

**A STUDY ON HEALTH CARE NEEDS OF HEROIN DEPENDENTS
: A CASE STUDY OF MALE PATIENTS IN GOVERNMENT DRUG
DEPENDENT TREATMENT CENTRES
IN THE SOUTHERN REGION.**



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จาก

บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล

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This research aimed to study the health care level and factors influencing health care of male heroin dependents in government drug dependent treatment centers of the southern region. Data collection was gathered by the questionnaire method. The population study included 112 patients. Percentage, frequency, and mean were used for the multiple regression analysis.

The results found what male heroin dependents need in regard to financial support psychosocially, health behavior and social support, and health management at different levels. Hire ling and the expectation of stopping heroin dependency were factors that influence health care needs at a moderate level ($R= 0.423$). This could explain the factors which influence health care needs at a rate of 17.9, with statistical significance ($p<0.05$).

These results indicate a recommendation that drug dependent treatment centers emphasize voluntary treatment screening specific intended patients, or those who like to be treated. The steps of rehabilitation emphasize occupational training and developing life skills including emphasizing participatory social networks for treatment.

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การบำบัดรักษา : ศึกษาเฉพาะกรณีผู้ป่วยชายในสถานบำบัดรักษายาเสพติดของรัฐในภาคใต้.

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การวิจัยครั้งนี้มีวัตถุประสงค์เพื่อศึกษาระดับความต้องการการดูแลสุขภาพ และปัจจัยที่มีอิทธิพลต่อความต้องการการดูแลสุขภาพของผู้ป่วยเพศชายที่ติดยาเสพติด ซึ่งเข้ารับการบำบัดรักษาเป็นผู้ป่วยในสถานบำบัดรักษายาเสพติดของรัฐในภาคใต้ โดยรวบรวมข้อมูลเชิงปริมาณซึ่งได้จากการสัมภาษณ์ประชากรที่ทำการศึกษา จำนวน 112 คน วิเคราะห์ข้อมูลด้วยสถิติ ความถี่ ร้อยละ ค่าเฉลี่ย และทดสอบทางสถิติด้วยสถิติวิเคราะห์ถดถอยพหุ (Multiple Regression Analysis)

ผลการวิจัยพบว่า ผู้ป่วยที่ติดยาเสพติดมีความต้องการการดูแลสุขภาพทางด้านเศรษฐกิจและจิตสังคม ด้านพฤติกรรมสุขภาพและการสนับสนุนทางสังคม และด้านการจัดการสุขภาพ ในระดับปานกลาง อาชีพรับจ้างและความคาดหวังที่จะเลิกเสพยาเสพติดเป็นปัจจัยที่มีอิทธิพลต่อความต้องการการดูแลสุขภาพได้ในระดับปานกลาง ($R = 0.423$) และสามารถอธิบายความแปรปรวนของตัวแปรที่มีอิทธิพลต่อความต้องการการดูแลสุขภาพได้ ร้อยละ 17.9 อย่างมีนัยสำคัญทางสถิติที่ระดับ 0.05

จากผลการวิจัยในครั้งนี้ผู้วิจัยมีข้อเสนอแนะว่า สถานบำบัดรักษายาเสพติดในระบบสมัครใจควรให้ความสำคัญในการคัดกรองผู้ติดยาเสพติดที่มีความตั้งใจ หรือมีความคาดหวังว่าจะเลิกเสพยาเสพติดอย่างจริงจังเข้ารับการบำบัดรักษา สำหรับขั้นตอนการฟื้นฟูสมรรถภาพควรเน้นการฝึกวิชาชีพและการพัฒนาทักษะชีวิตเพื่อกลับไปสู่สังคมได้อย่างเข้มแข็ง และเน้นการมีส่วนร่วมจากเครือข่ายทางสังคมในการบำบัดรักษามากขึ้น

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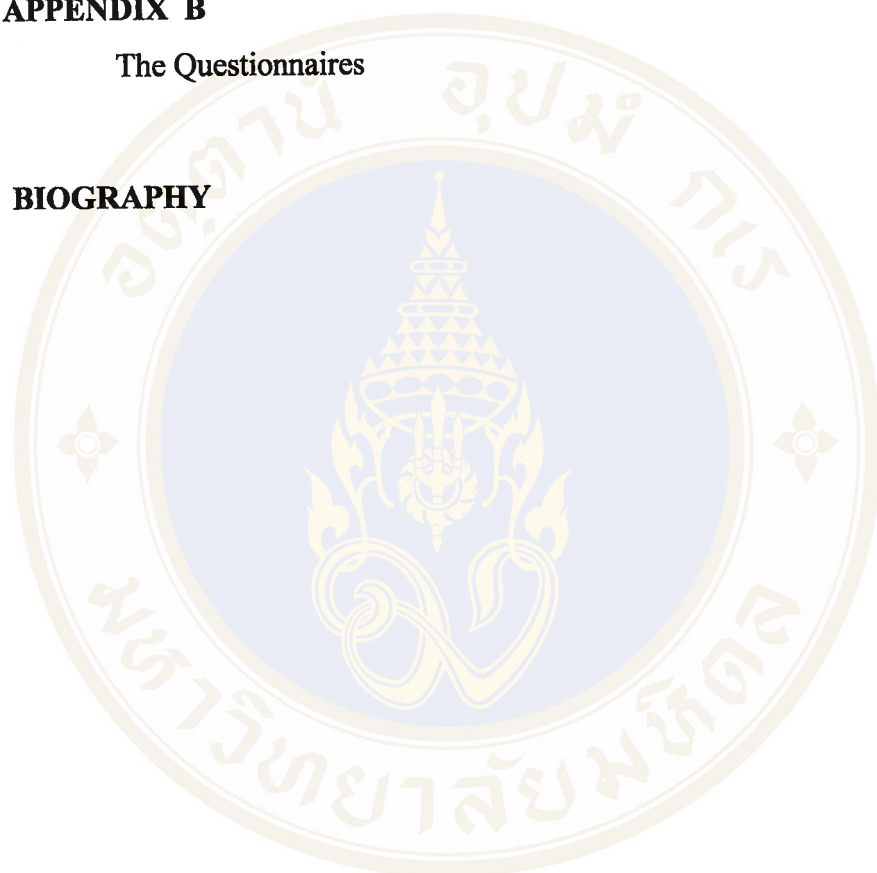
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CHAPTER I

INTRODUCTION

1. Rationale and background

Narcotic problem is major problem of Thailand and another country throughout the world. This problem affect to economic, losing source of personal and criminal problem. These are social problem which the government have to solve and will loss the budgeting for implementing control, force throughout prevention and therapeutic heroin dependent patient. This problem is effect to security of country and barrier to developing country.

From the report of heroin dependent patient in the southern region during 1994-1999, it was found that in 1994 case of heroin dependent patient was 10,161 cases, in 1995 was 12,438 cases, in 1996 was 14,949 cases, in 1997 was 16,557 cases, in 1998 was 15,060 cases and 1999 was 15,708 cases which had high trend every year. From statistic in 1999, there were the male patients 97.7 and age range 15-19 years old were 64.6 and had 58.84 of patients who was admitted in drug dependent treatment centres in the southern Region. There were Songkhla, Narathiwat, Yala, Satoon province. The Most of patients who therapeutic intention were Songkhla province, Narathiwat, Nakhornsri thamraj, and Pattani respectively. When considered on the patients by classified on kind of drug found that heroin therapy was (50.3%) and Amphetamine (42.5%) and in addition, there were opium, marijuana and the other (Office of the Narcotics Control Board, 1999: 11) in each year found that trend of situation was more increased in 1984,1985,1986 to 1999. Heroin abusers were 49,108,

54,313, 41,547 and 56,315 cases respectively. The patients admitted in hospital were age ranges 20-24 years, the most of heroin abusers were age range 15-19 years (23.3%) and 25-29 years (15.9%) respectively. The important issue as interesting was age at first of addiction was age range 15-19 years. (Office of the Narcotics Control Board, 1999: 1) For reporting in Thailand found that there was heroin abusers of 1,267,590 cases. (Thailand Development of Research Institute, 1995 cited by Nonglak Tobunleaphop, 1996: 2) These were important problem as must solve by government.

In the southern region was found that narcotic problem was more severity every year. As shown detail in office of Narcotics Control Board report in 1999 and found that the field in the southern region about 4,119 villages of all 7,408 villages had narcotic rapid.

From report of drug dependent treatment centres in the southern region showed that in 1993-1998 there was heroin patients 10,161 cases, 12,438 cases, 14,949 cases, 15,060 cases, and 15,708 cases respectively. The ratio/100,000 populations which classified all regions was 100.28 / 100,000 populations and ratio of Bangkok metropolitan 350.55 / 100, 000 populations in the northern region was 40.46 /100, 000 populations, in the northeastern region was 3.12 / 100,000 populations (Office of the Narcotics Control Board, 1999: 125-137).

Table1 Number of heroin dependent patients in drug dependent treatment centres in the southern region as classified on newly patients and old patients in 1993-1998.

Year	new case		old case		Total
	no.	percent	no.	percent	
2536	2,093	20.3	8,068	79.4	10,161
2537	2,401	19.3	10,037	80.7	12,438
2538	3,214	21.5	11,735	78.5	17,949
2539	4,090	24.7	12,467	75.3	16,557
2540	3,087	20.5	11,973	79.5	15,060
2541	3,550	22.6	12,158	77.4	15,708

As above - mentioned in table 1 (Office of the Narcotics Control Board, 1999: 5-7) showed that government drug dependent centres still treat many old patients and had more trend in the future.

From data of drug dependent centres in the southern region where is under government controlled. It is one of place where treat out and in-patients. It has statistic of heroin abusers during 1993-1997.

Table 2 Number of drug abuser in drug dependent centres in the southern region, Songkhla province as classified on out-patients and in-patients during 1993-1997.

Year	Out-patients	%	In-patient	%	total
2536	835	78.9	223	21.1	1,058
2537	815	68.1	381	31.9	1,196
2538	614	43.3	805	56.7	1,419
2539	643	37.8	1,056	62.2	1,699
2540	820	42.6	1,104	57.4	1,924

From mention statistic found that number of patients in drug dependent centre was increased every year and proportional patients who seriously addicted and admitted in hospital were increased every year.

Pornsiri Chatiyanon (1977: abstract) studied the causation of repeat addition and serious symptom, found that 218 samples who was interviewed, found that they was aimed to treat specific to physical. But insufficient rehabilitation of mental and follow up, when they backed to previous environment they would repeat addict which consistent with the study of Pitsamai Kupitak, et al. (1981: abstract) studied on patients addicted found that they repeat addicted which derived from they lacked self-efficacy on avoiding risk behavior which supported study of Chankanit-K. Suriyamni et al., (1986: abstract) found that cause of repeat addicted due to they lived near the narcotics resource, inducted, these affected to repeating addiction. There were amounts of heroin patients repeat addicted heroin during 12 months. The most of drug

abuser treated in drug centres approximately 72.30% who had ever treated more than 1 time and 31.10% had ever treated more than 7 times. (Office of the Narcotic Control Board, 1986: 4). For the southern region centres had patients were all dose or detoxification. The medical doctor would treat with Methadone to relief withdrawal symptoms but no over 21 days. Where as, the others symptoms were not treated over 45 days. In 1998 the patients retired from a program at rate 50.87% and in 1999 were 30.26%. They declared that they could not practice follow by taboo. In addition they retired before rehabilitation step which they had to participate in therapeutic community in 1998 approximately 88.89% and in 1999 at rate 96.5% because of they were bored to treat in this centres and dislike to participate in activity. When they backed to previous environment, they would repeat addict. From initial implementation of drug dependent treatment in the southern centres found that drug abusers could not quit heroin abusing and changed the place for treatment. (Wanchai Tamsatjakan, 1999: 33) Social was changed, drug abusers problem also changed. Proper treatment was necessary for these victims. (Wattana Sukpot, 2000: 71) Health care needs were important to treatment.

Thus, the response of need and backed to quality of life among heroin abuser was health care needs as regards physical, spiritual, economy and psychosocial.

Health care was accepted that it is important to living of human which health care refers to action as reaction to other person such as: avoiding risky behavior (Yeesun Jaidee, 1997: 40) person would have healthy condition and well life style, they must to have positive behavior. The theory which applied on this study was therapeutic intervention Larson's concept (1989 cited by Bauluang Samdangrit, 1995: 17-19) revealed that practiced professional comprised with 3 dimensions as follows:

care, cure and coordination. Those of 3 dimensions had the care was core for treatment. The involved staff would have to take account to this process following aspects:

1. Treatment dimensions such as: taking methadone, complication treatment.
2. Coordination dimensions such as: there has coordination between caretakers and patients e.g. medical doctors, psychologists, nurses and religious leaders etc.
3. Care dimensions such as: cared physical, reinforcing economy and psychosocial for patients and their families.

From these concept would encourage to health care needs among heroin abuser and suit for implementation.

Health belief model was one concept as developed on describes personnel behavior. Especially preventive behavior or illness behavior. This concept based on of Levin's field theory that explained to life style of person or life space as comprised with positive value e.g. healthy and positive value e.g. illness including neutral value. The extrovert activity of person was persuasion value of that person and the driving positive value which was explained detail as follows:

1. Perceive threat of disease as comprised with perceived susceptibility to disease occurrence and perceived severity of disease.
2. Likelihood of action such as: perceived benefit and barrier in action.
3. A cue to action was situation or reinforcing person.
4. Modifying factors was factor as no influenced to behavior but would directly effected by perception. There were following aspects:

- Factor on socio-demographic characteristics such as: gender, age, marital status, and education.

- Factor on psychosocial such as: personality, social classification, peers group and influence of citatory group.

- Factor on basic structure such as: disease knowledge, experiential disease contacted. (Becker, et al., 1975).

In this study the researcher applied on Larson's self-care, 1968 and Becker's Health belief model, et al., 1975 and Albert Bandura 's self-efficacy theory, 1977 to be conceptual frame work. Larson stated that self-care had varies patterns such as: physical care, spiritual and reinforcing financial support and psychosocial for patients and their families. Where as, the measurement of health care needs of drug abuser patients in government drug dependent treatment in the southern region. The author applied the measurement from of Berk's health care needs, 1995 on this study. It was used for hospital patient AIDS unit Baltimore which cited to health care needs in regard to physical, spiritual and financial support and psychosocial so.

From health care concept found that treatment was response to perception of patients. Need is necessary to human living when the need did not balance, persons were stress, could not solve their problem and be sad. Thus, persons could develop themselves. They would be reposed by caretakers in a program. They could apply cognitive process on health care (Dodge, 1969; Frank-Stromberg & Wright, 1984; King, 1985 cited by Bauluang Samdangrit, 1995: 25-28) in this finding was studied on basic factors regarding age, education level, occupation, time period of abusing heroin, number of time of treatment and factor on psychology as regards perceived

physical change, perceived severity of detoxification and expectation on stopped heroin addiction.

Thus, at present we would seek a new method to study health care needs of patients. It was necessary to study on physical, psychosocial and spiritual, these were benefit to behavioral modification. This finding studied basic needs of person which base on Maslow's need hierarchy theory to formulate conceptual framework. In this study was emphasized on 1 folders. It was safety and security needs, which consistent with study of Medical Science Research Institution of Chulalongkorn University revealed that after treatment the victims would modify their emotion therefore there should continually, support activities. (Wichai Posyachinda, 1998: 467- 468).

The author would be interested in health care and factor as influenced to health care needs of patients in government drug dependent treatment in the southern region by applying health care concept under therapeutic community of Larson, 1989. After completely finished the author expect that this achievement was guideline to patients' treatment, which direct to patients' need.

2. Research problem

2.1 Which health care needs as heroin abusers who treated in government drug dependent treatment centres need ?

- Financial support and psychosocial
- Health behavior and Social support
- Health management.

2.2 Whether basic factors and psychological factors influenced to health-care needs of heroin abusers in government drug dependent treatment centres, or not ?

3. Objective of this research

3.1 To studied level of health-care needs of male heroin dependents in government drug dependent centres in the southern region.

3.2 To studied factors as influence to health care needs of male Heroin dependents in government drug dependent treatment centres in the southern region.

4. Hypothesis of this research

4.1 Age influenced to health-care needs

4.2 Education level influenced to health-care needs

4.3 Occupation influenced to health-care needs.

4.4 Income influenced to health-care needs.

4.5 Time period of addiction influence to health-care needs.

4.6 Number of time of treatment in centre influenced to health-care needs.

4.7 Perceived physical change influenced to health care needs.

4.8 Perceived severity of detoxification influenced to health care needs.

4.9 Expectation on stopping Heroin dependent influenced to health care

5. Scope of this research

1. This research was studied on the factors as influence to health-care needs of male heroin dependents in government drug dependent treatment centres in the southern region. The populations were hospital in-patient in government drug dependent treatment centres in the southern region, Songkhla province and Pattani province.

2. Variables of this study as followed:

2.1 Independent variables were divided into groups:

2.1.1 Basic factors

- Age
- Education level
- Occupation
- Time period of heroin abused
- Number of time-admission.

2.1.2 Psychological factors

- Perceived physiological factor
- Perceived severity of detoxification.
- Expectation on stopping heroin abused.

2.2 Dependent variable was health-care needs.

6. Definition of term

Male patients refer to male who addicted heroin in government drug dependent treatment centres in the southern region, Songkhla and Pattani province.

Government drug dependent centres in the southern region refer to health centres where was allowed by Ministry of Public Health for implement on treating drug abuser. In this study was conducted in 2 centres as follows:

1. Drug dependent centres in the southern region where available services on out-patient and in-patient. There is Government Drug Dependent Centres in the southern region, Songkhla and Pattani province.

Health-care needs refer to heroin abuser's perception regarding illness impact as effected to health condition e.g. physical, mental and subconscious. The achievement was responded and received helping. It was assessed by assessment form of Berk (1995: 109-116). It was comprised with 3 parts following aspects:

1. Assessment form on health-care needs about financial support and psychosocial followed aspects:

- Adjustment
- Personal relationships
- Income/financial resources
- Financial concern
- Financial assistance
- Money management

2. Assessment form on health-care needs about health behavior and social Support followed aspects:

- Appetite
- Sleep /activity pattern
- Physical activity
- Pain /discomfort
- Social network
- Employment

3. Assessment form health-care needs about health arrangement

followed aspects:

- Religious beliefs
- Resource utilization
- Care-taking system
- Motivation
- Comparison
- Technical skill

Age refers to full number of age, which was counted since birth to present.

Education level refers to highest education level of Heroin dependent patients in centres which was divided into 4 levels as follows: primary school (1-6), secondary school (grade 7-12 vocational), certificate/ undergraduate and bachelor upper.

Occupation refers to regularly job before treatment such as: civil servant, company and privacy.

Income refers to number of salary or daily income from employer or another incomes.

Period of heroin dependent refers to period of treatment of patients.

Number of time-admission refers to number of time as treatment in government drug treatment centres such as: drug treatment centres under ministry of Public Health and Ministry of Interior.

Perceived physical change refers to feeling or heroin abuser's idea to physical change and self-efficacy on working due to heroin abused.

Perceived severity of detoxification refers to feeling or heroin abuser's idea to experiential detoxification. The symptoms were squeezing, muscle pains, bone-pain, induct pinpoint pupils, vomiting, and diarrhea or bleeding in intestine. These symptoms occurred after stopping heroin abused about 3-4 hours.

Expectation on stopping heroin abused refers to the experience of patients in regard to stopping heroin abused by assessed from their feeling to action or self-behavior for health care such as: available public health services and practice followed caretaker's recommendation. Seeking knowledge about disease / therapeutic source to stopped drug abused.

7. Conceptual framework

Independent variables

Dependent variables

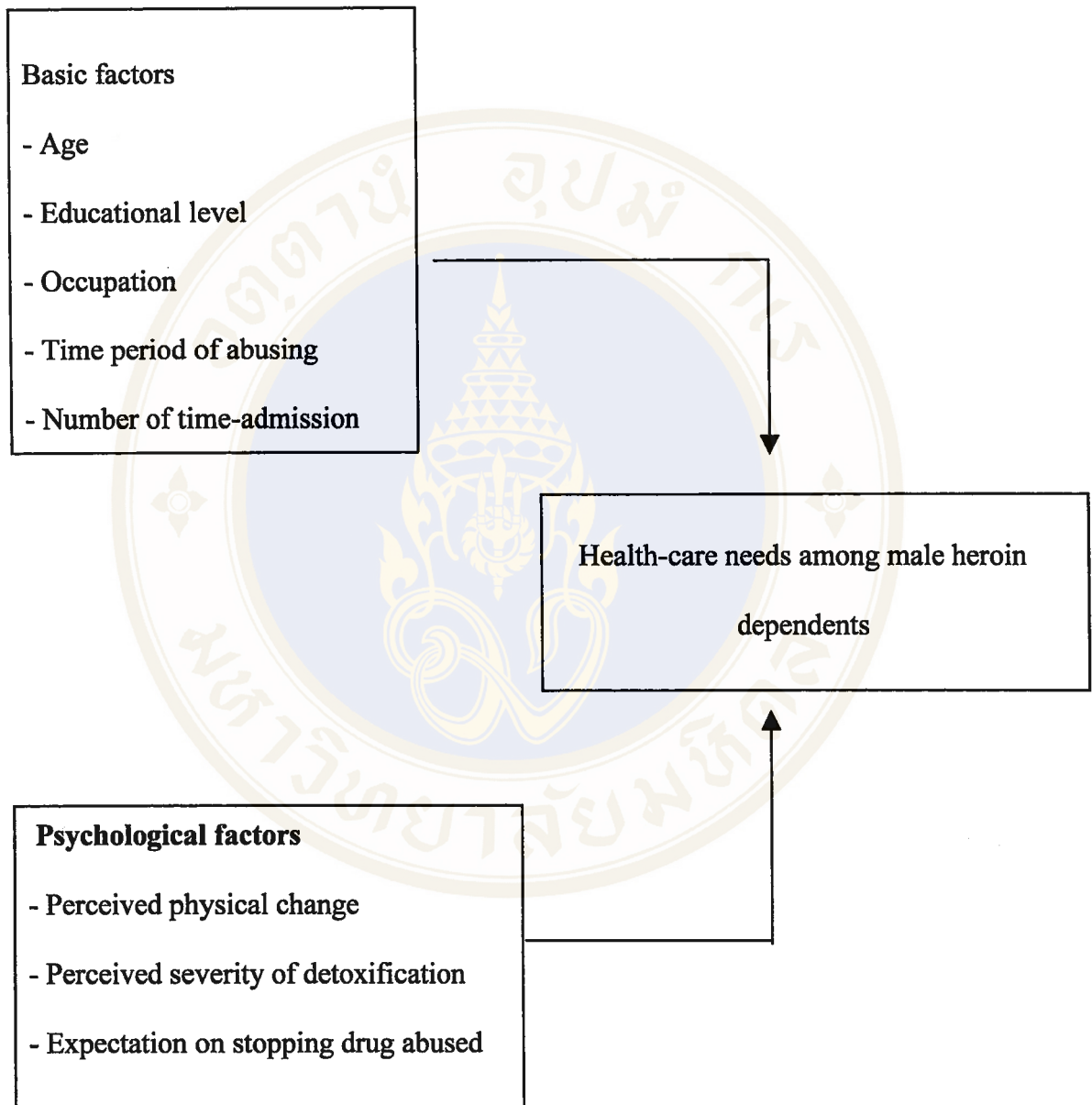


Figure 1 Conceptual framework

CHAPTER II

LITERATURE REVIEW

This research was studied on health-care needs of male heroin dependent. The author studied, review literature and relevant research for be guideline to research as followed below:

1. Concept about heroin problem
2. Heroin abuser treatment concept.
3. Health care needs concept
4. Factors influenced to health-care needs of heroin abuser.

1. Concept about heroin problem

At the present, 60 million of populations were estimated that 1.26 million addicted drug, the most of them were 15-35 years of age. The narcotic which was the important problem, there were heroin, marijuana, tinnier and alcohol. In addition to found that the narcotic problem was spread into the village approximately 22,000 village. It was 42 percent of all village in the country (Pinyo Thongchai, 1996 cited by Benchaporn Thongsuk, 1997: 1-2). In addition, this problem was expected that it will be more problem and found that it is the 1st category of all narcotics. It is heroin

and follow by amphetamine including other narcotics such as: opium, volatile, marihuana.(Office of the Narcotic Control Board, 1999: 4)

In addition, from surveying patient as treated in Bangkok Metropolitan treatment of drug abused centers and boundary area were found that the most of treatment were heroin. In 1996 there were 41.1%of heroin abused. (Office of prevention and Narcotic enforcement committee, 1996 cited by Chaukhing Chucruit, 1998: 1). In the southern region found that most of patients were heroin abused. There was male at rate 50.3%, age less than 29 years at rate 67%. It was 100.28% per 100,000 populations. (Office of the Narcotic Control Board, 1999: 1-4)

1.1 Narcotics

(WHO, 1944 cited by the nation of social welfare, 1995: 10) gave meaning narcotics that drugs and other chemicals which was addicted into physical by general method and continually addicted which affect to physical, mental of abuser. There were 4 features as follows:

1. After addicted, would like to addict continue.
2. Will increase using quantity.
3. Detoxification symptom such as: muscle pain, squeeze, vomiting and vertigo.
4. When use long time, drug abuser's health is bad.

1.2 Definition of heroin

Heroin has chemistry name that “ Diacetyl Morphine. Germany developed it, heroin was developed from morphine and be the 1st hazardous. Heroin is white powder, no smell and use for eat and injection

1.3 Health impact

There were 3 features e.g. physical, psychosocial and spiritual.

1.3.1 Physical impact

Thongchai Unakelap, (2000: 21-23) illustrated to physical impact of drug abusers (amphetamine, volatile, arihuana and heroin) as follows:

1. Nerve stimulant drug such as: amphetamine, caffeine and cannabis. These will stimulate cerebrum when the victims addicted, they will be fresh, exited high blood pressure and heart rate and muscle pain finally, they are weakness.
2. Addictive volatile such as: tinier, benzene and lacquer. These affect to their physical and lead to disability such as: loss memory and have cerebella degeneration.
3. Cannabis dependent, it affects to their physical as regard nerve system.
4. Heroin dependent, heroin is hazardous narcotics (it is more dangerous than opium 50-100). It is easy to addict, difficult to treatment and more expensive. Who are narcotics owner will be arrested for drug offense. Side effect of

heroin is lazy to work, thin and symptoms occur when they want to addict. The symptoms was showed as follows:

- Doziness, watery eyes, runny nose, yawning, sneeze.
- Shallow respiration, heart rate, blood pressure are elevate and high temperature.
- Vomiting, diarrhea and chills.
- Pain in the bones and muscle spasms and extremities, stomach cramp, loss of appetite and death.

Addictive heroin affects to them health such physical and mental. After addicted they are loss appetites, generative health. In the foreign, there are various research which was found that causation of loosing blood was intravenous injection at rate 87.5% of male's Hemoglobin 10.0-14.9 %. They were more infected than normal persons because of they did not take account to septic technique. These affected to increase white blood cells of them at rate 25.42%. in addition, those of heroin were affected to pathology of kidney, lung. Pratheaug Thaniyapon (1987: 20-21) which consistent with the research of Suvilai Sangwan (1990: 13) illustrated that from autopsy found that the organic system was changed such as: lung, liver, heart and including the abuser could not control muscle system and nerve deficit. (Wolner, 1965 cited by Chaukhing Chucruit, 1998: 16) IF they continually addicted long period or more than 4 years they would have symptoms mention. From problems mention found that adolescents who addicted heroin could not learn or work finally, they would be retire and drop their learning.

1.3.2 Psychosocial impact

Being in the same family with other persons was unpleasant of other persons. Because of heroin abuser change their emotion and mental condition was deviated. The initial addictive drug was goose flesh, well being and after that they would be confused in their thinking and evil. (Arunnea Mongkonnvstearn, 1998: 16-17). Nerve system was depressed long time and it affected to mental health and physical. Finally, they would become evil, loss memory and loss decision-making. Those of symptoms affected to their working and daily activities. (Arunnea Mongkonnvstearn, 1998: 18). Heroin abuser was bad health and easy illness and the government was loosen amount of money to prevent and enforce drug dependent treatment. (Knockporn Kanyansute, 1989: 3).

Heroin abuser's health condition and behavior were changed, these affected to their role in families and social including insufficient social support and loss self-image and low self-esteem, hopeless finally they would be death (Arunnea Monkonnvstearn, 1998: 16-19). In addition, Belkin, et al., 1992 cited by Rochana Wiriyombat, 1997: 26). Studied on correlation physical symptoms with depressive symptoms were found that depressive symptoms and physical symptoms could predict on suicidal causation of 2 features.

1. There was correlation depressive symptoms with patients' suicide and more increased follow by physical need level.
2. Most of patients would like to suicide. These effected to physical need level together with depressive symptoms.

1.3.3 Spiritual impact

Spiritual condition is one dimension of persons as reaction with the other dimension of persons in regard to physical and mental. Person deviated in what dimension thus, it was deviated in spiritual too. Especially illness period, it affected to physical and mental. These affected to spiritual need deficit and spiritual distress. (Auyporn Tanmukyakul, 1991: 36-46, Bupha Chaubchai, 1994: 16).

Thus, those of impact also would affect to spiritual and they felt that hopeless and could not seek their life goal, lost value and low dignify. They would response on different behavior such as: no understanding in life goal meaning and general belief. Tasna Bunthong (1991: 21-29) and Pornchun Suwanchart (2000: 1-2) stated that presenting spiritual was emotional indicator, feeling in subconscious.

1.3.4 Family impact

Having drug abuser in family Because of their behaviors were negative. From research of Chaukhing Chucruit (1998: 16) revealed that monthly expense of drug abusers were 1,000-5,000 baht which supported with the research of Ludda Teauksuban (1995: 130) found that drug abuser use heroin combine with Marihuana paid for it approximately 100-300 baht. These led to quarrel including criminal.(Pornsri Pattanapong, 1977 cited by Chaukhing Chucruit, 1998: 16).In addition, they were bad physical and easy to illness.

1.3.5 Social impact

Who was under drug dependent, they will need whole time and could not working but addictive need was high thus, these led to doing offense committed by negligence such as: robbery, thief and snatching including doing an act of violence and being prostitute. (Arunnea Monkonvstearn, 1998: 18).

1.3.6 Security of country impact

From the various research found that drug abuser could not control their emotion and self-mental. They might be induced illicit. Chaukhing Chucruit (1998: 17) Which consistent with the research of Knockporn Kanlyasute (1989: 3) revealed that using narcotics destroyed population such heroin, cannabis, opium and amphetamine was illicit. Because of the population were important to country.

From heroin abusers impact as regards family, social, economy and security of country. Including related research showed that health condition change of Heroin abusers affected to health care need of them. They wished to be under taking care of public health personnel in drug dependent treatment center especially, medical doctor and nurse who continually take care and proper method including emphasized on patients center and patients' participation.

2. Heroin abuser treatment concept

2.1 Principle of heroin abuser treatment.

General heroin abuser treatments were following aspects (Sheaunchit Wongpodee, 1991: 29-35)

- Willingness preparation
- Stopping drug abuse
- Symptoms treatment or symptoms occurred after withdrawal
- Complication treatment
- Treatment as regards rehabilitation
- Reinforcing mind and physical maintenance
- A guideline to back to social and working by self
- Followed up
- From above concept mention, it was a guideline to implementation for

physical rehabilitation and mental. The initial implementation integrated current medicine with old medicine, which was divided into 3 systems: voluntary system and correction system and compulsory system.

1. Voluntary system is the clients are pleased to treatment and conduct in government center. All clients have to be under the law of that center which divided into 2 features.

1.1 Out-patients, the patients is available service whole day-opened (go and back).

1.2 In-patients, the patients were admitted in hospital.

Directly responsibility office is Department of medicine, Ministry of Public Health where cooperate with other organization such as: general health places under Ministry of Public Health and Health place under Ministry of Military, service place under and Health center of Bangkok Metropolitan. In addition, there are privacy organization give cooperation.

2. Correction system is treatment system among accused narcotic or controlled behavior by court. During

2.1 Step of treatment

2.2.1 Pre-admission

2.2.2 Detoxification

3. Rehabilitation

3.1 Physical rehabilitation

3.2 Mental rehabilitation

3.3 Occupational rehabilitation

3.4 Social rehabilitation

4. Follow-up and after care

Public health should follow up to assess their change by home visit. In case of the case who can not connect, they would be information by letter to support their mind.

3. Health care needs concept

3.1 Health belief model

The health belief model was developed initially in the 1950s by a group of social psychologists in the U.S. public health service in an effort to explain the widespread failure of people to participate in programs to prevent or to detect disease (Hochbaum, 1958; Rosenstock, 1960, 1966, 1974 cited by Praphaphen Suvan, 1989: 89-99). Later, the model was extended to apply to people's responses to symptoms (Kirscht, 1974: 49-57) and to their behavior in response to diagnosed illness, particularly their compliance with medical regimens (Becker, 1974: 12). Although the model evolved gradually in response to very practical programmatic concerns that will be described presently, its basis in psychological theory is provided here as an aid to understanding its rationale and its strengths and weakness.

Component of the HBM theory

1. Perceived susceptibility

The dimension of perceived susceptibility measures an individual's subjective perception of his or her risk of contracting a health condition. For case of

medically established illness, the dimension has been reformulated to include the individual's acceptance of the diagnosis, personal estimates of resusceptibility, and susceptibility to illness in general.

2. Perceived severity

Perceived severity addresses feelings concerning the seriousness of contracting an illness or of leaving it untreated. Perceived severity includes evaluation of both medical and clinical consequences (such as death, disability, and pain) and possible social consequences (such as effects of the condition on work, family life, and social relations). The combination of susceptibility and severity has been labeled the perceived threat.

3. Perceived benefits

Although acceptance of personal susceptibility to a condition also believed to be serious (that is, susceptibility to a perceived threat) produces a force leading to behavior, the particular course of action taken will depend up on beliefs regarding the disease threat, termed the perceived benefits of taking health action. Other factors include non-health-related benefits (for example, quitting smoking to save money or getting a mammogram to please a family member). Thus, an individual exhibiting an optimal level of beliefs in both susceptibility and severity would not be expected to accept any recommended health action unless that action were perceived as potentially efficacious.

4. Perceived Barriers

The potentially negative aspects of a particular health action, the perceived barriers, may act as impediments to undertaking the recommended behavior. A kind of nonconscious cost-benefit analysis occurs, where in the individual weighs the action's expected effectiveness against perceptions that it may be expensive, dangerous (having negative side effects or outcomes), unpleasant (painful, difficult, or upsetting), inconvenient, time consuming, and so forth. Thus, "the combined levels of susceptibility and severity [provide] the energy or force to act and the perception of benefits (less barriers) [provide] a preferred path of action" (Rosenstock, 1974 cited by Praphaphen Suwan, 1989: 89-99).

5. Cues to action

Various early formulation of the HBM discussed the concept of cues that trigger action. Hochbaum (1958: 72-75), for example, thought that the readiness to take action (perceived susceptibility and perceived benefits) could be potentiated only by other factors and particularly by cues such as bodily events and environmental events, for example, media publicity, that instigate action. He did not, however, research the role of cues empirically. Cues to action may ultimately prove to be important, but they have not been systematically studied. Indeed, even though the concept of cues as trigger mechanisms is appealing, it has been difficult to research in explanatory surveys; a cue might be as fleeting as a sneeze or the barely conscious perception of a poster.

6. Other variables

Diverse demographic, socio-psychological, and structural variables may affect an individual's perceptions and thus indirectly influence health-related behavior. Specifically, socio-demographic factors, particularly educational attainment, are believed to have an indirect effect on behavior by influencing the perception of susceptibility, severity, benefits, and barriers.

Health Belief Model Components and Linkages.

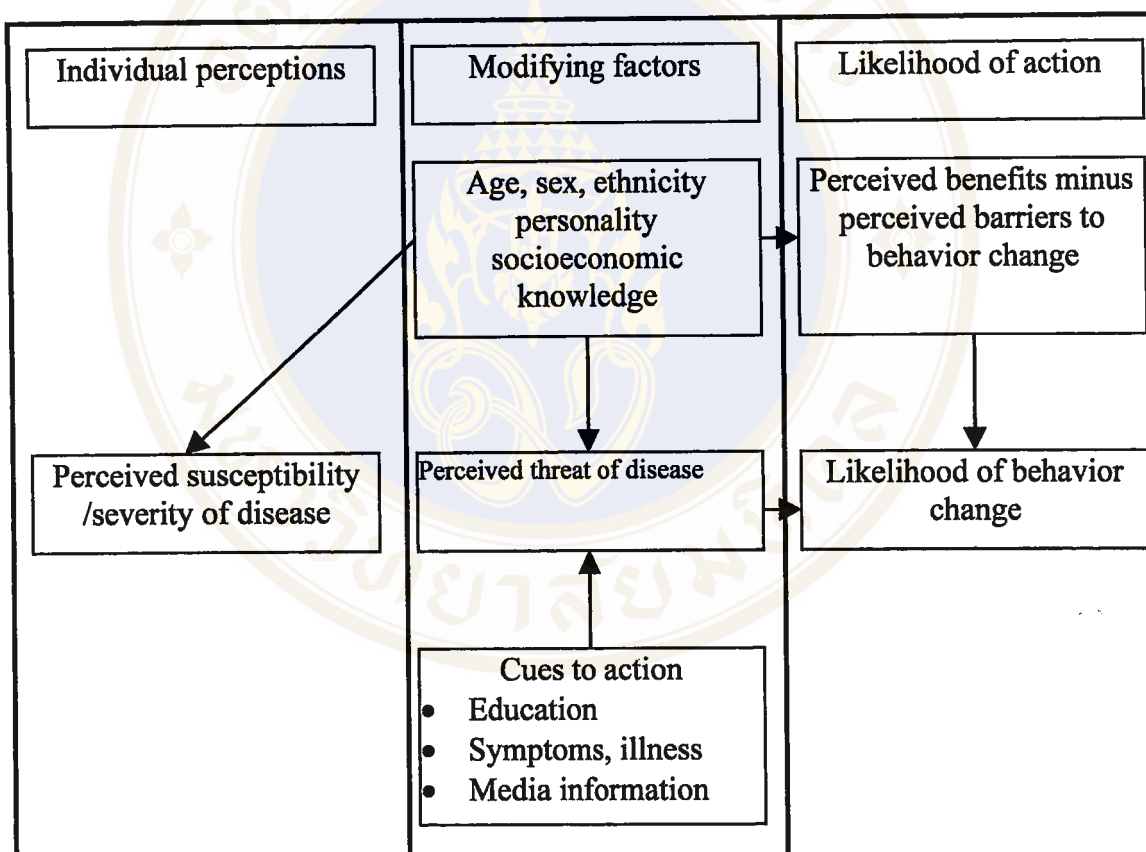


Figure 2 Health Belief Model Components and Linkages.

Table 3 Key concepts and definitions of the health belief model.

Concept	Definition	Application
Perceived susceptibility	One’s opinion of chances of getting a condition.	Define population(s) at risk, risk levels. Personalize risk based on a person’s characteristics or behavior. Make perceived susceptibility more consistent with individual’s actual risk.
Perceived severity	One’s opinion of how serious a condition and its sequel are.	Specify consequences of the risk and the condition.
Perceived benefits	One’s opinion of the efficacy of the advised action to reduce risk or seriousness of impact.	Define action to take: how, where, when; clarify the positive effects to be expected.

Table 3 Key concepts and definitions of the health belief model. (Cont.)

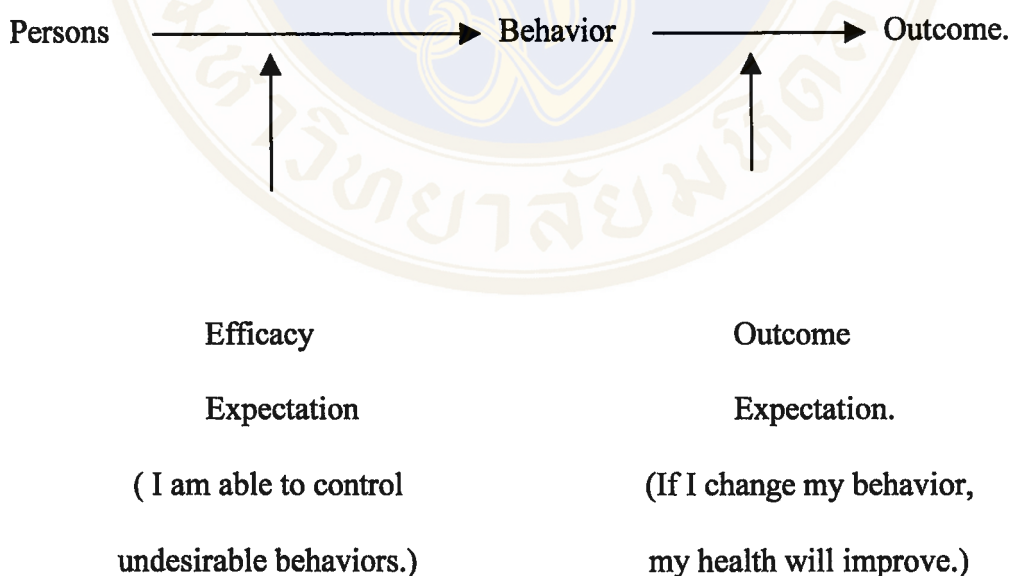
Concept	Difinition	Application
Perceived barriers	One’s opinion of the tangible and psychological costs of the advised action.	Identify and reduce perceived barriers through reassurance, correction of misinformation, incentives , assistance.
Cues to action	Strategies to activate one’s “readiness.”	Provide how-to information, promote awareness, employ reminder systems.

From health belief model theory could apply on disease prevention. In this research the author applied 3 parts such as: part1: Modifying factors which was applied on increasing questionnaire as comprise with these variables e.g. age, education level, occupation, income. Part2: Perceived benefits were applied on increasing questionnaire as regards: time period in treatment and number of time of treatment. Part3: Perceived seriousness or severity was applied on increasing

questionnaire about psychology factors e.g. perceived physical change and perceived detoxification.

3.2 Self-efficacy theory.

In 1977, Bandura introduced the concept of self-efficacy, an important theoretical and practical applications for health promotion and disease prevention. Self – efficacy is a key component of the self – system which Bandura defines as our self – perception of how well we can function in a given situation. The key to behavioral change is the alteration of expectations of personal efficacy. We can see the following figures to express the role of self-efficacy in health behavior change and maintenance.



According to Bandura, health behavior and health outcomes are a function of two beliefs : efficacy expectations and outcome expectations. An efficacy expectation or “perceived self-efficacy” is the conviction that one can successfully execute the behavior required to produce the outcome or it can be defined as people judgments of their capabilities to organize and execute courses of action required to attain designated types of performances.

Outcome expectations are beliefs, estimates that one’s behaviors will lead to particular outcome or a judgement of the likely consequence that such behavior will produce. Individual’s efficacy and outcome expectations may be inconsistent .Efficacy expectations influence all aspects of behavior .In each conviction, people usually choose tasks that they judge themselves capable of handling but they avoid those they believe will exceed their capabilities. For a specific behavior and context, self-efficacy influences the amount of effort expended to change behavior and how long that effort will be maintained in the face of obstacles. We have a reciprocal relationship between efficacy expectation and performance: successful changes in health behavior should increase efficacy expectation, which in turn raise perception of self efficacy. Normally, outcome expectations depend largely on people’s judgements of how well they will perform in given situation (efficacy expectation). However, outcome expectations are important in health promotion for two reasons. If a change of health behavior is fairly simple with uncertain perceived consequences, the initial motivation and decision to change behaviors may rest largely on outcome expectations. Similarly, if the behavior is very difficult to change with uncertain

consequences, both efficacy and outcome expectations may be crucial in achieving behavior change .

Summarily, the relationships between efficacy expectation and outcome expectations affects the decisions of individual behaviors as follows :

Out come expectation.

	(High)	(Low)
efficacy expectation (high)	tendency to do exactly	tendency not to do
efficacy expectation. (low)	tendency not to do	tendency not to do exactly

Figure 3 Out come expectation.



Sources of self-efficacy information's.

(Determinants of self-efficacy)

Bandura suggests that self-efficacy is acquired through any one or a combination of four sources: performance accomplishments (Inactive attainment) ,vicarious experiences, verbal persuasions, and state of bodily (emotional) arousal .

Source	Mode of induction
Performance accomplishment	Participant modeling
	Performance desensitization
	Performance exposure
Vicarious experience	Self-instructed performance
	Live modeling .
	Symbolic modeling
Verbal persuasion	Suggestion
	Exhortation
	Self-instruction
	Interpretive treatments
Emotional arousal	Attribution
	Relaxation, biofeedback
	Symbolic desensitization
	Symbolic exposure .

Performance accomplishments .

The most important source of efficacy is past experiences of success and failure in attempts to achieve desired outcomes. Success raises efficacy appraisal, repeated failures lower them, especially if the failure occurs early in the course of events. A person's past record of success and failure influences their belief in future success and failure, past success creating the belief of future success.

Vicarious experience.

It is not as influential as actual past performance but self-efficacy appraisals are partly influenced by vicarious experiences. Seeing or visualizing other people successfully perform a behavior can instill strong perceptions of self-efficacy in observers that they, too, are able to master comparable activities. But watching others of similar competence repeatedly fail despite sustained efforts would likely lower observers' judgments of their own capability to perform comparable actions .

Verbal persuasion.

Efficacy expectations may also be acquired and or modified through convincing people that they possess the capabilities needed to accomplish their goals .Persuasive boosts in self-efficacy lead people try hard enough to succeed ,they promote development of skills and a sense of personal efficacy. Persuasory efficacy attributions, therefore, have their greatest impact on people who have some reasons to believe that they can produce effects through their actions. But Bandura hypothesizes

that the power of verbal persuasion is limited by the perceived status and authority of the persuader.

State of emotional arousal. (Physiological state)

Because people monitor their level of efficacy by reference to their level of emotional arousal in the face of stressful or threatening situations, any method that lower arousal will increase efficacy expectations. So people are far more likely to expect to succeed when they are not tense and emotionally aroused.

Effects of self- efficacy on behaviors

Self- percepts of efficacy are not simply inert estimates of future action. People's beliefs determine how they behave, their effort, the persistence and the learning / achievement .

1. Choice behavior: people tend to choose activities at which they will succeed and tend to avoid activities at which they believe they will fail.

2. Effort: people will tend to put forth greater effort if they believe that they will be successful .

3. Persistence: people will tend to persist at an activity longer if they believe that they will be successful.

4. Learning / achievement: people believe that they are likely to be successful, will put forth greater effort and will persist longer, and thus will tend to learn and achieve at a high rate .

3.3 Maslow's need hierarchy theory

Maslow seemed to sense that aside from the people with emotional limitations and problems, there were times when man was at his best. Although Maslow avoided the word "spiritual", he did introduce psychology to truth, goodness, beauty, unity, transcendence, aliveness, uniqueness, perfection, justice, order and simplicity. These values he called "B-values".

Before Abraham Maslow, the psychological world was awash in behaviorism and psychoanalysis. Maslow changed this focus on broken brains, by popularizing psychological humanism. Famous people like Abraham Lincoln were subjects of research instead of people with broken brains. One of Maslow's most important contributions to psychology was his theory of human needs, developed in the late 1960's. This theory explained that human needs were hierarchical in nature. Maslow, perhaps the greatest humanistic psychologist, passed away due to a fatal heart attack on June 8, 1970. Many of his books and papers were written towards the end of his life.

He believed that people are not merely controlled by mechanical forces (the stimuli and reinforcement forces of behaviorism) or unconscious instinctual impulses of psychoanalysis, but should be understood in terms of human potential. He believed that humans strive to reach the highest levels of their capabilities. People seek the frontiers of creativity, and strive to reach the highest levels of consciousness and wisdom. People at this level and below were labeled by other psychologists as "fully functioning" or possessing a "healthy personality". Maslow called the people who were at the top "self-actualizing" persons.

Maslow set up a hierarchical theory of needs. The animal or physical needs were placed at the bottom, and the human needs at the top. This hierarchic theory can be seen as a pyramid, with the base occupied by people who are not focused on values, but just staying alive. A person who is starving dreams about food, thinks about food and nothing else. Each level of the pyramid is somewhat dependent on the previous level for most people. Maslow hierarchy of needs (rephrased) includes seven levels:

1. Physiological needs. Biological needs such as oxygen, food, water, warmth / coolness, protection from storms and so forth. These needs are the strongest because if deprived, the person could or would die.

2. Safety needs. Felt by adults during emergencies, periods of disorganization in the social structure (such as widespread rioting). Felt more frequently by children who often display signs of insecurity and their need to be safe.

3. Love, affection and belongingness needs. The needs to escape loneliness and alienation and give (and receive) love, affection and the sense of belonging.

4. Esteem needs. Need for a stable, firmly based, high level of self-respect, and respect from others in order to feel satisfied, self confident and valuable. If these needs are not met, the person feels inferior, weak, helpless and worthless.

5. Self-actualization needs. Maslow describes self-actualization as an ongoing process. Self-actualizing people are involved in a cause outside their own skin. They are devoted, work at something, something very precious to them—some calling or vocation, in the old sense, the priestly sense. When you select out of a

careful research, very fine and healthy people, strong people, creative people, saintly people, sagacious people...etc. You get a different view of mankind. You ask how tall can people grow, what can a human being become.

Maslow also describes self-actualization as a person's need to be and do that which the person was born to do. It is his "calling". "A musician must make music, an artist must paint, and a poet must write." If these needs are not met, the person feels restlessness, on edge, tense, and lacking something. Lower needs may also produce a restless feeling, but here it is much easier to find the cause. If a person is hungry, unsafe, not loved or accepted, or lacking self-esteem the cause is apparent. It is not always clear what a person wants when there is a need for self-actualization.

Maslow believes that the only reason that people would not move through the needs to self-actualization is because of the hindrances placed in their way by society. For example, education is often a hindrance with imposed ideas of the culture. On the other hand respectful teaching promotes personal growth. Maslow indicated that educational process could take some of the steps listed below to promote personal growth:

1. We should teach people to be authentic, to be aware of their inner selves and to hear their inner-feeling voices.

2. We should teach people to transcend their own cultural conditioning, and become world citizens.

3. We should help people discover their vocation in life, their calling, fate or

destiny. This is especially focused upon finding the right career and the right mate.

4. We should teach people that life is precious, that there is joy to be experienced in life, and if people are open to seeing the good and joyous in all kinds of situations, it makes life worth living.

5. We must accept the person and help him or her learn their inner nature. From real knowledge of aptitudes and limitations we can know what to build up on, what potentials are really there.

6. We must see that the person's basic needs are satisfied. That includes safety, belongingness and esteem needs.

7. We should refresh consciousness, teaching the person to appreciate beauty and the other good things in nature and in living.

8. We should teach people that controls are good, and complete abandon is bad. It takes control to improve the quality of life in all areas.

9. We should teach people to transcend the trifling problems and grapple with the serious problems in life. These include the problems of injustice, of pain, suffering and death.

10. We must teach people to be good chooses. They must be given practice in making choices, first between one goody and another.

3.4 Health care needs

Larson, 1986 cited by Boulaung Samdangrit (1995: 17-19) stated health care that it was therapeutic intervention which has treatment model of 3 dimensions as

follows: Care and Coordination which has health care was core. There was staff who helps them e.g. medical doctor, nurse and psychologist including patients who participate in a treatment program. The patients would be treatment in 3 model such as 1) Treatment dimension e.g. taken methadone drug treated complication after heroin abuse. 2) Coordinating dimension e.g. coordinated between heroin abuser and staff or personnel in centers. 3) Attention dimension e.g. directly take care physical, reinforcing patients' mental health and their family or side effect. These affected to the clients were happiness.

In this research , the author interviewed heroin abuser in centre, which the questionnaires were, applied on measure the health care needs of patients with AIDS of Berk (1995: 109-116) There was sample of 35 patients in Baltimore hospital, Maryland state, USA, between 1990-1992. The research evaluated environment, mental-social, financial support, social support and adjustment. The measurement form was divided into 19 items, which separate on 3 groups. Following aspects:

1. Assessment form on health care as regards economy and, mental-social as follows:

- Adjustment
- Personal relationships
- Personal support
- Income/ financial resource
- Financial concern
- Financial assistance

- Money management

2. Assessment form on health behavior and social support as follows:

- Appetite
- Pain / discomfort
- Physical activity
- Sleep / activity pattern
- Social network
- Employment

3. Assessment forms on health care needs as regards health as follows:

- Religious beliefs
- Resource utilization
- Care-taking system
- Motivation
- Comprehension
- Technical skill

In Thailand Rochna Wiriysombat applied health care needs of Berk, 1995 among AIDS complex in 1997. There were 140 patients who admitted in Bamrajnaradoon hospital, Hadyai hospital and Songkhla hospital. Data gathering by interviewing about general factors such as: socio-demographic characteristics and assessed health care needs e.g. financial support and psychosocial, behavior and social support and adjustment, social factors, economic factors, health factors e.g.

physical function and illness and vision factors. These were association with health care needs with statistical significance at $p\text{-value} = 0.001$. Those of factors were explained that health care needs were change at rate 23%, 15% and 32% (Multiple $R^2 = 0.227, 0.153, 0.322$ respectively) and then found that changing in family, severity of disease, physical change and level of ability to work influenced to changing health care needs in each parts of factors. (Beta = 0.36, 0.26 and 0.32) respectively.

In this research the author applied measure the health care needs of Berk (1995: 109-116) to interview among male heroin dependents in government drug dependent treatment centers in southern region. Whereas, the questionnaire on adjustment was applied Larson, 1986. The sampled research was in-patients.

4. Factors influenced to health care needs of male heroin dependent.

4.1 Basic factors

4.1.1 Age

Dodge (1969 cited by Boulaung Samdangrit, 1995: 25) stated that age was association with health care needs. The youth wanted to health care needs more than adult whom need regarding disease progress, type of available services and cure. Because of age was indicator of experience such as: adjustment. Dosge, 1969 studied among surgery patients found that less age patients (less than 40 years) concerned on necessary self-care. Where as, the age of more than 60 years no

concerned on self-care. The research of Wimonrat Puvravutipanich (1989: b) and Siriwal Wattasin (1991: b) found that age was negative correlation with self-care deficit of patient and cardiovascular patient. The research of Porter, et al., 1993 cited by Thitthaya Haomsub (1995: 7) revealed that patients with HIV infected were age range 15-24 years were more attentive their health than patients with HIV infected age range 15-24 years and 50 years upper. While the research of Samerchun Anatep (1992: 84) illustrated that age was positive association with AIDS preventive behavior among intravenous injection drug abuser who was treated with Methadone. Mallika Thungcharearn (1991: 34) indicated that age was positive association with health care needs for preventing AIDS infection among women sex workers.

Thus, the author expected that age influenced to health care needs of Heroin abuser.

4.1.2 Education Level

Education level indicated that which level persons need, patients were high education level will concern in problem and understand. Because of education level reinforced to perception of person. They could seek varies knowledge and practiced in self-care better than patients were less education. (Praphaphen Suwan, 1983 cited by Sureerat Chaungsawatsak, 1998: 5) which supported with the research of Angkana Nuanyong (1992: 97) who stated that as high education person would be more attentive and self-care than less education person and the research of Mullika Tangcharearn (1991: 44) found that education level was positive association with ability to self-care on AIDS prevention. In summarized, person as high education

would perceive and concern in usage information which consistent with the research of Dodge (1969 cited by Boulaung Samdangrit, 1995: 27) revealed that patients who was high education will need health care more than less education person.

Thus, the author expected that education level influence to health care needs of heroin roin abuser.

4.1.3 Occupation

Occupation was indicator of economic status and social (Hnucharunkul, 1988 cited by Premruthai Noimuenwai, 1993: 41). Those were benefit resource of self-care. (Orem,1985 cited by Premruthai Noimuenwai, 1993: 41). The occupation was correlation with education and income. That was person who work good job, it indicated that they was high education.

4.1.4 Income

Income was indicator of economy and social status, because of income was important factor for living.(Vimonrat Phuvravutipanhich, 1989 cited by Sureerat Chaungswatsak, 1998: 30) Money was important factor to treatment which it was expenditure for treatment, vehicle and facility needs. Person had high income, they would be not difficult to treatment. They could recruit and seek available services. While the poor man had to work hard for their family thus, they would be not interested in their health care which consistent which the research of Sureerat Chaungswatsak (1998: 64) revealed that economic status was correlation with health

care needs, person had high economy would receive taking care more than low economy person. (Norbeck, 1981:49).

Thus, the author expected that income might influence to health care needs of heroin addiction patient.

4.1.5 Time period of heroin abuse

Period of illness was indicator of health condition or health care needs of person and formulated health care needs in future and present (Orem, 1991:117) the research of Ragsdale & Morrow, 1990 cited by Premruthai Noimueanvai (1993: 43) found that quality of life among 95 patients with AIDS infected who was AIDS complex and no symptoms found that Patients AIDS infected had different quality of life. The patients AIDS at first stage had quality of life better than patients of other stage with statistical significance and the research of Chaukhing Chucruit (1998: 75) indicated that time period of heroin abuse was one factor as could predict judgement process to treatment which supported with research of Wallapa Sabying (1991: 40) illustrated that youth as addicted drug more than 4 years, they would be bored to use it due to they were insufficient money and weakness. The research of Pornsiri Chartiyanon, 1977 cited by Chaukhing Chucruit (1998: 76) stated that drug abuser as addicted in short period, could quit abusing.

Thus, the author expected that time period would influence to health care of heroin abuser.

4.1.6 Number of time as treatment

Illness or hospitalization was stress. Therefore, person would like to be under taking care of medical doctor, nurse and psychologist (Doge, 1969 cited by Yeesun Chaidee, 1997: 27-29) and found that person wished to be under taking care of public health staff which consist of Bauluang Samdangrit (1995: 24) and Wallapa Sabying (1991: 40).

Thus, the author expected that number of time as treatment would influence to health care needs of heroin abuser.

4.2 Psychological factors

4.2.1 Perceived physical change

Health and physical working were important to every body, this was important component of living such healthy, good working. These were led to quality of lives (Zhan, 1992 cited by Praphaporn Jinantuya, 1993: 16) which consistent with research of Torrance, 1987 cited by Suttida Kanchanarangsri (1995: 18) stated that health problem was one factor which influence to quality of life. This problem would influence to emotion, physical, social and mental health which supported the research of Srisombat bunmeuang (1984: 114) and Sakdina bunpeam (1991, 64) who studied on drug dependent among in Tanyarak hospital found that there was patients of 31.5% had health problem.

Thus, the author expected that number of time, as treatment would influence to health care of heroin abuser.

4.2.2 Perceived severity of detoxification

Perception was express feeling, understanding in one-self (New Webster's Dictionary, 1975) which Siriwan Sangin (1993: 30) summarized that perception was interpreting process or translated stimulus by depend on initial experience and responding newly thing. Whereas, Kanya suwansang (1989: 50) stated to important of perception that " correct perception was important base of learning, good knowledge, understanding and positive attitude began positive perception" whereas, detoxification was stated by Thongchai Aunakelap (1989: 30). He found that heroin abuser did not regularly addict thus, their physical was increased the dose of narcotic "Withdrawal" or "detoxification" The withdrawal syndrome was severity such as: vomiting, muscle spasm and diarrhea finally bleeding. The withdrawal syndrome was the most severity about one-to-three day's period after that it was slightly decreased down and would be better on 7th – 8th. The symptom was more or less, it was depended on various factors e.g. time period as heroin abuse, basic of mental and environment of abuser. Some victims admitted in the hospital to treat those symptoms. Which supported the research of Kuantu Phuwlrlyatela (1998: 28).

Thus, the author expected that perceived severity of detoxification symptom would influence to health care needs of heroin abuser.

4.2.3 Expectancy on stopping heroin abuse

Dictionary of Oxford University, 1989 stated that expectation was mental condition, which was ideology or critical thinking of person who could predict

futuristic situation. They could expect that what is happens in the future. Pratueng Sungsuwan (1991: 28) summarized that expectation was the need, feeling or critical thinking of predicting person or predicted that what is happen in the future situation. The research of Mc. Instyle, et al., 1983 found that association self-efficacy with smoking after treatment among 68 samples. It was found that score on expectancy on self-efficacy correlated with smoking in period of 3 to 6 months. But did not correlated with smoking during 1 year. Smoking during treatment was less association with expectancy on self-efficacy. The research of Kamlaitip Ranoi (1993: 75) revealed that an effectiveness of health education program to quitting smoking among physical collage in Bangkok Metropolitan. The samples were male students in the 1st – 4th year who have been smoking and volunteered to participate in program. The samples were separated on experimental group of 54 students and comparison group of 49 students. The experimental group was participated in a program. At post-test found that they changed their behavior as regard self-efficacy on quitting smoking, out-come expectancy and behavior in quitting smoking more than pre-test and comparison group with statistical significance. In addition, it was found that self-efficacy on stopping smoking, out-come expectation were association with behavior in stopping smoking with statistical significance. Whereas, the research of Sasitorn Pornpairin, (1998: 128) illustrated that male heroin dependents who participated in program of heroin abused stopping had out-come expectation on heroin stopping better than patients who did not participate in program with statistical significance at $p = 0.01$.

They, the author expected that self-efficacy on stopping heroin abuse would influence to health care needs of heroin patients.



CHAPTER III

RESEARCH METHODOLOGY

This research was exploratory research to study on health care needs and factors as influenced to health care needs of male heroin abuser in government drug dependent treatment centers in the southern region. It was studied on basic factors such as: age, education level, occupation, income, time period as addicted heroin , number of time-admission and psychological factors such as: perceived physical change, perceived severity of detoxification and expectation on stopping heroin abused.

From the concept, theory and related research including conceptual framework in this study could be a guideline to study on health care needs of male heroin abuser in government drug dependent treatment center in the southern region. The study was conducted as follows:

1. Population of this research

The populations of this research were male in-patients heroin addicted in government drug dependent treatment centers in the southern region. There were 79 patients in Songkhla center and 33 patients in Pattani center. (Office of the Narcotics Control Board, 1992: 5). Total populations of this research were 112 male-patients.

2. Instruments of this research

The instrument was questionnaire as comprised with 2 parts following aspects:

Part 1: Questionnaire on socio-demographic characteristics, which was divided into 2, parts as follows:

1. Data on basic factors such as: age, education level, occupation, time period as Heroin addiction and number of time-admission.

2. Data on psychological factors such as: physical change, perceived severity of detoxification and expectation on stopping Heroin addicted.

For measured question about perception of psychology consisted of perceived physical change and perceived severity of detoxification. The author created and developed by applying Liketr's scale for set score interval which each statement comprised with strongly agree, agree, unsure, disagree, strongly disagree. The question characteristic was positive statement and negative statement, which had 5 multiple choices. There was a criterion as follows:

Positive statement		Negative statement	
Strongly agree	score on 5	score on	1
Agree	score on 4	score on	2
Unsure	score on 3	score on	3
Disagree	score on 4	score on	4
Strongly disagree	score on 5	score on	5

In regard to expectancy on stopping heroin abused had 5 multiple choices. So there was a criterion as follows:

Positive statement		Negative statement	
Often	score on 5	score on	1
Slightly often	score on 4	score on	2
Moderate	score on 3	score on	3
Sometime	score on 2	score on	4
Never	score on 1	score on	5

Part 2: Measurement form on health care needs.

This term was translated from Berk’s health care needs (1995: 109-116) which was found that caretaker and patients gave information consistent with health care needs.

This form comprised with 19 questionnaires, which each information was divided into 3 segments

Segment 1: Measurement form on health care needs as regards financial support and psychosocial.

There was adjustment, personal relationship, income/financial, resources, financial concern, financial assistance, money management.

Segment 2: Measurement form on health care needs as regards health behavior and social support.

There was appetite, sleep/activity pattern, physical activity, pain/discomfort, social network, and employment.

Segment 3: Measurement form on health care needs as regards health management.

There were religious beliefs, resource utilization, caretaking, system, motivation, comparison, and technical skill.

2.1 Criteria of need level consideration

- 0 refers no need
- 1 refers to less need
- 2 refers to moderately need
- 3 refers to mostly need

2.2 Interpretations of need level.

The criterion of score classification on health care needs in 3 parts such as: financial support and psychosocial, health behavior and social support, health management. The author applied on score classification by group (Somwang Pitayanuwat, and Usawadee Chantlonti, 1994 cited by Teerachai Detkhad, 2001: 52-63) stated that score classification by group should be investigated that which score level of studied populations were in each group. The separated score was decried regarding mean score, standard deviation by using $\bar{X} \pm S.D.$ whereas, interpretation of score on health care needs among heroin abuser. The total 19 questions were calculated and full score was $19 \times 3 = 57$ scores.

The resulted research of health care needs in total 3 parts. In this research, Mean score was 19.56, S.D = 8.67, minimum score was 3 and maximum score was 43.

The result of health care needs were 3 levels as follows:

- | | |
|--|----------------------|
| Score on low need ($X < \bar{X} - S.D.$) | lower than 11 scores |
| Score on moderately need ($\bar{X} - S.D. \leq X \leq \bar{X} + S.D.$) | between 11-28 scores |
| Score on high need ($X > \bar{X} + S.D.$) | more than 28 scores |

For score classification of each part of health care needs as follows:

Health care needs as regards financial support and psychosocial

The result of health care needs in regard to financial support and psychosocial (7questions). In this finding had mean score = 8.19, S.D = 3.88

The result of health care needs were 3 levels as follows:

Score on low need ($X < \bar{X} - S.D.$)	lower than 5 scores
Score on moderately need ($\bar{X} - S.D. \leq X \leq \bar{X} + S.D.$)	between 5-12 scores
Score on high need ($X > \bar{X} + S.D.$)	more than 12 scores

Health care needs on health behavior and social support

The result of health care needs on financial support and psychosocial (6 questions). In this finding had mean score = 6.11, S.D = 3.01

The result of health care needs were 3 levels as follows:

Score on low need ($X < \bar{X} - S.D.$)	lower than 4 scores
Score on moderately need ($\bar{X} - S.D. \leq X \leq \bar{X} + S.D.$)	between 4- 9 scores
Score on high need ($X > \bar{X} + S.D.$)	more than 9 scores

Health care needs as regards health management

The result of health care needs in regard to financial support and psychosocial (6 questions). In this finding had mean score = 5.27, S.D = 3.17

The result of health care needs were 3 levels as follows:

Score on low need ($X < \bar{X} - S.D.$)	lower than 3 scores
Score on moderately need ($\bar{X} - S.D. \leq X \leq \bar{X} + S.D.$)	between 3-8scores
Score on high need ($X > \bar{X} + S.D.$)	more than 8 scores

3. Instruments test.

3.1 Validity

The questionnaire was proved validity content by the advisors and experts as show detail in appendix.

- The expert about narcotic treatment 1 person.
- The expert about social science 1 person.

After the questionnaire were approved already. After that it was developed by the author and began implementation followed by recommendation.

3.2 Reliability

The developed questionnaire was administrated by gathering data among In-patient in Tanyarak hospital numbering 30 cases. The data was analyzed on reliability regarding perceived physical change, perceived severity of detoxification, expectancy on stopping heroin abused and health care needs all 3 parts (financial support and psychosocial, health behavior and social support and health management). These were analyzed by using Cronbach's Alpha Coefficient. (Phaungrut Thavirut, 1995: 125)

Formula

$$\alpha = \frac{n}{n-1} \left\{ 1 - \frac{\sum S^2 i}{S^2 t} \right\}$$

α = Alpha coefficient

n = Number of question

$\sum S^2 i$ = Total of variation score on item by item.

$$S^2t = \text{Total of variation of total score}$$

From the created questionnaire had reliability as follows:

3.2.1 Perceived physical change was reliability = 0.78

3.2.2 Perceived severity of detoxification was reliability = 0.64

3.2.3 Expectation on stopping Heroin abused was reliability = 0.75

3.2.4 Health care needs were reliability (3 parts) = 0.89

3.3 Discrimination

The researcher investigated on critical rate with t –test which had formula as follows:

Formula

$$t = \frac{\bar{X}_{\max} - \bar{X}_{\min}}{\sqrt{\frac{S_{\max}^2}{n_{\max}} + \frac{S_{\min}^2}{n_{\min}}}}$$

t refers to group's mean score was high.

\bar{X}_{\max} refers to group's mean score was low.

\bar{X}_{\min} refers to group's mean score was high.

S_{\max}^2 refers to score on variation was equal.

S_{\min}^2 refers to score on variation was high

n refers to number of case in each group as equal

The Methodology was conducted as follows:

3.3.1 Set score from maximum score to minimum score by applied on proportion of 25% then divided into 2 parts.

3.3.2 Taken maximum and minimum score described frequency by separate on item by item for analyzed mean score and standard deviation, item by item.

3.3.3 Analyzed maximum score and minimum score and variation score on group's high score and group's low score with t-test to calculate discrimination.

3.3.4 Selected the item as t-value was high due to which item had high discrimination, it was suitable to use in study. But which item was low, that item should deleted.

4. Data collection

Data were collected using self administered questionnaires following aspects:

4.1 The researcher requested a letter from graduate school to director of drug dependent treatment center and head of nurse at drug dependent treatment center in Songkhla and Pattani province. To collected data in this site.

4.2 The researcher invited one-self to head' ward to collected data in this ward and informed the objective of this study including screened patient to interview about 15-20 cases.

4.3 The clients were interviewed in arranged room and the author and assistant research would create relationship and added ask-questions. The clients

would be rescanned regarding background, illness and their family, they could response or no response.

4.4 When the clients cooperated to interview, interview regarding basic factors and psychological factors was begun the implementation.

4.5 After finished interview the author would express thank to all clients for their cooperation and checked questionnaire complete.

5. Data processing and analysis

The data collected were processed and analyzed through microcomputer SPSS/PC⁺ (Statistical Package for the Social Science/Personal Computer Plus) which formulated statistically significance at $p\text{-value} = 0.05$. There were steps for canalization as follows:

1. Data on basic factors and psychology by analyzed
2. Data on health care needs in all parts and each part. The data was described frequency, mean score and compared ratio.
3. Data on health care needs as item by item. The data was described frequency, mean score, compared ratio and standard deviant.
4. Analyzed association between basic factors and psychology with health care needs of heroin abuser by using multiple regression analysis, to studied general factors as influence to health care needs of heroin abuser.

CHAPTER IV

RESULTS

This research studied on health care needs among male drug dependent patients who treated in government drug dependent treatment centers in the southern region, Songkhla and Pattani province. There were 112 male patients, which had detail as follows:

1. Socio-demographic characteristics
2. History of heroin addiction and treatment.
3. Characteristic of psychology after heroin addicted
4. Satisfaction level to health care needs.
5. Influenced factors to health care needs.

1. Socio-demographic characteristics

From this research found that the studied populations had age range 16-25 years and 26-35 years (46.4%) were equal. Age average was 26 years ($\bar{X} = 26.31$, S.D. = 5.75) age was highest 48 years and lowest 17 years. The majority of studied populations were single (81.3%) followed by couple and divorce/ separate (8.9%) the minority of studied populations were widow (0.9%)

Before participated in program the majority of studied populations had education and hire (41.9%) followed by unemployed (21.4%), students, merchant, civil servant and enterprise (13.4, 12.5, 8.0, 2.7 and 0.9 respectively). The most of income were 3,000-6,000 baht/month (43.8%) followed by 0-lower than 3,000

baht/month (33.0%). In addition, there was 6,001-10,000 baht/month and 10,001-15,000 baht/month (19.6%) and (3.6%) respectively). Average income was 4,100 baht/month ($\bar{X} = 4,107.6$, S.D. = 3,666.50), the highest income was 15,000 baht/month

The most of studied populations were Buddhist (85.7%) and Islam, Christ (12.5% and 1.8 respectively). most of studied populations' education level were secondary/ vocational (75.9%), under graduate/ certificate (15.2%) and primary school and bachelor (8.0%, 0.9% respectively) as shown detail in table 4.

Table 4 Number and percentage of male heroin abused as classified on age and marital status.

Socio-demographic characteristics	Number	Percentage
Age		
16-25 years	52	46.4
26-35 years	52	46.4
more than 36 years	8	7.1
$\bar{X} = 26.31$ S.D. = 5.75 Max = 48 Min = 17		
Marital status		
Single	91	81.3
Couples	10	8.9
Widow	1	0.9
Separate/divorce	10	8.9
Occupation		
Students	15	13.4
Civil servant	4	3.6
Agriculture	9	8.0
Merchant	14	12.5
Labor	47	41.9
Unemployed	23	21.4

Table 4 Number and percentage of male heroin abused as classified on age and marital status. (Cont.)

Socio-demographic characteristics	Number	Percentage
Income/month		
Lower than 3,000 bath	37	33.0
3,000 - 6,000 bath	49	43.8
6,001-10,000 bath	22	19.6
10,001-15,000 bath	4	3.6
$\bar{X} = 4,107.6$ S.D. = 3,66.5 Max = 15,000 Min = 0		
Region		
Buddhist	96	85.7
Islam	14	12.5
Christ	2	1.8
Education level		
Primary school	9	8.0
Secondary school	85	75.9
Undergraduate/ certificate	17	15.2
Bachelor	1	0.9

2. History of heroin addicted and treatment

It was found that most of studied populations addicted heroin at first were 17-21 years (61.6%) followed by 12-16 years (29.5%), the minority of studied populations addicted heroin at first time were age range 22 – 26 years and 27 - 31 years (7.1% and 1.8% respectively), age average at first which addicted heroin was 18 years ($\bar{X} = 18.21$, S.D. = 3.38). The majority of age as addicted heroin at first time was

32 years and lowest was 11 years. Period of addiction was 6 – 10 years (50.9%), 1 - 5 years (35.7%) and 11 years upper was 13.4years) time period as addicted heroin was 7 years ($\bar{X} = 7.32$, S.D. = 3.38) long period was 22 years, short period was 1 year. Where as, the method of addiction, the majority of studied populations injected into intravenous (76.8%), smoke with bamboo (6.3%), mixed with cigarette (5.4%), smoked with bamboo or mix with cigarette and together with intravenous injection (5.4%), mix with cigarette and intravenous injection (4.5%). The minority of studied populations smoked with bamboo together with intravenous injection (0.9%) and smoked with bamboo together with intravenous injection and mix with Amphetamine (0.9%)so as shown detail in table 5.

Table 5 Number and percentage of male heroin abused as classified on history of heroin addiction.

History of heroin addicted	Number	Percentage
Age at first to addicted		
12-16 years	33	29.5
17-21 years	69	61.6
22-26 years	8	7.1
27-31 years	2	1.8
$\bar{X} = 18.21$	S.D = 3.38	Max = 32
		Min = 11
Addiction period		
1-5 years	40	35.7
6-10 years	57	50.9
more than 11 years	15	13.4
$\bar{X} = 7.32$	S.D = 3.38	Max = 22
		Min = 1



Table 5 Number and percentage of male heroin abused as classified on history of heroin addiction. (Cont.)

History of heroin addicted	Number	Percentage
Method of Heroin addicted		
With bamboo	7	6.3
Mix with cigarette	6	5.4
Inject in intravenous	86	76.8
Smoked with bamboo + mix with cigarette		
+ Inject in intravenous	6	5.4
With bamboo + Inject in intravenous	1	0.9
With bamboo + Inject in intravenous and mix with amphetamine.	1	0.9
Mix with cigarette + Inject in intravenous	5	4.5

History of treatment of studied populations was found that the majority of studied populations had ever treated (89.3%), minority of them had never treated (10.7%). Where as, site for treatment the majority of studied populations had treated more than 2 sites (54.5%), had treated in therapeutic clinic in general hospital (13.4%, at therapeutic clinic in center hospital (10.7%), drug dependent treatment in the southern region, Songkhla province and Pattani (7.1%), enterprise drug dependent treatment center such as: enterprise hospital (1.8%) and therapeutic community center such as: temple and general community (1.8%) so. The method of treatment, most of studied populations admired to current medial therapy (56.3%), current medical therapy with herbal using (11.6%) and current medical therapy with taken concentrate

(11.65%). So The remainder was current medial therapy with herbal using and taken concentrate (8.05%) and current medial therapy with herbal using and taken concentrate and immerse in water (0.9%). Number of time as treated 1 - 5 times (54.5%), 6 – 10 times (17.95%) and 11 time upper (17.05%). The remainder never treated anywhere (10.7%). Number of time as treated average 6 times ($\bar{X} = 6.32$, S.D. = 5.68) number of the highest time as treated was 30 times. Whereas, step of current treatment among heroin abuser in rehabilitation step. They were rehabilitation step (53.6%) and detoxification step (46.4%) as shown detail in table 6.

Table 6 Percentage of score on health care need among male heroin abused as regards on history of heroin addiction.

History of heroin addicted	Number	Percentage
Ever treated		
Ever	100	89.3
Never	12	10.7
Center of drug dependent of government		
Treated Narcotics Clinic of general hospital	15	13.4
Treated Narcotics Clinic of hospital center	12	10.7
Drug dependent treatment center(2 sites)	8	7.1
Clinical Enterprise	15	13.4
Clinical Community	2	1.8
More than one site	83	74.1
Never treatment	12	10.7

Table 6 Percentage of score on health care need among male heroin abused as regards on history of heroin addiction. (Cont.)

History of heroin addicted	Number	Percentage
Method of treatment		
Current medicine	85	75.9
Current medicine together with herbal medicine	14	12.5
Current medicine together with taken concentrate	13	11.6
Current medicine + herbal medicine taken concentrate + immerse in water	1	0.9
Never treated	12	10.7
Number of time of treatment		
Never	12	10.7
1-5 times	61	54.5
6-10 times	20	17.9
11 times upper	19	17.0
$\bar{X} = 6.32$	S.D = 5.68	Max = 30 Min = 0
Steps of treatment at present		
Preparation	0	0.0
Detoxification	52	46.4
Rehabilitation	60	53.6

3. Characteristic of psychology after heroin addicted.

3.1 Perceived physical change

From the study found that the majority of studied populations perceived physical change after heroin addiction were negative. They would agree and strongly agree. Where as, the full score was 75 score of 15 items. There was full score 75 scores ($15 \times 5 = 75$). Mean score on perceived physical change was 54.9 scores ($\bar{X} = 54.9$, S.D. = 7.85). High score was 72 scores, low score was 31 scores. These can be explained that most of studied populations perceived physical change was slightly high such as: face was dark (93.7%), sleepy (92.9%), loss appetites (90.2%) scar on body (90.2%). In addition, they would agree approximately $\frac{3}{4}$ of studied populations as regards lip was dark and loss moisturize, loss sex need, degenerate memory, lazy and bad looking including had complication (86.6%, 79.55%, 77.7%, 73.3%, 73.2%, 71.5% and 62.5% respectively) as shown detail in table 7.

Table 7 Percentage of score on health care need among male heroin as regards perceived physical change.

Physical change	Strongly Agree		Unsure		Disagree		Strongly disagree	
	agree	agree	disagree	disagree	agree	disagree	agree	disagree
- Loss of appetite	43.8	46.4	0.9	8.0	0.9			
- General organism could reaction	15.2	28.6	10.7	38.4	7.1			
- Complication e.g TB	18.8	52.7	8.0	14.3	6.3			
- Addicting heroin would affect to creation	11.6	34.8	16.1	33.9	3.6			

Table 7 Percentage of score on health care need among male heroin as regards perceived physical change. (Cont.)

Physical change	Strongly	Agree	Unsure	Disagree	Strongly
	agree				disagree
- Face was dark	49.1	44.6	0.9	5.4	0.0
- There was infect wound all their body	48.2	42.0	1.8	5.4	0.0
- It was positive impact because of the weigh loss	14.3	23.2	8.9	33.0	20.5
- Dislike to bath and well dressing	20.5	42.0	8.0	23.2	6.3
- Lazy to working / learning	21.4	51.8	8.9	16.1	1.8
- Loss memory	24.1	53.6	7.1	13.4	1.8
- Decrease painful	1.8	18.8	8.0	44.6	26.8
- Dozy / sleepy	40.2	52.7	2.7	3.6	0.9
- Loss sex need	26.8	52.7	6.3	12.5	1.8
- Like to lonely	30.4	42.9	4.5	18.8	3.6
$\bar{X} = 54.99$	S.D = 7.85	Max = 72	Min = 31		

3.2 Perceived severity of detoxification

From the study found that Perceived severity of detoxification among studied populations, the majority of studied populations had negative perception; most of them were agreed and strongly agreed. The term of perceived severity of detoxification comprised with 13 questions which had full score was 65 scores (13 items x 5). Mean score on perceived severity of detoxification was 49.2 scores ($\bar{X} = 49.2$, S.D = 5.52). High score was 60 scores and low score was 30 sores. These can be explained that the studied population’s perceived severity of detoxification was slightly high regarding unable to sleep, heart rate (92.9%), The symptom of

detoxification severity was pain in bone (92.9%), serious withdrawal e.g. vomiting, diarrhea, bleeding intestine and so painful (91.0%), who was decreased drug would be easy offense (89.3%). Muscle spasm, bleeding intestine and diarrhea were alarming (76.8%) Withdrawal in serious step affected to self-control (76.8%), was conflicted in them self (76.8%), regularly withdrawal. Affected to generate physical (64.35) as shown detail in table 8.

Table 8 Percentage of score on health care needs among male heroin abused as regards perceived severity of detoxification.

Severity of detoxification	Strongly agree	Agree	Unsure	Disagree	Strongly disagree
-Vomiting, diarrhea or muscle spasm these were dangerous.	27.7	49.1	10.7	9.8	2.7
-Muscle pain after addicted was normal	4.5	20.5	4.5	38.4	32.1
-Physical would be weakness	9.8	54.5	12.5	22.3	0.9
-Stopping addicted heroin 3-4 hours, it was primary detoxification	13.4	61.6	11.6	11.6	1.8
-Vomiting with blood & diarrhea were suffering	46.4	44.6	5.4	3.6	0.0
-Severity detoxification was no control one-self	26.8	50.0	5.4	15.2	2.7
-Convulsion was a part of detoxification	14.3	51.8	16.1	16.1	1.8
- No sleep and heart rate	39.3	53.6	1.8	5.4	0.0
-Pain in the bone	56.3	36.6	2.7	4.5	0.0
-Drug abuser was anxiety after withdrawal	15.2	44.6	9.8	21.4	8.9
-Conflict in their feeling	17.9	58.9	7.1	15.2	0.9
-Easy to do offense during withdrawal	51.8	37.5	0.9	9.8	0.0
-They may be death during withdrawal	25.0	33.0	27.7	14.3	0.0
$\bar{X} = 49.02$ S.D = 5.52 Max = 60 Min = 30					

3.3 Expectation on stopping heroin addicted

From the study was found that expectation on stopping heroin addicted, the majority of studied populations expectation on stopping heroin addicted was positive. The term of expectation comprised with 14 questions and full score was 70 scores (14 items x 5 scores). Mean score on expectation on stopping heroin addicted was 46 scores. ($\bar{X} = 46.866$, S.D. = 7.871), maximum was 63 scores, minimum score was 24 scores. These can be explained that patients' expectation on stopping heroin addicted as regards self-practice such as: intended to stop heroin addiction (87.5%). Cleaned physical, clothes (86.75%), participated in activity (79.5%), taking healthy food and sufficient (71.5%), practice followed by recommendation of medical doctor, nurse and psychologist (67.91%), used time to be usage after finished treatment (63.4%), taken concentrate or practice in religion (57.1%) as shown detail in table 9.

Table 9 Percentage of score on health care needs among male heroin abused as regards expectancy on stopping heroin abused.

Expectancy on stopping heroin dependent	Often	Slightly often	Moderate	Sometime	Never
- Practice followed by public health's recommendation.	29.5	38.4	16.1	16.1	0.0
- Asked question to staff about complication.	8.0	33.0	23.2	31.3	4.5
- Exercise after finished treatment.	30.4	33.0	13.4	22.3	0.9
- Though that should have healthy food (quality/quantity).	31.3	40.2	17.9	10.7	0.0

Table 9 Percentage of score on health care needs among male heroin abused as regards expectancy on stopping heroin abused. (Cont.)

Expectancy on stopping heroin dependent	Often	Slightly	Moderate	Sometime	Never
- You could read about treatment and health care.	9.8	14.3	17.0	41.1	17.9
- You could create your confidant by doing concentrate mind or religious activities.	33.0	24.1	12.5	21.4	8.9
- You intended to stop addiction for long time.	55.4	32.1	6.3	6.3	0.0
- When you were lonely, you will smoking.	5.4	26.8	11.6	29.5	26.8
- When you were alone, you will think to your friend as addicted heroin.	6.3	39.3	14.3	28.6	11.6
- Asked methodological treatment in center with staff.	4.5	22.3	21.4	39.3	12.5
- Participated in treatment activity.	41.1	38.4	11.6	8.9	0.0
- Tried to forget but difficult to do.	1.8	18.8	9.8	25.9	43.8
- Could help newly patient and recommended.	17.9	32.1	12.5	31.3	6.3
- Cleaned your body, bed and privacy thing.	43.8	42.9	7.1	6.3	0.0
$\bar{X} = 46.86$	S.D = 7.87	Max = 63	Min = 24		

4. Satisfaction level to health care needs.

4.1 Health care needs on financial support and psychosocial.

Health care needs on financial support and psychosocial. This term was explained as regards adjustment as derived from heroin addiction, personal relationships, social support, financial resource, financial concern and money

management. Those of term were assessed and found that ½ of studied populations had health care needs in regard to financial concern (50.9%) followed by money management, financial assistance, adjustment and financial resource (39.3%, 35.7%, 32.2%, and 32.2%) respectively. In addition, there found that ½ of studied populations was less health care needs as regards personal support, personal relationship (50.9% and 43.8%) where as, had not health care needs on personal relationships (34.8%) as shown detail in table 10.

Table 10 Percentage of score on health care needs among male heroin abused regards as on financial support and psychosocial.

Items	Health care needs			
	No need	Less need	Moderate	Strongly need
- Financial concern	14.3	34.8	33.9	17.0
- Money management	21.4	39.3	33.0	6.3
- Personal relationships	34.8	43.8	16.1	5.4
- Income/ financial resources	22.3	45.5	28.6	3.6
- Financial assistance	6.3	33.0	58.0	2.7
- Adjustment	24.1	43.8	30.4	1.8
- Social support	27.7	50.9	21.4	0.0

From the study found that health care needs on financial support and psychosocial. It was found that the majority of studied populations' health care needs on financial support and psychosocial were moderately level (64.3%) and health care needs was low and most level (17.9%), as shown detail in table 11.

Table 11 Number and percentage of score on health care needs among male heroin abused as regards all financial support and psychosocial.

Health care needs on economy and psychosocial	Number	Percentage
Less need (lower than 5 scores)	20	17.9
Moderate (5-12 scores)	72	64.3
Strongly need (more than 12 scores)	20	17.9
Total	112	100
$\bar{X} = 8.19$ S.D = 3.88 Max = 17 Min = 0		

4.2 Health care needs on health behavior and social support

Health care needs on health behavior and social support. These term were explained appetite, sleep/ activity pattern, pain/discomfort, social network and employment. It was found that approximately ½ of studied populations had health care needs on employment, social network, appetite, pain/discomfort, sleep/ activity pattern and physical activity (40.2%, 33.1%, 24.1%, 18.8%, 17.9%, and 15.2% respectively). In addition, there found that more than half of studied populations had health care needs on sleep/ activity pattern, pain/discomfort. (60.7% and 55.4% respectively). More than 1/3 of studied populations had less health care needs on appetite, employment physical activity and social network (45.5%, 44.6%, 43.8%, and 40.2% respectively). When considerate on each item found that studied populations (41.1%) had not health care needs on physical activity, less than 1/3 of studied populations had not health care needs on appetite, social support, pain/discomfort. Sleep/activity

pattern and employment. (30.4% , 26.8% , 25.9% , 21.4%, and 15.2% respectively) as shown detail in table 12.

Total 12 Percentage of score on health care needs on among male heroin abused as regards on health behavior and social support.

Items	Health care needs			
	No need	Less need	Moderate	Strongly need
- Employment/ learning	15.2	44.6	29.5	10.7
- Social network	26.8	40.2	27.7	5.4
- Appetite	30.4	45.5	21.4	2.7
- Sleep/ activity pattern	21.4	60.7	16.1	1.8
- Pain/ discomfort	25.9	55.4	17.9	0.9
- Physical activity	41.1	43.8	14.3	0.9

From the study found that health care needs on health behavior and social support. It was found that the studied populations' health care needs on health behavior and social support were low level (67.0%), had less and most health care needs were similarly (17.0% and 16.1%) respectively as shown detail in table 13.

Table13 Number and percentage of score on health care needs among male heroin abused as regards all health behavior and social support.

Health behavior and social support	Number	Percentage
Less need (lower than 4 scores)	19	17.0
Moderate (4-9 scores)	75	67.0
Strongly need (more than 9 scores)	18	16.1
Total	112	100
$\bar{X} = 6.11$ S.D = 3.01 Max = 13 Min = 0		

4.3 Health care needs on health management.

Health care needs on health management. This term was explained as regards religious belief, resource utilization, care-taking system, motivation, comprehension and technical skill. These of term was investigated and found that more than half of studied populations and more than 1/3 of studied populations had not health care needs regarding term of health management (67.0%, 47.3%, 29.5 %, 26.8%, 25.9%, and 23.2% respectively), except issue of motivation which had more than 1/3 of studied populations had more health care needs (35.8%) as shown detail in table 14.

Table 14 Percentage of score on health needs among male heroin abused as regards health management.

Items	Health care needs			
	No need	Less need	Moderate	Strongly need
- Resource utilization	29.5	42.9	17.0	10.7
- Motivation	25.9	38.4	30.4	5.4
- Comprehension	26.8	59.8	10.7	2.7
- Religious belief	67.0	21.4	8.9	2.7
- Care-taking system	47.3	33.0	17.9	1.8
- Technical skill	23.2	61.6	15.2	0.0

From the study found that health care needs on health management. It was found that the studied population's health care needs on health management were moderate level (66.1%), had less and most health care needs were similarly (18.8% and 15.2% respectively) as shown detail in table 15.

Table 15 Number and percentage of score on health care needs among male heroin abused as regards all health management.

Health management	Number	Percentage
Less need (lower than 4 scores)	21	18.8
Moderate (4-9 scores)	74	66.1
Strongly need (more than 9 scores)	17	15.2

Table 15 Number and percentage of score on health care needs among male heroin abused as regards all health management. (Cont.)

Health management	Number	Percentage
Strongly need (more than 9 scores)	17	15.2
Total	112	100
$\bar{X} = 5.27$ S.D = 3.17 Max = 14 Min = 0		

4.4 All health care needs

Physical and mental Impact of studied populations was found that they had health care needs from closely person and caretaker in centre. From the study revealed that they had health care needs by divided into 3 level as follows: lower than 11 scores refers to they had low health care needs level, 11 - 28 scores referred to the had moderate health care needs level, higher than 28 scores refer to they had high health care needs level. Mean score was 8 scores ($\bar{X} = 8.19$, S.D. = 3.88) and found that the majority had all health care needs were moderately level (69.6%), most and low level were (17.0% and 13.4% respective) as shown detail in table 16.

Table 16 Number and percentage of score on health care needs among male heroin abused as regards on all variables.

Health care needs level 3 parts	Number	Perc entage
Less need (lower than 11 scores)	19	17.0
Moderate (11-38 scores)	78	69.6
Strongly need (39-57 scores)	15	13.4
Total	112	100
$\bar{X} = 19.56$ S.D = 8.67	Max = 43	Min = 3

5. Analyzing correlation of other factors with health care needs.

From analyzing of these factors by used multiple regression analysis for analyzed 9 variables. whereas, dummy variable was showed as below:

5.1 Factor influenced to health care needs among male heroin abused as treated in center.

Correlation analysis between general factors with health care needs

1. Education was dummy variable as below:

High school = 1

ects = 0

2. Occupation, there was 3 groups as follows: hire, unemployed and others. There was 2 dummy variables.

2.1 Hire Ling (Rj) = 1

ects = 0

2.2 Unemployed (Wh) = 1
 ects = 0

For quality of this study, the author applied on Pearson’s Moment Correlation Coefficient for analysis between variables and within variables. It was found that independent variable was high correlation level. ($r > 0.75$) where as, Age and time of addiction were high within correlation ($r = 0.775$). the author would exclude its as shown detail in table 17.

Table 17 Pearson’s correlation coefficient(r) of studying variables by presented correlation metric model.

Variables	Tneed	Age	Income	Number	Ch	Pc	Ex	Ned	Rj	Wh
Tneed	1.000									
Age	-.094	1.000								
Income	-.012	.438**	1.000							
Number	-.088	.275**	.061	1.000						
Ch	-.147	.188*	.122	.163*	1.000					
Pc	-.058	.037	.069	.041	.249**	1.000				
Ex	.305**	-.153	-.030	-.075	-.018	.186*	1.000			
Ned	-.011	-.086	-.083	.084	-.189*	-.178*	.118	1.000		
Rj	.152	.298**	.273**	-.061	.175*	.232**	.085	-.028	1.000	
Wh	.014	-.260**	-.530**	-.045	-.078	-.054	-.089	.028	-.432**	1.000

* P < 0.05

** P < 0.01

From applied on multiple regression analysis by together with 9 variables found that all independent variables could explained health care needs 17.9 ($R^2 = 0.179$) and 9 variables could explain health care needs with statistical significance as regards expectation on stopping heroin abused (Ex) and hire ling (Rj). Beta was 0.324 and 0.259 respectively. Expectation and hire ling were variables as positive influence to health care needs of male heroin in drug dependent treatment center in the southern region.

The researched result found that if they had expectation on stopping heroin abused and hire which two variables which influence to health care needs was moderate level ($R = 0.423$). These could explain variation of variables as influence to health care needs 17.9 % ($R^2 = 0.179$) as shown detail in table 18.

Table 18 The results of regression analysis of basic factor as regards to psychology as influenced to health care needs of male heroin abused..

Variables	B	Beta	T
Expectancy on stopping Heroin dependent	0.285	0.324	3.428**
Hire	4.963	0.259	2.412*
Unemployed	3.523	.150	1.315
Age	-.154	-.093	-.849
Education	-2.338	-.106	-1.116
Income	0.0002	.067	.585
Number of time addiction	0.003	.020	.206
Perceived physical change	-.175	-.151	-1.595
Perceived severity of detoxification	-.154	-.153	-1.562

Multiple R = 0.423

$R^2 = 0.179$

* P < 0.05

** P < 0.01

CHAPTER V

DISCUSSION

From this research aimed to study health care needs level and factors as influenced to health care needs of male heroin dependent in government drug dependent center in the southern region. It was summarized on objective and hypothesis following aspects:

1. Health care needs level

In this research was found that the studied populations had health care needs level in 3 parts as follows: financial support and psychosocial, health behavior and social support, health management was moderate level at rate 69.6% which was discussed in each part as follows:

1.1 Health care need on financial support and psychosocial

The research result was found that 64.3% of male heroin abuser had need health care on financial support and psychosocial were moderate level. These were term of adjustment about illness. Receiving will power from other person, personal relationship, financial resource, financial concern, financial support and money management. In summarizing, health care needs in regard to money concern (50.9%) and more than 1/3 of clients had need health care on money management, financial support, financial resource and adjustment in illness. The studied studied populations

were age range 16-35 years (92.6%), age average was 26 years, education was secondary school / vocational (75.9%), single status (81.3%) and hire (46%), income /month average 4,000 baht ($\bar{X} = 4,107.6$, S.D = 3,666.5). thus, they were not responsibility to their family and they received expenditure from their guardians for traetment. Therefor, health care needs on financial support and psychosocial was moderate level.

1.2 Health care needs on health behavior and social support

The research result was found that 67.0% of clients had need health care in regard to health behavior and social support was moderate level. The issue as regards appetite, sleep/ activiy pattern, physical activity, pain/ discomfort, social network and employment. Those of clients had more need health care regarding employment (40.2%) and more than 1/3 of clients had health care needs on social network. Whereas, the less health care was appetite, sleep/activity pattern, physucal activity, pain/discomfort during treatment. Because of the ampled population in this study were age rage 16-35 years (92.8%). Approximaely (46.4%) were 16-25 years which they were in student year. 46.4% of them were age range 26-35 years who should be working-year and 33.8% was unemployed.

1.3 Health care needs on health management

The reaserch result was found that 61.1% of clients had health care needs on health management was low level which was issue of religious beliefs, resource utilization, caretaking system, motivation, comprehension and technical skill. Those

of clients had health care needs on religious beliefs, resource utilization, motivation, comprehension and technical skill and they had health care approximately 1/3. All this because of 3/4 of sampled population in this study was secondary/vocational who was literate but they still lacked experience, knowledge, attitude and practice in health management. which consistent with study of Kuantu Puriwitayatera (1998: 67) studied self-management among heroin abuser by intravenous injection. Found that consuming behavior, physical activity and preventive complication were high level, moderately level behavior was exercise, seeking knowledge about complication, relaxation, keeping appointment, consult and treatment including bodily examination which supported Larson's study, 1986 cited by Baulaung samdanglit (1998: 54) stated that an activity as important to treatment of patients was self-care activity which conducted by staff including safety.

2. Factor as influenced to health care needs

2.1 Basic factors

2.1.1 Hire ling was positive association with health care needs with statistical Significance. The participants in drug dependent treatment center in the southern region was more hire ling and wished health care needs than other occupation. This can be explained as follows: hire ling (46%), average income was 4,1000bath ($\bar{X} = 4107.6$, S.D.= 3,666.5) these were low income and it was expense for heroin. The study of Ladda Teauksuban (1995: 130) found that drug abuser mixed heroin with cannabis and loss expense for heroin about 100-300 baht. These affected to

family problem thus, they would decide to participate in program. The study of Watchalee Meesinl (2000: 111) studied selecting factors as related to therapeutic behavior during detoxification step found that the most of studied populations were hire ling (54.8%) and they volunteered to cure due to they could not buy it and more expensive which consistent with health belief model concept. This concept had explained to disease prevention and illness behavior. In this term found that hire ling was one variable of demographic factors and modifying factors. It direvly affected to perception.

2.2 Psychological factors

2.2.1 Expectancy on stopping heroin dependent

Expectancy on stopping heroin dependent was positive correlation with health care needs with statistical significance. The clients were high expectation on stopping heroin abused and had health care needs. This can be explained that the expectation of studied populations were high level and could change their behavior. In contrast, if expectation of studied populations were low level, they will have health behaviuor was low level. In this study was found that they had mean score on expectation of stopping heroin abused were low level ($\bar{X} = 46.866$, S.D = 7.871). The conceptof Elise, 1987 cited by Dawrung Supaporn (1997: 5) stated that expectation was individual experience which achievement would be fail or success. it became perception. In HBM showd that perceived susceptibility to being disease was important factor and influenced to other factors. Thus, Becker summarized that person

perceived susceptibility to being disease would have positive behavior and could prevent disease. Those of Becker supported self-efficacy theory as applied on social cognitive.

Self-efficacy influenced to learning and modifying behavior of person. Thus, expectancy on stopping heroin addiction influenced to health care needs of male heroin abused in government drug dependent center in the southern region.

3. Factors as no influenced to health care needs

The factors as no influenced to health care needs of studied population was variable as no association with health care needs was 7 variables such as: age, education level, income, time period of addiction, perceived physical change and perceived severity of detoxification which was shown detail following aspects:

Age found that age as no influenced to health care needs of studied populations. Because of the most of studied populations were age range 16-35 years (98.2%), age average 26 years ($\bar{X} = 26.31$, S.D = 5.75) This can be explained that although, how the studied populations were more age, they could cure and free, in present the government emphasized on treatment in hospital including enforcing narcotics.

Education level found that there was no association with health care of male heroin abuser in grig dependent treatment center in the southern region. This can be explained that even if which level as the studied populations were, health care was no different. All this, because of at present the government were interested in narcotic enforcement and treatment. Information accessed in service places by direct and indirect way and people could explore the information. Health education was important to treatment including therapeutic group which they were under taking care closely. From research result was found that the majority of studied populations were secondary/vocational (75.9%). It affected to education level was no association with health care needs.

Income found that income was no association with health care needs of the Studied populations which can be explained that although, they had different income, healt care was no different. All this, because of they could receive several informations such as: newspaper, radio, journal television and participating treatment.

Number of time as treatment found that it was no association with health care needs although, they would participate in program many time, it did not affect to different health care needs all this, because of most of studied populations gave reason that they were bored to addict heroin (75%) weakness(13.3%) Chauking Chucriut (1998: 74-75) characterized that they intended to stop heroin addiction which did not involve to treatment activity. This can be explained that number of time as treatment as different did not affect to health care needs.

Perceived physical change it was found that perceived physical change was no correlation with health care needs of studied populations which illustrate that regardless of they would more perceive or less, it did not affect to different health care needs. The majority of studied populations were age range 16-35 years (92.8%), age average 26 years ($\bar{X} = 26.31$, S.D = 5.75) and single status (81.3%) The study of Sakdina Boompeam (1991: 64) found that heroin abuser in Tanyayrak hospital. (32.5%) of studied populations' health was degenerated. It affected to perceived physical change was no association with health care needs. Although, they perceived that how it was hazardous but they still practice because of it was happiness when they addicted.

Perceived severity of detoxification found that there was no association with health care needs of studied populations, which explained that, although, they would more perceive severity of detoxification or less, health care needs did not different. Because of the studied populations had ever treated about 6-10years (50.9%), period of addiction about 7 years ($\bar{X} = 7.32$, S.D. = 53.38, max = 22, min = 1). Data on interview found that they perceived information on detoxification was high level such as: unable to sleep, hearth rate (92.9%), pain in bone (92.9%), vomiting diarrhea and suffering (91.0%). They perceived severity of detoxification was high level but they could avoid that symptom by repeat used. The study of Tongchai Unaklap (1987: 30) stated that the victims would be suffering if they don't addict it. The withdrawal symptoms were vomiting, muscle spasm, diarrhea, bleeding intestine. This symptom was appeared about 3-4 days and decreased down in 4-7

days. The studied populations would take Methadone. The study of Suwilai Sangwan (1990: 13) stated that when they had addicted it has reaction to physical and cerebellum. The symptoms after addicted; sleepy, decreased painful, vomiting.



CHAPTER VI

CONCLUSION AND RECOMMENADTION

This research was aimed to study health care needs of male heroin dependent in government drug dependent treatment centres in the Southern region and studied factors as influence to health care needs such as: Age, education level, occupation, income, time period as dependence, number of time as dependence and psychological factors such as: perceived physical change, perceived severity of detoxification and expectancy on stopping heroin dependent.

The studied population of this study was male in-patient in government drug dependent treatment centres in the southern region, Songkhla and Pattani province. In addition, these centres had treatment in the 3rd step was rehabilitation, it was divided into 4 parts as follows: physical rehabilitation, mental, occupation and social. These activities were done in therapeutic treatment centre where compounded in the centre. The centre of songkhla available services 7 provinces in upper Southern region and centre of Pattani available services 7 provinces in lower Southern region.

The instruments of this study was interviewing questionnaire which was created by stying textbook, documents and related research as comprised with 4 parts asfollows:

Part 1: Data on basic factors

Part 2: Data on psychological factors

Part 3: Health care needs as divided into 3 segments as follows:

Segment 1: Health care needs on financial and psychosocial

Segment 2: Health care needs on health behavior and social support

Segment 3: Health care needs on health management

Part 4: recommendation about health care needs.

Data gathering was conducted by the author which coordinate with head ward. The author informed objective of this study to participants before implementation. The implementation began by the author and 2 assistants.

Analysis statistic used multiple regression analysis by analyzed all factors as influence to health care needs of male heroin abused.

Conclusion

1. Basic data

1.1 Data on socio-demographic of heroin abuser in drug dependent treatment centre.

The studied population in this study was in-patients in government drug dependent treatment centre in the southern region, songkhla and Pattani. Total 112 cases, most of studiedstudiedstudied populations (92.8%) were age range 16-35 years, single status (81.3%) and respected Buddhist (85.7%. Education level was

secondary school/ vocational (75.9%). Occupation was hire (41.9%), income/ month was 3,000-6,000 baht. Student/unemployed (34.8%).

1.2 History of treatment

The majority of treatments were heroin abuser (50.9%), Time period as heroin addiction was 6-10 years and had ever treated in this centre about 1-5 times (54.5%).

2. Data on psychology

2.1 Perceived physical change

Perceived physical change after heroin dependent among male heroin abused. Most of studied populations perceived that after addicted the physical was negative change such as: face was dark, sleepy, loss appetite, loss sex need, degenerative memory and complication e.g. TB, depressive symptoms.

2.2 Perceived severity of detoxification

Perceived severity of detoxification after addicted the patients would have negative behavior such as: heart rate, pain in bone, could not control one-self, conflicted, weight loss and more than 3 / 4 thought that during withdrawal, they might offense and detoxification was suffering.

2.3 Expectation on stopping heroin abused

Most of participants about 3/4 expected that they could stop heroin addiction if they attended their self as follows: attempted to stop, cleaned physical; clothes and

participated in activities of centre. Taken healthy food and sufficient. More than 2/3 could practice followed by medical doctor's recommendation and psychologist such practiced concentration, exercised and practiced in religious principle.

3. Health care needs

Health care needs among male heroin abused in government drug dependent treatment centre in the southern region, Songkhla and Pattani. Found that most of participants need health care on financial support and psychosocial (82.2%), health behavior and social support (83.1%), health management (81.3%) and health care needs all 3 parts; financial support and psychosocial, health behavior and social support, health management (83%).

Factors as influenced to health care needs

From studied factors as influenced to health care needs among male heroin abused which analysis by using multiple regression analysis. All variables were 9 variables and found that all variables could explain health care needs among patients at rate 17.9 % ($R^2 = 0.179$). Two variables which described health care needs among patients at $p\text{-value} = 0.05$ were expectation on stopping heroin abused and earn a living hire. These had Regressive coefficient = 0.324 and 0.259 respectively.

And this research is following and confirm self-efficacy theory which is a key component of the self-system which Bandura defines as our self-perception of

how well we can function in a given situation. And the key to behavioral change is the alteration of expectations of personal efficacy.

Recommendation from this research

Recommendation for applying results to further more research.

1. Heroin abuser treatment by voluntary system in service place, there should emphasize on patients as intended participation or expected that would stop heroin addiction. Because of treatment used time and loss budget to rehabilitated physical, mental and social.
2. In treatment progress of rehabilitation step should emphasize on training occupation and developed life skills for back to social with happiness and strength. Because of the patients were low knowledge and low economy.
3. There should create social network for treated patient among follow up and after care. There should emphasize on participation of general organization to participate in program.

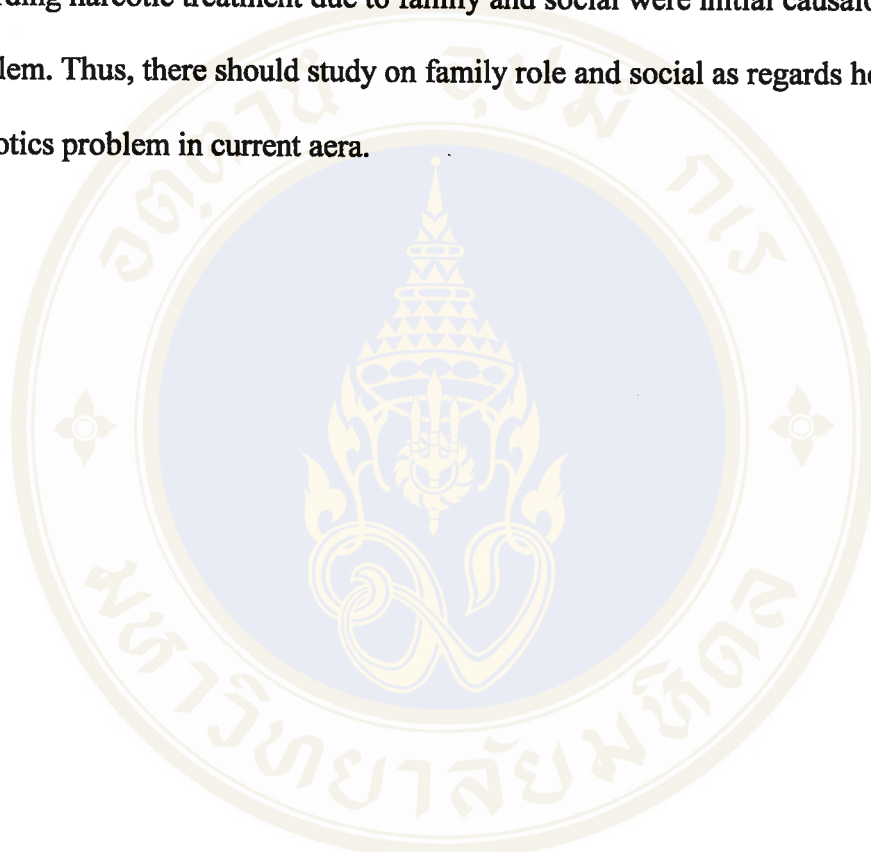
Recommendation for Further more Research.

1. This research was studied on health care of male heroin abuser in patients in government drug dependent treatment centre in the southern region, Songkhla and Pattani. The further research should study comparing research of patients who addicted serious narcotics.



2. There should study factors as influence to stopping drug abused which treatment problem was sensitive problem. There would be necsseary to study in-dept knowledge so.

3. There should study on acception and participation of community regarding narcotic treatment due to family and social were initial causaion of narcotic problem. Thus, there should study on family role and social as regards how to solving narcotics problem in current aera.



BIBIOGRAPHY**In English**

Bandura, A. (1977). Social learning theory. Engwood Cliff, N.J.Practice hall.

Becker, M.H.(1977). The Health Belief Model and Prediction of Dietary Compliance: Afield Experiment. Journal of Health and Behavior, 18, 348.

Becker, M.H. (1974). The Health Belief Model and Sick Role Behavior. Health Education, 2, 409-417.

Berk, R.A. (1995). Use of primary caretakers as proxies to measure the health care needs of patients with AIDS. Public Health Nursing, 12, 109-116.

Dodge, I. (1969). "Factors Related to Patients' Perceptions. Of their Cognitive Needs." Nursing Research. 18 (November / December 1969): 502-513.

Leininger. (1988). Care; The Essence of Nursing and Health. Detroit: Wayne State University. Nursing Science Quarterly. 2 (4): 11-20.

Maslow, A. (1970). Motivation and Personality. (2nd ed.), London: Harper and Row.

Morse, J.M. et al. (1990). " Concepts of Caring and Caring as a Concept." Advanced In Science. 13: 1-14.

Orem, D.E. (1991). Nursing concepts of practice. 4th ed. St. Louis: Mosby Year Book.

Zhan, L. (1992). Quality of life : concept and measurement issues. Journal of Advanced Nursing, 17, 795-800.

BIBIOGRAPHY

In Thai

- กนกพร กัลยาณสูตร. (2532). การวิเคราะห์แนวทางการบำบัดรักษาของผู้ติดยาเสพติดให้โทษในระบบคุมประพฤติผู้ใหญ่. วิทยานิพนธ์ปริญญาสังคมสงเคราะห์ศาสตรมหาบัณฑิต, สาขาวิชาสังคมศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยธรรมศาสตร์.
- กัญญา สุวรรณแสง. (2532). จิตวิทยาทั่วไป. กรุงเทพมหานคร: สำนักพิมพ์บำรุงสาส์น.
- กองทัพภาคที่4. (2537). รายงานการสรุปผลการปฏิบัติงานโครงการเพื่อความหวังใหม่ แผนภาคใต้ปลอดภัยยาเสพติด ในปีคศ.2000. (พิมพ์ครั้งที่3) กรุงเทพมหานคร: พับลิคบิสเนสพริ้นท์.
- กองบำบัดรักษา สำนักงาน ป.ป.ส. รายงานผลการวิเคราะห์ข้อมูลผู้ติดยาเสพติดที่สมัครใจเข้ารับ การบำบัดรักษาในปีงบประมาณ 2528.- 2529. (อัดสำเนา).
- กอบกุล พันธุ์เจริญวรกุล. (2531). มโนคติแบบการพยาบาลแบบองค์รวม. การประชุมวิชาการ คณะพยาบาลศาสตร์. (อัดสำเนา).
- กำไลทิพย์ ระน้อย. (2536). ประสิทธิผลของโปรแกรมสุขศึกษาในการงดสูบบุหรี่ของนักศึกษาชายวิทยาลัยพลศึกษากรุงเทพฯ. วิทยานิพนธ์ปริญญาสาธาณสุขศาสตรมหาบัณฑิต, สาขาวิชาสาธาณสุขศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ขวัญดา ภูริวิฑาชีระ. (2541). พฤติกรรมการปฏิบัติตนด้านสุขภาพของผู้ติดยาเสพติดที่สมัครใจเข้ารับ วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต, สาขาวิชาสุขภาพจิตและพยาบาลจิตเวชศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล
- ชาญคณิต ก.สุริยะมณี และคนอื่นๆ. “ปัจจัยที่มีผลต่อการติดยาเสพติดซ้ำของวัยรุ่น.” รายงานการวิจัย สำนักงานคณะกรรมการวิจัยแห่งชาติ, 2529.
- ชาญชัย เรืองขจร และคนอื่นๆ. (2534). การศึกษาข้อมูลพื้นฐานสภาพปัญหายาเสพติดในจังหวัดสงขลา ประจำปี 2534. รายงานการวิจัย วิทยาลัยครูสงขลา.
- ชื่นจิตต์ วงษ์โพธิ์ดี. (2534). ทัศนคติของเจ้าหน้าที่ตำรวจและบุคลากรทางการแพทย์ต่อแนวความคิดในการปฏิบัติต่อผู้เสพติดในลักษณะผู้ป่วย. วิทยานิพนธ์ปริญญาสังคมศาสตรมหาบัณฑิต, สาขาวิชาอาชญาวิทยาและงานยุติธรรม บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ช่อกิ่ง ชูครุฑ. (2541). ปัจจัยที่มีผลต่อกระบวนการตัดสินใจของผู้ติดยาเสพติดที่เข้ารับการรักษา: ศึกษาเฉพาะกรณีวัยรุ่นชายในสถานบำบัดเขตกรุงเทพมหานครและปริมณฑล. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาสุขภาพจิตและการพยาบาลจิตเวชศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.

- คุณฉวี ชาญปริษา. (2541). ผลของกระบวนการกลุ่มร่วมกับแรงสนับสนุนทางสังคมต่อความรู้ทัศนคติและพฤติกรรมกับการบำบัดรักษาของผู้เสพติดเฮโรอีน โรงพยาบาลธัญญารักษ์ จังหวัดปทุมธานี. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาสาธารณสุขศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ทัศนีย์ บุญทอง. (2534). มโนคติของจิตวิญญาณการพยาบาล. ในการพยาบาลในมิติจิตวิญญาณ. กรุงเทพมหานคร: เรือนแก้วการพิมพ์.
- ทิศย์ทยา หอมทรัพย์. (2538). ความสัมพันธ์ระหว่างการรับรู้ภาวะสุขภาพ ปัจจัยพื้นฐานกับความพร้อมในการดูแลตนเองของผู้ติดเชื้อโรคเอดส์. วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต, สาขาวิชาการพยาบาลผู้ใหญ่ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ธีระชัย เต็ดขาด. (2544). การมีส่วนร่วมของประชาชนในกิจกรรมความมั่นคงปลอดภัยในชีวิตและทรัพย์สินของชุมชน: ศึกษาเฉพาะประชาชนในพื้นที่สถานีตำรวจนครบาลหลักสอง. วิทยานิพนธ์ปริญญาศึกษาศาสตรมหาบัณฑิต, สาขาวิชาประชากรศึกษา บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ธงชัย อุ่นเอกลาภ. (2541). การบำบัดรักษาผู้ติดยาเสพติดแบบผู้ป่วยนอก จัดพิมพ์และเผยแพร่โดยกองประสานการปฏิบัติการบำบัดรักษาผู้ติดยาเสพติด กรมการแพทย์ กระทรวงสาธารณสุข.
- ธีรารัง ทัศนอาชวลี. (2538). การบำบัดรักษาผู้ติดยาเสพติด : ระบบรูปแบบและระบาควิทยา. วารสารกรมการแพทย์, 20 (10), 373-379.
- นงลักษณ์ โดบันลือภพ. (2539). การประยุกต์ทฤษฎีจิตใจในการป้องกันโรคร่วมกับแรงสนับสนุนทางสังคมเพื่อป้องกันการพึ่งยาแอมเฟตามีน ของนักเรียนชั้นมัธยมศึกษาตอนต้น อำเภอเมือง จังหวัดลำปาง. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาสาธารณสุขศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- บั้งอร บุญรักษาสัตย์. (2533). การศึกษาปัจจัยที่มีอิทธิพลต่อการไม่เข้ารับการบำบัดรักษาในพื้นที่ผู้สมรรถภาพของผู้ป่วยยาเสพติด โรงพยาบาลธัญญารักษ์ จังหวัดปทุมธานี วิทยานิพนธ์ปริญญาสังคมสงเคราะห์ศาสตรมหาบัณฑิต, สาขาวิชาสังคมศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยธรรมศาสตร์.
- เบญจพร ทองสุข. (2540). อิสลามกับปัญหาเสพติด: ศึกษาความค้ำึงทางศาสนากรณีปัญหาเสพติดในชุมชนมุสลิม จังหวัดยะลา. วิทยานิพนธ์ปริญญาสังคมศาสตรมหาบัณฑิต, สาขาวิชาศาสนาเปรียบเทียบ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.

- บุปผา ขอบใจ. (2534). ความต้องการจิตวิญญาณของผู้ป่วยสูงอายุที่ป่วยด้วยโรคมะเร็ง ใน จินตนา ยูนิพันธ์ และพยอม อยู่สวัสดิ์. (บรรณาธิการ), การประชุมสมาคมศิษย์เก่าพยาบาลศิริราชฯ. ครั้งที่ 8. วิจัยทางการพยาบาลเพื่อพัฒนาคุณภาพชีวิตในทศวรรษหน้า : ทิศทางและรูปแบบ (หน้า 167-171). นครปฐม: สถาบันพัฒนาสาธารณสุขอาเซียน มหาวิทยาลัยมหิดล.
- บัวหลวง สำแดงฤทธิ์. (2538). ความต้องการการดูแลและการได้รับการดูแลจากพยาบาลตามการรับรู้ของผู้ป่วยมะเร็งปากมดลูก ที่ได้รับการรักษาด้วยรังสีในโรงพยาบาลรามาธิบดี. วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต, สาขาวิชาการพยาบาลผู้ใหญ่ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ประเทือง ธนิยพล. (2530). การใช้วิธีการบำบัดรักษาและอบรมแก้ไขและฟื้นฟูจิตใจแทนการใช้เรื้อนจำต่อผู้กระทำผิดฐานเสพยาเสพติด. วิทยานิพนธ์ปริญญาสังคมศาสตรมหาบัณฑิต, สาขาวิชาสังคมศาสตร์การแพทย์และสาธารณสุข บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ประเทือง สูงสุวรรณ. (2534). การศึกษาการรับรู้ และความคาดหวังของครูต่อสภาพแวดล้อมโรงเรียนของโรงเรียนเอกชนในกรุงเทพมหานคร. วิทยานิพนธ์ปริญญาศึกษาศาสตรมหาบัณฑิต, สาขาวิชาสิ่งแวดล้อม บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ประภาพร จินันทุยา. (2536). คุณภาพชีวิตของผู้สูงอายุในชมรมผู้สูงอายุคืนแดง. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาพยาบาลศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- เปรมฤทัย น้อยหมื่นไวย. (2536). แรงบันดาลใจทางสังคม ความพร้อมในการดูแลตนเอง และคุณภาพชีวิตของผู้ติดเชื้อ. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาพยาบาลศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ผจงจิตร อินทสุวรรณ และคนอื่นๆ. (2539). ปัจจัยที่เกี่ยวข้องกับพฤติกรรมการติดยาเสพติดของเยาวชน. รายงานวิจัย, สถาบันวิจัยพฤติกรรมศาสตร์ มหาวิทยาลัยศรีนครินทรวิโรฒ-ประสานมิตร.
- พิศมัย คู่พิทักษ์ และคนอื่นๆ. (2524). การติดตามศึกษาหลังจากได้รับการบำบัดแล้ว. รายงานการวิจัยเรื่องการวิเคราะห์ผลงานการวิจัยด้านยาเสพติด ม.ป.ท.
- พรจันทร์ สุวรรณชาติ. (2534). แนวคิดเกี่ยวกับการพยาบาลจิตวิญญาณ. ใน อรพินท์ วีระฉัตร (บรรณาธิการ). การประชุมวิชาการเรื่อง การพยาบาลในมิติจิตวิญญาณ. (หน้า1-7). กรุงเทพมหานคร: โรงพิมพ์เรือนแก้วการพิมพ์.

- พรศิริ ชาติยานนท์ และคนอื่นๆ. (2520). การศึกษาภาวะการติดยาเสพติดซ้ำ. รายงานการวิจัย. คณะสังคมสงเคราะห์ศาสตร์ มหาวิทยาลัยธรรมศาสตร์.
- พวงรัตน์ ทวีรัตน์. (2538). วิธีการวิจัยทางพฤติกรรมศาสตร์และสังคมศาสตร์. สำนักงานทดสอบทางการศึกษาและจิตวิทยา มหาวิทยาลัยศรีนครินทรวิโรฒประสานมิตร.
- มัลลิกา ตั้งเจริญ. (2534). การรับรู้เกี่ยวกับโรคเอดส์และความสามารถในการดูแลตนเองของหญิงอาชีพพิเศษ. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาพยาบาลศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ยี่สุน ใจดี. (2540). ปฏิบัติการพยาบาลที่เป็นการดูแลในโรงพยาบาลรามารบิตี. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาพยาบาลมารดาและทารก บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- รจนา วิริยะสมบัติ. (2540). ความต้องการดูแลด้านสุขภาพของผู้ติดเชื้อเอชไอวีระยะที่ปรากฏอาการ. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาการพยาบาลผู้ใหญ่ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ลัดดา เทือกสุบรรณ. (2538). การขยายการบำบัดรักษายาเสพติดเข้าสู่ชุมชน: กรณีศึกษาผู้ติดยาเสพติด ตำบลหัวเขา อำเภอสิงหนคร จังหวัดสงขลา. วารสารวิชาการเขต 12, 20 (4), 422-426.
- วัฒนา สุขพรต. (2533). ความสัมพันธ์ของตัวแปรด้านเภสัชวิทยา ด้านจิตวิทยา ด้านสังคม กับระยะเวลาในการติดยาซ้ำของผู้ติดยาโรอินในระหว่างการบำบัดรักษา. วิทยานิพนธ์วิทยาศาสตรมหาบัณฑิต, สาขาวิชาวิจัยพฤติกรรมศาสตร์ประยุกต์ บัณฑิตวิทยาลัย มหาวิทยาลัยศรีนครินทรวิโรฒประสานมิตร.
- วันชัย ธรรมสังการ. (2541). ปัจจัยที่สัมพันธ์กับการติดยาและสารเสพติดของผู้ป่วยในศูนย์บำบัดรักษาเสพติดภาคใต้. รายงานวิจัย, ศูนย์วิจัยพฤติกรรมศาสตร์เพื่อการพัฒนา ภาควิชาสารเสพติดศึกษา คณะศิลปศาสตร์ มหาวิทยาลัยสงขลานครินทร์.
- วัลภา สบายยิ่ง. (2534). ความรู้ความเข้าใจทางจริยธรรมเกี่ยวกับพฤติกรรมต่อตนเองของวัยรุ่นติดสิ่งเสพติดชนิดร้ายแรงที่เข้ารับการบำบัดรักษาในสถานบำบัดรักษากรุงเทพมหานคร. วิทยานิพนธ์ปริญญาศิลปศาสตรมหาบัณฑิต, ภาควิชาจิตวิทยา บัณฑิตวิทยาลัย จุฬาลงกรณ์มหาวิทยาลัย.
- วิชัย โปษยะจินดา. (2541). การวิจัยปัญหาสารเสพติด แผนกลยุทธ์การวิจัยสุขภาพ. สำนักงานประธานคณะกรรมการวิจัยแห่งชาติ สาขาวิทยาศาสตร์การแพทย์ สภาวิจัยแห่งชาติ.

- วิมลรัตน์ ภู่วราวุฒิปานิช. (2531). สำรวจความพร้อมในการดูแลตนเองของผู้ที่สูญเสียขา.
วิทยานิพนธ์ปริญญาพยาบาลศาสตรมหาบัณฑิต, สาขาวิชาพยาบาลศาสตร์ บัณฑิต
วิทยาลัย มหาวิทยาลัยมหิดล.
- ศักดิ์นา บุญเปี่ยม. (2534). ทัศนคติของผู้ป่วยยาเสพติดที่มีต่อการเปิดรับข่าวสารเรื่องการรักษา
รักษา: ศึกษาเฉพาะกรณีโรงพยาบาลธัญญารักษ์ กระทรวงสาธารณสุข. วิทยานิพนธ์
ปริญญาวารสารศาสตรมหาบัณฑิต, สาขาวิชาสื่อสารมวลชน บัณฑิตวิทยาลัย
มหาวิทยาลัยธรรมศาสตร์.
- ศิริวรรณ แสงอินทร์. (2536). ความสัมพันธ์เกี่ยวกับการรับรู้เกี่ยวกับโรคเอดส์สัมพันธ์ภาพของกลุ่ม
สมรสกับพฤติกรรมป้องกันการโรคเอดส์ของสตรีที่เป็นโรคติดต่อทางเพศสัมพันธ์.
วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาพยาบาลศาสตร์ บัณฑิตวิทยาลัย
มหาวิทยาลัยมหิดล.
- ศิริวัลย์ วัฒนสินธุ์. (2534). ความสัมพันธ์ระหว่างความรู้เกี่ยวกับการดูแลตนเอง ปัจจัยพื้นฐาน
กับความพร้อมในการดูแลตนเองในผู้ป่วยภายหลังการผ่าตัดเปลี่ยนลิ้นหัวใจ.
วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาพยาบาลศาสตร์ บัณฑิตวิทยาลัย
มหาวิทยาลัยมหิดล.
- ศรีสมบัติ บุญเมือง. (2527). การรับรู้ข้อมูลเกี่ยวกับยาเสพติดที่มีผลต่อการติดยาของวัยรุ่น.
วิทยานิพนธ์ปริญญาสังคมศาสตรมหาบัณฑิต, สาขาวิชาอาชญาวิทยาและงานยุติธรรม
บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- ศูนย์บำบัดรักษาเสพติดภาคใต้. (2541). กลุ่มงานวิชาการ. สถิติผู้ป่วยติดยาเสพติด. (อัดสำเนา).
- ศูนย์บำบัดรักษาเสพติดภาคใต้. (2543). กลุ่มงานวิชาการ. สถิติผู้ป่วยติดยาเสพติด. (อัดสำเนา).
- สภาสังคมสงเคราะห์แห่งประเทศไทยในพระบรมราชูปถัมภ์. (2538). สถานการณ์ยาเสพติดและ
การลดความต้องการยาเสพติดในประเทศไทย. กรุงเทพมหานคร: กรุงเทพมหานคร
สมอจันทร์ อนะเทพ. (2535). ความสัมพันธ์ระหว่างการรับรู้เกี่ยวกับโรค ความรู้สึกมีคุณค่าใน
ตนเอง กับพฤติกรรมป้องกันการโรคเอดส์ของผู้เสพยาเสพติดทางเส้นเลือดที่ได้รับการ
รักษาด้วยยาเมธาโดน. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาการ
พยาบาลศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- สุชา จันทร์เอม. (2538). จิตวิทยาเด็ก. กรุงเทพฯ: ไทวัฒนาพานิช.
- สุธิดา กาญจนรังษี. (2538). ปัจจัยที่มีผลกระทบต่อคุณภาพชีวิตของผู้สูญเสียขา. วิทยานิพนธ์
ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาการพยาบาลผู้ใหญ่ บัณฑิตวิทยาลัย
มหาวิทยาลัยมหิดล.

- สุรรัตน์ ช่วงสวัสดิศักดิ์. (2541). ความต้องการของญาติในฐานะผู้ดูแลผู้ป่วยโรคหลอดเลือดสมอง
วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาการพยาบาลผู้ใหญ่ บัณฑิต
วิทยาลัย มหาวิทยาลัยมหิดล.
- สุวิไล แสงวัฒน์. (2533). ความรู้และการรับรู้เกี่ยวกับโรคเอดส์และการติดยาเสพติดที่มีผลต่อ
พฤติกรรมการกินเมธาโดน. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชา
สังคมศาสตร์การแพทย์และสาธารณสุข บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- สำนักงานป้องกันและปราบปรามยาเสพติด. (2536). กรอบทิศทางป้องกันและแก้ไขปัญหายาเสพติด
ในปีงบประมาณ 2538. กรุงเทพมหานคร: สำนักงานคณะกรรมการป้องกันและ
ปราบปรามยาเสพติด สำนักนายกรัฐมนตรี.
- สำนักงานป้องกันและปราบปรามยาเสพติด. (2542). การศึกษาผู้ป่วยติดยาเสพติดรายใหม่.
วารสาร ป.ป.ส., 12 (1), 15.
- สำนักนายกรัฐมนตรี. สำนักงานประมาณ. งบประมาณโดยสังเขปประจำปีงบประมาณ 2541.
กรุงเทพฯ: บริษัท พี.เอ.ลิฟวิ่ง จำกัด.
- หลุย จำปาเทศ. (2533). จิตวิทยาสัมพันธ์. กรุงเทพฯ: โรงพิมพ์จุฬาลงกรณ์มหาวิทยาลัย.
- อังคณา นวลยง. (2535). ความสัมพันธ์ระหว่างการรับรู้เกี่ยวกับโรค การสนับสนุนทางสังคมกับ
พฤติกรรมการดูแลตนเองของหญิงตั้งครรภ์ที่มีความดันโลหิตสูงเนื่องจากการตั้งครรภ์.
วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาพยาบาลศาสตร์ บัณฑิตวิทยาลัย
มหาวิทยาลัยมหิดล.
- อรัญณี มงคลนวลเสถียร. (2541). ปัจจัยที่มีผลต่อกระบวนการตัดสินใจของผู้ที่ติดเฮโรอีนที่เข้ารับ
การบำบัดรักษา: ศึกษาเฉพาะกรณีชายวัยผู้ใหญ่ที่ว่างงานในสถานบำบัดเขตกรุงเทพ
มหานครและปริมณฑล. วิทยานิพนธ์ปริญญาวิทยาศาสตรมหาบัณฑิต, สาขาวิชาสุขภาพ
จิตและพยาบาลจิตเวชศาสตร์ บัณฑิตวิทยาลัย มหาวิทยาลัยมหิดล.
- อวยพร ตันมุขยกุล. (2540). พลังอำนาจกับการเสริมสร้างพลังอำนาจในวิชาชีพพยาบาล.
วารสารพยาบาลศาสตร์, 24(1), 1-9.



APPENDIX A.

List Name of Expert of This Research

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Department of Social and Medical Science Faculty of Social Science and Humanities Mahidol University.

2. Mr. Anggune PataraKorn

Head of Section of Detoxification Tanyarak hospital, Pathumthani province.

APPENDIX B.

Direction : The Questionnaire about A Study on Health Care Needs of Heroin Dependents: A Case Study of Male Patients In Government Drug Dependent Centres In Southern Region.

- Part 1 :** Questionnaire on basic factors
- Part 2 :** Questionnaire on psychology
- Part 3 :** Questionnaire on health care needs which was separated on 3 Segments
- Part4 :** Question on general data

In Privilege of Studies Population of This Research

In privilege of research population of this study. The author invited one-self and informed the objective of this study following aspects:

My name is Mr.Patikom Wiwattananon, I am student of Master of education (Education Population) Faculty of Social Science and Humanities, Mahidol University. I am interested in studying Health care needs of Heroin dependents.

A case study of male patients in government drug dependents treatment centres in Southern region. The achievement was applied, as be guideline to treatment among male Heroin abuser in drug dependent. These were arranged direct to patient needs and added more efficiency. These request cooperation from on patients to give your concept in this study. The Questionnaire was divided into 3 parts, used time about 30 minutes. All answer will be to secret and you can answer or can not.

Questionnaire

The Issue of A Study on Health Care Needs Among Heroin Dependents: A Case Study of Patient in Government Drug Dependent Treatment Centers in Southern Region.

Explanation: The created questionnaire for measured with health care needs among Heroin abuser. For seek a guideline of treatment among heroin abuser. The questionnaire comprised with 4 parts as follows:

Part 1 : Questionnaire on basic factors

Part 2 : Questionnaire on psychology

**Part3 : Questionnaire on health care needs which was separated on 3
Segments**

Segment1: Health care needs form on financial support and
psychosocial

Segment 2 : Health care needs form on health behavior and social
support

Segment 3: Health care needs form on Health management

Part4 : Question on general data

No. case.....

HN / AN.....

Date on data collection.....month.....

Part1: Data on basic factors

1. Age.....years

2. Marital status

Single

Couple

Widow

Divorce/separate

3. Religion

Buddhist

Islam

Christ

Else(pleased specify).....

4. Education level.....

5. Occupational before treatment

student

sevil servant

enterprise

Agriculture

Merchant

Hire

Unemployed

else (please specify

6. Your income/monthbath

7. Time period as addictedyear

8. Age at first of addictionyear

9. Had you ever treated in anywhere?

ever

never

10. If you had ever treated, where did you available service. (more than 1 item)

- General hospital
- Center hospital
- Drug dependent treatment centers in Southern region (Songkhla and Pattani)
- Enterprise clinic
- Community
- Else (please specify

11. From item 10. How did they do. (answered more than 1 item)

- Current medicine
- Herb
- Taken concentrated
- Magic
- Else (please specify).....

12. Number of time-admissiontimes (added this time)

13. Which method did you addict before treatment. (answered more than 1 item)

- with bamboo
- mixed with cigarette
- injected in intravenous
- else(please specify.....

14. At present, which step you treat ?

- Preparation
- Detoxification
- Rehabilitation
- Follow up

Questionnaires

The issue of a study on Health care need of Heroin dependents: a case study of male patients in government drug dependent treatment centers in Southern region

Explanation: The created questionnaire for measures with Health care needs among Heroin abuser to seek a guideline of treatment among Heroin abuser.

The questionnaire comprised with 4 parts as follow.

Part 1. Questionnaire on basic factor

Part 2. Questionnaire on psychological

Part 3. Questionnaire on Health care need as deviled into 3 parts as Follow:

- Part 1 Assessment form on financial support and psychosocial
- Part 2 Assessment form on health behavior and social support
- Part 3 Assessment form on health management
- Part 4 Question for expressing idea

Part 2: Data on Psychology.

Assessment form on psychology (perceived physical change, perceived severity of detoxification and expectation of stopping Heroin abused) among Heroin abuser in drug department treatment center in Southern region.

Explanation: The objective of this questionnaire to study concept of Heroin abuser in the center as regards perceived physical change, perceived severity of detoxification and expectation on stopping Heroin abused. You could answer with real feeling. It was corrected top a secret Please fill (/) in correct answer.

Issue on Perceive Physical Change and Preceived Severity of Detoxification, each

Question refer to:

- | | |
|----------------|--|
| Strongly agree | refer to you feel strongly accept in behavior. |
| agree agree | refer to you feel accept in behavior. |
| unsure agree | refer to you feel unsure in behavior. |
| Disagree agree | refer to you feel unaccepted in behavior. |
| Strongly agree | refer to you feel strongly unaccepted in behavior. |

The issue on expectation on stopping Heroin abused, each item refer to:

- | | |
|----------------|--|
| Often | refer to you think that you can most practice. |
| Slightly often | refer to you think that you can more practice. |
| Moderate | refer to you think that you can moderate practice. |
| Sometime | refer to you think that you can less practice. |
| Never | refer to you think that you can not practice. |

Part 3 Questionnaire Assessment on Health care needs.

Explanation: This Form Aim to Health Care Needs Comprise with 3 Parts as

Follow:

Part 1: Health care needs form on financial support and psychosocial as comprise with multiple choice of 7 items such as item 1-7.

Part 2: Health care needs form on health behavior and social support Comprise with multiple choice of 6 items such as item 1-6.

Part 3: Health care needs form on health management as comprise with multiple choice of 6 items such as item 1-6.

2.1 Assessment Form on Physical Change

How did you about detoxification ?

Statement	Strongly agree	agree	unsure	disagree	Strongly disagree
1. After addicted Heroine, you have poor appetite.					
2. Majority of Heroin abuser were still work.					
3. After addicted, complication was appeared such as: dermatitis, peptic ulcer.					
4. Heroin addiction was good, it encouraged on creative thinking.					
5. There face was dark due to addicted Heroin.					
6. After addicted Heroine, there was scar on their skin.					
7. Heroin affected to loss weigh.					
8. The lips were dark like to smoking					
9. After addicted you dislike to take bath.					
10. Heroin abuser was lazy.					
11. After addicted in short period, your memory was degenerated and deficit function.					

12. Heroin addiction was decreased painful such as: wound, broken bone.					
13. After addicted Heroin, you were lazy and sleepy.					
14. Heroin abuser was loss sex need.					
15. After Heroin addiction, you don't like to chat with any persons.					

2.2 Assessment Form on Perceived Severity of Detoxification .

How did you about detoxification?

Statement	Strongly agree	agree	unsure	disagree	Strongly disagree
1. Vomiting, muscle spasm, diarrhea was dangerous.					
2. Running tear, muscle pain, loss appetite after Heroin addiction was normally symptom.					
3. Repeatable detoxification affected to degenerated physical.					
4. Stopping Heroin abused about 3-4 hours was positive effect to detoxification.					
5. Severity of detoxification e.g. vomiting, diarrhea or bleeding in intestine, these were suffering.					
6. Withdrawal symptom affected to emotional Heroin abuser.					
7. Convulsion symptom, fever, hypertension were withdrawal symptom.					

8. Severity of detoxification forced them unable to sleep and heart rate.					
9. Severity of detoxification was pained in bone.					
10. Detoxification symptom was devil, moody.					
11. Severity of detoxification affected to decision making.					
12. Withdrawal symptoms was bleeding in intestine and death					
13. The clients as withdrawal would be Easy to offense due to lack Heroin.					

2.3 Expectation on stopping Heroin abused.

How did you practice with these issues?

Statement	Often	Slightly often	moderate	sometime	never
1. You could follow recommendation of physician, nurse.					
2. You could ask staff about complication after had addicted Heroin and advanced treatment.					
3. You could exercise after treatment.					
4. You could have healthy food.					
5. Read the book as related to Heroin treatment or health care					
6. Take concentrated or practice in religion					
7. You intended to quit Heroin.					

8. When you were lonely, you will smoking					
9. When you have free time you like to be alone.					
10. You participated in program in center.					
11. You could depress your mind no think to Heroin.					
12. You could be leader to advise your peers in drug dependent treatment center.					
13. You could cleaned your bed, clothing.					
14. You could be leader to advise your peers in drug dependent treatment center.					
15. You could cleaned your bed, clothing.					

Questionnaire on Part 3

Assessment Form on Health Care Needs

Explanation: Assessment form on health care needs aimed to study on health care needs which direct to your feeling as comprised with 3 parts as follows:

Part 1: Health care needs form on financial support and psychosocial as comprised with 7 questions such as: item 1-7.

Part 2: Health care needs form on health behavior and social support as comprised with 6 questions such as: item 1-6.

Part 3: Health care needs form on health management as comprised with 6 questions such as: item 1-6.

Part1: Health Care Needs on Financial Support and Psychosocial

How did you think with these issues?

Issues	Need level
1.Adjustment	(0) I am adjusting well to my illness. (1) I have some difficult adjusting to my illness. (2) I have considerable difficulty adjusting to my illness. (3) I am totally unable to adjust to my illness.
2.Personal relationship	(0) I have good personal relationship (1) I some difficulties in my personal relationship. (2) I have poor relationship. (3) My person relations are so poor that I feel neglected.
3.Personal: are supportive.	(0) My family and/or others have been very supportive. (1) My family and/or others could be more supportive. (2) My family and/or others are supportive. (3)I have no family and/or others to provide support.

<p>4. Income / financial resource</p>	<p>(0) I have enough income or financial resources to cover all of my living and health care expenses. (1) Although I have enough income or financial resources, they are in danger of being lost or cut back. (2) I do not have enough income or financial resources to cover all my living and health care expenses. (3) I do not have enough income or financial resource to cover my basic necessities, e.g., food, shelter and clothing.</p>
<p>5. Financial concern</p>	<p>(0) I do not have to worry about owing money. (1) I am concerned about the money that I owe. (2) I am anxious about money owing money. (3) I feel completely overwhelmed by the amount of money that I owe.</p>
<p>6. Financial assistance</p>	<p>(0) I have no need for financial assistance. (1) I have applied for financial assistance. (2) I refuse to apply for financial assistance. (3) I never applied for financial assistance.</p>
<p>7. Money management</p>	<p>(0) I (or someone else) manage my finances without difficulty. (1) I (or someone else) have trouble managing my finances. (2) I (or someone else) poorly manage my finances. (3) I (or someone else) am totally unable to manage my finances.</p>

Part2: Health Care Needs Form on Health Behavior and Social Support.

How did you think with these issues?

<p>Issues</p>	<p>Need level</p>
<p>1. Appetite</p>	<p>(0) I have a good appetite. (1) I have fair appetite. (2) I have a poor appetite. (3) I have no appetite.</p>

2. Sleep/activity pattern	<p>(0) I have no sleeping problem.</p> <p>(1) I have some sleeping problems, but they do not interfere with my usual activities.</p> <p>(2) My sleeping problems interfere with my usual activities.</p> <p>(3) My sleeping problems make it impossible for me to perform my usual activities.</p>
3. Physical activity	<p>(0) I am physically active despite my illness.</p> <p>(1) I am physically active but have had to change my level of activity because of my illness or its treatment.</p> <p>(2) I am not physically active at all because of my illness or its treatment.</p> <p>(3) I am not physically active at all for reasons other than my illness or its treatment.</p>
5.Pain/discomfort	<p>(0) I do not experience pain or discomfort.</p> <p>(1) I experience pain or discomfort on occasion, but it usually goes away with treatment.</p> <p>(2) I experience pain most of the time and it usually goes away with treatment.</p> <p>(3) I experience severe pain that never response to treatment</p>
5.Social network	<p>(0) I frequently see and/or talk with people outside of my household.</p> <p>(1) I occasionally see and/or talk with people outside of my household.</p> <p>(2) I rarely see and/or talk with people outside of my household.</p> <p>(3) I never see and/or talk with people of my household.</p>
6. Employment	<p>(0) I am able to hold a steady job.</p> <p>(1) My health is threatening my ability to hold a steady job.</p> <p>(2) I am not able to hold a steady job due to my health.</p> <p>(3) I am not able to hold any job due to my health.</p>

Part3: Health Care Needs Form on Health Management.

How did you think with these issues?

Issue	Need level
1. Religious belief	(0) My religious belief do not interfere with my medical care. (1) I comply with my medical care even when it goes against my religious belief. (2) I do not comply with my medical care it goes against my religious beliefs. (3) I do not comply with my medical care when it goes against my religious beliefs even though medical personnel feel that puts my life in danger.
2.Resource utilization	(0) I arrange for my own health care needs or using available community resources when I need them. (1) I need help arranging for my health care needs, but I have difficulty outside help. (2) I am not able to arrange for my health care needs, but I have difficulty accepting outside help. (3) I never need outside help.
3. Caretaking system	(0) I take care of myself(or take care of me is dependable most of time. (1) The person who is supposed to take care of me is dependable of the time. (2) The person who is supposed to take care of me is rarely dependable. (3) I have no one to take care of me(or the person who is supposed to take care of me does me more harm than good).
4. Motivation	(0) I motivate my self about health related issues. (1) I need someone else to motivate me about health related issue. (2) I can not get motivated over health related issues at all. (3) I am uninterested in self care.

<p>5. Comprehension</p>	<p>(0) I usually do not have trouble understanding health care instruction.</p> <p>(1) I usually need to have health care instructions repeated several times before I understand them completely.</p> <p>(2) I rarely understand health care instruction.</p> <p>(3) Health care instructions could be repeated a hundred times and still I would not understand them.</p>
<p>6. Technical skill</p>	<p>(0) I am willing and able to correctly perform procedures with instruction</p> <p>(1) I am willing to perform procedures, but I need guidance or supervision to correctly perform them.</p> <p>(2) I am unwilling or unable to correctly perform procedures unless they are needed perform them.</p> <p>(3) I am unwilling or unable to correctly perform procedures that are needed to keep me alive.</p>

Part4 : Question on general data

1. How did you think about health care need ?

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2. Which extivities as you need for health care ?

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BIOGRAPHY

NAME	Mr. Patikom Vivatthananon
DATE OF BIRTH	October 17, 1963
PLACE OF BIRTH	Chumphon, Thailand
INSTITUTIONS ATTENDED	Surajthani Rajabhat Institute, 1993-1995 Bachelor of Science (Health Education) Mahidol University, 1996-2001 Master of Education (Population Education)
POSITION & OFFICE	PRESENT Disease control Technician officer Southern Regional Epidemiological center, Songkhla.

