitation not successful.

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CHAPTER 6
CONCLUSION AND RECOMMENDATION

The study of "Achievement of FAST-model Treatment and Thai traditional treatment in Methamphetamine Addict Rehabilitation: Thanyarak Institute and Wat Tham-Krabok" was objective for study to achievement of FAST-model and Thai traditional rehabilitation, involved attitude, feeling, confident and rate of return to consume again of addict's rehabilitation. Results of this study take to develop effectiveness treatment, by collected data from Thanyarak institute and Wat Tham-Krobok for 200 cases, used descriptive statistic, inductive statistic and analysis of variance for Data analysis. Concluding the result of study as follow;

6.1 Conclusion

6.1.1 Personal and General Data of the sample groups; found that the majority of the sample groups were 26 – 35 years old of average with single status and Buddhist. They studied in elementary level and Part-time job. Most of them had the average income per month less than 5,000 baht; their hometown is province, 4 to 6 people in their family, 2 people of relation in family, to be the first of child. There was more than a person live with them, closely relationship. While rehabilitation, their family had sometime come to visit, their family was pleasant and welcomed when they came back to home. Most of member in their family never addicted drug, their community was city and their neighbors consumed and sold drug. When they came back to community, everybody accepted and helped them, they will stop to involve with methamphetamine and all drug.

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6.1.2 The chronicle of used to drug of the sample groups

A cause of the first consuming was curious. Methamphetamine was a kind of drug, which the first consuming, they consumed drug the first since 12 to 21 years old. The inhaled method was widely consuming. Before the first used drug, addict's rehabilitation knew drug information in moderate level. They treated at the FAST-model institute the first time since 1998 – 2006. After rehabilitation, addict's rehabilitation stopped drug for 1 to 10 months most a long time and reason of the first rehabilitation because they had been forced. After the first rehabilitation, they returned to consume again because they had depressed from their family. Lately, FAST-model rehabilitation was the treatment method, which had used more than Thai traditional rehabilitation.

From as mentioned data, the differential of FAST-model rehabilitation and background data affected to differential attitude of rehabilitation also. For Thai tradition rehabilitation, found that the differential of background influence toward.

Summary that, the differential of background data and the chronicle data used drug abuse of sample group, influence toward the differential of attitude affected to achievement of FAST-model and Thai traditional rehabilitation. Addict's rehabilitation in FAST-model treatment was differential more than Thai traditional treatment. Therefore, hypothesis testing is correctly but there was differential in detail of each independence variables.

6.2 Recommendation

6.2.1 Rehabilitation each methods, got the differential achievement of rehabilitation, so achievement of most rehabilitation depend on addict's rehabilitation who was intent to stop drug and no come back to consume again. Therefore, government should be created recognize in the rehabilitation process each method, for addict's rehabilitation and follow up.

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6.2.2 Thai traditional rehabilitation got the achievement well could be acceptable from foreign widely and free expenses. Government should be support and promote continued toward various countries approve of Thai traditional treatment.

6.2.3 Government should be protect and suppress the spread out of methamphetamine consistently be careful youth return to consume drug again.

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APPENDIX

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First part: General information

1. Age …….. Year old

2. Marital Status

A. Single
B. Marriage
C. Divorce
D. Widow

3. Religion

A. Buddhism
B. Christianity
C. Islam
D. The other, please specify…….

4. Education

A. No take the education
B. Elementary education
C. High school education
D. Higher education
E. Higher than higher education

5. Occupation

A. Student
B. Full time job
C. Part time job
D. Unemployed

6. Nationality

A. Thai
B. The other, please specify……..

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7. Average income per month

A. Less than 5,000 baht
B. 5,000 – 10,000 baht
C. 10,000 – 20,000 baht
D. higher than 20,000 baht

8. Domicile

A. Bangkok
B. The province

9. Number of member in family ……person(s)

10. The relatives ……person(s)
An order of child ……

11. Person who you live now with (can answer more than 1 answer)

A. Father
B. Mother
C. Relative
D. Spouse
E. Children
F. Friend
G. Stay alone
H. The other, please specify……..……..

12. The relation between members within a family

A. Be close to family
B. Do not be close to family
C. Be estranged
D. The other, please specify……..…

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13. While, reach take the cure heals your family visit

    A. Often visit

    B. Visit sometime

    C. Never visit

    D. The other, please specify……

14. When you get back to cure house heals your family

    A. Is glad

    B. Be indifferent

    C. Do not welcome

    D. The other, please specify……..…

15. Person in your family

    A. Ever be amphetamine addict.

    B. Never be amphetamine addict

16. Environment in your community is

    A. City area

    B. Rural area

17. Mostly friend in your community is

    A. Sells and addicts the amphetamine

    B. Never be amphetamine addict

    C. Sells amphetamine.

    D. The other, please specify……....

18. When, you get back to community takes the cure heals, your community

    A. Admit and help

    B. Hate

    C. Refuses

    D. Be indifferent

    E. The other, please specify……

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19. When depart the treatment area heals, you intend to

A. Not get involved with amphetamine and every kind drugs

B. Be not sure

C. Gets back to addicts amphetamine again

D. The other, please specify……..…

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Second part : Information about the history of usage drug.

1. Important cause in addicts the amphetamine for the first time is

   A. Want to try
   B. For the amusement
   C. A friend persuades
   D. Get into trouble
   E. help in the work
   F. Use in disease preservation
   G. The others, please specify……..……..

2. A kind of the drug that you take for the first time is…….……

3. For the first time, you addicts amphetamine when ……..……years old

4. The method addicts amphetamine is……...……

5. Before you addict the amphetamine, you're realize about danger of the amphetamine

   A. A lot
   B. Moderate
   C. A little
   D. None

6. You take the cure heals the amphetamine for the first time that…….
   When……..…….
   After treatment, you can stop amphetamine……...…months

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7. The reason that you want to stop amphetamine in the first time

   A. Enforced and beg
   B. The health is not good
   C. Fear the police catches
   D. Have no money
   E. Want to quit by yourself
   F. The others please specify……..

8. You had ever to stop drugs……month(s)

9. After you already cure? What the cause you get back to addict amphetamine again……

10. At the time you can to stop the amphetamine, you change the cure with the way

   A. Western way
   B. Thai way
   C. The other, please specify……..……

11. The cure heals proceeding by Western way, you can stop the amphetamine ……..….month(s)

12. The cure heals proceeding by Thai way, you can stop the amphetamine ……..….month(s)

13. The amount time at you reaches to take the cure heals……time(s)

14. Each time, the amount of money that use in amphetamine buying to take …….baht

15. Money that you bring to buy the amphetamine, get from……..……

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16. Before reach take the cure heals the amphetamine this time you have ever to reach take the cure s heal the narcotic, what type?

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Third part: Information about the opinion in treatment by Fast Model Rehabilitation and Thai Traditional

The explanation: Please tick (✓) where you think according to your opinion.

The opinion about the treatment by Fast Model Rehabilitation and Thai Traditional	Fast Model Rehabilitation					Thai Traditional				
	5	4	3	2	1	5	4	3	2	1
1. The practice that restricted until cannot follow.										
2. Medicine that clinic gives its make the health more deteriorates.										
3. Some method is not suit with Thai Characteristic.										
4. Limit choice in job training and it's not respond the requirement of patient.										
5. The way treat can cause the intervening disease.										
6. The period of recuperate have the free time too much, and then it make get back thinking of the narcotic again.										
7. the cure have no the law enforces , then it can not make the drug addict stays to heal fully step										
8. Steps prepares before the preservation , it take time long ago, then it might not make the drug addict can change one's mind										
9. Enrolling must use many complicated evidences.										

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The opinion about the treatment by Fast Model Rehabilitation and Thai Traditional	Fast Model Rehabilitation					Thai Traditional				
	5	4	3	2	1	5	4	3	2	1
10. Clothing of nursing home don't be attractive for wear										
11. Expenses in the cure are too high										
12. the staff still not enough to service										
13. Veracity alms, promise and inquiring intention gets into trouble dissolute, waste time.										
14. The place of the treatment area near the community and convenient transportation, make easy build habit-forming uses.										
15. Don’t have building believes and spirit between the cure.										
16. Lack of spiritual restraint between the cure										

5 = Most agree, 4 = Agree, 3 = Uncertain, 2 = Disagree, 1 = Most disagree

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Fourth part : Information about the opinion in result of treatment by Fast Model Rehabilitation and Thai Traditional.

The explanation: Please tick (✓) where you think according to your opinion.

The opinion in result of treatment by Fast Model Rehabilitation and Thai Traditional	Fast Model Rehabilitation					Thai Traditional				
	5	4	3	2	1	5	4	3	2	1
1. lengthy cure has gotten into trouble at a temple difficult										
2. effective cure is low because a lack of intention will to quit a drug										
3. Both of Fast Model Rehabilitation and Thai Traditional still can not cover the all cure.										
4. Fast Model Rehabilitation and Thai Traditional are lack of cooperate with each other.										
5. the result of cure are not clear, then the patient bored, lack of spirit										
6. The result of cure is not good because internal problem is problem between patients.										
7. The measure in the cure is not suit the patient then they are lack of intention.										
8. The result of cure does not have attendance for improve.										
9. The cure heals should go together with the attendance then effective.										
10. The follow after cure will help more result that is effective.										

5 = Most agree, 4 = Agree, 3 = Uncertain, 2 = Disagree, 1 = Most disagree

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Suggestion of person answer the questionnaire

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