ACTIVITY DEVELOPMENT FOR REHABILITATION OF THE YOUTH DRUG ADDICTS IN JUVENILE OBSERVATION AND PROTECTION CENTER

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A THESIS SUBMITTED IN PATIAL FULFILLMENT
OF THE REQUIREMENT FOR
THE DEGREE OF MASTER OF ARTS
(ADDITIONOLOGY)
FACULTY OF GRADUATE STUDIES
MAHIDOL UNIVERSITY
2014

Thesis
entitled

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was submitted to the Faculty of Graduate Studies, Mahidol University
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ACKNOWLEDGEMENTS

I would like to express my sincere thanks to my thesis advisor, Dr. Tanunsak Barwornnuntakul for his invaluable help, practicable advice and constant encouragement throughout the course of this research. I would not have achieved this far and this thesis would not have been completed without all the support that I have always received from him.

I would also like to many thanks to my thesis supervisory committee, Dr. Indhira Chivarum and Pol.Col. Dr. Meechai Sicharoen for suggestions and all help to complete this research.

In addition, I am grateful for the teachers of addictionnologyfor my all study here.

Furthermore, I would be appreciated to my bosses, Mrs. Pormpring Pathamindra Mrs.Thanompan Permpoon and Mr. Boontham Robkrob, my supervisors, Mr. Songpol muagyoo and Mr. Korakot chunthong and to all my co-workers of the Office of Nonthaburee Juvenile observation and protection for all their successful helps to my research methodologies and kindly give me a chance of this study.

Finally, I most gratefully acknowledge my grandparents, parents and my friends for all their support throughout the period of this research

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ACTIVITY DEVELOPMENT FOR REHABILITATION OF THE YOUTH DRUG ADDICTS IN JUVENILE OBSERVATION AND PROTECTION CENTER

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ABSTRACT

The objective of this study was to analysis the activity development processes use for rehabilitation of the youth drug addicts in the Juvenile Observation and Protection Center, and factors related to activities. The sample consisted of four hundred youths in the juvenile observation program, and its vicinity. The tool used to collect data was questionnaire, and SPSS was used to program determine Anova for statistical analysis.

The results of this study were revealed as follows,

1) The majority of sample were male, age between 16-18 year old; separated parent; and family income were between 10,000 – 30,000 Baht. Additionally, they had a routine group of friends, and reasons for drugs consuming was to meet their need to try illegal drugs received from their friends.

2) Evaluation of the benefits from activity in the Juvenile Observation and Protection Center showed the majority of teens in the sample were in the risk juvenile group had expressed their assessment opinion for benefit at the highest level on the sports for combating the drug, while the drug addicted groups had revealed on assessment opinion of benefit at the highest level in all activities .

3) Factors affected for the rehabilitation activity were obviously gender, age, old domicile, educational levels, income, marital status of parent, reason to drug abuse including access to illegal drugs.

Recommendations for this study were to enhance sport design based activities to accommodate future plans that include consultation programs in the activities, and content for life expectation. In addition, youth participation in activity planning should included quality research regarding impact of such activities.

KEY WORDS: REHABILITATION / DRUG ADDICTS IN JUVENILE OBSERVATION

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แนวทางพัฒนาการจัดกิจกรรมบำบัดฟื้นฟู ด้านยาเสพติดในสถานแรกรับเด็กและเยาวชน
ACTIVITY DEVELOPMENT FOR REHABILITATION OF THE YOUTH DRUG ADDICTS IN JUVENILE OBSERVATION AND PROTECTION CENTER

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คณะกรรมการที่ปรึกษาวิทยานิพนธ์ : ฐนันดร์ศักดิ์ บวรนันทกุล, ปร.ด., พ.ต.อ.มีชัย สีเจริญ, ปรด., อินทิรา ฉิวรัมย์, ปร.ด...

บทคัดย่อ

การศึกษาวิจัยนี้มีวัตถุประสงค์เพื่อศึกษาแนวทางพัฒนาการจัดกิจกรรมบำบัด ฟื้นฟู ด้านยาเสพติดในสถานแรกรับเด็กและเยาวชนและปัจจัยที่สัมพันธ์กับการจัดกิจกรรมบำบัดฟื้นฟู ด้านยาเสพติดในสถานแรกรับเด็กและเยาวชน ประชากรที่ใช้ศึกษาเป็นเด็กและเยาวชนในสถานแรกรับเด็กและเยาวชน ในเขตกรุงเทพมหานครและปริมณฑล ที่เข้าร่วมกิจกรรมบำบัดด้านยาเสพติด ในสถานแรกรับเด็กและเยาวชน จำนวน ๔๐๐ คน โดยใช้แบบสอบถามเป็นเครื่องมือในการเก็บรวบรวมข้อมูล วิเคราะห์ข้อมูล โดยใช้โปรแกรม SPSS ใช้สถิติ ANOVA ในการวิเคราะห์ข้อมูล ผลการวิจัยสรุปได้ดังนี้

ผลการวิจัยสรุปได้ดังนี้

1) ด้านข้อมูลส่วนบุคคล ประชากรกลุ่มตัวอย่างส่วนใหญ่เป็นเพศชาย อายุระหว่าง ๑๖-๑๘ ปี บิดามารดา หย่าร้าง/แยกทางกัน รายได้รวม/ต่อเดือน รวมทั้งครอบครัว ๑๐,๐๐๐ – ๓๐,๐๐๐ บาท รองลงมารายได้ต่อเดือน ๓๐,๐๐๐ – ๕๐,๐๐๐ บาท เพื่อนที่คบหาสมาคมส่วนใหญ่ทั่วไปและหลากหลาย เหตุผลในการใช้ยาเสพติดคือ ต้องการอยากรู้อยากลองและหายาเสพติดได้จากซื้อหรือได้จากเพื่อน

2) ด้านการประเมินประโยชน์ที่ได้รับในกิจกรรมบำบัดด้าน ยาเสพติด ในสถานแรกรับเด็กและเยาวชน ที่เข้าร่วม โดยภาพรวม กิจกรรมกลุ่มเสี่ยง กลุ่มตัวอย่างมีความเห็นในการประเมินประโยชน์ในระดับมากในทุกๆด้านและมากที่สุดในกิจกรรมที่ ๔ เรื่องเกมส์กีฬา ด้านยาเสพติด กลุ่มเสพ จากกลุ่มตัวอย่างส่วนใหญ่มีความคิดเห็นเกี่ยวกับการประเมินประโยชน์ในกิจกรรมบำบัดด้าน ยาเสพติด ในสถานแรกรับเด็กและเยาวชน ที่เข้าร่วม โดยภาพรวมอยู่ในระดับมาก

3) ปัจจัยที่สัมพันธ์กับการจัดกิจกรรมบำบัด ฟื้นฟู ด้านยาเสพติด ในสถานแรกรับเด็กและเยาวชน ได้แก่ เพศ อายุ ภูมิลำเนาเดิม เพื่อน ระดับการศึกษา รายได้ สถานภาพสมรสของบิดามารดาปัจจุบัน เหตุผลในการใช้ยาเสพติดและการเข้าถึงของแหล่งยาเสพติด

4) ข้อเสนอแนะจากการวิจัย ได้แก่ ส่งเสริมกิจกรรมที่มีกีฬาเป็นพื้นฐาน คัดเลือกจัดกิจกรรมที่ช่วยเสริมการวางแผนอนาคต สอดแทรกการให้คำปรึกษาในกิจกรรม เพิ่มเนื้อหาที่สนับสนุนเป้าหมายชีวิตให้เด็กและเยาวชนมีส่วนร่วมในการวางแผนสร้างกิจกรรมรวมทั้ง การวิจัยเชิงคุณภาพเกี่ยวกับผลกระทบของการจัดกิจกรรม

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CHAPTER I
INTRODUCTION

1.1 Rational

Social problems are the general factors that affect and damage society. A social problem is normally a term used to describe problems with a particular area or group of people in the world. Social problems often involve problems that effect real life. Sudjith Jennopkarn (B.E.2546:2) said that development of the country and economic growth is as another factor that causes a change in the social and economic environment, social environment, and how to live with chaos. These aspects had affects every system in the society, particularly, and also affect the stability of the family unit (Caused family weakness and collapse eventually became the root of the social problems) especially the children and youth of all ages who suffer from different aspects, be it a little until serious problems such as the problem of delinquency among children and youth.

Juvenile delinquency is driven by the negative consequences of social and economic development, in particular economic crises, political instability, and the weakening of major institutions (including the State, systems of public education and public assistance, and the family). Socio-economic instability is often linked to persistent unemployment and low incomes among the young, which can increase the likelihood of their involvement in criminal activity.

Young people who are at risk of becoming delinquent often live in difficult circumstances. The problem of juvenile delinquency is becoming more complicated and universal, and crime prevention programmes are either unequipped to deal with the present realities or do not exist. Many developing countries have done little or nothing to deal with these problems, and international programmes are obviously insufficient. Developed countries are engaged in activities aimed at juvenile crime prevention, but the overall effect of these programmes is rather weak because the mechanisms in place are often inadequate to address the existing situation.

Statistical data in many countries show that delinquency is largely a group phenomenon; between two-thirds and three-quarters of all juvenile offences are committed by members of various groups. Even those juveniles who commit offences alone are likely to be associated with groups. According to data from the Russian Federation, the rate of criminal activity among juveniles in groups is about three to four times higher than that of adult offenders. Juvenile group crime is most prevalent among 14-year olds and least prevalent among 17-year-olds. The rates are higher for theft, robbery and rape, and lower for premeditated murder and grievous bodily harm.

Pratheawng Thaniyapol (B.E.2538: 90-91) had reflected children and young people is an important asset of the nation. If children behave well, it will be a good citizen of the future. If a child's behavior to deviate in a bad way, it can lead to delinquency and crime and become a cause of social problems including a threat to society and the nation. Problems of juvenile offenders, then, are a problem in every society. Crimes, many of conducting, are consequences of juvenile delinquency because a large number of children and young people, about half of the total population. Such issues are important enough to be on it. Because if you let it, it becomes a "good turn deserves another" crime is deteriorating with age and experience. Resolve difficult and eventually become criminals in the future as adults.

The first reason of the high rates of juvenile delinquency is the negative influence of commercialized mass media. Publishers of books or program producers are more concerned with profits than with the quality. Thus books or movies may have negative effects on children. Taken obscene books and violence movies are as examples. They are very dangerous to children. Once the children are exposed to violence or bad and dirty ideas are introduced into their mind, there will be lifelong harm. Some young children watch hours of murders, fights and crimes every week, with no adult to tell them that life is not like that most of them. The effect of the heavy dose of violence is to suggest to children that violence is an ordinary way of life, and that shooting and cheating are ways to succeed. Such a mis-believe usually leads them to a wrong way in near future.

The second reason of high rates of juvenile crime is that modern youth are more revolutionary and more independent that the elder generation. When this tendency goes to an extreme, problems arise. Some of the young want to throw away

all the traditional principles and beliefs, most of which are very good for self-cultivation. They are reluctant to listen to the advice from elder generation. If they behave in the way, as they like, they might commit crimes without realizing it.

The third significant factor of juvenile crime is the increasing number of single-parent families. Studies show that juvenile-delinquency rates are twice as high for youngsters from single-parent homes as for those in traditional households. Children in single-parent families are taken less care of and thus have feelings of being neglected, discriminated and isolated. The lack of parental love makes them hostile and cynical towards the society.

In Criminology, young offenders often assume that the action which he or she done was accepted. These young offenders are not only person who does not know the law but also a sense of action with it. Such state seniority and maturity of the child were both ideally and restraint in the offense and inexperienced in life.

In psychology and sociology, it was considered the offender's youth as they go astray by ignorance or with the ignorant and feeble mind. That may hone in on a good turn and should not be used to treat them like criminals. If we do so, even if it means pushing him towards evil dramatized.

Thailand is also used to treat juvenile offenders in a way that is different from an adult perpetrator. By treatment of juvenile offenders committed to the training to provide relief instead of criminal sanctions. The special court had sat up a trial court to juvenile offenders separate from the ordinary courts. Some countries called as the juvenile court Later the Family Court Act had passed and Juvenile Court Procedure Act B.E. 2534

Trial court for juvenile delinquency was to establish with the aims that the child or young offenders' aims to give children were fed control and strict discipline. Case by case basis taking into account the welfare and the future of children and youth were made together with the safety. As mentioned previously, the present state of society in Thailand found that juvenile crime is increasing dramatically. The juvenile offenders have multiple causes numerous present purpose of punishment or a way to punish children and youth have changed. With an emphasis on rehabilitation treatment to modify behavior, juvenile remand home. The Vocational Training Center for Children and Youth is responsible for the treatment of juvenile rehabilitation by such

guidelines. Apart from this, the Juvenile Observation and Protection are consisted with concerned personals such as psychologists, social workers, nurses, academics and vocational training. Need to identify the causes of juvenile delinquency before we can plan the treatment and relief directly to the cause to be effective in helping children and young people most.

Therefore, the government has established the juvenile and family court and determined the place for the judgment as the juvenile observation and protection of children and youth that support the mission of the agency and the youth's family. Such centers as a place for the remedies were which marks the beginning of the most juvenile remand home for children and youth rehabilitation activities. Children and young people with risk factors and behaviors associated with drug abuse can be divided into risk groups; the group also has a habit of using the drug activity for a period of 11 activities for 11 weeks, as follows;

Group 1

Activity1:Knowledge on Smoking, Tobacco and Alcohol.

Activity 2: Knowledgeon Drugs and drug abuse.

Activity 3:Knowledge about AIDS.

Activity 4: Games against drugs.

Activity 5: Musical richness of life.

Activity 7: Artistic mind.

Activity 8: Decision making skills.

Activity 9:How to reject without losing a friend.

Activity 10: Most valuable thing for me.

Group 2 Drug addict Groups: This consisted of the children and young people who had addicted drug. The activities are as the following 10 classes;

Activity 1: Effect immense of drug.

Activity 2: The stimulus.

Activity 3: Anti-drug recidivism.

Activity 4: Decision making skills.

Activity 5: Problem solving skills.

Activity 6: Refusal skills.

Activity 7: Listening skills.

Activity 8: Pride promotion.

Activity 9:An intelligences and mind reflection.

Activity 10: Life planning.

However, during the operation of activities,rehabilitation activities in the drugs in the first place for children and youth center have a little development as well as evaluation. Then, the therapy for drug such first place center for children and youth are not effective enough. Sometime there are some evident to point out the juvenile delinquency and drug abuse increased. The researchers would like to assess the efficient conduct of such activities in the Juvenile Observation and Protection Centre. Therefore it is interesting to study the development and evaluation of the implementation of the rehabilitation activities of the drug in the first place for children and youth in Bangkok and its vicinity. To make known the results of the rehabilitation activities for drugs in the center for children and youth, that will be leading to improve the process of rehabilitation and development activities of the drug in the first place for children and youth further.

1.2 Objectives of the study.

A. To study the activity development for rehabilitation of the youth drug addicts in the Juvenile Observation and Protection Center in Bangkok and its vicinity

B. To study the factors influenced the rehabilitation for the Juvenile Observation and Protection Center in Bangkok and its vicinity

1.3 Scope of the Study

This study had limited for the youth those who had drug addicted and had deliver to keep in the juvenile observation and protection center in Bangkok Metropolitan and its vicinity**.**

1.4 Hypothesis of the study

1.4.1 Youth in the observation and protection center in Bangkok and its vicinity who had different sex getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

1.4.2 Youth in the observation and protection center in Bangkok and its vicinity who had different age getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

1.4.3 Youth in the observation and protection center in Bangkok and its vicinity

1.4.4 Youth in the observation and protection center in Bangkok and its vicinity that had different school based education getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

1.4.5 Youth in the observation and protection center in Bangkok and its vicinity that had different marital status of parent getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

1.4.6. Youth in the observation and protection center in Bangkok and its vicinity that had different income getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

1.4.7 Youth in the observation and protection center in Bangkok and its vicinity that had different peer group getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

1.4.8 Youth in the observation and protection center in Bangkok and its vicinity that had different access to drug abuse getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

1.4.9 Youth in the observation and protection center in Bangkok and its vicinity who had different reasons to consume drug getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

1.4.10. Youth in the observation and protection center in Bangkok and its vicinity that had different risk conditions to drug circle getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

1.4.11 Youth in the observation and protection center in Bangkok and its vicinity who had different access to drug rehabilitation getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

1.5 Parameters used in the study

This study is divided the variable into two types:

1.5.1 Independent Variables (Independent Variables) are personal factors as sex, age, geographic domicile, school based education, marital status of parent, income, peer group ,access to drug abuse including reasons to consume drug ,risk conditions to drug circle, access to drug rehabilitation

1.5.2 Dependent Variables is the Activity Development for rehabilitation which consisted with 5 Attributes as:

A. Self-Help Aspects

B. Family Support

C. Understanding of Dimensions

D. Peer relationship

E. Life Planning

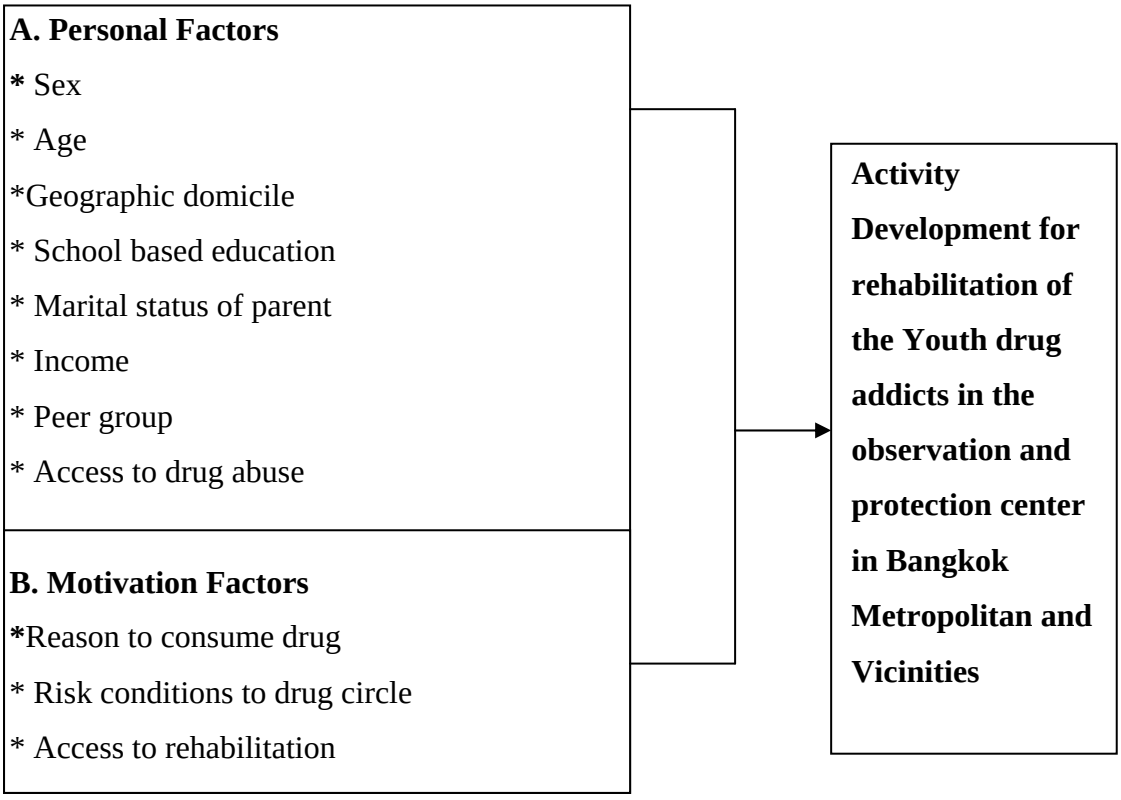
F. Opportunity to develop and skills

1.6 Variable Measures

Type of Variable	Level of measure
▪ **Independent Variables**	
A. Personal Factors	
***** sex	Nominal
* Age	Interval
* Geographic domicile	Ordinal
* School based education	Nominal
* Marital status of parent	Nominal
* Income	Interval
* Peer group	Nominal
* Access to drug abuse	Nominal
B. Motivating Factors	
* Reasons to consume drug	Nominal
* Risk conditions to drug circle	Nominal
*Access to drug rehabilitation	Nominal
▪ **Dependent Variables**	
* Activity Development for rehabilitation of the Youth drug addicts in the observation and protection center in Bangkok Metropolitan and Vicinities	Ordinal (Likert Scale)

1.7 Conceptual Framework

☐ **Independent Variables** ☐ **Dependent Variables**



1.8 Operational Definitions

To get mutual understanding for this research, the researcher had determined the operational definitions as follows;

Activity development means

Rehabilitation means

School based education means

Access to drug abuse means

Reason to consume drug means

Risk conditions to drug circle means

Access to rehabilitation means

Self-Help Aspects means

Family Support means roles of family in awareness of bad effects of drug abuse and

Understanding of Dimensions means

Peer relationship means

Life Planning means

Opportunity to develop and skills means

Reason to consume drug means

Risk conditions to drug circle means

Access to rehabilitation means the

1.9 Expected benefits

A. To know and understand the activity development for rehabilitation of the youth drug addicts in the Juvenile Observation and Protection Center in Bangkok and its vicinity.

B. To know and understand the factors influenced the activity development for rehabilitation of the youth drug addicts in the Juvenile Observation and Protection Center in Bangkok and its vicinity.

C. To be as a guideline in developing any activities for rehabilitation in the juvenile observation and protection center efficiently.

CHAPTER II
LITERATURE REVIEW AND RELATED RESEARCHES

In this research on Activity Development for rehabilitation of the Youth drug addicts in the Juvenile Observation and Protection Center, the researcher had reviewed concerned literatures and related researches as follows;

2.1 Drug Addict: An Overview
2.2 Drug Addict among Youth
2.2.1 Nature of Youth Drug Addict
2.2.2 The impact of Youth Drug Addict
2.2.3. Rehabilitation of Youth Drug Addict
2.3 Theories of Youth Drug Addict
2.3.1. Theories of Youth Drug Addict: An Overview
2.3.2 The Psychological Aspects of Youth Drug Addict
2.3.3 The Sociological Approach of Youth Drug Addict
2.3.4 Addiction of Youth Drug Addict
2.4 Drug Addict of Youth in Thailand.
2.5 Factors affecting of Youth Drug Addict
2.6 Related Researches
2.6.1 National Related Researches
2.6.2 International Related Researches

2.1 Drug Addict: An Overview

Physicians commonly employ the term "abuse" to refer to the use of a drug outside a medical context; this is the official definition of drug abuse given by the American Medical Association. The term, however, conveys a moral rather than a scientific judgment. Since "abuse" clearly connotes something negative or bad, to employ the term is to discredit and stigmatize drug use rather than to understand or

describe it. Those who use the term declare that nonmedical drug use is invariably harmful, without first investigating whether it is in fact so or what constitutes harm in the first place. "Abuse" puts forth the claim that only physicians should be permitted to administer drugs.

But since the term "drug" is a social and not a medical concept, such strictly medical claims are inconsistent. One never hears of "medically unsupervised" use (and therefore "abuse") of alcohol, even though alcohol has effects similar in many ways to those substances that physicians feel they ought to control or veto. By the AMA definition, *any* use of marijuana, regardless of its medical consequences, constitutes abuse, since the drug is not approved for medical purposes by most, and by the most credible, physicians. Purposes such as euphoria, pleasure, relaxation, or mind transformation are considered illegitimate.

As "abuse" is used in context, however, it conveys the distinct impression that something quite measurable is being referred to, something very much like a disease, a medical pathology, a sickness in need of a cure. Thus the term simultaneously serves two functions: it claims clinical objectivity, and it discredits the phenomenon it categorizes. "Abuse" announces to the world that the nonmedical taking of drugs—actually, only *certain types* of drugs, since legal drugs such as alcohol are magically exempt from the definition (and thus the medical definition is a passive and curious reflection of the legal situation)—is undesirable, that the benefits obtained from illegal drugs are counterfeit, and that they are in any case outweighed by the hard rock of medical damage.

But since the weighing of values is a moral and not a scientific process, we are able to see the ideological assumptions built into the term Furthermore, the linguistic category *demands verification.* By labeling anything "abuse," it becomes necessary to prove that the label is valid. The term so structures our perceptions of the phenomenon that it is possible to see only "abusive" aspects in it. Therefore data must be collected to "demonstrate" the damages of nonmedical drug use. In such ways do science and medicine become the handmaidens of morality and politics?

The prevalence of ideology in the drug realm is exemplified by the unwillingness of most observers, including physicians and scientists, to attempt a systematic investigation of the reality of drug use from the point of view of the user.

This unwillingness is typically verbalized in a rhetoric of objectivity—the user is inevitably biased and hence cannot tell us anything about the phenomenon of drug use. This position confuses "objective" and "subjective" effects, and tends to ignore the drug experience. The fact is that no one except the drug taker is capable of reporting the nature of the drug experience; thus it is absolutely essential to elicit his descriptions. At the same time, we are totally at the mercy of those descriptions.

Traditional behaviorists surmount this dilemma by completely ignoring internal states, judging them to be too ephemeral and subject to distortion and error to be reliable. Clinicians, at least of the psychoanalytic school, resolve the dilemma by assuming that overt descriptions and statements by drug users represent some deeper hidden meaning that only the psychoanalyst can understand and interpret. But if we wish to put together a complete picture of the drug reality, we cannot afford to be so restrictive. How can we utilize descriptions by subjects of the drug experience without becoming a victim of such distortions as might obtain from reliance on this type of data?

A few examples will highlight this "objective-subjective" dilemma. Recent laboratory experiments have shown that, contrary to the opinions of most users and nonusers alike, marijuana does not cause dilation of the pupils of the eyes (Weil, Zinberg, and Nelsen 1968). The traditional behavioral scientist will cite this finding as an example of how even experienced users will believe the myths about marijuana, and hence as further proof that it is risky to accept the "subjective" word of drug users about any aspect of the drug reality.

However, there are different *levels* of the drug reality. The presence or absence of some external drug manifestations (such as pupil dilation) can be verified objectively. Other drug effects are located purely within the subjective realm and are beyond the reach of traditional scientific instruments; in order to explore them we must ask the drug user to re-create the subjective and expressive character of the drug "high." It would be absurd to claim that science can "disprove" the reality of a drug experience as it can the occurrence of a certain physiological effect. Rather the two are in totally different realms. For example, marijuana users often claim that they can hear music more acutely under the influence of the drug (Halikas, Goodwin, and Guze 1971; Tart 1971; Hochman and Brill 1971). However, researchers have been unable to

verify this in laboratory experiments: under the influence of marijuana, the activity of perceiving and reporting on auditory stimuli is not significantly different from normal (Caldwell et al. 1969).

The traditional laboratory scientist will feel that this disproves the users' claims, and he will view it as evidence of the distortions inherent in reasoning from subjective reports—as well as evidence for relying exclusively on laboratory findings accumulated by trained scientists. However, to conclude that the drug user is simply an untrustworthy guide through the dark wood of fact would be hasty and simple-minded. To understand the *subjective impact* of sense stimuli, we have to abandon the strict laboratory approach. Users report overwhelmingly that their identification with, involvement in, appreciation of, and enjoyment of music under the influence of marijuana are heightened, that the experience of listening to music becomes richer and more exciting when they are high. This is not a question of a "misperception"—the user's experience is in fact the perception itself, and the perception is the phenomenon to be measured. The subjective grasp of the experience is the very reality itself.

Similar observations may be made with regard to time. Under the influence of marijuana, users commonly report that time appears to pass very slowly, that it is elongated, and they consistently overestimate the amount of time passing (Tart 1971; Goode 1970; Hochman and Brill 1971; Halikas, Goodwin, and Guze 1971). Now there are a number of different ways of approaching time. To the laboratory scientist, time is a fixed quantum that can be divided into infinitely reproducible segments of equal magnitude. Thus the researcher would say that the marijuana user, under the influence of the drug, estimates the passage of time incorrectly. But this conception is not relevant to the dimension of *meaning,* to the quality of time as experienced. By looking at the marijuana users' experience as a "distortion," the laboratory scientist is imposing his own views on the reality and is attempting to disprove the validity of the perception itself. The fallacy of the strict behaviorist approach is the substitution of the observer's perspective—that of the scientist—for that of his subjects. It is the failure to take the role of the other, to see the world as the subject sees it.

2.2 Drug Addict among Youth

In the early 1960s, the World Health Organization, in an effort to devise a new terminology that would apply to the "abuse" of all drugs, not just addicting drugs, adopted the term "drug dependence." According to WHO "drug dependence" is a state of psychic dependence or physical dependence, or both, on a drug, arising in a person following administration of that drug on a periodic or continued basis. The characteristics of such a state will vary with the agent involved, and these characteristics must always be made clear by designating the particular type of drug dependence in each specific case.... All of these drugs have one effect in common: they are capable of creating, in certain individuals, a particular state of mind that is termed "psychic dependence……..."

As in this situation, there is a feeling of satisfaction and psychic drive that require periodic or continuous administration of the drug to produce pleasure or to avoid discomfort (Eddy et al. 1965, p. 723).

Under the new terminology, each drug has its own characteristic type of dependence: there is a "drug dependence of the morphine type," a "drug dependence of the cannabis [marijuana] type," a "drug dependence of the alcohol type," and so on. In other words, the new terminology is a definition, or a series of definitions, by enumeration, for it was felt that no single term could possibly cover the diverse actions of the many drugs in use (or "abuse").

In reality, however, the new definition, as well as the accompanying elimination of the term "addiction," is without any utility and confuses more than it clarifies. Its intent is patently ideological in nature: to make sure that a discrediting label is attached to as many widely used (or "abused") drugs as possible. Under the old terminology, it was not possible to label a wide range of drugs as "addicting." As in the "narcotics" controversy, it was necessary to stigmatize such substances as marijuana with a term that sounded very much like "addicting" but that also had a ring of truth to it. In other words, the scientists and physicians who created the new terminology were being employed as propagandists to convince the layman that nonaddicting substances were just as "bad" for him, that he would be just as "dependent" on them as on any truly "addicting" drug, and that the repeated use of both arose out of a compulsion. Under the new terminology, drugs and patterns of

drug use that are really radically different are linked together to appear similar in important respects.

If we wish to adopt a less propagandistic stance toward the terms "psychic" or "psychological" dependence, it is necessary to abandon them altogether. The difference between psychic dependence and classic addiction (that is, physical dependence) is the following. If you take or are administered a truly addicting drug such as heroin, morphine, or any of the barbiturates in sufficient doses over a long period of time, you will become addicted—that is, your cells will crave the drug, and if the drug is discontinued, you will undergo withdrawal sickness It does not matter what you think, what ideas and attitudes you have about the use or effects of the drug, your cells will still crave that drug. (Even if you have not been told that you are being given the drug you will experience discomfort, although you will not attribute your discomfort to the drug.) In contrast, if you take or are administered a nonaddicting drug such as marijuana over a period of time, nothing essentially will happen to you when you are "withdrawn" from the drug. It is impossible to induce addiction to marijuana.

Now some individuals do use nonaddicting drugs such as marijuana regularly and frequently. But to say that marijuana "causes" a psychic dependence is meaningless. Medical "authorities" label continued (or even sporadic) marijuana use as "dependence" for the simple reason that they cannot understand why anyone should want to use it at all. It is not the properties of marijuana that "cause" a psychic dependence; rather it is the personality structure of certain *individuals* who happen to use it frequently. It is the individuals that bear looking into, not the drug. It is illogical to attempt to explain something that is variable (some users smoking marijuana heavily and some infrequently) in terms of something that is constant (the drug supposedly producing a psychic dependence).

Eliot Freidson, a sociologist, has labeled psychic dependence "the overwhelming product of psychiatric scholasticism"; in a letter to the editor of *Trans-action* magazine, Freidson commented on the "psychic dependence" of marijuana: "What does this phrase mean? It means that the drug is pleasurable, as is wine, smoked sturgeon, poetry, comfortable chairs, and *Trans-action.* Once people use it, and like it, they will tend to continue to do so if *they can.* But they can get along without it if they

must, which is why it cannot be called physically addictive" (Freidson 1968, p 75). The point is that psychic dependence means the use on a continued basis of anything that certain medical figures disapprove of. The key word here is disapproved, since the use of other substances that these medical figures do not disapprove of is not labeled a dependency.

An addicting drug makes cells dependent—it makes them "crave" that drug. When a pharmacologist says that a drug such as morphine or alcohol produces a physical dependence, he means simply that body cells respond in a certain way to continued administration of these drugs. However, it would be completely improper to say that as a direct consequence of this cellular response humans become addicted to the drugs in question. Whether humans do in fact become addicted is dependent largely on social and psychological factors.

Nonaddicting drugs do not produce biochemical dependence in animal cells. Whether or not they lead to continued use is also a social and psychological matter, but continued administration of a nonaddicting drug cannot be equated with dependence, physical or psychic. A person who has taken high-quality heroin several times a day over a period of time is un4uestionably physically dependent on heroin. A person who smokes marijuana several times daily is displaying a pattern that is a manifestation of something going on in his mind and in his social milieu, and it has little to do with marijuana as a drug.

It should be clear, then, that there are two quite separable components in the addiction-dependence equation: one is the direct physical action of the drug; the other is how people respond, behaviorally, to the physical action. One component does not translate automatically into the other. The knowledge of what a drug does to the human body does not explain what humans will do in relation to the drug in question.

The basic fallacy of the World Health Organization's new terminology is its reductionism—that is, its assumption that the biochemical properties of a drug determine the behavioral reality in relation to that drug. If the old definition of addiction is understood as a strictly biochemical description, then it contains some validity, although with serious flaws. But the new terminology is completely invalid, because it is trying to deal with the social dimension by absorbing, distorting, and underplaying what is in fact the central feature of drug taking.

2.2.1 Nature of Youth Drug Addict

A drug can be said to be any substance use in medicine. It can also be said to be any substance taken by some people to get certain effect, such as happiness and excitement. Driving from these definitions above, drugs can be classified into two categories;

1) The soft Drug e.g antibiotics and analgesics.

2) The hard drugs e.g. cocaine, marijuana heroin e.t.c. Consequently, a drug addict is said to be someone whose life has become dependent on drugs, hence drug abuse.

As for cause of drug abuse among youth, there are two primary causes of drug abuse among the youths. These are

1) Peer pressure

Peer pressure means any youth associates with different types of people otherwise known as friends. Through the pressure from these friends a child they tend to have a taste of these drugs and once this is done, they continue to take it and become addicted to it at the long run.

2) Depression.

Depression means another primary cause of drug abuse is depression. When certain things happen to someone that is considered very sad and disheartening, the person started thinking of the best way to become happy once more hence the use of hard drugs will come in. This later on turns to a habit, hence drug abuse.

Another major cause of drug abuse is said to be the rate of unemployment among the youth. Furthermore, drugs can be said to be abuse when youth don’t keep to the prescribe dosage and a continuing use of a particular drug for a long time without doctors approval. This kind of abuse is associated with soft drugs.

Within the effect of drug abuse.;- The effect of drug abuse on youth is going to be viewed from three aspects. these are;

1) Social aspect

Social aspect;- the hard drug make the taker hyperactive at the point of taking this drug. This make the taker to behave abnormally, contribute to immoralities such as armed robbery, sexually transmitted diseases e.g HIV AIDS and many other societal vices.

2) Financial aspect

Financial effects;- The person that so much addicted to drugs tend to spend more money on the purchase of these drugs. This can make the taker to become bankrupt or start searching for money by all means. This will eventually increase the problem of the taker.

3) Health aspect

Health effect;- It makes the taker becomes unstable .the taker tends to go mad and started behaving abnormally. It infiltrates a lot of diseases into the system of the taker and can eventually lead to death.

As for remedies of drug abuse, we can use principles as ;

1) Aggressive extinction of all the sources of these hard drugs including the farms where they are planted by a joint force of the UNO.

2) Parents should monitor the kind of friends their children with and guide against bad company.

3) Rehabilitation of the affected persons.

4) Teaching the effects of drug abuse in schools.

5) Continuous campaign against the use of hard drugs at the governmental and local levels.

6) Consent of a doctor should be sought before a prolong take of a particular soft drug.

7) Stiff penalty should be meted against anybody found dealing on hard drugs.

2.2.2 The impact of Youth Drug Addict

Teenagers often experiment with a variety of activities and substances. Unfortunately, this experimentation can lead to substance abuse and addiction. Statistics show that drug abuse is a growing problem among teens. In addition to cocaine, Ecstasy and other club drugs, a recent Monitoring the Future Study showed that the top six most abused drugs by teens are: marijuana, Vicodin , amphetamines , cough medicine , sedatives & tranquilizers . Without treatment, the effects of drug abuse on teens can lead to serious consequences now and well into adulthood.

There are many symptoms of drug abuse, but some of the most common signs your teen is abusing drugs are:

* Problems with the law, such as DUI, breaking curfew, stealing, etc.

* Problems at school, such as excessive tardiness, poor grades, suspension, etc.

* Mood swings

* Loss of interest in favorite activities

* Drug paraphernalia

* Violent behavior

* Withdrawal

* Depression

* Poor hygiene

* Missing money

Effects of Drug Abuse on Teens

Drug abuse at any age can cause serious health effects, but teens who abuse drugs are at particular risk for negative consequences. Teens who abuse drugs are more likely to struggle with addiction later in life and have permanent and irreversible brain damage. Some other common negative effects of teen drug abuse are:

* Emotional problems. Drug abuse can cause or mask emotional problems such as anxiety, depression, mood swings, suicidal thoughts and schizophrenia. In fact, among teens with major depression, 34.6 percent report using drugs. Unfortunately, drug use can also increase the severity of these emotional problems. For example, teens who use marijuana weekly double had their risk of depression and anxiety.

* Behavioral problems. Teens who abuse drugs have an increased risk of social problems, depression, suicidal thoughts and violence. According to a recent survey by the Substance Abuse and Mental Health Services Administration, teens who abuse drugs are more likely than teens who don’t abuse drugs to engage in delinquent behaviors such as fighting and stealing.

* Addiction and dependence. Studies prove that the younger a person is when they begin using drugs the more likely they are to develop a substance abuse problem and relapse later in life.

* Risky sex. Teens that use drugs are five times seem more likely to have sex than teens who don't use drugs. Teens that use drugs are also more likely having unprotected sex and have sex with a stranger. This leads to higher risks of STDs, teen pregnancy and sexual assault.

* Learning problems. Drug abuse damages short-term and long-term memory and can lead to problems with learning and memory later in life.

* Diseases. Teens who abuse drugs with needles increase their risk of blood-borne diseases like HIV, AIDS and Hepatitis B and C.

* Brain damage. Drug abuse among teens can result in serious mental disorders or permanent, irreversible damage to the brain or nervous system. Brain damage among teens who abuse drugs includes brain shrinkage; impaired learning abilities; amnesia and memory problems; impaired reasoning, perception and intuition; increased or decreased socialization; and changes in sexual desire.

* Car accidents. Teenagers who abuse drugs are more likely to be involved in car accident-related injuries or death. One study showed that 4 to 14 percent of drivers who are injured or die in traffic accidents test positive for THC.

2.2.3. Rehabilitation of Youth Drug Addict

1. Defining treatment

Treatment can be defined in general terms as the provision of one or more structured interventions designed to manage health and other problems as a consequence of drug abuse and to improve or maximize personal and social functioning. According to the World Health Organization (WHO) Expert Committee on Drug Dependence, the term "treatment" refers to "the process that begins when psychoactive substance abusers come into contact with a health provider or any other community service, and may continue through a succession of specific interventions until the highest attainable level of health and well-being is reached.

The United Nations Office on Drugs and Crime of the Secretariat (formerly called the Office for Drug Control and Crime Prevention of the Secretariat) publication Demand Reduction: A Glossary of Terms adds:

"Essentially, by providing persons, who are experiencing problems caused by their use of psychoactive substances, with a range of treatment services and opportunities which maximize their physical, mental and social abilities, these persons can be assisted to attain the ultimate goal of freedom from drug dependence and to achieve full social reintegration. Treatment services and opportunities can include detoxification, substitution/maintenance therapy and/or psychosocial therapies and counseling.

Additionally, treatment aims at reducing the dependence on psychoactive substances, as well as reducing the negative health and social consequences caused by, or associated with, the use of such substances.

The nature of treatment interventions, including medical, psychosocial, traditional healing and other rehabilitative services, can take a different form across different countries. Those interventions are not static and are subject to various political, cultural, religious and economic factors that influence how they are organized and delivered and how they evolve over time.

2. International consensus on treatment strategy development there is now a consensus among the States Members of the United Nations to invest and develop a range of prevention and treatment activities. The Declaration on the Guiding Principles of Drug Demand Reduction states that "Demand reduction programmes should cover all areas of prevention, from discouraging initial use to reducing the negative health and social consequences of drug abuse. They should embrace information, education, public awareness, early intervention, counseling, treatment, rehabilitation, relapse prevention, aftercare and social reintegration. Early help and access to services should be offered to those in need." The Declaration also set out specific principles that should underpin strategy development.

The development of effective programs and interventions to reduce juvenile recidivism is a national priority (Bradshaw & Roseborough, 2005).This inquiry is significant because the inquiry will examine therapeutic methods and vocational education that are used to help juvenile delinquents re-enter back into

society. The main purpose of rehabilitation is to rehabilitate the juvenile delinquent and lessen the amount the juvenile delinquent recidivates. Chronic juvenile offenders often lack the means to become productive citizens (Sametz, Ahren, &Yuan, 1994). This inquiry will review programs and therapy methods to determine if they help the juvenile delinquent maintain a healthy lifestyle and confidently live crime free or give them alternatives to do so. This inquiry will look at programs and therapy techniques to examine the methods that are used that are ineffective.

Different alternatives for rehabilitation will be examined to show how the use of different forms of rehabilitative methods for juvenile delinquents helps reduce recidivism. Overall, this section will examine scholarly research studies and articles that address juvenile delinquency and rehabilitation in reference to juvenile delinquents, as well as therapeutic methods that that help with rehabilitating the juvenile delinquents which include: a) group therapy b) group housing c) family therapy. Vocational education is another area that will be examined in relation to juvenile delinquents with rehabilitation and reducing recidivism. This analysis will investigate all different types of rehabilitative methods aforementioned that can be used to rehabilitate juvenile delinquents so that as a result juvenile offenders do not recidivate.

2. Rehabilitation model

The rehabilitative model focuses on the treatment of the offender with the assumption that interventions such as probation supervision, work readiness, training, cognitive skills training, and behavior therapy will change behavior and reduce the frequency of juvenile offenses (Bradshaw & Roseborough , 2005). Rehabilitation is essential to juvenile delinquents and re-entry into mainstream society because being rehabilitated sets the foundation to lead a healthy lifestyle in the community once out of the juvenile justice system. The rehabilitation model is ideal over retributive model because the retributive model which primarily focuses on punishment as deterrence is not as effective (Bradshaw & Roseborough, 2005).

Rehabilitation is practical because some rehabilitative methods addresses the personal needs of juvenile delinquents and gives juvenile delinquents realistic options to make it in society without having to recidivate. The rehabilitation model ties into the Strain theory by Merton (1938) which states that in life there are

“goals and means” and everyone wants to achieve their own version of the American Dream. When one does not have the means to obtain goals, sometimes one is forced to resort to illegal means to achieve one’s goals. Therefore, rehabilitation is vital because it teaches one through the process of rehabilitation there are necessary steps that are taken to obtain goals and the means of getting one’s goals accomplished in a legitimate way.

Juvenile delinquents’ receiving proper rehabilitative methods is important because this lessens the likelihood of juvenile delinquents that will recidivate and have to re-enter the juvenile justice system. Child delinquents are expensive to taxpayers and society (Lober, Farrington, Petechuk, 2003). Due to the fact that juvenile delinquents are rehabilitated through local, state, and federal funded programs and interventions, the money that supports these interventions are tax payers. Rehabilitative methods have to be realistic to implement and teach juvenile delinquents how to make it in society after being treated. The need for rehabilitative methods to be effective is essential so that more money does not have to be wasted on programs that do not properly rehabilitate juvenile delinquents.

Furthermore, rehabilitation is a major factor for juvenile delinquents’ successful re-entry into mainstream society. Effective intervention plays an essential role in any strategy designed to diminish the rates of juvenile delinquency (Lipsey, Wilson,)

Most countries have a national drug master plan or a broader national policy framework designed to organize and guide how the country is tackling the problem. Because drug abuse problems can affect many sections of the population and lead to health, social and legal problems, those plans are often integrated within existing law enforcement, justice, education, health, labour, and agriculture, economic and social policy.

Successful drug abuse treatment strategies must be placed in that broader policy framework where drug supply and demand reduction is of central importance. Treatment and prevention responses are critical dimensions that support the successful implementation of a balanced demand reduction response. While prevention policy is not within the remit of the present study, it must be developed at the same rate as treatment policy if an overall balanced approach is to be achieved.

Overall, strategic planning is a critical task in which one or more agencies determine the nature and extent of the needs of a population and establish a framework to make the best use of resources to address those needs.

3. Key features of a strategic framework for treatment

There is a growing expectation in many communities that a range of treatment services should be accessible, regardless of age, race, gender, sexual preference, and social and economic class and location. The key to successful responses to drug abuse is partnership and active cooperation between central and local governments, non-governmental agencies, service providers and the community.

Drug abusers are often a stigmatized population and the community partners may need to take an advocacy role along with opinion leaders to promote understanding of drug abuse problems and how they can be effectively treated. Support for treatment services in the community is clearly advantageous. It can foster a positive climate of drug abuse prevention and can help to ensure that the interventions receive the necessary resources for the operation and development of the services.

A treatment framework presents a description of important principles that underlie the approaches to treatment in the country and set out the goals, objectives and activities for the national treatment system. Resources, agencies and organizations involved in delivering outputs based on the framework are identified, allowing the activities to be monitored through achievement indicators.

In some countries, plans of that nature have evolved to become detailed and elaborate policy and action statements. However, a strategic framework document does not have to be long and detailed. It does, however, need to reflect the cultural and economic context of the nation and its identified priorities in tackling the problem.

It is important to state the overall principles and goals clearly in the framework document. It is also important to set out specific activities that will be undertaken, together with an agreed set of indicators that are to be used to judge how well the strategy is meeting its objectives. Importantly, strategic frameworks for treatment are best viewed as living documents that have a fixed lifespan and are subject to regular review and updates as required.

Although they vary, strategic plans on drug abuse share some common features. In particular, most plans:

• Estimate and describe the populations affected by drug abuse and the nature and extent of the problems to be treated;

• Summarize the beliefs, values, goals and objectives of the national, regional, community and service provider agencies that are to be involved in tackling the problem;

• Identify a governing body or individual who will have responsibility for governance of the policy;

• Describe the general roles of each of the national, regional and local (governmental and non-governmental) agencies involved and how they will contribute to the various stages of the planning and implementation of the policy;

• Specify the mechanisms for community involvement and representation;

• Specify the legislative framework and provisions that will allow treatment to take place;

• Detail specific types of treatments that are to be developed or otherwise enhanced, and the activities that need to be undertaken to do that;

• Specify the levels of financial and human resources that will be made available;

• Identify realistic outcomes that can be expected from treatment and the methods to assess the attainment of those outcomes;

• Specify how the strategy will be monitored and reviewed and its operation and impact communicated and considered within the nation.

As for the development and implementation of a treatment strategy, those areas are as follows:

• Involving partner agencies;

• Involving service users and the community;

• Ensuring policy commitment;

• Conducting sound assessment and planning;

• Allocating resources in accordance to needs;

• Building on research evidence;

• Developing an incremental and step-by-step approach;

• Fostering collaboration, coordination and integration;

• Building on community-based responses;

• Ensuring service availability and accessibility;

• Monitoring performance.

• nvolving partner agencies

In a number of countries, drug abuse treatment is predominantly provided within the health sector, while, in other countries, it tends to be provided by social welfare agencies or predominantly in the criminal justice system. While the balance of the contributions of the health, social and criminal justice sectors may vary over time, ideally all sectors should be involved.

In addition to helping people to stop using drugs, treatment services also focus on attaining immediate health benefits through reducing harmful drug-taking and associated behavior that poses a health risk. Specialist treatment programmes also need to collaborate with other service providers to resolve the range of health, behavioral, social and economic problems confronting individuals and families affected by drug abuse.

It is important to be aware of the wide array of agencies that can be involved in modern treatment systems. There are public sector or government-funded agencies as well as private sector, non-governmental and other.

The involvement of service users in strategy development aims at promoting the following:

• Individual behavior change;

• Improvement of the responsiveness of health services to user needs;

• Improvement of the utilization of health services;

• Community-oriented interventions;

• Supportive public opinion and health policy.

In the planning process, an effort should be made to contact and involve those groups that are likely to be affected by the development of the strategic framework or system of treatment. That can lead to local support and

advocacy for treatment. The reduction of any local resistance to the development of a drug abuse treatment service in a local area should be a key objective.

When planning developments in treatment, it is important to consult with a broad range of individuals and groups in the community, including:

- Local community organizations;
- Clients of existing services;
- Client advocacy and representative groups;
- Developing a strategic framework for treatment

A good example of developing the national drug strategy is Ireland. The Government of Ireland developed a drug strategy during 2000 for the period 2001-2008. Part of the process of development was to engage in a wide consultation process with the public. A review of the existing strategy included the extensive consultative process, research focused on international examples of best practice and an examination of various relevant evaluation reports and other literature. All statutory authorities and key community stakeholders and professional groups were invited through national newspaper advertisements to submit views on existing gaps and to recommend new approaches or, if necessary, new arrangements through which to deliver a new drug strategy.

Eight regional consultation forums were conducted throughout the country. At the forums, the Minister responsible for the drug strategy presented an overview of the current strategy, followed by presentations from the sectors of health and education, and from non-governmental organizations and the police. An open forum discussion with questions and answers was held. That was followed by workshops on the key areas of risk reduction, treatment and rehabilitation, supply reduction, education approaches and other issues, including emerging drug problems and gaps in the current strategy. Subsequently, 34 groups representing government departments, agencies, service providers and other interested parties were invited to meet the Minister and members of the Review Group to discuss their respective contributions to overcoming the drug problem and to explore how they might address issues emerging from the forums.

The overall aim of the drug strategy of the Government of Ireland is to provide an effective, integrated response to the problems posed by drug abuse. Three basic principles underpin the strategy:

• The response to the drug problem must take into account the different levels of drug abuse being experienced around the country;

• All programmes and services that respond to the drug problem should be delivered in a coherent and integrated manner;

• Communities experiencing the highest levels of drug abuse should be encouraged to participate in the design and delivery of the response to the problem in their areas. (http://www.gov.ie/tourism-sport/pressroom/ archive/ndstrategy)

• Drug abusers who are not in treatment;

• Parent groups and other concerned community and

• Representative bodies of professional groups;

• Social welfare and community agencies;

• Clinical staff;

• Existing drug abuse programme managers and administrators;

• Health-care providers and organizations;

• Official policy makers and strategic planners;

• Government agencies in the areas of health, social welfare and justice;

• Technical advisers (as required).

In some countries, for example, there are political and community objections to some forms of pharmacotherapy programmes to alleviate drug dependence. Public policies influence both the adverse consequences of drug abuse as well as the likelihood of developing effective treatment responses. At the same time, there is a widespread expectation that the investment of national resources into treatment will have a beneficial impact on reducing harms and inequalities.

Governments have a natural inclination to require arrangements to be put in place to monitor performance and outcome and to demonstrate a “return on investment”.

In a wider context, a commitment by the Government to a regular review of the legal framework concerning substance abuse and treatment provision is also advantageous, and, in some countries, specialist professional advisory bodies are employed to inform that process.

Effective treatment responses are based on sound assessment. The present Guide provides the technical means for assessing and developing needs-based interventions associated with substance abuse. Needs-based assessments allow the matching of resources, both human and technological, to the problems as they manifest themselves in the community. They also ensure that services are located where there is the greatest need. Further guidance on how to assess the nature and extent of the need for treatment in a particular locality or country is provided in chapter III of the Guide.

In some countries, valuable experience has been gained in revising and refocusing the current strategy for the treatment of drug abuse. That process involves an analysis of existing needs and resources and a reallocation of resources in accordance with a set of predefined need indicators.

International research has provided a well-established evidence base for the effectiveness of some types of treatment, and that has done much to make the case for treatment provision to Governments and service funders.

However, the evidence is far from complete, and some countries have to rely almost exclusively on treatment outcome and other research that has been conducted in other countries. It may be difficult to judge whether the findings from other countries can be fully applied to a particular cultural context, since there are often marked differences in the types of people who take part in outcome studies and in the structure and operation of the services studied. That may have led to an increasing commitment by Governments to build on the research evidence, and often a desire to employ and adapt international studies and experience, as a means of providing a sure footing for the national strategy.

A systematic approach should be followed to ensure the best utilization of available resources for the development of drug treatment services. The type of services to be developed will obviously be determined by the amount of available local and national resources. While, in all cases, a combination of primary

care and specialized services will be required, in many situations such services will need to be developed using a “building blocks” approach. Where there is a major resource constraint, services will need to rely on the adequate training of personnel within community and primary care frameworks. However, as soon as resources become available, there is a possibility to add specialist services.

Over the last 10 years, the public health sector in Chile, which covers 70 percent of the population, has implemented a range of measures to deal with alcohol and drug problems. The main aspects of the action undertaken are as follows:

• Increasing human resources in the health services with the greatest need;

• Facilitating the stabilization of therapeutic communities;

• Training professionals in the addiction and rehabilitation field;

• Increasing the early detection of alcohol and drug abuse problems among primary health-care patients;

• Facilitating the reactivation of, and coordination with, self-help groups, especially multifamily groups.

A 2001 in-depth evaluation of treatment plans has resulted in a decisive course of action involving the collaboration of the Ministry of Health and the Consejo Nacional para el Control de Estupefacientes (CONACE) in a new strategy with the following key elements:

• Institutional alliance. The Ministry of Health and CONACE, together with the 28 health services (each responsible

for the health needs of from 50,000 to 1 million people) and the National Health Fund, have established an alliance under which each party takes responsibility, as appropriate, for particular aspects such as financing, the establishment of norms, technical support and supervision, in order to ensure more extensive and qualified care of abusers;

• Adequate use of available information. Strategic decisions are based on objective information (for instance, last month prevalence and addiction rates) provided by household surveys carried out by CONACE, which permit an estimate of potential treatment demand;

• Investment according to a needs hierarchy. Health services are ranked according to the characteristics of their catchment areas, and more resources go to those with a higher prevalence of consumption, a lower human development index, a higher potential for expanding treatment and a lower level of investment;

• Designing diversified services. Six treatment plans have been created and clinical protocols to support and guide the implementation of each plan are being drawn up. The plans are as follows:

• First-response intervention plan, implemented by the primary health-care units:

• Basic outpatient plan;

• Intensive outpatient plan;

• Residential treatment plan;

• Withdrawal syndrome treatment plan (detoxification);

Dual diagnosis treatment plan;

• Financial transfers to treatment centres.

Transfers are carried out regularly according to a previously estimated and agreed upon workload for each centre. Funds are received from CONACE through the mediation of the National Health Fund;

• Records. Treatment centres keep a standard system of records to allow monitoring of the services provided to patients, on a local and a national basis;

• Evaluation. Two studies have been conducted: a comparative study of treatment centres and their capacities and results; and a cost evaluation of the different treatment plans;

• Capacity-building. Programmes have been established for professionals and technicians working in rehabilitation, including staff training to ensure the required level of quality of care. Capacity-building also involves initiating a supervisory mechanism to solve difficulties.

The first 10-month evaluation demonstrates satisfactory levels of functioning in most of the nearly 200 operating treatment centres. Approximately 4,000 people have been or are in treatment. Coordination has been a significant burden

to management, but client and staff satisfaction are on the rise. The next step, currently in a preliminary phase, will be an outcome evaluation based on information provided by regular data collection at each treatment centre, and on the results of the three- and six-month follow-up periods after discontinuation of treatment.

Treatment responses focus on multiple levels, including individuals, families, the immediate community context and the wider social environment. Core underlying principles of an effective intervention response include the need to encourage engagement at the level of the individual, families, services, communities, environments and policies. Treatment provision should also be seen in the context of a broad, collaborative approach aimed at the prevention of problems and linking schools-based and public education and communication initiatives with community-based advice, information and treatment provision.

No single treatment is appropriate for all individuals. Effective substance abuse responses depend on an integrated response at all levels including the community. Agencies involved in treatment programmes should not only work together but also integrate with related programmes.

Integration may include the following dimensions:

• The integration of different types of demand reduction programmes, of which treatment and rehabilitation are a component, with each other;

• The integration of issues relating to illicit drug abuse with the abuse of other substances and with other general health issues, in particular HIV and acquired immunodeficiency syndrome (AIDS);

• The integration of demand reduction and supply reduction programmes as part of a comprehensive strategy;

• The integration of programmes related to drug abuse with those dealing with major social and humanitarian issues such as poverty, housing refugees, employment or rural development.

Strategies for community-based treatment intervention are an effective means of delivering interventions. Many people affected by the adverse consequences of substance abuse may have limited contact with existing organizations. Innovative methods are needed in order to reach populations most affected by substance abuse.

A community-based response involving local agencies and organizations, including outreach services, is a necessary component of a strategy that seeks to reach drug abusers who are not in contact with services. A community-based response aims at:

• Encouraging behavior changes directly in the community;

• Actively involving local organizations, community members and target populations;

• Establishing an integrated network of community based services.

It is also important to mention the term “community empowerment”, which implies something more than just community participation. If communities can establish a sense of ownership of facilities and services, the latter are much more likely to be successful and sustainable.

Being “community-based” in the context of drug treatment is often perceived as involving little more than placing a residential treatment centre in a community with a few limited aftercare facilities provided in the community. Many services are still based on an approach focused on an in-patient treatment centre,

Key determinants of effective service delivery include diversification, availability and accessibility. Services need to be effective in making and retaining contact with target populations. They need to be able to provide a variety of services in order to be responsive to the health and service needs of the target populations. The key ingredients include:

• Being user-friendly;

• Geographical accessibility;

• Economic affordability;

• Community-based response;

• Provision of an adequate, coordinated mix of agency-based and non-agency-based services;

• Encouraging client participation and involvement;

• Providing secondary prevention as well as treatment;

• Services that is flexible and open to improvement and change.

Achieving major goals for any strategy is usually a result of partnership and combined efforts between different organizations. In order to monitor progress, a performance management framework is used by many countries for each of the elements in a strategy.

Each goal of a strategy should have a core objective and a set of indicators and targets in the short, medium and longer term. Those indicators should, as far as is feasible, meet certain criteria. In particular, they should:

• Be specific and easily interpretable;

• Be measurable;

• Be time-bound;

• Be sensitive to change and thus capable of reflecting progress in tackling drug abuse;

• Be feasible and affordable, in terms of a viable, economic and sustainable measurement and reporting system;

• Be informed by international performance indicator systems and United Nations global reporting systems

• Provide valuable information for strategy evaluation and local planning.

The key performance indicators for the treatment strand are designed to increase the number of participant substance misusers in substance misuse treatment programmes by 40 per cent in 2002; by 70 per cent by 2005; and by 100 per cent by 2008. Those targets are increases on the estimated baseline of people in treatment before 2002. The additional supporting indicators are designed to reduce the health and social damage that substance misuse's inflict on themselves.

Other indicators are designed to:

• Increase the number of problem substance misusers in contact with substance misuse services;

• Increase access to appropriate services for people with dual diagnosis of substance misuse and mental health problems;

• Reduce the time spent by substance misusers waiting for an assessment of their needs;

• Reduce waiting time between assessment of need and availability of treatment;

• Reduce the proportion of drug misusers who inject and the proportion of those sharing injecting equipment over the previous three months;

• Reduce the number of deaths relating to substance misuse.

The key points covered in chapter II of the Guide are as follows:

• A strategic framework is a critical element of an integrated and successful treatment response;

• There is a need to see treatment within the context of broader demand reduction policies, which are encompassed in the national drug control master plan or the national policy framework;

• The framework should emphasize the importance of broad community involvement and consultation with a full range of stakeholders;

• The framework clarifies roles of policy makers, planners and providers of services and reflects key guiding principles of an effective treatment response;

• The key elements of a strategic framework are:

(i) Description of the population affected by drug abuse;

(ii) National statement setting out values, principles and goals and objectives;

(iii) Identification of priority areas with clear goals and measurable objectives;

(iv) Specification of the governing body of the strategy, as well as of the governmental and non-governmental agencies involved and their shared responsibilities and role expectations;

(v)Mechanisms for community involvement and representation;

(vi)The legislative framework;

(vii) Specification of the types of treatments to bedeveloped and action to be taken to that end;

(viii) Financial and human resources available;

(ix) Realistic outcomes and methods of assessing their attainment;

(x) Monitoring, review and communication arrangements to support the strategy;

(i) Involving all partner agencies in strategy development;

(ii) Involving service users and the community;

(iii) Ensuring policy commitment by Governments and official agencies;

(iv) Conducting sound assessment and planning;

(v) Building on research evidence;

(vi) Rationalizing resource allocation in accordance with needs;

(vii) Developing an incremental and step-by-step approach;

(viii) Fostering collaboration and integration of different programmes;

(ix) Building on community-based responses;

(x) Ensuring service diversification, availability and accessibility;

(xi) Planning for monitoring performance

4. Principles of Effective Treatment

1) Addiction is a complex but treatable disease that affects brain function and behavior. Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences.

2) No single treatment is appropriate for everyone. Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

3) Treatment needs to be readily available. Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.

4) Effective treatment attends to multiple needs of the individual, not just his or her drug abuse. To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.

5) Remaining in treatment for an adequate period of time is critical. The appropriate duration for an individual depends on the type and degree of the patient's problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6) Behavioral therapies—including individual, family, or group counseling—are the most commonly used forms of drug abuse treatment. Behavioral therapies vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.

7) Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies. For example, methadone, buprenorphine, and naltrexone (including a new

long-acting formulation) are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Acamprosate, disulfiram, and naltrexone are medications approved for treating alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (available as patches, gum, lozenges, or nasal spray) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioral treatment program.

8) An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs. A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a continuing care approach provides the best results, with the treatment intensity varying according to a person’s changing needs.

9) Many drug-addicted individuals also have other mental disorders. Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.

10) Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse. Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and can, for some, pave the way for effective long-term addiction treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification. Motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement.

11) Treatment does not need to be voluntary to be effective. Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.

12) Drug use during treatment must be monitored continuously, as lapses during treatment do occur. Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.

13) Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as provide targeted risk-reduction counseling, linking patients to treatment if necessary. Typically, drug abuse treatment addresses some of the drug-related behaviors that put people at risk of infectious diseases. Targeted counseling focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Counseling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical treatments. Substance abuse treatment facilities should provide onsite, rapid HIV testing rather than referrals to offsite testing—research shows that doing so increases the likelihood that patients will be tested and receive their test results. Treatment providers should also inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations, and help link them to HIV treatment if they test positive

2.3 Theories of Youth Drug Addict

Dozens of explanations have been proposed for drug use and abuse. In the early 1980s, the National Institute of Mental Health (NIDA) published a volume that spelled out more than 40 theories of drug abuse (Lettieri, Sayers, and Pearson, 1980). The number of theories proposed by experts today is even greater than this number.

2.3.1. Theories of Youth Drug Addict: An Overview

As is true of theories of crime, there are three broad types of explanations for drug use:

(1) Biological theories,

(2) Psychological theories, and

(3) Sociological theories.

Each focuses on a different range of factors as crucial in determining why people use and abuse psychoactive substances. Of course, even within each broad type, there is a range of specific theories. All biological theories, and nearly all psychological theories, are individualistic in that they focus on differences between and among people. They can be referred to as “kinds-of-people” theories: Since most of these theories explain only a piece of the puzzle, most of them are complementary rather than contradictory. Still, some explanations do contradict others: If one is true, one or more others cannot be true. It’s important to understand the implications of each one so that we have a clear idea of what manner of evidence confirms or falsifies it. Biological theories are those that postulate specific physical mechanisms in individuals that impel or influence them either to experiment with drugs or to abuse them once they are exposed to them. Some are constitutional, that is, are based on mechanisms that are present at birth and vary from one person to another. Others are partly environmental; that is, inborn factors in conjunction with environmental factors generate drug-using behavior. Two of these explanations are genetic theories and the theory of metabolic imbalance.

2.3.2 The Psychological Aspects of Youth Drug Addict

A Theories relying on psychological factors fall into two basic varieties: those emphasizing the mechanism of reinforcement, and those stressing that the personalities of the drug user, abuser, and especially addict are different from those of the abstainer, and are causally related to use and abuse. The mechanism of reinforcement is fairly straightforward: People tend to maximize reward and minimize punishment; they continue to do certain things because they have a past history of being rewarded for doing them. Drug users are individuals who have been rewarded for use, and hence they continue to use. While reinforcement theories underplay

personality factors, personality theories, as you might expect, emphasize their important role in causing drug use and abuse. The precise personality configuration that is said to determine drug use and abuse varies with the theorist; a range of personality factors is invoked here. The key factor that binds these psychodynamic theories together, however, is that they postulate that certain individuals have a type of personality that impels them to drug use and abuse.

A major psychological theory underplays the idea of personality differences between users and nonusers, and emphasizes the role of reinforcement. Even animals use certain drugs compulsively under the right experimental conditions, casting doubt on the need to invoke psychodynamic variables in the development of addiction (McAuliffe and Gordon, 1980, p. 139; Wikler, 1980, p. 174). In addition, experiments have shown that, independent of personality factors, human subjects who are administered opiates without knowing what they have taken wish to repeat taking the drug; their desire grows with continued administration (McAuliffe, 1975). For some aspects of the drug-taking process, a consideration of personality variables is not necessary. (At the same time, there is individual variation in reactions to and experiences of drug effects.) However, it is an axiom in science that you can't explain a variable with a constant. After all, if two people are taking the same highly reinforcing drug (a constant), and one becomes addicted to it while the other does not (a variable), it is insufficient to argue that reinforcement explains continued use because it does not account for the difference in behavior. Consequently, we need to bring into the picture variables or factors in addition to simple reinforcement.

There are two distinctly different types of reinforcement—positive and negative—and consequently two different theories that cite reinforcement as a mechanism in continued drug use. (Actually, some approaches make use of both these mechanisms—different types of reinforcement for different types of drugs or drug abusers.) Positive reinforcement occurs when the individual receives a pleasurable sensation and, because of this, is motivated to repeat what caused it. In brief, "The pleasure mechanism may . . . give rise to a strong fixation on repetitive behavior" (Bejerot, 1980, p. 253). With respect to drug use, this means that getting high is pleasurable, and what is pleasurable tends to be repeated.

According to this view, the continued use of all drugs that stimulate euphoria is caused by their “extremely potent reinforcing effects” (McAuliffe and Gordon, 1980, p. 137). Inferring from the way that users behave, it is difficult to draw a sharp distinction between a strong psychological and a physical dependency. Indeed, physical dependence is not even a necessary mechanism for the proponents of the theory of positive reinforcement. What is referred to as addiction is simply an end point along a continuum indicating that “a sufficient history of reinforcement has probably been acquired to impel a high rate of use” in the user (McAuliffe and Gordon, 1980, p. 138). This also means that ongoing, even compulsive, use and abuse do not require the mechanism of a literal physical addiction to continue taking place. Many users are reinforced—that is, they experience euphoria—from their very first drug experience onward, and the more they use, the more intense the sensation and the greater the motivation to continue use.

Negative reinforcement occurs when an individual does something to seek relief or to avoid pain, thereby being rewarded—and hence motivated—to do whatever it was that achieved relief or alleviated the pain. In the world of drug use and addiction, when someone who is physically dependent on a particular drug undergoes painful withdrawal symptoms upon discontinuing the use of that drug, and takes a dose to alleviate withdrawal distress, he or she will experience relief with the termination of the pain. Such an experience will motivate the addict to do what has to be done to obliterate the painful sensations associated with withdrawal.

While positive reinforcement can occur with any euphoric drug—indeed, with any pleasurable sensation (Bejerot, 1972, 1980)—the theory emphasizing the mechanism of negative reinforcement as a major factor in drug abuse is largely confined to drugs that produce a physical dependence, especially the opiates. Relatively little attempt has been made to apply this theory to explain either the continued use of nonaddicting drugs or the use of opiates that does not involve a literal physical dependence. (However, some nonaddicting drugs, such as cocaine and marijuana, may provide relief from depression; this factor has also been mentioned as a reason for continued use.)

The argument invoking negative reinforcement goes as follows. Initially, pleasure dominates as a motivating force in use. Hence, the first few weeks of narcotic

drug use have been called the “honeymoon” phase of addiction. However, the user gradually becomes physically dependent without realizing it. Because of the body’s growing tolerance to narcotics, the user, in order to continue receiving pleasure, is forced to increase the doses—eventually to a point at which addiction takes place. If use is discontinued, whether because of arrest, disruption in supply, or lack of money to purchase the drug, painful withdrawal symptoms wrack the addict’s body. Because the user recognizes that doses of a narcotic drug can alleviate these symptoms, an intense craving is generated for the drug over time.

According to Alfred Lindesmith (1947, 1968), the earliest proponent of this theory: The critical experience in the fixation process is not the positive euphoria produced by the drug but rather the relief of the pain that invariably appears when a physically dependent person stops using the drug. This experience becomes critical, however, only when an additional indispensable element in the situation is taken into account, namely a cognitive one. The individual not only must experience withdrawal distress but must understand or conceptualize this experience in a particular way. He [or she] must realize that his [or her] distress is produced by the interruption of prior regular use of the drug. (Lindesmith, 1968, p. 8)

In short, the perception of withdrawal symptoms as being due to the absence of opiates will generate a burning desire for the drug (Sutter, 1966, p. 195). According to this theory, addicts continue taking their drug of choice just to feel normal.

Recent evidence suggests that, as originally stated, the theory does not account for most narcotic use among addicts. The majority of addicts and other compulsive drug abusers do experience euphoria, and this is a major factor in their continued drug use. In one study of addicts, all of whom used heroin at least once a day, 98 percent of the sample (63 out of the 64 interviewed) said that they got high or experienced euphoria at least once a month, and 42 percent did so every day (McAuliffe and Gordon, 1974, p. 804). In this sample, euphoria was consciously desired and sought: 93 percent said that they wanted to be high at least once a day, and 60 percent wanted to be high all the time (McAuliffe and Gordon, 1974, p. 807). Heavy, compulsive heroin users continue to seek and achieve euphoria, and its attainment is a major motivating force behind their continued use.

A resolution to the apparent conflict between the positive and the negative reinforcement models of drug addiction has been offered. (While the negative reinforcement school argues that only the avoidance of pain and the desire to feel normal motivate the addict, the positive reinforcement advocates argue that both factors, as well as others, may be operative.) It is likely that there are actually two types of narcotic addicts—the maintainers and the euphoria-seekers. The maintainer takes just enough narcotics to avert withdrawal distress.

Some addicts lack the financial resources, and are unwilling to engage in a life centered around the commission of crime, to obtain enough heroin to attain euphoria. They are simply staving off the agony of withdrawal, “nursing” their habit along (McAuliffe and Gordon, 1974, p. 826). To achieve the high they really want would require taking such substantial quantities of the drug that their lives would be transformed utterly and completely.

In contrast, the pleasure-seeking addict takes narcotics in sufficient quantities and at sufficiently frequent intervals to achieve euphoria. This habit is extremely expensive, and hence, typically requires illegal activity to support it. In addition, the lifestyle of the euphoria-seeking addict is sufficiently disruptive that a legal job is not usually feasible; he or she must resort to criminal activity instead. It is also difficult for the non-addict to fit in with and be capable of tolerating the addict’s lifestyle, so marriage and a family are a chancy proposition unless the addict’s spouse is also addicted.

Further, since heavy opiate use depresses the sexual urge, intimate relationships are difficult. In short, the euphoria seeking addict sacrifices conventional activities and commitments for the hedonistic pursuit of pleasure, and to engage in this pursuit, a commitment to a deviant and criminal lifestyle is also necessary. Such sacrifices would make no sense “if they were directed solely toward reducing withdrawal symptoms, which could be accomplished with much less effort, as every addict knows” (McAuliffe and Gordon, 1974, p. 828).

Inadequate Personality

Several psychological theories of drug use rely on the notion of a psychological pathology, defect, or inadequacy: There is something wrong in the

emotional or psychic life of certain individuals that makes drugs attractive to them. They use drugs as an escape from reality, as a means of avoiding life's problems and retreating into euphoric bliss and drugged-out indifference. Euphoria, says one inadequate-personality theorist, is adaptive for the immature individual who lacks responsibility, a sense of independence, and the ability to defer hedonistic gratification for the sake of achieving long-range goals (Ausubel, 1980, pp. 4–5).

Although drug use is adaptive for the defective personality in that it masks some of life's problems, it is adaptive only in an exclusively negative way: The problems never get solved, only covered up, and meanwhile, drug use itself generates a host of other, more serious problems. Normal people, who do not share this inadequacy, do not find drugs appealing and are not led to use them. Of course, not all drug users share personality inadequacies and defects to the same degree; some will be impelled to experiment or use simply because of social pressure or availability. However, the more inadequate the personality, the greater the likelihood of becoming highly involved with drug use, and the more that use becomes abuse and eventually addiction. In short, for the weak, drug abuse is a kind of crutch; for the strong, experimentation leads to abstention, not abuse. To the inadequate-personality theorist, drug abuse is an adaptation or a defense mechanism, a means of obliterating feelings of inferiority (Wurmser, 1980, pp. 71–72).

One major variety of the inadequate-personality approach is the self-esteem or self derogation perspective. This theory holds that drug use and abuse, like deviant and criminal behavior generally (Kaplan, 1975), are responses to low self-esteem and self rejecting attitudes. (But it does not apply in societies in which the particular type of drug use being explained is practically universal and normatively accepted by the majority.) Low self-esteem could come about as a result of "peer rejection, parental neglect, high expectations for achievement, school failure, physical stigmata, social stigmata (e.g., disvalued group memberships), impaired sex-role identity, ego deficiencies, low coping abilities, and (generally) coping mechanisms that are socially disvalued and/or are otherwise self-defeating" (Kaplan, 1975, p. 129). For some, normatively approved activities and group memberships are sources of painful experiences; deviant or disapproved activities and memberships, however, are effective sources of self-enhancement. Drug use provides exactly such a deviant

activity and group membership, and one that permits a deadening of the painful feelings stirred up by self-rejection. It is difficult to reconcile such self-derogation theories, which explain drug use as being brought on in part as a consequence of social rejection, with the fact that illicit drug users tend to have more, not fewer, intimate friends than do nonusers (Kandel and Davies, 1991), as the theory would predict. In addition, in recent years, the entire edifice of self-esteem theory—that low self-esteem "is to blame for a host of social ills, from poor academic performance and marital discord to violence, crime, and drug abuse" (Erica Goode, 2002, p. D1)—has come crashing to the ground. Most researchers no longer believe that a poor sense of oneself accounts for any of the behaviors that were once attributed to it, and that includes drug abuse.

2.3.3 The Sociological Approach of Youth Drug Addict

What can a sociologist tell us about drug use that we do not already know? If there is anything particularly distinctive about the sociologist's view, it is his emphasis on *social context.* It might appear that this concept seeped into the public consciousness long ago, that it is a banality. But if this were so, the stupendous blunders committed every day by drug researchers and commentators would not occur. If the concept were really understood, a large part of the drug problem would also be understood.

Biological and psychological theories tend to emphasize individualistic factors, although the researchers who propose them usually indicate that broader factors are at work. For instance, two psychologists associated with the problem behavior–proneness line of thinking (Jessor and Jessor, 1980, p. 105) incorporate the environment or, to be more specific, the "perceived environmental system"—especially parents and friends—into their model.

However, their focus is on the characteristics of the individual. In contrast, sociologists tend to make broader, structural factors the focus of their theories. For most sociologists, the crucial factor to be examined is not the characteristics of the individual, but the situations, social relations, or social structures in which the individual is, or has been, located. More specifically, it is the individual located within specific structures.

The social context of drug use powerfully influences—indeed, it might almost be said determines—at least four central aspects of the drug reality, aspects that traditionally have been presumed to grow directly out of the chemical and pharmacological properties of drugs themselves, independent of human intervention. These four aspects are *drug definitions, drug effects, drug-related behavior,* and *the drug experience.* The sociological perspective stands in direct opposition to what might be called the *chemicalistic fallacy*—the view that drug A causes behavior X, that what we see as behavior and effects associated with a given drug are solely (or even mainly) a function of the biochemical properties of that drug, of the drug plus the human animal, or even of the drug plus a human organism with a certain character structure.

Drug effects and drug-related behavior are enormously complicated, highly variable, and contingent on many things. And the most important of these things are social and contextual in nature. In the animal world, it is quite a bit easier to predict what drugs will do. But experiments with rats do not tell us very much about human behavior. This is why social context is so important.

The field of sociology proposes seven partially overlapping sociological theories to help explain drug use: (1) anomie, (2) social control, (3) self-control, (4) social learning and subcultural, (5) selective interaction/socialization, (6) social disorganization, and (7) conflict. (I'll mention an eighth theory, routine activities theory, only in passing.) The overlap among these theories is sufficiently great that some of the theorists who endorse one of them also support one or all of the others.

Anomie Theory

In the 1930s, sociologist Robert K. Merton generated what came to be referred to as the anomie theory of deviant behavior. In his view, deviant behavior—illicit drug use included—takes place when avenues to material success are blocked off. Anomie theory, as Merton developed it (1938, 1957, pp. 131–160; 1968, pp. 185–248), argues that in a competitive, materialistic, achievement-oriented society, success is encouraged as attainable for all members but actually is attainable to only a small proportion of the society.

Individuals who do not succeed must devise “deviant” or disapproved adaptations to deal with their failure. Those who have given up on achieving society’s materialistic goals, whether by approved or disapproved means, become retreatists. “In this category fall some of the adaptive activities of psychotics, autists, pariahs, outcasts, vagrants, vagabonds, tramps, chronic drunkards, and drug addicts” (Merton, 1957, p. 153). An extension of this theory holds that the person most likely to become a drug addict has already attempted to use both legal (or legitimate) and illegal (or illegitimate) means to achieve success, and has failed at both. The addict is a “double failure” who has “retreated” into the undemanding world of addiction (Cloward and Ohlin, 1960, pp. 179–184).

The sociologist's view of drugs and drug use goes a good deal further than merely recognizing that there are variable interpretations of similar drug realities and drug-related situations. It also emphasizes that the drug experience and drug effects will vary when different meanings are brought into the drug-taking situation. The one-dimensional, chemicalistic view of drug taking is that humans are basically passive receptors for drug actions, and that when a certain drug is administered a certain effect, or standard set of effects, takes place. This view has been discredited as a general model, but the comments of many drug experts indicate that it is still operative. It is not uncommon to encounter analyses that utilize such concepts as the "complete marihuana intoxication syndrome" (Wikler 1970, p. 324), as if the effects of marijuana were a clinical entity with distinct configurations analogous to an H2O molecule or a cumulus cloud; or the notion that drug users are part of "an abnormal subculture" (Willis 1969, p. 34), as if this could be determined by means of objective, scientific examination.

Naturally, Anomie theory has been applied by others to drug use and abuse (Cloward and Ohlin, 1960, pp. 178–184; Palmer and Linsky, 1972, pp. 297–301), but, some believe, never entirely successfully. Indeed, devastating critiques have been leveled at anomie theory and its application to drug use and abuse. (Lindesmith and Gagnon, 1964, is one of the most thorough.) The perspective experienced an eclipse in the late 1960s and remained at a low ebb throughout the 1970s and early to mid-1980s. At that time, many researchers believed that the perspective had been discredited and “disconfirmed” (Kornhauser, 1978, p. 180) as completely irrelevant to

an understanding of the etiology, or causality, of drug use. Some argued that the theory had become something of an embarrassment to the field and, as it applied to drug use and addiction, was utterly fanciful, generated in the almost total absence of knowledge of the world of drug use (Lindesmith and Gagnon, 1964; Preble and Casey, 1969).

The model addict that predominates in anomie theory is that of the Chinese opium addict, puffing on his pipe in a dreamy, somnolent state. However, the world of the addict is anything but undemanding. It is a brutal, abrasive world requiring extreme skills and maximum effort to survive (Preble and Casey, 1969). Moreover, it is not the poorest members of poor communities—the most clear-cut "failures"—who turn to heroin, but those who are a rung above them financially and occupationally. In the view of many, anomie theory explained no significant feature of drug use, abuse, or addiction.

However, beginning in the late 1980s, anomie theory experienced a renaissance; scholars began to look at the perspective in a fresh way, revised some concepts and assumptions, and pursued fresh lines of research (Adler and Laufer, 1995; Messner and Rosenfeld, 1997). Is the anomie approach relevant to drug abuse after all? It is possible that the earlier judgments about the theory were premature and overly harsh in at least one sphere of behavior—that of drug selling. Since legitimate achievement is blocked off for a significant proportion of the members of society, one avenue of illegitimate achievement is rendered more attractive as a consequence. What is drug dealing but an innovative attempt to maintain the goal of achieving material success by engaging in an illegitimate, illegal, and deviant enterprise? Drug dealing is an innovative adaptation to blocked or frustrated material success for many members of society who have learned to expect that success but who live in a setting in which high levels of achievement are all but impossible. Hence, anomie theory has a great deal to say about one major aspect of the drug scene (dealing), but not, as it turns out, drug use, abuse, or addiction.

Social Control and Self-Control Theory

Two major theories whose adherents attempt to explain deviant and criminal behavior— and, by extension, drug use and abuse as well—are social control

or bonding theory and self-control theory or the “general theory of crime.” Both are individualistic theories, and not group or structural, which is the approach adopted by most sociologists. These two theories make extensive use of the concept of control and focus on why some people conform to society’s norms and laws. Both assume that deviance and, by extension, drug use do not need to be explained. If left to their own devices, everyone would deviate, break the law, use drugs, and get high; they would simply be doing what comes naturally. What really needs to be explained is why some people do not deviate from the norms, violate the law, use drugs, or get high. However, they differ considerably in the emphasis they place on the dynamics of deviance, crime, and drug use, and the relevant explanatory time frame.

2.3.4 Addiction of Youth Drug Addict

Statistical data in many countries show that delinquency is largely a group phenomenon; between two-thirds and three-quarters of all juvenile offences are committed by members of various groups. Even those juveniles who commit offences alone are likely to be associated with groups. According to data from the Russian Federation, the rate of criminal activity among juveniles in groups is about three to four times higher than that of adult offenders. Juvenile group crime is most prevalent among 14-year olds and least prevalent among 17-year-olds. The rates are higher for theft, robbery and rape, and lower for premeditated murder and grievous bodily harm

Research shows that previously incarcerated youth return to the justice system at alarmingly high rates (Sametz, Ahren, Yuan, 1994). Eventually incarceration youth have to come out of the correctional facilities and be re-intergraded back into mainstream society once time has been served. This inquiry attempts to examine current rehabilitation methods and the affect on juvenile delinquents.

Juvenile delinquents are coming into the juvenile justice system with an array of problems that have caused them to commit delinquent acts (Mincey, Maldonado, Lacey, &Thompson, 2008). Once juvenile delinquents finish their sentience, they must re-enter society. Correctional facilities that over see the rehabilitation process for juvenile delinquents have to address problems that include:

a. Receiving adequate treatment that rehabilitates the juvenile offender so they are less likely to recidivate

b. Making sure the juvenile delinquent has realistic and obtainable resources and means to make it in society

c. Making sure the juvenile delinquent is fully aware and ready for the transition back into society

Many juvenile delinquents, male and female are faced with issues such as poverty, substance abuse, and being victims of child abuse and rape (Mincey et al., 2008). Any of these issues can trigger the juvenile to lash out and commit delinquent acts. The question is what happens next? The juvenile delinquent commits the delinquent act, is found guilty, and they serve time in a correctional facility. They go through the juvenile justice system and they get the opportunity to have a second chance. Juvenile criminal offenses are a significant societal problem with great financial and social costs (Bradshaw & Roseborough, 2005) .What is the next step for these juvenile delinquents once they get out of the system and try to reintegrate back into society?

Juvenile delinquency is a major problem that effects America's youth. Child delinquents represent a significant concern for both society and the juvenile justice system (Lober, Farrington, Petechuk, 2003). To understand reasons how one can help rehabilitate juvenile delinquents researchers must delve into uncovering some of the reasons why children resort to acts of delinquency at such a young age. Child delinquency is an enduring and troubling phenomenon that requires more research and the efforts of a broader community to be fully understood and addressed (Lober,Farrington, Petechuk, 2003). Generations of studies in criminology show that the best predictor of future behavior is past behavior (Lober, Farrington, Petechuk, 2003). For example, children who are in environments such as poverty stricken neighborhoods where children are exposed to other young children, adolescences, and adults committing criminal activity are more likely to emulate that behavior because it is deemed as acceptable. This example lends evidence to understanding Differential Association theory by Sutherland (1947) because this theory states that all behavior is learned , delinquent behavior learned in small groups, and delinquent behavior is learned from collective and specific situational events (Mincey et al., 2008).

Juvenile delinquency is a problem that has been occurring at younger ages within society at higher rates and more frequently (Lober, Farrington, Petechuk,

2003). One must begin to look at other factors that may trigger reasons why younger children are resorting to delinquency. Children showing persistent disruptive behavior are likely to become child delinquents and in turn, child delinquents are likely to become serious, violent, or chronic juvenile offenders (Lober, Farrington, Petechuk, 2003). As stated in the original study from (Kazdin and Kendall, 1998a), understanding the early emergence of problem behaviors may help in the creation of earlier, effective interventions for prevention of child delinquency (Lober, Farrington, Petechuk, 2003). For this reason, the issue of understanding re-occurring and persistent problems in behavior of children is essential to pointing out some of the risk factors that lead to juvenile delinquency.

The closer a child is to the mother; the less likely a child is to be at risk for delinquency (Lober, Farrington, Petechuk, 2003). This statement lends evidence and validation to understanding the Control theory by Hirschi (1969) because this theory states that social bonds are things that keep people from committing criminal acts having strong bonds with family and social institutions such as church and school can aid in juveniles not resorting to delinquency (Mincey et al , 2008) .

Additionally, many risk factors are interrelated that affect the reasons why some children commit delinquent acts at young ages. Early anti-social behavior, family characteristics are important predictors of early –onset offending (Lober, Farrington, Petechuk, 2003). Family characteristics include: anti-social parents, substance –abusing parents, history of family violence, large family size, and prevalence of physical abuse are some of the risk factors that play into children participating in juvenile delinquency (Lober, Farrington, Petechuk, 2003). When looking at reasons why children commit delinquent acts the issue of “peer pressure” must be addressed. Prior research suggests that peer associations are the most important proximate cause of adolescent delinquency (Payne & Cornwell, 2007).

As stated in the original study conducted by (Coie & Miller- Johnson, 1995) youth who associate with deviant peers are likely to be arrested earlier than youth who do not associate with such peers (Lober, Farrington, Petechuk, 2003). Going back to the Control theory by Hirschi (1969) if a juvenile delinquent has strong social bonds that are negative and perpetuate committing criminal deviant acts the juvenile delinquent is more likely to be influence to participate in deviant acts with

peers who engage in the acts as well. The importance of having accomplices cannot be overstressed in child delinquency (Lober, Farrington, Petechuk, 2003).

Juvenile delinquency is a huge issue that has to be addressed because it is becoming more visible and accepted in today's society. Juvenile delinquency is a complex trend that must be critically dissected to begin to understand specifically all the reasons why children turn to delinquency. Unlocking the key to understanding juvenile delinquency is important because this deeply shapes ways in which juvenile delinquents who go through the juvenile justice system are rehabilitated. Also this shapes and creates ways in which prevention and intervention programs can be tailored to at risk youth before becoming juvenile delinquents

2.4 Drug Addict of Youth in Thailand.

Another survey was conducted in the early 1980s involving nearly 7,000 students in postsecondary institutions (Vocational and Teacher Colleges) from all regions of the country. This survey reported the following proportions of ever-users of various drugs: 24.5 percent had ever used marijuana, 13.8 percent amphetamines, 3.3 percent opium, 2.9 percent heroin, 3.9 percent "eunoctin" and 9.0 percent inhalants. Among ever-users, the following proportions were reported as current users (defined as using the drug during 1–5 days in the 30-day period prior to the survey): 19.0 percent currently used marijuana, 11.6 percent amphetamines, 14.5 percent opium, 25.7 percent heroin, 20.7 percent "eunoctin" and 14.2 percent inhalants (Ministry of Education, n.d.). These proportions contrast with those from another study by the Division of Educational Supervision, Department of Teacher Training, which gives a user rate of less than 1 percent for each of the substances listed above (Division of Educational Supervision, Department of Teacher Training 1987).

Several other studies looked at knowledge and attitudes toward drug use and determinants of such knowledge and attitudes among adolescents. Again, the focus was mainly on the in-school adolescents, rather than the general youth population. A few undertook studies of drug addiction cases in treatment centers, but all of them lack information on the extent of drug use at the national level. Lack of

large-scale, national representative studies on drug use is understandable given the illegal status of drug use and the social sanctions associated with it, which makes it a difficult subject for the survey method.

In the absence of national survey data, the only sources that can give information on the extent of drug use are the government's drug treatment centers located in different regions of the country. But information from these sources has one serious limitation; it includes only those who voluntarily come to the centers for treatment, and not the unknown number who do not. In addition, information from these centers needs careful scrutiny before it can be used for study purposes. In the past, research use of the data from drug treatment centers has been limited.

According to an unpublished study by the Institute of Health Research, Chulalongkorn University, in collaboration with the Department of Medical Services, Ministry of Public Health (which is in charge of drug treatment centers), the number of new drug-dependence cases of all ages reported to all centers increased steadily throughout the 1980s, from 4,152 at the beginning to 13,101 at the end of the decade. Although there was a minor fluctuation after 1985, overall increase during this period was more than 215 percent (Perngparn et al. 1992). Among youth aged 15–24, new cases of drug dependence showed a similar pattern of increase, reaching a peak around 1985 and then declining slightly thereafter. The overall increase from the beginning to the end of the 1980's was 115 percent among the youth. Aggregated data for the 1990's are not available, but given the increased supply of drugs commonly reported in the local media there is good reason to believe that overall the number of new cases continued to rise up to the present despite campaign efforts of various kinds.

New forms of substances are also believed to be more available in the 1990s than in the 1980s. The document referred to above observe that toward the end of the 1980s there emerged a new form of drug use among adolescents, particularly in the Northeastern region of Thailand. This is organic solvent sniffing, mainly toluene in paint thinner, lacquer and glue. By and large, heroin is the most predominant form of substance used. Others major substances include opium, marijuana, and inhalants. Recently an epidemic of amphetamine use among drivers, laborers and adolescents in schools has been of increasing concern. The current strength of the demand for amphetamine and new forms of drugs such as cocaine and ecstasy is indicated by the

increasing supply despite an apparent increase in efforts to control it by concerned authorities in recent years.

The scarcity of information regarding drug use, the sensitive nature of the user's behavior and the illegality of drug production and distribution make it unwise to expect accurate statistics in this regard. Results from behavioral surveys, such as those reported here, cannot be expected to provide more than broad indicators of trends and differentials.

As the juvenile delinquency in Thailand must to conduct as the international standard, Then, the juvenile observation and protection of children and youth had sat up the mission of the rehabilitation agency for take them back to such youth's family. Such centers as a place for the remedies were which marks the beginning of the most juvenile remand home for children and youth rehabilitation activities. Children and young people with risk factors and behaviors associated with drug abuse can be divided into risk groups; the group also has a habit of using the drug activity for a period of 10 activities for 10 weeks, as follows;

Group 1

Activity1: Knowledge on Smoking, Tobacco and Alcohol.

Activity 2: Knowledge on Drugs and drug abuse.

Activity 3: Knowledge about AIDS.

Activity 4: Games against drugs.

Activity 5: Musical richness of life.

Activity 7: Artistic mind.

Activity 8: Decision making skills.

Activity 9: How to reject without losing a friend.

Activity 10: Most valuable thing for me.

Group 2 Drug addict Groups: This consisted of the children and young people who had addicted drug. The activities are as the following 10 classes;

Activity 1: Effect immense of drug.

Activity 2: The stimulus.

Activity 3: Anti-drug recidivism.

Activity 4: Decision making skills.

Activity 5: Problem solving skills.

Activity 6: Refusal skills.

Activity 7: Listening skills.

Activity 8: Pride promotion.

Activity 9: An intelligences and mind reflection.

Activity 10: Life planning.

To make known the results of the rehabilitation activities for drugs in the center for children and youth, that will be leading to improve the process of rehabilitation and development activities of the drug in the first place for children and youth further.

Activity1: Knowledge on Smoking, Tobacco and Alcohol. These activities have the aims as to make aware for such juvenile on the bad effects and impacts of smoking, tobacco and alcohol including giving essential data for stopping such drug addicts.

Activity 2: Knowledge on Drugs and drug abuse. This activities have the aims as to make understanding for such juvenile on the bad effects and impacts of drug and drug abused including encourage them to avoid such drug addicts.

Activity 3: Knowledge about AIDS. These activities have the aims as to make aware for such juvenile on the bad critical effects and impacts of un-safe sex including giving essential data for AIDS.

Activity 4: Games against drugs. This activities have the aims as to make enjoy and fun and to drain the drive out of the body including encourage the physical muscle and respect the athletically sprits**.**

Activity 5: Musical richness of life. This activities have the aims as to make recreation and release the stress among the youth who stayed together collectively including cultivate the musical appreciation.

Activity 7: Artistic mind. This activity has the aims as to aware the moral and integrity in their life including the giving of moral reasoning.

Activity 8: Decision making skills. This activity has the aims as to explain the process for any person to decide and make decisions based on the situation appropriately.

Activity 9: How to reject without losing a friend. This activity has the aims as to make youth understanding several methods for rejecting appropriately in any situations.

Activity 10: Most valuable thing for me. These activities have the aims as to make youth aware the worthy thing in particular, self esteem and values as a man.

Activities for the drug addicted youth

Activities for the drug addicted youth are consisted with

1. The tremendous impact.

These activities have the aims as to make members are aware of the consequences of using drugs and encourage to quit drugs.

2. The Urges.

These activities have the aims as to make members to classify the internal and external undertakings within the influence of the drug. So that members can assess the risk of a return to drug abuse and find ways to manage risk appropriately

3. To prevent repeated abuse.

These activities have the aims as to make members to aware of the situation that caused the addiction and analyzed to provide solutions or avoiding methods.

4 The decision making skills.

These activities have the aims as to make members can decide to assess and manage with the problem when in risk situations.

6 The refusal skills.

These activities have the aims as to make members to refused to give in to dissipate the lessons that may be drawn with the behavior suggested the risk to use drugs again.

7. Listening skills.

These activities have the aims as to make members use the listening skills and to learn how to get benefits properly.

8. Promoting pride

These activities have the aims as to make members feel proud of themselves and looking self esteem.

9. Across intelligences reflects one self

These activities have the aims as to make members know the meaning of self-control. So that members realize the importance of self-control.

10. Life planning

These activities have the aims as to make members have a concrete plan of life and build awareness of the needs of his own present.

Activities for the risked drug addicted youth

Activities for the risked drug addicted youth are as the first group as follows;

Activity1: Knowledge on Smoking, Tobacco and Alcohol. These activities have the aims as to make aware for such juvenile on the bad effects and impacts of smoking, tobacco and alcohol including giving essential data for stopping such drug addicts.

Activity 2: Knowledge on Drugs and drug abuse. This activities have the aims as to make understanding for such juvenile on the bad effects and impacts of drug and drug abused including encourage them to avoid such drug addicts.

Activity 3: Knowledge about AIDS. These activities have the aims as to make aware for such juvenile on the bad critical effects and impacts of un-safe sex including giving essential data for AIDS.

Activity 4: Games against drugs. This activities have the aims as to make enjoy and fun and to drain the drive out of the body including encourage the physical muscle and respect the athletically sprits**.**

Activity 5: Musical richness of life. This activities have the aims as to make recreation and release the stress among the youth who stayed together collectively including cultivate the musical appreciation.

Activity 7: Artistic mind. This activity has the aims as to aware the moral and integrity in their life including the giving of moral reasoning.

Activity 8: Decision making skills. This activity has the aims as to explain the process for any person to decide and make decisions based on the situation appropriately.

Activity 9: How to reject without losing a friend. This activity has the aims as to make youth understanding several methods for rejecting appropriately in any situations.

Activity 10: Most valuable thing for me. These activities have the aims as to make youth aware the worthy thing in particular, self esteem and values as a man.

2.5 Factors affecting of Youth Drug Addict

There are a lot of factors affecting of youth drug addict as follows;

1. Outcome variable: The outcome variable in this analysis is consumption of alcohol and tobacco and use of other drugs (marijuana, heroine, painkillers, amphetamines, inhalants). Fays provides information on lifetime and current use of these substances. Any use in the past month is considered "current use."

2. Independent variables: Our independent variables consist of two sets of measures, one on family background and the other on individual background.

Family background encompasses mainly measures of family structure (living arrangement), family socioeconomic status (primary sources of family income, parental education) and family relations (relationships with parents, relationships with siblings, family control).

Individual background consists of the following measures: self esteem, personal values, frequency of exercise activities, and frequency of visiting entertainment places, peer influences, and exposure to media. Descriptions of each measure are provided below.

(1) Family Background

Families with children and young people in custody should be provided in a family environment and interactions that represents love, understanding, acceptance and support of their family. Parents should be a good mentor to children and youth. Many of the study revealed that family conflict are variables that can predict amphetamine of children and youth. Families with high family conflict or even just resulted in the children and youth at risk of high amphetamine and more. In order to prevent children and young people the opportunity to become involved in drugs and

to reduce family conflict. Parents should educate children and young people appropriate to the needs of children at different ages. The methods of rearing should focus on parenting and reasoning, love rather than emotional support or dictatorship. Encourage children and young people the opportunity to express their opinions and participate in decision making about future events. Parents should be assigned all the necessary functions explicitly. To members appropriately and ensure that each member has served in full, the children and young people have the freedom to do some things that kids like to do so.

As for the participation in the family, parents should look for opportunities to talk or do activities as a family to create intimacy and learning including understand the character of each member of the family. Build a good relationship and familiarity between family members are also important too. When the parent is able to consult with children and young people in the family, parents should take care and consistency in the practice of children and young people to study habits. Family is parents, siblings or children to love. They should monitor their children's friends. Commentaries and advice for dating and friends regularly make available to control the behavior of children and young people appropriately. Parents must understand the nature of children and young people, often with friends in the same age group. And tend to be more important than parents. When problems do often like to talk with friends, parents should get to know your equipment quirks and behavior of children and young people to get to know each child and youth living in group homes, good or bad. To guide the children and youth to know dating a good friend and not led to a decline in the same time, parents should have the attitude of a friend's child and youth friendly manner in a friendly gesture, not shunned.

Living arrangements: So much has been found about the significance of family structure, especially living with parents versus all other forms of living arrangements, although findings are not always consistent. While information from the conventional data tells us the place of residence at the time of interview, life history information allows us to link key events in the respondent’s life (such as first experience of drinking or smoking) to the type of living arrangement around the time of the event. Based on knowledge from previous studies about the significance of family structure on adolescent risk behaviors we hypothesize that living with both or

any of the parents has greater protective value against risk behaviors than other forms of living arrangements.

Primary source of family income: This is a measure of socioeconomic status of the family which is believed to facilitate opportunities for adolescent development (or lack thereof). Low family socioeconomic status may put some youth at higher risk of problem behaviors compared to youth from families of high socioeconomic status. This measure is based on information from a direct question on the primary source of family income. Our analysis tests if this assumption holds for drinking, smoking and use of other substances.

Parental education: This is another measure of family socioeconomic status which may impinge upon youth risk behaviors. For our analysis, only the educational level of mother or father (the higher of the two), is taken to represent “parental education.” If one of the parents died before the respondent was 10 years old, the education of the surviving parent is used. In case both parents died before the respondent was 10 years old, the case is excluded from analysis. This criterion yields the following distributions of cases in the sample: about 80 percent had parents with only some or completed elementary education; 10 percent with some middle-high school level; 5 percent with college education or higher; the rest (over 4 percent) have parents with no education. Studies in some Western settings indicate a mixed effect of parental education; some found it to have a protective effect (Forste and Heaton 1988), while others found no effect of this measure on youth’s risk taking behavior such as sexual intercourse (Miller, Forehand, and Kotchick 1999; Small and Luster 1994). In our analysis we expect youth whose parents have higher levels of education to be less likely to engage in drinking, smoking, or substance use.

Relationship with parents: The respondents were asked to assess their relationships with parents (biological or adoptive). Responses are grouped into three categories: “good with both mother and father,” accounting for 79.3 percent of the sample, “good with either mother or father” (15.1 percent), and “good with neither of them” (5.6 percent). For analysis, we hypothesize that youth who have good relationships with both parents are less likely to be involved in drinking, smoking or substance use. This hypothesis reflects an assumption that the protective function of

the family rests upon, among other things, the quality of relationships between parents and children.

Relationship with siblings: To adolescents, siblings are other family members with similar social status who largely share common ideas and attitudes. This fact provides a basis for the assumption that siblings may influence each other in their behaviors, especially when they have good relationships. On the other hand, when the relationship is not smooth, this may cause stress and tension that may eventually lead adolescents to drinking or drug use. In the survey, respondents were asked to assess their relationships with other siblings (full or half). Those with no siblings were excluded. Nearly all respondents (93 percent) reported that they had a "good relationship with all siblings" while negligible proportions said they had a "good relationship with some siblings only" (six percent) or a "good relationship with none of their siblings" (one percent). Our analysis tests the hypothesis that youth with good relationships with all siblings are less likely to engage in drinking and smoking and drug use.

Family control: As indicated by some previous studies (see review above), parental control has significant preventive effects against adolescent problem behaviors. In our analysis we anticipate similar effects of parental control on the drinking and smoking behavior of youth in the sample. We use the concept of "family control" rather than "parental control" for two reasons. First, in most Asian societies (Thailand included) control of children's behavior is not affected by parents alone; any adults in the family, or even extended kin in some cases, can play important roles. Second, this concept fits better with how the information for this measure was obtained. In the questionnaire the relevant question reads: "At present how much freedom (i.e., not being under strict control from other family members) do you think you have in the following aspects." The questions address freedom with regard to the kind of people to make friends with, spending money, going out for fun, choosing a job, having a boyfriend /girlfriend, dressing/ clothing, choosing whom to marry, and choosing what to study. A three-point scale response was provided for each item, ranging from 1 (no freedom at all) to 3 (a lot of freedom). For our purpose here, lack of freedom in any of these items is considered more family control; more freedom, less family control. The index of family control is taken as the percentage of the total

score obtainable from all completed items. For the entire sample the observed index ranges from 0.39 to 1.0, with the mean of 0.59 (S.D. = .081). An index value lower than the mean is considered “low family control”; equal to or higher than the mean value, “high family control.” Based on this treatment, 56.8 percent of the sample youth were of low family control. Our analysis tests whether lower risks of drinking or smoking are associated with higher levels of family control.

(2) Individual Background

Self-esteem: This variable is measured as an index based on the total score obtained from completed responses to the following statements: feeling of having a number of good qualifications; as important to your family as other members; can accomplish many things just as other people; hardly proud of yourself (reverse-coded); always know your own strengths and weaknesses; many things do are not so meaningful for yourself; and feel that mean much to your friends. Cases with an index lower than the mean are grouped under “low self-esteem,” and those with a score equal to or higher than the mean are classified “high self-esteem.” Approximately half of the youth in the sample were of low self-esteem.

Personal values: This measure is constructed in the same way as self-esteem. The concept of “value” is understood here simply as “importance” that an individual gives to something. Although statements of “things” listed in the questions are generally positive, we anticipate respondents to differ in their responses reflecting what they regard as important or not important, i.e., they are of different personal values. In the survey, the respondents were asked to indicate how important each of the following “things” is to them: freedom to do things the way one wants, honesty, fun and enjoyment, religion and morality, a goal-oriented life, friendship, collective interest over individual interest, equality of men and women, and self-restraint. Respondents chose their answers from a four-point scale ranging from 1 (not important) to 4 (most important). An index score lower than the mean is considered “low personal value,” otherwise “high personal value.” More than half of youth (55.7 percent) in the sample are of high personal values. Our analysis tests a hypothesis that high personal values are associated with a lower risk of drinking or smoking.

2.6 Related Researches

2.6.1 National Related Researches

Chalermsri Rachanachan (B.E.2550) had studied life phenomena of amphetamine abuse youth with the purpose of this research was to study the amphetamine abuse youth phenomena. The method was qualitative research. Data were gathered via in-depth interviews, participant and non- participant observations. Key informants were 17 of 14-25 years old amphetamine abusers who used amphetamine during last 12 months, and 24 stakeholders. The findings indicated that, most of amphetamine abusers were 19-22 years old. and studying in high vocational certificate education, 82.35 percent used drug about 1-5 years, 64.71 percent high with single parent or relatives.

Their family's occupations were travail, they had estranged relationship, parenting styles were unstable pattern, during childhood they had controlled behavior and got freedom at early adolescent. Before being to be amphetamine abuser, everyone had normal lifestyle and development. They became to be amphetamine abuser because of the environment and desiring to have experience.

Most of them were similar lifestyles, spent most of times with their peer groups, used amphetamine, separated from families, inattention to study, taking risk behaviors and used high frequency and more than dose of amphetamine. They were easily access to amphetamine wherever they needed. Drug abuse affected themselves and their families. During the treatment period, everyone could abstain amphetamine about 1-2 months, self aware of amphetamine impacts, spent more times with their families. The perceived meaning of amphetamine was "help" that made them get better.

The method to take them away from amphetamine abuse were the participation of overall stakeholder and educated them about adolescent development, addiction sociology of stakeholder overall, including adjust their attitude that drug abuse was chronic disease. Research suggestion;

1) The government should set confluent policy indicated that, the abuser had to be obtained treatment.

2) The Ministry of Public Health should arrange the transfer forum about drug abuse.

3) Future research should be followed up among drug users who have long abstinence.

Seearoon Lampoo et al.(B.E.2552) had studied the Effects of an intrinsic motivation program on motivation &acceptance to rehabilitation treatment among drug dependent clients at one Treatment Center for Drug Dependence in Pathumthani Province the problem of drug dependent clients do not going to rehabilitation, leads to their higher relapse rates. Thus, fostering motivation for rehabilitation is important. The purpose of this quasi-experimental study was to determine the effects of an intrinsic motivation program on motivation & acceptance to rehabilitation treatment among drug dependent clients at one treatment center for drug dependence in Pathumthani province.

Eighty participants were randomized equally into experimental and control groups (n = 40 for each group). The control group only received usual detoxification care, whereas the experimental group received usual care plus the intrinsic motivation program. This program emphasized for drug dependent clients recognize the respond of 3 basic psychological needs, 1) need for competence 2) need for autonomy and 3) need for relatedness. There are including giving information, modeling, exercising, and positive feedback.

Data were collected using an intrinsic motivation questionnaire and counting who decide to continue with rehabilitation. Statistical analysis was performed using Chi-square test and independent t-test.

The results indicated that before the intervention, the two groups had equal level of mean motivation scores. After the experiment the mean difference in motivation scores between pre and post test was significantly higher among the experimental group than that of the control group ($p < .05$) and a higher proportion of the experimental group decided to continue with rehabilitation than that of the control group ($p = .05$)

In conclusion, this study revealed that the intrinsic motivation program was effective in increasing acceptance of rehabilitation treatment among the drug dependent clients. Further studies should be conducted could larger groups.

2.6.2 International Related Researches

Dennis, M.L., Dawud-Noursi, S., Muck, R.D., McDermeit, M. (2002) had studied the need for developing and evaluating adolescent treatment models. (In S.J. Stephens & A.R. Morral (Eds.), Adolescent Substance Abuse Treatment in the United States: Exemplary Models from a National Evaluation Study (pp. 3-33). New York: TheHaworth Press.) It was found that adolescent substance abuse follows different patterns and progression than with adults, and treatment models for adults have provided mixed results when used with adolescents. Dennis describes the increase in adolescent substance abuse and associated problems, chronicles the history and evaluation of adolescent treatment, and reviews data and evaluations of the public treatment system as it has been applied to adolescents in the United States in the last century. The Adolescent Treatment Model (ATM) program is described as an effort to identify, evaluate, and formalize models of effective adolescent substance abuse treatment. By utilizing standardized assessment, tracking and evaluation tools, researchers are finding early indications of improvements in actual practice in community based treatment models.

Diamond G.S., & Liddle, H.A. (1999) had studied transforming negative parent-adolescent interactions: From impasse to dialogue (Family Process, 38, 5-26.) This studied had providing in-depth case descriptions of therapeutic impasse in family therapy, he describe strategies that shift the therapeutic focus from behavior management to interpersonal relationship failures as a way to advance therapeutic progress. The article examines the theoretical foundation of the Multidimensional Family Therapy “shift intervention” strategy, the phenomenology of the conflict leading to what is termed “the impasse,” and the specific therapist’s actions that guided the family’s resolution process.

Diamond, G., & Liddle, H.A. (1996) had studied resolving a therapeutic impasse between parents and adolescents in multidimensional family therapy (Journal of Consulting and Clinical Psychology, 64, 48l-488.) It was found that conflict between family members in therapy sessions often results in an impasse that can lead to noncompliance, early termination and treatment failure. By employing a Multidimensional Family Therapy (MDFT) strategy called “shift intervention” to resolve in-session conflict between parents and adolescents, the therapist can resolve

the impasse. Diamond report on the design of the “shift intervention” technique, provide an in-depth analysis of its application to episodes of therapeutic impasse, and evaluate its effectiveness both short and long term.

Liddle, H.A. (2002, May) had meta-analysis research renaissance in adolescent substance abuse treatment through an overview of advances in research in adolescent substance abuse and the potential for applying research-derived therapies to regular clinical settings. The author reports on how clinical practice has benefited from new developmental knowledge changing the way treatment is provided. Research focus is expanding beyond treatment outcomes to process questions, and specialized and multi-component treatment models have shown promise with more advanced forms of adolescent dysfunction.

Liddle, H.A. (1999) had studied theory development in a family-based therapy for adolescent drug abuse. Journal of Clinical Child Psychology, 28, 521-532. This article traces theory refinement within family therapy leading to the formation of Multidimensional Family Therapy. The goal of treatment development research has been to develop effective therapeutic models for treating adolescent problem behavior and drug abuse. Operating from a theoretical level regarding dysfunction, risk factors, interpersonal processes, and historical perspective, researchers developed an expanded theoretical definition of change leading to targeted, theory-derived intervention strategies.

Liddle, H.A. (1994). The anatomy of emotions in family therapy with adolescents.Journal of Adolescent Research, 9, 120-157.Liddle focuses on the growing understanding of the role of emotions in the development and functioning of adolescents, describing them as important factors in family development, problem behaviors and problem solving, and dysfunctional family patterns. Through clinical illustration, this article examines chronic, stable and quick-to-escalate negative emotional exchange between family members participating in Multidimensional Family Therapy, a family-based-treatment approach designed to treat adolescent drug abuse and behavior problems. This case study illustrates how emotions are targets of therapeutic work as well as mediating variables and can become part of a positive intervention strategy.

Liddle, H.A., Dakof, G.A., Parker, Diamond, G., Barrett, & Tejeda, M. (2001).Multidimensional Family Therapy for adolescent drug abuse: Results of a randomized clinical trial. American Journal of Drug and Alcohol Abuse, 27(4), 651-688. This study reports on a study comparing the effectiveness of Multidimensional Family Therapy (MDFT) and two alternative treatments in reducing adolescent drug use and associated problems such as delinquent behaviors, school failure, and maladaptive family functioning. Comparison therapies were selected because of the theory-based contrasts, testing the influence and limits of treatments developed from psychotherapy rather than drug counseling traditions. Measured by outcome indicators of attrition, drug use, problem behaviors, school performance, and family functioning, results showed that all treatments resulted in improvements. Treatment effectiveness was greatest for MDFT, maintained even at a 1-year follow-up.

Liddle, H.A., Rowe, C.L., Quille, T.J., Dakof, G.A., Mills, D.S., Sakran, E., Biagge, H. (2002). Transporting a research-developed adolescent drug abuse treatment into practice. Journal of Substance Abuse Treatment, 22, 1-13. Special Edition on Transferring Research to Practice. (D. Simons, Ed.).

This study presents the details of a process of experimentally testing the integration of Multidimensional Family Therapy (MDFT) into an existing community-based adolescent drug abuse program. The study described is a collaborative project between researchers at the University of Miami School of Medicine and treatment providers at the University of Miami/Jackson Memorial Hospital, and was designed to adapt and transport MDFT interventions into a day treatment program for substance abusing youth. The authors detail the process including the technology transfer involved, its challenges and evidence of initial success.

Pond A, Aguirre-Molina M, Orleans J. (2002) had studied the adolescent substance abuse treatment workforce: Status, challenges, and strategies to address their particular needs. Princeton: Robert Wood Johnson Foundation. A background paper commissioned by the Robert Wood Johnson Foundation to facilitate discussion among adolescent substance abuse researchers and practitioners about the current status of the adolescent treatment workforce, challenges associated with treating adolescents, major issues impacting the adolescent treatment workforce’s recruitment and retention in the field, and innovative strategies to strengthen the workforce over both the short and

long terms. Based on a review of current literature as well as interviews with researchers and practitioners associated with substance abuse workforce issues, this paper addresses issues on the staff, organizational, systems, and policy levels, and suggests strategies for reform.

Rowe, C. Liddle, H., McClinti, K., Quille, T., (2002)had studied an integrative treatment development: MDFT for adolescent substance abuse. Several specific interventions are described in the context of the role of the therapist. Results of MDFT outcome and process research studies are also discussed.

Spoth, R., Goldberg, C., Neppl, T., Trudeau, L., & Ramsetty-Mikler, S. (2001)had studied Rural-urban differences in the distribution of parent-reported risk factors for substance use among young adolescents. Based on the body of literature reporting that adolescents in rural populations showed higher prevalence substance abuse than urban areas, researchers studied rural-urban differences in cumulative risk for youth substance abuse among young adolescents using parent surveys. Data was collected using a statewide sample in Iowa. Analysis showed parent reported cumulative risk for young adolescent substance use was significantly higher for rural youth.

National Household Survey on Drug Abuse. Washington, DC had also studied substance Abuse and Mental Health Services Administration. (2002). Researchers can access NHSDA data to run their own tables. Links to the NHSDA full report covering topics such as ecstasy, injection drug, alcohol, marijuana and tobacco use, prevention-related measures, treatment, mental health issues are available, as well as press releases and fact sheets. Other NHSDA reports available include summary of findings, state data, special NHSDA studies on topics such as mental health, drug use and driving, workplace policies, and drug use by racial and ethnic groups. Over 50 reports are available.

CHAPTER III
RESEARCH METHODOLOGY

This research had design as a survey research within the objectives for study the activity development for the rehabilitation of the drug addiction in the observation and protection juvenile center in Bangkok and vicinities including delineate factors associated with such activity development of such juvennile youth. The researcher has steps in operating as follows;

3.1Targeted Population

The targeted population of this research include the youth who had delivered to rehabilitating for drug addict in the observation and protection juvenile centers in Bangkok and its vicinity.

3.2 Sample and sampling

The research was conducted by a random selection of samples and sampling by divided in several steps as follows;

1) List the names of the youth as the drug abused youth, the risked youth in the observation and protection juvenile centers in Bangkok and vicinity came to be sampled and able to determine.

1.1 The observation and protection juvenile centers in Bangkok

1.2 The observation and protection juvenile centers in Vicinities

2) Within the observation and protection juvenile centers in Bangkok the and vicinities as the sample, the researcher classified in term of the youth as the drug abused youth, the risked youth and define the random sampling then, in any the

observation and protection juvenile centers also using the same as group or equivalent. Results of the sampling are as the target faculties as;

2.1 Baan Methra Observation and Protection Juvenile Center

2.2 Baan Karunna Observation and Protection Juvenile Center

2.3. Baan Pranee Observation and Protection Juvenile Center

2.4 Baan Fahsai Observation and Protection Juvenile Center

2.5 Nonthaburee Observation and Protection Juvenile Center

2.6 Samut prakan Observation and Protection Juvenile Center

2.7 Nakhon pathom Observation and Protection Juvenile Center

2.8 Pathum Thani Observation and Protection Juvenile CenterSampling population had used the multi-stages that starting from a random stratified (Stratified Random Sampling), then using simple random sampling (Simple Random Sampling) because an unknown number of population is using the calculation formula Yamane (1967) proposed a formula to calculate the sample size, the proportion of one group.

$$n = \frac{N}{1 + Ne2}$$

By n = sample size as calculated

N = number of population

e = the error to be acceptable (allowable error)

We had determined by the ratio was 0.5 and the 95% confidence level.

The calculated sample size = 400.

2. Interview the concerned governmental officials in each observation and protection juvenile centers through the teacher or leader the activities of the drug addict rehabilitation to find out the opipion on such defined activities and allow them to assess the concepts and procedure that using the rehabilitation activities for the drug addict youth from abroad including how to appied the programs to develop in Thailand appropriately.

3.3 Research Tools

A tool used in this research is a questionnaire that the researchers created as process through the constructed as follows;

1) The research had survey various literature from books, journals and research papers related to the research and consulting the experts in related field.

2) Set up a framework concept and research scope including consideration of the issues and objectives of the research.

3) Take various concepts derived from the relevant literature to create a questionnaire that covers the content we need to study, independent variables which includes questions on personal factors and factors stimulated including set the questions in terms of the activities development of rehabilitation fot the drug addict youth in the observation and protection juvenile centers in Bangkok and vicinity to a scale level 5, which is adapted from the estimation method of Likert Scale, with a range of criteria are as follows.

Strongly agree to be score as 5

Agree to be score as 4

Not sure to be score as 3

Disagree to be score as 2

Strongly disagree to be score as 1

4) Lead the questionnaire created to through the experts to make available and qualified including modified to achieve the accuracy of the contents (Content Validity).

5) Modification defect of the questionnaire, then take the questionnaire to collect data to test the following questionnaire. The population of the test, within the

test of questionnaire, is similar to the same population. That is to say, they are the drug addict youth in the observation and protection juvenile centers in Bangkok and vicinity who are classified at different levels, the youth as the drug abused youth, the risked youth in the observation and protection juvenile centers in Bangkok and vicinities for the 30's person.

6) Take questionnaire as has been preliminary tested as such to the test the reliability values by coefficient alpha test (Coefficient Alpha) for the reliability of the questionnaire about the activities development of rehabilitation fot the drug addict youth in the observation and protection juvenile centers . In case of the vales from reliability test is greater than 0.75, it is to be considered for reliable in this questionnaire.

7) Lead such questionnaire to collect data from people who want to study further.

3.4 Data Collection

1) Bring a letter from the Dean, Faculty of Graduate Studies to the Directors of targeted the observation and protection juvenile centers in Bangkok and vicinities and explain the research aims and targeted population and sample. Ask for the cooperation for the youth to fill data in questionnaire.

2) Lead the questionnaire to the youth in such defined the observation and protection juvenile centers and clarification the research purposes including suggest how to answer questionnaire.

3) Ask for the number of the youth in the observation and protection juvenile centers in each Bangkok and vicinities in the targeted observation and protection juvenile centers in the amount specified in the classified groups at all levels as the youth as the drug abused youth, the risked youth randomly stratified. The number of samples is conducting as the number of already defined.

4) Ask the to Directors of targeted the observation and protection juvenile centers in Bangkok and vicinities deliver the questionnaire for the targeted youth in the observation and protection juvenile centers in each and ask for get the questionnaire back in 2 weeks.

5) Review the right of questionnaire.

3.5 Data Analysis

Researchers analyzed data by using the software package SPSS FOR WINDOW as detailed below;

1) Determine the basic statistics with frequency, percentage, mean (Mean) and standard deviation (Standard deviation).

2) Tested the differences of the mean by t-test (t - test) and the F-statistic (F - test).

3) Analyze the correlation coefficient between variables. Correlation coefficient using the formula of Pearson (Pearson's Product Moment Correlation Coefficient), using the relative level of correlation coefficient (r) as follows: (Prakrong Karnasuta, B.E.2528).

Ranged from 3.67 to 5.00 mean as relative high

Ranged from 2.34 to 3.66 mean as relative moderate

Ranged from 1.00 to 2.33 mean as relative low

4) Using discriminant analysis of Duncan to set mean comparison between groups to want to know whether any group that has opinions on activity development of the drug addict rehabilitation vary.

CHAPTER IV
RESEARCH RESULTS

The study on development of rehabilitation activities for the drug addict in the Juvenile primary acceptant center was conducted through four hundreds children and youth from such centers by questionnaire and analysis as four parts as follows;

1. Background factors or personal data
2. Benefit assessment from the rehabilitation activities against drug addict in the center
3. Rehabilitation activities for the drug addict in the กรับฯ
4. Hypothesis

The data analysis had been shown as following tables;

Part 1 Background factors or personal data

Part 1: this part is a presentation for the background factors or personal data of the sample those who answer the questionnaire. The results had shown as follows;

Table 4.1 Number and Percentage **of background factors or personal data** of the sample (n =400)

Background factors or personal data	Number	Percentage
1). Gender		
Male	361	90.3
Female	39	9.8
2). Age		
Below13 Year	4	1.0
Between 13-15 Year	41	10.3
Between 16-18 Year	328	82.0
More than 18 Year (Please specific).....	27	6.8

Table 4.1 Number and Percentage **of background factors or personal data** of the sample (n =400) (cont.)

background factors or personal data	Number	Percentage
3). Old domicile		
Bangkok Metropolitan and its vicinity	337	84.3
North Region	10	2.5
Northeastern Region	20	5.0
South Region	1	.3
Others (Please specific).....	32	8.0
4). Educational background		
Never attain in school		
Prathomsuksa level	137	34.3
Primary High school (Mo.1-3)	218	54.5
Secondary High school (Mo.4-6)	30	7.5
Others (Please specific).....	15	3.8
5). Current marital status of the parent		
marriage and live together	123	30.8
parent died	40	10.0
marriage but separated	22	5.5
divorced	191	47.8
(Please specific).....	24	6.0
6). Current income/month(family in all)		
Between 1๐,๐๐๐ – 3๐,๐๐๐ Baht	311	77.8
3๐,๐๐๐ – 5๐,๐๐๐ Baht	64	16.0
More than 5๐,๐๐๐ Baht	25	6.3
7). Current associated peers		
juvenile and deviance	43	10.8
general and variety	317	79.3
drug use and gambling	23	5.8
Others (Please specific).....	17	4.3

Table 4.1 Number and Percentage **of background factors or personal data** of the sample (n =400) (cont.)

background factors or personal data	Number	Percentage
8). Reasons for drug addict		
Family problems	33	8.3
Challengeable and friend motivation	102	25.5
Need to know and try	227	56.8
Others (Please specific).....	38	9.5
9). Sources of drug taking		
Purchase or getting from friends	171	42.8
known persons	115	28.8
unknown persons	31	7.8
ever to be sale agent and also consumed	53	13.3
Others (Please specific).....	30	7.5
10). Motivated or encouraged objects to drug consume		
personal need or motivating factor	262	65.5
associated peers	94	23.5
Family and community	8	2.0
Others (Please specific).....	36	9.0
11). You had known or ever to drug rehabilitation		
ever	138	34.5
Never	262	65.5
12) If you had ever to drug rehabilitation anyone who took you to cure is		
friends advised or took to cure	24	6.0
Family and relatives	62	15.5
Any organizes/Associations/governmental units	173	43.3
Others (Please specific).....	141	35.3

Within Table 4.1 personal factors of the sample were as follows;

Gender it was found that the majority of sample was gender as Male as 361 persons as Percentage 90.3.Gender as female as 39 persons as percentage 9.8 respectively.

Age it was found that the majority of sample were age between 16-18 Year old as 328 persons as percentage 82.0 and the subordinate were as age between 13-15 Year as 41 persons as percentage 10.3 Age as upper more than 18 year as 27 persons as percentage 6.8 and age below13 Year as 4 persons as percentage 1.0 respectively.

Old Domicile it was found that the majority of sample had old domicile in Bangkok Metropolitan and its vicinity as 337 persons as percentage 84.3 and the subordinates were as other domiciles as number 32 persons as percentage 8.0 Northeastern Region were as 20 persons as percentage 5.0, North region as 10 persons as percentage 2.5 and South Region as 1 persons as percentage 0.3 respectively.

Educational background it was found that the majority of sample had primary high school (Mo.1- 3) as 218 persons as percentage 54.5 the subordinates were as the primary school as 137 persons as percentage 34.3 the high school(Mo.4-6)as 30 persons as percentage 7.5 and others as 15 persons as percentage 3.8 respectively.

Current marital status of the parent it was found that the majority of sample had the marital status of parent as divorced as 191 persons as percentage 47.8 the subordinates were as marriage and live together as 123 persons as percentage 30.8 parent died as 40 persons as percentage 10.0 Others as 24 persons as percentage 6.0 and marriage but separated as 22 persons as percentage 5.5 respectively.

Current income/month (family in all) it was found that the majority of sample had current income /month between ๑,๐๐๐ – ๓๐,๐๐๐ Baht as 311 persons as percentage 77.8 the subordinates were current income as ๓๐,๐๐๐ – ๕๐,๐๐๐ Baht as 64 persons as percentage 16.0 including current income as more than ๕๐,๐๐๐ Baht as 25 persons as percentage 6.3 respectively.

Current associated peers it was found that the majority of sample had intimated friends as general and variety as 317 persons as percentage 79.3 the subordinates were as juvenile and deviance as 43 persons as percentage 10.8 peers with drug use and gambling as 23 persons as percentage 5.8 including others as 17 persons as percentage 4.3 respectively.

Reasons for drug addict it was found that the majority of sample had expressed reason to drug addict as need to know and try as 227 persons as percentage 56.8 the subordinates were as challengeable and friend motivation as 102 persons as percentage 25.5, others as 38 persons as percentage 9.5 and family problems as 33 persons as percentage 8.3 respectively.

Sources of drug taking it was found that the majority of sample had purchase or getting drug from friends as 171 persons as percentage 42.8, the subordinates were as known persons as 115 persons as percentage 28.8, ever to be sale agent and also consumed as 53 persons as percentage 13.3, purchase from the unknown person as 31 persons as percentage 7.8 including others as 30 persons as percentage 7.5 respectively.

Motivated objects or encouraged things to drug it was found that the majority of sample had their motivated objects or encouraged things to drug from need to try or personal motivation as 262 persons as percentage 65.5 the subordinates were as associated peers as 94 persons as percentage 23.5, others as 36 persons as percentage 9.0 and family and community as 8 persons as percentage 2.0 respectively.

Within conditions as never known or ever attain to drug rehabilitation it was found that the majority of sample had expressed that never known or ever attain to drug rehabilitation as 262 persons as percentage 65.5 และ ever as 138 persons as percentage 34.5 respectively.

In case of ever to rehabilitation, **who do to take to its rehabilitation** it was found that the majority of sample had revealed that those who had ever took to rehabilitation as any organizes/associations/governmental units as 173 persons as percentage 43.3, the subordinates were as others as 141 persons as percentage 35.3, family and relatives as 62 persons as percentage 15.5 and friends advised or took to cure as 24 persons as percentage 6.0 respectively.

Part 2 Benefit assessment from the rehabilitation activities against drug addict in the center

A. Activities for the risked groups

Table 4.2 show the Number and Percentage **of** benefit assessment from the rehabilitation activities against drug addict in the center (n=400)

Benefit assessment from the rehabilitation activities against drug addict in the center	Level of Opinion					$\bar{x}$	S.D.	Results
	Extremely Agree	Agree	Unsure	Disagree	Extremely disagree			
The Risked groups						3.96	.67	Agree
Activity 1 Introduction to cigarette and alcohol	57 (21.0)	144 (52.9)	47 (17.3)	15 (5.5)	9 (3.3)	3.83	.94	Agree
Activity 2 Introduction to amphetamine and drug abuse	104 (38.2)	117 (43.0)	25 (9.2)	15 (5.5)	11 (4.0)	4.06	1.03	Agree

Table 4.2 show the Number and Percentage **of** benefit assessment from the rehabilitation activities against drug addict in the center (n=400) (cont.)

Activity 3 Introduction to AIDS	78 (28.7)	112 (41.2)	50 (18.4)	12 (4.4)	20 (7.4)	3.79	1.13	Agree
Activity 4 Athletics against drug addict	121 (44.5)	104 (38.2)	34 (12.5)	9 (3.3)	4 (1.5)	4.21	.89	Extremely Agree
Activity 5 Music: the colored of life	65 (23.9)	131 (48.2)	46 (16.9)	18 (6.6)	12 (4.4)	3.81	1.02	Agree
Activity 6 Art for heart management	71 (26.1)	140 (51.5)	43 (15.8)	14 (5.1)	4 (1.5)	3.96	.87	Agree
Activity 7 Skills for decision making	80 (29.4)	138 (50.7)	45 (16.5)	1 (0.4)	8 (2.9)	4.03	.86	Agree
Activity 8 How to reject without losing friends	86 (31.6)	109 (40.1)	52 (19.1)	15 (5.5)	10 (3.7)	3.90	1.03	Agree
Activity 9 The most value thing for my life	88 (32.4)	130 (47.8)	40 (14.7)	7 (2.6)	7 (2.6)	4.05	.90	Agree
Activity 10 The more you know the better you get	94 (34.1)	121 (43.8)	39 (14.1)	10 (3.6)	12 (4.3)	4.00	1.01	Agree

Within Table 4.2 it was found that the majority of sample had expressed their opinion on benefit assessment from the rehabilitation activities against drug addict in the center as overall was at a level as agree (mean = 3.96) and as considering by the item orderly as mean from agree to disagree the sample had their opinion as activity 4 Athletics against drug addict was at a level as extremely agree (mean =4.21) the subordinates were as

Activity 2 Introduction to amphetamine and drug abuse was at a level as agree (mean =4.06)

Activity 9 the most values for me activity was at a level as agree (mean =4.05)

Activity 7 Skills for decision making was at a level as agree (mean =4.03)

Activity 10 the more you know the better you get was at a level as Agree (mean =4.00)

Activity 6 Art for heart management was at a level as agree (mean =3.96)

Activity 8 How to reject without losing friends was at a level as agree (mean =3.90)

Activity 1 Introduction to cigarette and alcohol was at a level as agree (mean =3.83)

Activity 5 5 Music: the colored of life was at a level as agree (mean =3.81)

Activity 3 Introduction to AIDS was at a level as agree (mean =3.79)

B. The Drug Addict Groups

Table 4.3 show the Number and Percentage **of** benefit assessment from the rehabilitation activities against drug addict in the center
(n=400)

Benefit assessment from the rehabilitation activities against drug addict in the center	Level of Opinion					$\bar{x}$	S.D.	Results
	Extremely Agree	Agree	Unsure	Disagree	Extremely disagree			
B). The drug Addicted group						4.09	.67	Agree
Activity 1 The Great impacts	94 (30.3)	171 (55.2)	28 (9.0)	10 (3.2)	7 (2.3)	4.08	.85	Agree
Activity 2 Encouraging	79 (25.5)	164 (52.9)	54 (17.4)	7 (2.3)	6 (1.9)	3.98	.83	Agree
Activity 3 Prevention for reuse **of drug**	141 (45.5)	124 (40.0)	29 (9.4)	12 (3.9)	4 (1.3)	4.25	.87	Extremely Agree
Activity 4 Skills for decision making	133 (42.9)	124 (40.0)	43 (13.9)	6 (1.9)	4 (1.3)	4.21	.85	Extremely Agree
Activity 5 Skills for problem solving	127 (41.0)	148 (47.7)	22 (7.1)	9 (2.9)	4 (1.3)	4.24	.81	Extremely Agree
Activity 6 Skills for rejection	144 (46.5)	112 (36.1)	32 (10.3)	18 (5.8)	4 (1.3)	4.21	.94	Extremely Agree
Activity 7 Skills for relax	93 (30.0)	135 (43.5)	67 (21.6)	11 (3.5)	4 (1.3)	3.97	.88	Agree

Table 4.3 show the Number and Percentage **of** benefit assessment from the rehabilitation activities against drug addict in the center

(n=400) (cont.)

Activity 8 Pride contribution	93 (30.0)	152 (49.0)	51 (16.5)	7 (2.3)	7 (2.3)	4.02	.87	Agree
Activity 9 Reflexion skills	54 (17.4)	141 (45.5)	98 (31.6)	10 (3.2)	7 (2.3)	3.73	.87	Agree
Activity 10 Life planning	154 (49.7)	101 (32.6)	41 (13.2)	10 (3.2)	4 (1.3)	4.26	.90	Extremely Agree

Within Table 4.3, it was found that the majority of sample had expressed their opinion on benefit assessment from the rehabilitation activities against drug addict in the center as overall was at a level as agree (mean = 4.09) and as considering by the item orderly as mean from agree to disagree the sample had their opinion as

Activity 10 Life planning was at a level as extremely agree (mean = 4.26) the subordinates were as

Activity 3 Prevention for reuse of drug was at a level as extremely agree (mean = 4.25)

Activity 5 Skills for problem solving was at a level as extremely agree (mean = 4.24)

Activity 4 Skills for decision making was at a level as extremely agree (mean = 4.21)

Activity 6 Skills for rejection was at a level as extremely agree (mean = 4.21)

Activity 1 the Great impacts was at a level as agree (mean = 4.08)

Activity 8 Pride contribution was at a level as agree (mean = 4.02)

Activity 2 Encouraging was at a level as agree (mean = 3.98)

Activity 7 Skills for relax was at a level as agree (mean = 3.97)

Activity 9 Reflexion skills was at a level as agree (mean = 3.73)

Part 3: Questions on Activity for Drug Rehabilitation in the Center

C .Activity Management

Table 4.4 show the Number and Percentage Activity for Drug Rehabilitation in the Center on Activity Management
(n=400)

Activity for Drug Rehabilitation in the Center	Level of Opinion					$\overline{x}$	S.D.	Results
	Extremely Agree	Agree	Unsure	Disagree	Extremely Disagree			
C. Activity Management						4.18	.54	Agree
1.Rehabilitation activity were various and appropriate for each children and youth	142 (35.5)	214 (53.5)	38 (9.5)	2 (0.5)	4 (1.0)	4.22	.72	Extremely Agree
2. Rehabilitation activity were reflexes as readiness on equipment and teacher	114 (28.5)	242 (60.5)	38 (9.5)	2 (0.5)	4 (1.0)	4.15	.69	Agree
3. Rehabilitation activity were contributed in other skills except from drug addict	182 (45.5)	179 (44.8)	31 (7.8)	4 (1.0)	4 (1.0)	4.33	.75	Extremely Agree

Table 4.4 show the Number and Percentage Activity for Drug Rehabilitation in the Center on Activity Management
(n=400) (cont.)

Activity for Drug Rehabilitation in the Center	Level of Opinion					$\bar{x}$	S.D.	Results
4.There were an evaluation on any activities and improved for suitable in each groups	112 (28.0)	236 (59.0)	46 (11.5)	2 (0.5)	4 (1.0)	4.13	.70	Agree
5.There are enough time in each activities	88 (22.0)	226 (56.5)	75 (18.8)	7 (1.8)	4 (1.0)	3.97	.75	Agree
6.Each activity had its aim to resolve behavior and consult to improve obviously	166 (41.5)	184 (46.0)	42 (10.5)	4 (1.0)	4 (1.0)	4.26	.76	Extremely Agree

Within Table 4.4 it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on activity management as overall was at a level as agree (mean = 4.18) and as considering by the item orderly as mean from agree to disagree the sample had their opinion as

(item 3.) Rehabilitation activity were contributed in other skills except from drug addict was at a level as extremely agree (mean = 4.33) the subordinates were as

(item 6.) Each activity had its aim to resolve behavior and consult to improve obviously was at a level as extremely agree (mean = 4.26)

(item 1.) Rehabilitation activity were various and appropriate for each children and youth was at a level as extremely agree (mean = 4.22)

(item 2.) Rehabilitation activity were reflexes as readiness on equipment and teacher was at a level as agree (mean = 4.15)

(item 4.) There were an evaluation on any activities and improved for suitable in each groups was at a level as agree (mean = 4.13)

(item 5.) There are enough time in each activities was at a level as agree (mean = 3.97)

D).The Relationship with other Rehabilitations

Table 4.5 show the Number and Percentage for Drug Rehabilitation in the Center on the Relationship with other Rehabilitations (n=400)

Activity for Drug Rehabilitation in the Center	Level of Opinion					$\bar{X}$	S.D.	Results
	Extremely Agree	Agree	Unsure	Disagree	Extremely Disagree			
C. Activity Management						4.13	.55	Agree
7.There are any medical cure within the rehabilitation activity	123 (30.8)	204 (51.0)	53 (13.3)	14 (3.5)	6 (1.5)	4.06	.85	Agree
8.Activity are made within the aims to resolve not only physical but also psychological aspects	139 (34.8)	217 (54.3)	40 (10.0)	-	4 (1.0)	4.22	.70	Extremely Agree

Table 4.5 show the Number and Percentage for Drug Rehabilitation in the Center on the Relationship with other Rehabilitations (n=400)

Activity for Drug Rehabilitation in the Center	Level of Opinion					$\bar{x}$	S.D.	Results
9.The activity participation were on compulsory aspects	93 (23.3)	180 (45.0)	94 (23.5)	20 (5.0)	13 (3.3)	3.80	.96	Agree
1○. There were any monitoring on activity continuingly	143 (35.8)	211 (52.8)	33 (8.3)	2 (0.5)	11 (2.8)	4.18	.82	Agree
11. There are any consultation within an activities	184 (46.0)	192 (48.0)	14 (3.5)	4 (1.0)	6 (1.5)	4.36	.74	Extremely Agree

Within Table 4.5 it was found that the majority of sample had expressed their opinion on Activity for drug rehabilitation in the center on the relationship with other rehabilitations as overall was at a level as Agree (mean = 4.13) and as considering by the item orderly as mean from agree to disagree the sample had their opinion as (item 11.) There are any consultation within an was at a level as extremely agree (mean = 4.36) the subordinates were as (item 8.) Activity are made within the aims to resolve not only physical but also psychological aspects was at a level as extremely agree (mean = 4.22) (item 10.) There were any monitoring on activity continuingly was at a level as agree (mean = 4.18) (item 7.) There are any medical cure within the rehabilitation activity was at a level as agree (mean = 4.06) (item 9.) The activity participation were on compulsory aspects was at a level as agree (mean = 3.80)

E) Results of Activity procedure

Table 4.6 show the Number and Percentage **for** Drug Rehabilitation in the Center on Results of Activity procedure (n=400)

Drug Rehabilitation activity in the Center	Level of Opinion					$\overline{X}$	S.D.	Results
	Extremely Agree	Agree	Unsure	Disagree	Extremely Disagree			
E)Results of Activity procedure						4.46	.47	Extremely Agree
12. Activity are made within the long and continuing aspects to see concrete output	204 (51.0)	164 (41.0)	30 (7.5)	2 (0.5)	-	4.42	.65	Extremely Agree
13,.Conducting activity help to make strength both physical and mental aspects	180 (45.0)	198 (49.5)	22 (5.5)	-	-	4.39	.59	Extremely Agree
14.All activities encourage to logic and analysis thinking	225 (56.3)	150 (37.5)	21 (5.3)	4 (1.0)	-	4.49	.65	Extremely Agree
15.To participate in activities encourage you to response for your family, yourself and society	242 (60.5)	134 (33.5)	24 (6.0)	-	-	4.55	.61	Extremely Agree

Table 4.6 show the Number and Percentage **for** Drug Rehabilitation in the Center on Results of Activity procedure (n=400) (cont.)

Drug Rehabilitation activity in the Center	Level of Opinion					$\bar{x}$	S.D.	Results
16. After finishing all activities you feel love more love family and society	207 (51.8)	149 (37.3)	40 (10.0)	4 (1.0)	-	4.40	.71	Extremely Agree
17.To participate in activity help in life planning rightly and appropriately	229 (57.3)	150 (37.5)	21 (5.3)	-	-	4.52	.60	Extremely Agree

Within Table 4. 6, it was found that the majority of sample had expressed their opinion on activity for Drug Rehabilitation in the Center on results of activity procedure as overall was at a level as extremely agree (mean = 4.46) and as considering by the item orderly as mean from agree to disagree the sample had their opinion as (item 15.) To participate in activities encourage you to response for your family, yourself and society was at a level as extremely agree (mean = 4.55) the subordinates were as (item 17.) To participate in activity help in life planning rightly and appropriately was at a level as extremely agree (mean = 4.52)

(item 14.) All activities encourage to logic and analysis thinking was at a level as extremely agree (mean = 4.49)

(item 12.) Activity are made within the long and continuing aspects to see concrete output was at a level as extremely agree (mean = 4.42)

(item 16.) After finishing all activities you feel love more love family and society was at a level as extremely agree (mean = 4.40)

(item 13.) Conducting activity help to make strength both physical and mental aspects was at a level as extremely agree (mean = 4.39)

F).Results of activity for behavioral changes

Table 4.7 show the Number and Percentage **for** Drug Rehabilitation in the Center on Results of activity for behavioral changes
(n=400)

Drug Rehabilitation activity in the Center	Level of Opinion					$\overline{X}$	S.D.	Results
	Extremely Agree	Agree	Unsure	Disagree	Extremely Disagree			
F). Results of activity for behavioral changes						4.39	.42	Extremely Agree
18.Any activity help you to deeply understand on targets of life and self behavior	194 (48.5)	194 (48.5)	12 (3.0)	-	-	4.45	.556	Extremely Agree
19. Drug rehabilitation help to get more knowledge and skills such as communication, conflict resolution	177 (44.3)	203 (50.8)	20 (5.0)	-	-	4.39	.582	Extremely Agree
2๐. Content activity help to interest more on positive relationship with others	178 (44.5)	183 (45.8)	36 (9.0)	3 (0.8)	-	4.34	.671	Extremely Agree
21. Most activity help to concentrate on self development and positive changes	218 (54.5)	147 (36.8)	31 (7.8)	4 (1.0)	-	4.45	.681	Extremely Agree
22. The primary detention center allow you to choose any activities independently	190 (47.5)	171 (42.8)	24 (6.0)	12 (3.0)	3 (0.8)	4.33	.783	Extremely Agree

Within Table 4.7 , it was found that the majority of sample had expressed their opinion on activity for Drug Rehabilitation in the Center on results of activity for behavioral changes as overall was at a level as extremely agree (mean = 4.39) and as considering by the item orderly as mean from agree to disagree the sample had expressed their opinion as;

(item 18.) Any activities help to understand target of life and personal behaviors and (item 21.) Most activity help to concentrate on self development and positive changes was at a level as extremely agree (mean = 4.45) and the subordinates were as

(item 19.) Drug rehabilitation help to get more knowledge and skills such as communication, conflict resolution was at a level as extremely agree (mean = 4.39)

(item 20.) Content activity help to interest more on positive relationship with others was at a level as extremely agree (mean = 4.34)

(item 22.) The primary detention center allow you to choose any activities independently was at a level as extremely agree (mean = 4.33)

G). Need for more activities

Table 4.8 show the Number and Percentage **for** Drug Rehabilitation in the Center need for more activities

(n=400)

Drug Rehabilitation activity in the Center	Level of Opinion					$\bar{X}$	S.D.	Results
	Extremely Agree	Agree	Unsure	Disagree	Extremely Disagree			
H). Need for more activities						4.47	.427	Extremely Agree
23. You need any activities to allow in development of life skills	206 (51.5)	169 (42.3)	23 (5.8)	2 (0.5)	-	4.45	.63	Extremely Agree
24. Rehabilitation activity should be contributing in capacity building of career **life**	217 (54.3)	165 (41.2)	18 (4.5)	-	-	4.50	.58	Extremely Agree
25.You need any activity to improve ability for family and society acceptation	209 (52.3)	167 (41.8)	22 (5.5)	2 (0.5)	-	4.46	.62	Extremely Agree
26. You need independent to determine any activity by yourself	240 (60.0)	121 (30.3)	37 (9.3)	2 (0.5)	-	4.50	.68	Extremely Agree
27. Activity to contribute any good relation with other are to be needed	213 (53.3)	157 (39.3)	28 (7.0)	-	2 (0.5)	4.45	.67	Extremely Agree

Within Table 4. 8, it was found that the majority of sample had expressed their opinion on activity for Drug Rehabilitation in the Center need for more activities as overall was at a level as extremely agree (mean = 4.47) and as considering by the item orderly as mean from agree to disagree the sample had their opinion as

(item 24.) Rehabilitation activity should be contributing in capacity building of career life and (item 26.) You need independent to determine any activity by yourself was at a level as extremely agree (mean = 4.50) and the subordinates were as

(item 24.) 25. You need any activity to improve ability for family and society acceptation was at a level as extremely agree (mean = 4.46)

(item 24.) 23. You need any activities to allow in development of life skills was at a level as extremely agree (mean = 4.45)

(item 24.) 27. Activity to contribute any good relation with other are to be needed was at a level as extremely agree (mean = 4.45)

I). Appropriated with the activity management

Table 4.9 show the Number and Percentage for Drug Rehabilitation in the Center **on Appropriated with the activity management** (n=400)

Drug Rehabilitation activity in the Center	Level of Opinion					$\overline{X}$	S.D.	Results
	Extremely Agree	Agree	Unsure	Disagree	Extremely Disagree			
J). Appropriated with the activity management						4.27	.51	Extremely Agree
28. Table and period of time for any activities were appropriated	137 (34.3)	209 (52.4)	49 (12.3)	4 (1.0)	-	4.20	.68	Agree
29. Targets and aims of all activities can be understood clear	146 (36.5)	187 (46.8)	63 (15.8)	2 (0.5)	2 (0.5)	4.18	.75	Agree
3๐.You need more activities like these	211 (52.8)	133 (33.3)	43 (10.8)	9 (2.3)	4 (1.0)	4.35	.84	Extremely Agree
31. A lot of activities encouraged to make feel of guilty for yourself and family	198 (49.5)	153 (38.3)	43 (10.8)	6 (1.5)	-	4.36	.73	Extremely Agree

Within Table 4.9, it was found that the majority of sample had expressed their opinion on activity for Drug Rehabilitation in the Center on appropriated with the activity management as overall was at a level as extremely agree (mean = 4.27)

and as considering by the item orderly as mean from agree to disagree. The sample had their opinion as

(item 31.) A lot of activities encouraged to make feel of guilty for yourself and family as at a level as Extremely Agree (mean = 4.36) และthe subordinates were as

(item 30.) You need more activities like these was at a level as extremely agree (mean = 4.35)

(item 28.) Table and period of time for any activities were appropriated was at a level as agree (mean = 4.20)

(item 29.) Targets and aims of all activities can be understood clear was at a level as Agree (mean = 4.18)

K. Continuing benefits with social and family

Table 4.10 show the Number and Percentage **for** Drug Rehabilitation in the Center on Continuing benefits with social and family
(n=400)

Drug Rehabilitation activity in the Center	Level of Opinion					$\overline{X}$	S.D.	Results
	Extremely Agree	Agree	Unsure	Disagree	Extremely Disagree			
L). Continuing benefits with social and family						4.49	.47	Extremely Agree
32. You feel more value for your family after participating in activities	244 (61.0)	121 (30.3)	31 (7.8)	4 (1.0)	-	4.51	.68	Extremely Agree

Table 4.10 show the Number and Percentage **for** Drug Rehabilitation in the Center on Continuing benefits with social and family
(n=400)

Drug Rehabilitation activity in the Center	Level of Opinion					$\overline{x}$	S.D.	Results
33. Any activities that you took part in let you aware more for solving in wrongdoing and understand in family	201 (50.3)	183 (45.8)	16 (4.0)	-	-	4.46	.57	Extremely Agree
34. Your family and relatives had sound on your changing behavior after finishing from activities	213 (53.3)	152 (38.0)	35 (8.8)	-	-	4.44	.65	Extremely Agree
35. After finishing any activities, you feel to search for any chances to help and make benefits for society	238 (59.5)	147 (36.8)	15 (3.8)	-	-	4.56	.57	Extremely Agree

Within Table 4.10, it was found that the majority of sample had expressed their opinion on activity for Drug Rehabilitation in the Center on Continuing benefits with social and family as overall was at a level as extremely agree (mean = 4.49) and as considering by the item orderly as mean from an agree to disagree. The sample had their opinion as;

(item 35.) After finishing any activities, you feel to search for any chances to help and make benefits for society was at a level as extremely agree (mean = 4.56) and the subordinates were as;

(item 32.) You feel more value for your family after participating in activities was at a level as extremely agree (mean = 4.51)

(item 33.) Any activities that you took part in let you aware more for solving in wrongdoing and understand in family was at a level as extremely agree (mean = 4.46)

(item 34.) Your family and relatives had sound on your changing behavior after finishing from activities was at a level as extremely agree (mean = 4.44)

M) Development of rehabilitation activity

Table 4.11 show the Number and Percentage for Drug Rehabilitation in the Center on Development of rehabilitation activity (n=400)

Drug Rehabilitation activity in the Center	Level of Opinion					$\overline{X}$	S.D.	Results
	Extremely Agree	Agree	Unsure	Disagree	Extremely Disagree			
N) Development of rehabilitation activity						4.35	.46	Extremely Agree
36.Rehabilitation activity should be conducting continuingly	221 (55.3)	156 (39.0)	19 (4.8)	4 (1.0)	-	4.48	.64	Extremely Agree
37. Rehabilitation activity should be adding on internal self motivation	167 (41.8)	197 (49.3)	29 (7.3)	7 (1.8)	-	4.31	.68	Extremely Agree
38. Rehabilitation activity should be improving from results of evaluation conducting	140 (35.0)	194 (48.5)	60 (15.0)	4 (1.0)	2 (0.5)	4.17	.75	Agree
39. Rehabilitation activity should be developing in a lot of manners at the same time	190 (47.5)	169 (42.3)	41 (10.3)	-	-	4.37	.66	Extremely Agree

Table 4.11 show the Number and Percentage for Drug Rehabilitation in the Center on Development of rehabilitation activity (n=400) (cont.)

Drug Rehabilitation activity in the Center	Level of Opinion					$\bar{x}$	S.D.	Results
40. Rehabilitation activity should be allowing family in determining the process	192 (48.0)	175 (43.8)	27 (6.8)	6 (1.5)	-	4.38	.680	Extremely Agree
41. Rehabilitation activity should be assessing the success together from family and officials from the center	183 (45.8)	188 (47.0)	23 (5.8)	6 (1.5)	-	4.37	.66	Extremely Agree
42. Rehabilitation activity should be adjusting forms of activity through the group process with content	182 (45.5)	195 (48.8)	23 (5.7)	-	-	4.40	.60	Extremely Agree

Within Table 4.11, it was found that the majority of sample had expressed their opinion on activity for Drug Rehabilitation in the Center on Development of rehabilitation activity as overall was at a level as Extremely Agree (mean = 4.35) and as considering by the item orderly as mean from Agree to Disagree the sample had their opinion as

(item 36.) .Rehabilitation activity should be conducting continuingly was at a level as extremely agree (mean = 4.48) and the subordinates were as

(item 42.) Rehabilitation activity should be adjusting forms of activity through the group process with content was at a level as extremely agree (mean = 4.40)

(item 40.) Rehabilitation activity should be allowing family in determining the process was at a level as extremely agree (mean = 4.38)

(item 39.) Rehabilitation activity should be developing in a lot of manners at the same time was at a level as extremely agree (mean = 4.37)

(item 41.) Rehabilitation activity should be assessing the success together from family and officials from the center was at a level as extremely agree (mean = 4.37)

(item 37.) Rehabilitation activity should be adding on internal self motivation was at a level as extremely agree (mean = 4.31)

(item 38.) Rehabilitation activity should be improving from results of evaluation conducting was at a level as agree (mean = 4.17)

4. Hypothesis

1.4.1 Youth in the observation and protection center in Bangkok and its vicinity that had different sex getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

Table 4.12 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by Gender (n = 400)

Opinion on Activity for Drug Rehabilitation in the Center	Gender	Number	$\overline{X}$	S.D.	t	Sig.
An Overall	Male	361	4.3464	.36220	.569	.570
	Female	39	4.3123	.28023		
C. Activity Management	Male	361	4.1810	.55084	.670	.504
	Female	39	4.1197	.46665		
D). Relationship with other rehabilitation conducts	Male	361	4.1374	.56230	1.474	.141
	Female	39	4.0000	.45422		
E)Results of Activity procedure	Male	361	4.4524	.48045	-1.504	.139
	Female	39	4.5513	.37881		
F). Results of activity for behavioral changes	Male	361	4.4072	.41747	1.993*	.047
	Female	39	4.2667	.42633		
G). Need for more activities	Male	361	4.4598	.42317	-1.401	.162
	Female	39	4.5590	.38711		
H). Appropriated with the activity management	Male	361	4.2832	.51364	1.437	.151
	Female	39	4.1603	.44606		
I). Continuing benefits with social and family	Male	361	4.4917	.47133	-.351	.726
	Female	39	4.5192	.41113		
J) Development of rehabilitation activity	Male	361	4.3581	.46768	.461	.645
	Female	39	4.3223	.38739		

* as statistically significant as 0.05

Table 4.12 as the hypothesis testing, it was found that the sample both male and female had expressed their opinion on activity for Drug Rehabilitation in the center as overall not different as statistical significant (t-test = 0.569, Sig. = 0.570) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample both male and female had opinion on results of activity for behavioral changes different with as statistically significant as 0.05 (t-test = 1.993*, Sig. = 0.047) that coincident with the setting hypothesis. Meanwhile the others were not different as statistical significant that not consistent with the hypothesis testing.

1.4.2 Youth in the observation and protection center in Bangkok and its vicinity that had different age getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

Table 4.13 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by Age (n = 400)

Opinion on Activity for Drug Rehabilitation in the Center	Age	Number	$\overline{X}$	S.D.	t	Sig.
An Overall	Below16 Year	45	4.4130	.34141	1.406	.161
	more than 16 years	355	4.3342	.35604		
C. Activity Management	Below16 Year	45	4.3333	.40979	2.085*	.038
	more than 16 years	355	4.1549	.55484		
D). Relationship with other rehabilitation conducts	Below16 Year	45	4.1778	.51913	.691	.490
	more than 16 years	355	4.1172	.55826		
E)Results of Activity procedure	Below16 Year	45	4.4815	.56320	.250	.804
	more than 16 years	355	4.4596	.46005		

Table 4.13 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by Age (n = 400) (cont.)

Opinion on Activity for Drug Rehabilitation in the Center	Age	Number	$\overline{X}$	S.D.	t	Sig.
F). Results of activity for behavioral changes	Below16 Year	45	4.4711	.47512	1.317	.188
	more than 16 years	355	4.3837	.41205		
G). Need for more activities	Below16 Year	45	4.5111	.45638	.704	.482
	more than 16 years	355	4.4642	.41598		
ช). Appropriated with the activity management	Below16 Year	45	4.3667	.57801	1.193	.238
	more than 16 years	355	4.2592	.49832		
ฌ). Continuing benefits with social and family	Below16 Year	45	4.5278	.44665	.511	.610
	more than 16 years	355	4.4901	.46817		
ญ) Development of rehabilitation activity	Below16 Year	45	4.4349	.39823	1.243	.215
	more than 16 years	355	4.3445	.46694		

* as statistically significant as 0.05

Within Table 4.13 as the hypothesis testing, it was found that the sample who had different age had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (t-test = 1.406, Sig. = 0.161) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had different age had opinion on activity management

different with as statistically significant as 0.05 (t-test = 2.085*, Sig. = 0.038) that coincident with the setting hypothesis. As for the rest others were not different as statistical significant that not consistent with the hypothesis testing

1.4.3 Youth in the observation and protection center in Bangkok and its vicinity that had different geographical domicile getting any different opinions regarding the football gambling

Table 4.14 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by Domicile (n = 400)

Opinion on Activity for Drug Rehabilitation in the center	Domicile	Number	$\overline{X}$	S.D.	t	Sig.
An Overall	Bangkok and its vicinity	337	4.3329	.35601	-1.319	.188
	Others	63	4.3971	.34659		
C. Activity Management	Bangkok and its vicinity	337	4.1642	.56570	-.920	.358
	Others	63	4.2328	.39886		
D). Relationship with other rehabilitation conducts	Bangkok and its vicinity	337	4.0950	.57322	-2.441*	.015
	Others	63	4.2794	.40408		
E)Results of Activity procedure	Bangkok and its vicinity	337	4.4520	.47167	-.985	.325
	Others	63	4.5159	.47398		
F). Results of activity for behavioral changes	Bangkok and its vicinity	337	4.3840	.42015	-1.049	.295
	Others	63	4.4444	.41805		
G). Need for more activities	Bangkok and its vicinity	337	4.4677	.41338	-.203	.839
	Others	63	4.4794	.45937		

* as statistically significant as 0.05

Table 4.14 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by Domicile (n = 400) (cont.)

Opinion on Activity for Drug Rehabilitation in the center	Domicile	Number	$\overline{X}$	S.D.	t	Sig.
H). Appropriated with the activity management	Bangkok and its vicinity	337	4.2708	.51025	-.043	.965
	Others	63	4.2738	.50144		
I). Continuing benefits with social and family	Bangkok and its vicinity	337	4.4904	.45038	-.399	.690
	Others	63	4.5159	.54231		
J) Development of rehabilitation activity	Bangkok and its vicinity	337	4.3396	.46677	-1.520	.129
	Others	63	4.4354	.41723		

Table 4.14 as the hypothesis testing, it was found that the sample who had different domiciles had expressed their opinion on activity for Drug Rehabilitation in the Center as overall not different as statistical significant (t-test = -1.319, Sig. = 0.188) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had different domiciles had expressed their opinion on Relationship with other rehabilitation conducts different with as statistically significant as 0.05 (t-test = -2.441*, Sig. = 0.015) that coincident with the setting hypothesis. As for the rest others were not different as statistical significant that not consistent with the hypothesis testing

1.4.4 Youth in the observation and protection center in Bangkok and its vicinity that had different school based education getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

Table 4.15 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by Educational background (n = 400)

Opinion on Activity for Drug Rehabilitation in the center	Educational background	Number	$\overline{X}$	S.D.	F	Sig.
An Overall	Elementary School level	137	4.3751	.35526	5.264*	.006
	Junior Secondary School level	218	4.2972	.36020		
	Senior Secondary School level	45	4.4677	.28742		
	total	400	4.3430	.35489		
C. Activity Management	Elementary School level	137	4.2336	.43511	2.364	.095
	Junior Secondary School level	218	4.1216	.62372		
	Senior Secondary School level	45	4.2556	.37200		
	total	400	4.1750	.54299		
D). Relationship with other rehabilitation conducts	Elementary School level	137	4.1956	.49078	3.097	.052
	Junior Secondary School level	218	4.0615	.59868		
	Senior Secondary School level	45	4.2089	.47474		
	total	400	4.1240	.55371		
E)Results of Activity procedure	Elementary School level	137	4.5109	.45473	4.921*	.008
	Junior Secondary School level	218	4.4006	.49504		
	Senior Secondary School level	45	4.6111	.35176		
	total	400	4.4621	.47202		
F). Results of activity for behavioral changes	Elementary School level	137	4.3942	.46586	2.863	.058
	Junior Secondary School level	218	4.3651	.38673		
	Senior Secondary School level	45	4.5289	.40934		
	total	400	4.3935	.41988		
G). Need for more activities	Elementary School level	137	4.5358	.43246	5.092*	.007
	Junior Secondary School level	218	4.4092	.39851		
	Senior Secondary School level	45	4.5600	.44843		
	total	400	4.4695	.42037		

* as statistically significant as 0.05

Table 4.15 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by Educational background (n = 400) (cont.)

Opinion on Activity for Drug Rehabilitation in the center	Educational background	Number	$\overline{X}$	S.D.	F	Sig.
H). Appropriated with the activity management	Elementary School level	137	4.2847	.50837	2.533	.081
	Junior Secondary School level	218	4.2328	.51025		
	Senior Secondary School level	45	4.4167	.47970		
	total	400	4.2713	.50825		
I). Continuing benefits with social and family	Elementary School level	137	4.5091	.45919	1.416	.244
	Junior Secondary School level	218	4.4656	.47333		
	Senior Secondary School level	45	4.5889	.44003		
	total	400	4.4944	.46541		
J) Development of rehabilitation activity	Elementary School level	137	4.3368	.43577	5.813*	.003
	Junior Secondary School level	218	4.3211	.48223		
	Senior Secondary School level	45	4.5714	.36294		
	total	400	4.3546	.46016		

* as statistically significant as 0.05

Table 4.15 as the hypothesis testing, it was found that the sample who had different educational background had expressed their opinion on activity for Drug Rehabilitation in the Center as overall different with as statistically significant as 0.05 (F-test = 5.264*, Sig. = 0.006) that coincident with the setting hypothesis and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had different educational background had expressed their opinion on results of Activity procedure (F-test = 4.921*, Sig. =

0.008) Need for more activities (F-test = 5.092*, Sig. = 0.007)and development of rehabilitation activity (F-test = 5.813*, Sig. = 0.003) different with as statistically significant as 0.05 that coincident with the setting hypothesis. As for the rest others were not different as statistical significant that not consistent with the hypothesis testing

When we need to know that which groups as the sample had different educational background had different opinion by Duncan method, the result were as;

An Overall

Table 4.16 Compare the different opinion on activity management for rehabilitation against drug addict in the center as overall classified by educational background by Duncan method (n = 400)

Educational background	n	mean	Educational background		
			Junior Secondary School level	Elementary School level	Senior Secondary School level
Junior Secondary School level	218	4.2972	-		
Elementary School level	137	4.3751	-	-	
Senior Secondary School level	45	4.4677	*	-	-

* as statistically significant as 0.05

Within Table 4.16, it was found that the sample who had different educational background as Junior Secondary School level had expressed their opinion on activity for Drug Rehabilitation in the center as overall different from the sample who had different educational background as Senior Secondary School level as statistically significant as 0.05

On results of activity procedure

Table 4.17 Compare the different opinion on activity management for rehabilitation against drug addict in the center on Results of Activity procedure classified by Educational background by Duncan method (n = 400)

Educational background	n	mean	Educational background		
			Junior Secondary School level	Elementary School level	Senior Secondary School level
Junior Secondary School level	218	4.4006	-		
Elementary School level	137	4.5109	-	-	
Senior Secondary School level	45	4.6111	*	-	-

* as statistically significant as 0.05

Within Table 4.17, it was found that the sample who had different educational background as Junior Secondary School level had expressed their opinion on activity for Drug Rehabilitation in the Center on results of activity procedure different from the sample who had different educational background as Senior Secondary School level as statistically significant as 0.05

Need for more activities

Table 4.18 Compare the different opinion on activity management for rehabilitation against drug addict in the center on Need for more activities classified by educational background through Duncan method

(n = 400)

Educational background	n	mean	Educational background		
			Junior Secondary School level	Elementary School level	Senior Secondary School level
Junior Secondary School level	218	4.4092	-		
Elementary School level	137	4.5358	*	-	
Senior Secondary School level	45	4.5600	*	-	-

* as statistically significant as 0.05

Within Table 4.18, it was found that the sample who had different educational background as Junior Secondary School level had expressed their opinion on activity for Drug Rehabilitation in the Center need_for more activities different from the sample who had different educational background as elementary school level and educational background as Senior Secondary School level as statistically significant as 0.05

Development of rehabilitation activity

Table 4.19 Compare the different opinion on activity management for rehabilitation against drug addict in the center on Development of rehabilitation activity classified by Educational background through Duncan method (n = 400)

Educational background	n	mean	Educational background		
			Junior Secondary School level	Elementary School level	Senior Secondary School level
Junior Secondary School level	218	4.3211	-		
Elementary School level	137	4.3368	-	-	
Senior Secondary School level	45	4.5714	*	-	-

* as statistically significant as 0.05

Within Table 4.19, it was found that the sample who had different educational background as Junior Secondary School level had expressed their opinion on activity for Drug Rehabilitation in the Center on Development of rehabilitation activity different from_ the sample who had different educational background as Secondary School level as statistically significant as 0.05

1.4.5 Youth in the observation and protection center in Bangkok and its vicinity that had different marital status of parent getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

Table 4.20 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by Marital status of the parents
(n = 400)

Opinion on Activity for Drug Rehabilitation in the center	Marital status of the parents	Number	$\overline{X}$	S.D.	F	Sig.
An Overall	marriage and live together	123	4.3574	.36355	.177	.838
	divorced	191	4.3331	.37478		
	Father/mother died,Others	86	4.3446	.29495		
	total	400	4.3430	.35489		
C. Activity Management	marriage and live together	123	4.1369	.67785	.466	.628
	divorced	191	4.1972	.47674		
	Father/mother died,Others	86	4.1802	.46175		
	total	400	4.1750	.54299		
D). Relationship with other rehabilitation conducts	marriage and live together	123	4.0358	.65987	3.271*	.039
	divorced	191	4.1319	.50946		
	Father/mother died,Others	86	4.2326	.45901		
	total	400	4.1240	.55371		
E) Results of Activity procedure	marriage and live together	123	4.4512	.46151	.150	.861
	divorced	191	4.4756	.49292		
	Father/mother died,Others	86	4.4477	.44300		
	total	400	4.4621	.47202		
F). Results of activity for behavioral changes	marriage and live together	123	4.4341	.45283	1.352	.260
	divorced	191	4.3927	.41770		
	Father/mother died,Others	86	4.3372	.37102		
	total	400	4.3935	.41988		
G). Need for more activities	marriage and live together	123	4.4894	.43848	.632	.532
	divorced	191	4.4764	.41425		
	Father/mother died,Others	86	4.4256	.40907		
	total	400	4.4695	.42037		

* as statistically significant as 0.05

Table 4.20 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by Marital status of the parents
(n = 400) (cont.)

Opinion on Activity for Drug Rehabilitation in the center	Marital status of Parent	Number	$\overline{X}$	S.D.	F	Sig.
H). Appropriated with the activity management	marriage and live together	123	4.3455	.47856	2.739	.066
	divorced	191	4.2120	.56621		
	Father/mother died,Others	86	4.2965	.38827		
	total	400	4.2713	.50825		
I). Continuing benefits with social and family	marriage and live together	123	4.5589	.44593	2.120	.121
	divorced	191	4.4490	.49372		
	Father/mother died,Others	86	4.5029	.41920		
	total	400	4.4944	.46541		
J) Development of rehabilitation activity	marriage and live together	123	4.4077	.45312	1.182	.308
	divorced	191	4.3298	.49777		
	Father/mother died,Others	86	4.3339	.37356		
	total	400	4.3546	.46016		

* as statistically significant as 0.05

Table 4.20 as the hypothesis testing, it was found that the sample who had different Opinion on Activity for Opinion on Activity for Drug Rehabilitation in the center on Marital status of the parents had expressed their opinion on activity for Drug Rehabilitation in the Center as overall not different as statistical significant (F-test = 0.177, Sig. = 0.838) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had different Marital status of the parents had opinion on Relationship with other rehabilitation conducts(F-test = 3.271*, Sig. = 0.039) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing .When we would like to know which groups of

the sample who had different Marital status of the parents different opinion by Duncan method, It had revealed as follows;

Relationship with other rehabilitation conducts

Table 4.21 Compare the different opinion on activity management for rehabilitation against drug addict in the center on Relationship with other rehabilitation conducts by Marital status of the parents by Duncan method
(n = 400)

Marital status of the parents	n	mean	Marital status of the parents		
			marriage and live together	divorced	Father/mother died,Others
marriage and live together	123	4.0358	-		
divorced	191	4.1319	-	-	
Father/mother died,Others	86	4.2326	*	-	-

* as statistically significant as 0.05

Within Table 4.21, it was found that the sample who had different on Marital status of the parents, marriage and live together had expressed their opinion on activity for Drug Rehabilitation in the Center on Relationship with other rehabilitation conducts different from the sample who had different Father/mother died,Others as statistically significant as 0.05

1.4.6. Youth in the observation and protection center in Bangkok and its vicinity that had different income getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

Table 4.22 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by Current income

(n = 400)

Opinion on Activity for Drug Rehabilitation in the center		Number	$\overline{X}$	S.D.	t	Sig.
An Overall	10,000 – 30,000 Baht	311	4.3350	.35768	-.842	.400
	more than 30,000 Baht	89	4.3710	.34548		
C. Activity Management	10,000 – 30,000 Baht	311	4.2251	.41270	2.459*	.016
	more than 30,000 Baht	89	4.0000	.83485		
D).Relationship with other rehabilitation conducts	10,000 – 30,000 Baht	311	4.1254	.48230	.074	.941
	more than 30,000 Baht	89	4.1191	.75542		
E) Results of Activity procedure	10,000 – 30,000 Baht	311	4.4716	.45771	.701	.484
	more than 30,000 Baht	89	4.4288	.52035		
F).Results of activity for behavioral changes	10,000 – 30,000 Baht	311	4.3711	.42872	-2.006*	.046
	more than 30,000 Baht	89	4.4719	.37929		
G).Need for more activities	10,000 – 30,000 Baht	311	4.4341	.43314	-3.599*	.000
	more than 30,000 Baht	89	4.5933	.34700		
H). Appropriated with the activity management	10,000 – 30,000 Baht	311	4.2605	.53137	-.906	.366
	more than 30,000 Baht	89	4.3090	.41803		
I). Continuing benefits with social and family	10,000 – 30,000 Baht	311	4.4767	.47355	-1.423	.156
	more than 30,000 Baht	89	4.5562	.43261		
J) Development of rehabilitation activity	10,000 – 30,000 Baht	311	4.3160	.47657	-3.649*	.000
	more than 30,000 Baht	89	4.4896	.36920		

* as statistically significant as 0.05

Table 4.22 as the hypothesis testing, it was found that the sample who had different current income had expressed their opinion on activity for Drug Rehabilitation in the Center as overall not different as statistical significant (t-test = -0.842, Sig. = 0.400) that not consistent with the hypothesis testing and when considering an opinion on drug rehabilitation activity in the center in each items, it

was found that the sample who had different current income also had opinion on activity management (t-test = 2.459*, Sig. = 0.016) Results of activity for behavioral changes (t-test = -2.006*, Sig. = 0.046) Need for more activities (t-test = -3.599*, Sig. = 0.000) and Development of rehabilitation activity (t-test = -3.649*, Sig. = 0.000) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing

1.4.7 Youth in the observation and protection center in Bangkok and its vicinity that had different peer group getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

Table 4.23 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by associated peers
(n = 400)

Opinion on Activity for Drug Rehabilitation in the center	associated peers	Number	$\overline{X}$	S.D.	t	Sig.
An Overall	general and variety	317	4.3384	.35103	-.508	.612
	bad behavior, drug abused, gambling, and others	83	4.3607	.37092		
C. Activity Management	general and variety	317	4.1898	.56782	1.066	.287
	bad behavior, drug abused, gambling, and others	83	4.1185	.43362		
D).Relationship with other rehabilitation conducts	general and variety	317	4.1287	.57332	.332	.740
	bad behavior, drug abused, gambling, and others	83	4.1060	.47405		
E) Results of Activity procedure	general and variety	317	4.4679	.45636	.443	.658
	bad behavior, drug abused, gambling, and others	83	4.4398	.52998		

Table 4.23 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by associated peers
(n = 400) (cont.)

Opinion on Activity for Drug Rehabilitation in the center	associated peers	Number	$\overline{X}$	S.D.	t	Sig.
F).Results of activity for behavioral changes	general and variety	317	4.3804	.41885	-1.216	.225
	bad behavior, drug abused, gambling, and others	83	4.4434	.42259		
G).Need for more activities	general and variety	317	4.4637	.40297	-.537	.592
	bad behavior, drug abused, gambling, and others	83	4.4916	.48318		
H). Appropriated with the activity management	general and variety	317	4.2689	.49407	-.165	.869
	bad behavior, drug abused, gambling, and others	83	4.2801	.56228		
I). Continuing benefits with social and family	general and variety	317	4.4771	.43264	-1.235	.220
	bad behavior, drug abused, gambling, and others	83	4.5602	.57194		
J) Development of rehabilitation activity	general and variety	317	4.3308	.44748	-2.035*	.043
	bad behavior, drug abused, gambling, and others	83	4.4458	.49808		

* as statistically significant as 0.05

Table 4.23 as the hypothesis testing, it was found that the sample who had different associated peers had different opinion on activity for Drug Rehabilitation in the Center as overall not different as statistical significant (t-test = -0.508, Sig. = 0.612) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had different associated peers had different opinion on development of rehabilitation activity (t-test = -2.035*, Sig. = 0.043) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing

1.4.8 Youth in the observation and protection center in Bangkok and its vicinity that had different access to drug abuse getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

Table 4.24 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by Reasons for drug addict
(n = 400)

Opinion on Activity for Drug Rehabilitation in the center	Reasons for drug addict	Number	$\overline{X}$	S.D.	F	Sig.
An Overall C. Activity Management	Family problems, Others	71	4.3666	.28230	.944	.390
	Challengeable and motivated from their friends	102	4.3738	.31013		
	need to try	227	4.3219	.39196		
	total	400	4.3430	.35489		

Table 4.24 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by Reasons for drug addict
(n = 400) (cont.)

Opinion on Activity for Drug Rehabilitation in the center	Reasons for drug addict	Number	$\overline{X}$	S.D.	F	Sig.
D).Relationship with other rehabilitation conducts E) Results of Activity procedure	Family problems, Others	71	4.1995	.39200	.284	.753
	Challengeable and motivated from their friends	102	4.1977	.43735		
	need to try	227	4.1571	.62186		
	total	400	4.1750	.54299		
F).Results of activity for behavioral changes G).Need for more activities	Family problems, Others	71	4.1352	.49312	.021	.979
	Challengeable and motivated from their friends	102	4.1176	.44973		
	need to try	227	4.1233	.61279		
	total	400	4.1240	.55371		
H). Appropriated with the activity management I). Continuing benefits with social and family	Family problems, Others	71	4.5516	.41365	1.562	.211
	Challengeable and motivated from their friends	102	4.4461	.50962		
	need to try	227	4.4413	.47034		
	total	400	4.4621	.47202		
J) Development of rehabilitation activity	Family problems, Others	71	4.3183	.49751	1.520	.220
	Challengeable and motivated from their friends	102	4.4275	.34474		
	need to try	227	4.4018	.42322		
	total	400	4.3935	.41988		

* as statistically significant as 0.05

Table 4.24 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by Reasons for drug addict
(n = 400) (cont.)

Opinion on Activity for Drug Rehabilitation in the center	Reasons for drug addict	Number	$\overline{X}$	S.D.	F	Sig.
G). Need for more activities	Family problems, Others	71	4.4901	.37461	2.677	.070
	Challengeable and motivated from their friends	102	4.5431	.39339		
	need to try	227	4.4300	.44182		
	total	400	4.4695	.42037		
H). Appropriated with the activity management	Family problems, Others	71	4.2958	.45574	1.219	.297
	Challengeable and motivated from their friends	102	4.3284	.48362		
	need to try	227	4.2379	.53331		
	total	400	4.2713	.50825		
I). Continuing benefits with social and family	Family problems, Others	71	4.6021	.37459	3.516*	.031
	Challengeable and motivated from their friends	102	4.5294	.51137		
	need to try	227	4.4449	.46414		
	total	400	4.4944	.46541		
J) Development of rehabilitation activity	Family problems, Others	71	4.3400	.45392	.681	.507
	Challengeable and motivated from their friends	102	4.4006	.39600		
	need to try	227	4.3386	.48853		
	total	400	4.3546	.46016		

* as statistically significant as 0.05

Table 4.24 as the hypothesis testing, it was found that the sample who had any reasons for drug addict ต่างกันhad expressed their opinion on activity for Drug Rehabilitation in the Center as overall not different as statistical significant (F-test = 0.944, Sig. = 0.390) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was

found that the sample who had any reasons for drug addict had different opinion on continuing benefits with social and family (F-test = 3.516*, Sig. = 0.031) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing and if we would like to know which group of the sample who had any reasons for drug addict different opinion by Duncan method,

Continuing benefits with social and family

Table 4.25 Compare the different opinion on activity management for rehabilitation against drug addict in the center on continuing benefits with social and family classified by Marital status of the parents by Duncan method
(n = 400)

Reasons for drug addict	n	mean	Reasons for drug addict		
			need to try	Challengeable and motivated from their friends	Family problems, Others
need to try	227	4.4449	-		
Challengeable and motivated from their friends	102	4.5294	-	-	
Family problems, Others	71	4.6021	*	-	-

* as statistically significant as 0.05

Within Table 4.25, it was found that the sample who had any reasons for drug addict need to try had expressed their opinion on activity for Drug Rehabilitation in the center on Continuing benefits with social and family different from the sample who had different Family problems, Others as statistically significant as 0.05

1.4.9 Youth in the observation and protection center in Bangkok and its vicinity that had different reasons to consume drug getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

Table 4.26 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by sources of drug addict
(n = 400)

Opinion on Activity for Drug Rehabilitation in the center	sources of drug	Number	$\overline{X}$	S.D.	F	Sig.
An Overall	Purchase or getting from friends	171	4.3135	.33644	1.088	.354
	known persons	115	4.3479	.35528		
	Independent agents and others	61	4.4074	.35394		
	ever to be sale agent and also consumed	53	4.3539	.40886		
	total	400	4.3430	.35489		
C .Activity Management	Purchase or getting from friends	171	4.2086	.37096	1.699	.167
	known persons	115	4.2116	.46585		
	Independent agents and others	61	4.1339	.52777		
	ever to be sale agent and also consumed	53	4.0346	.99322		
	total	400	4.1750	.54299		

Table 4.26 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by sources of drug addict
(n = 400) (cont.)

Opinion on Activity for Drug Rehabilitation in the center	Sources of drug	Number	$\overline{X}$	S.D.	F	Sig.
D). Relationship with other rehabilitation conducts	Purchase or getting from friends	171	4.1322	.46332	1.179	.317
	known persons	115	4.1357	.45849		
	Independent agents and others	61	4.1869	.57372		
	ever to be sale agent and also consumed	53	4.0000	.88839		
	total	400	4.1240	.55371		
E) Results of Activity procedure	Purchase or getting from friends	171	4.4318	.42881	.597	.617
	known persons	115	4.4768	.47341		
	Independent agents and others	61	4.5219	.50779		
	ever to be sale agent and also consumed	53	4.4591	.55845		
	total	400	4.4621	.47202		
F). Results of activity for behavioral changes	Purchase or getting from friends	171	4.3602	.45068	1.045	.372
	known persons	115	4.4052	.37786		
	Independent agents and others	61	4.4689	.43648		
	ever to be sale agent and also consumed	53	4.3887	.38112		
	total	400	4.3935	.41988		

* as statistically significant as 0.05

Table 4.26 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by sources of drug addict
(n = 400) (cont.)

Opinion on Activity for Drug Rehabilitation in the center	Sources of drug	Number	$\overline{X}$	S.D.	F	Sig.
G). Need for more activities	Purchase or getting from friends	171	4.4281	.40077	2.603	.052
	known persons	115	4.4400	.47403		
	Independent agents and others	61	4.5541	.39563		
	ever to be sale agent and also consumed	53	4.5698	.36246		
	total	400	4.4695	.42037		
H). Appropriated with the activity management	Purchase or getting from friends	171	4.1930	.48435	4.257*	.006
	known persons	115	4.2630	.52340		
	Independent agents and others	61	4.3443	.49826		
	ever to be sale agent and also consumed	53	4.4575	.51594		
	total	400	4.2713	.50825		
I). Continuing benefits with social and family	Purchase or getting from friends	171	4.4415	.40974	1.701	.166
	known persons	115	4.5152	.54540		
	Independent agents and others	61	4.5902	.43309		
	ever to be sale agent and also consumed	53	4.5094	.47272		
	total	400	4.4944	.46541		

Table 4.26 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by sources of drug addict
(n = 400) (cont.)

Opinion on Activity for Drug Rehabilitation in the center	Sources of drug	Number	$\overline{X}$	S.D.	F	Sig.
J)Development of rehabilitation activity	Purchase or getting from friends	171	4.3124	.40732	1.883	.132
	known persons	115	4.3354	.51475		
	Independent agents and others	61	4.4590	.52948		
	ever to be sale agent and also consumed	53	4.4124	.39389		
	total	400	4.3546	.46016		

Table 4.26 as the hypothesis testing, it was found that the sample who had different Sources of drug had expressed their opinion on activity for Drug Rehabilitation in the Center as overall not different as statistical significant (F-test = 1.088, Sig. = 0.354) that not consistent with the hypothesis testing and when considering an opinion on drug rehabilitation activity in the center in each items, it was found that the sample who had different Sources of drug had different opinion on Appropriated with the activity management (F-test = 4.257*, Sig. = 0.006) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing and if we would like to know which group of the sample which group had different sources of drug different opinion by Duncan method, the results had revealed as follows;

Appropriated with the activity management

Table 4.27 Compare the different opinion on activity management for rehabilitation against drug addict in the center on Continuing benefits with social and family classified by Marital status of the parents by Duncan method
(n = 400)

Sources of drug	n	mean	Sources of drug			
			Purchase or getting from friends	known persons	Independent agents and others	ever to be sale agent and also consumed
Purchase or getting from friends	171	4.4281	-			
known persons	115	4.4400	-	-		
Independent agents and others	61	4.5541	-	-	-	
ever to be sale agent and also consumed	53	4.5698	*	-	-	-

* as statistically significant as 0.05

Within Table 4.27, it was found that the sample who had different Sources of drug on Purchase or getting from friends had expressed their opinion on activity for Drug Rehabilitation in the Center on appropriated with the activity management different from the sample who had ever to be sale agent and also consumed as statistically significant as 0.05

1.4.10. Youth in the observation and protection center in Bangkok and its vicinity that had different risk conditions to drug circle getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

Table 4.28 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by motivation or contribution for drug addict (n = 400)

Opinion on Activity for Drug Rehabilitation in the center	motivation or contribution for drug addict	Number	$\overline{X}$	S.D.	F	Sig.
An Overall	Curiosity or personal motivation	262	4.3490	.38277	2.082	.126
	associated peers	94	4.2907	.32831		
	Family and community , Others	44	4.4191	.18462		
	total	400	4.3430	.35489		
C. Activity Management	Curiosity or personal motivation	262	4.1514	.61465	.875	.418
	associated peers	94	4.2376	.36620		
	Family and community , Others	44	4.1818	.37496		
	total	400	4.1750	.54299		
D). Relationship with other rehabilitation conducts	Curiosity or personal motivation	262	4.1366	.59894	.336	.715
	associated peers	94	4.0830	.47511		
	Family and community , Others	44	4.1364	.41769		
	total	400	4.1240	.55371		
E) Results of Activity procedure	Curiosity or personal motivation	262	4.4650	.47584	10.219*	.000
	associated peers	94	4.3351	.46981		
	Family and community , Others	44	4.7159	.33830		
	total	400	4.4621	.47202		
F). Results of activity for behavioral changes	Curiosity or personal motivation	262	4.4412	.40398	12.364*	.000
	associated peers	94	4.2128	.45038		
	Family and community , Others	44	4.4955	.33268		
	total	400	4.3935	.41988		

Table 4.28 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by motivation or contribution for drug addict (n = 400) (cont.)

Opinion on Activity for Drug Rehabilitation in the center	motivation or contribution for drug addict	Number	$\overline{X}$	S.D.	F	Sig.
G). Need for more activities	Curiosity or personal motivation	262	4.4740	.41965	1.217	.297
	associated peers	94	4.4234	.45518		
	Family and community , Others	44	4.5409	.33572		
	total	400	4.4695	.42037		
H). Appropriated with the activity management	Curiosity or personal motivation	262	4.2739	.52125	.276	.759
	associated peers	94	4.2447	.45493		
	Family and community , Others	44	4.3125	.54486		
	total	400	4.2713	.50825		
I). Continuing benefits with social and family	Curiosity or personal motivation	262	4.4914	.47814	.404	.668
	associated peers	94	4.4761	.43544		
	Family and community , Others	44	4.5511	.45616		
	total	400	4.4944	.46541		
J) Development of rehabilitation activity	Curiosity or personal motivation	262	4.3588	.47318	.822	.441
	associated peers	94	4.3131	.45624		
	Family and community , Others	44	4.4188	.38407		
	total	400	4.3546	.46016		

Table 4.28 as the hypothesis testing, it was found that the sample who had different motivation or contribution for drug addict had expressed their opinion on activity for Drug Rehabilitation in the Center as overall not different as statistical

significant (F-test = 2.082, Sig. = 0.126) that not consistent with the hypothesis testing and when considering an opinion on drug rehabilitation activity in the center in each items, it was found that the sample who had different motivation or contribution for drug addict had different opinion on Results of Activity procedure (F-test = 10.219*, Sig. = 0.000) and results of activity for behavioral changes (F-test = 12.364*, Sig. = 0.000) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing and if we would like to know which group of the sample who had different motivation or contribution for drug by Duncan method, It had revealed as follows;

Results of Activity procedure

Table 4.29 Compare the different opinion on activity management for rehabilitation against drug addict in the center on Continuing benefits with social and family classified by motivation or contribution for drug addict by Duncan
(n = 400)

Motivation or contribution for drug addict	n	mean	Motivation or contribution for drug addict		
			associated peers	CURIOSITY OR PERSONAL MOTIVATION	Family and community , Others
associated peers	94	4.3351	-		
Curiosity or personal motivation	262	4.4650	-	-	
Family and community , Others	44	4.7159	*	*	-

* as statistically significant as 0.05

Within Table 4.29, it was found that the sample who had different motivation or contribution for drug addict, Family and community, Others had expressed their opinion on activity for Drug Rehabilitation in the Center on results of Activity procedure different from the sample who had different motivation or

contribution for drug addict, associated peers and curiosity or personal motivation as statistically significant as 0.05

Results of activity for behavioral changes

Table 4.30 Compare the different opinion on activity management for rehabilitation against drug addict in the center on results of activity for behavioral changes classified by motivation or contribution for drug addict by Duncan (n = 400)

Motivation or contribution for drug addict	n	mean	Motivation or contribution for drug addict		
			Associated peers	Curiosity or personal motivation	Family and community , Others
Associated peers	94	4.2128	-		
Curiosity or personal motivation	262	4.4412	-	-	
Family and community , Others	44	4.4955	*	-	-

* as statistically significant as 0.05

Within Table 4.30, it was found that the sample who had different motivation or contribution for drug addict, Family and community, Others had expressed their opinion on activity for drug rehabilitation in the center on results of activity for behavioral changes different from the sample who had different motivation or contribution for drug addict, associated peers as statistically significant as 0.05

1.4.11 Youth in the observation and protection center in Bangkok and its vicinity who had different access to drug rehabilitation getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

Table 4.31 Compare the opinion on Activity for Drug Rehabilitation in the Center classified by knowing or ever receive drug treatment

(n = 400)

	Knowing or ever receive drug treatment	Number	$\overline{X}$	S.D.	t	Sig.
An Overall	ever	138	4.4170	.32567	3.057*	.002
	Never	262	4.3041	.36394		
C .Activity Management	ever	138	4.2512	.44723	2.045*	.041
	Never	262	4.1349	.58399		
D). Relationship with other rehabilitation conducts	ever	138	4.2217	.50786	2.580*	.010
	Never	262	4.0725	.57062		
E) Results of Activity procedure	ever	138	4.5326	.47220	2.179*	.030
	Never	262	4.4249	.46856		
F). Results of activity for behavioral changes	ever	138	4.4261	.41139	1.127	.260
	Never	262	4.3763	.42405		
G). Need for more activities	ever	138	4.5014	.37063	1.167	.244
	Never	262	4.4527	.44409		
H). Appropriated with the activity management	ever	138	4.4384	.48969	4.910*	.000
	Never	262	4.1832	.49647		
I). Continuing benefits with social and family	ever	138	4.5960	.42215	3.334*	.001
	Never	262	4.4408	.47880		
J) Development of rehabilitation activity	ever	138	4.3685	.43728	.438	.662
	Never	262	4.3473	.47242		

* as statistically significant as 0.05

Table 4.31 as the hypothesis testing, it was found that the sample who had different Knowing or ever receive drug treatment had expressed their opinion on activity for Drug Rehabilitation in the center as overall different with as statistically significant as 0.05 (t-test = 3.057*, Sig. = 0.002) that coincident with the setting

hypothesis and when considering an opinion on drug rehabilitation activity in the center in each items, it was found that the sample who had different Knowing or ever receive drug treatment had different opinion on rehabilitation activity management (t-test = 2.045*, Sig. = 0.041) Relationship with other rehabilitation conducts (t-test = 2.580*, Sig. = 0.010) Results of Activity procedure (t-test = 2.179*, Sig. = 0.030) Appropriated with the activity management (t-test = 4.910*, Sig. = 0.000) including continuing benefits with social and family (t-test = 3.334*, Sig. = 0.001) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing.

CHAPTER V
DISCUSSION

The objective of this study was to analysis the activity development processes use for rehabilitation of the youth drug addicts in the Juvenile Observation and Protection Center, and factors related to activities. The sample consisted of four hundred youths in the juvenile observation, and its vicinity. The tool used to collect data was questionnaire, and SPSS was used to program determine ANOVA for statistical analysis.

The results of this study were revealed as follows,

1) Personal data; the majority of sample were male, age between 16-18 year old; separated parent; and family income were between 10,000 – 30,000 Baht. Additionally, they had a routine group of friends, and reasons for drugs consuming was to meet their need to try illegal drugs, received from their friends. This result had consistent with the study of many researches over many years has shown a clear relationship between the group of friends and the use and abuse of drugs (Kandel, Davies, Karus, & Yamaguchi, 1986; Latkin, Knowlton, Hoover, & Mandell, 1999).

2) Benefit evaluation of the benefits from activity in the Juvenile Observation and Protection Center, the majority of teens in the sample were in the risk juvenile group had expressed their assessment opinion for benefit at the highest level on the sports for combating the drug. This result had consistent with the study of Seearun LeampuiZ(2554B.E.) had focused the effects of motivating program for drug rehabilitation.

As while the drug addicted groups had revealed on assessment opinion on benefit at the high level in all activities obviously. This result had consistent with the study of Five Group Therapy Models TIP 41 describes five models of group therapy that are effective for substance abuse treatment: Psycho-educational Groups, skills

Development Groups, Cognitive–Behavioral/Problem-Solving Groups, Support Groups, Interpersonal Process Groups

3.) Factors affected for the rehabilitation activity were obviously gender, age, old domicile, educational levels, income, marital status of parent, reason to drug abuse including access to drug abuse. This result had consistent with the study of Stephan Quensel(2012) which related with a number of differences were found between the youth from different cities in relation to these concerns. Results indicate differences among the cities in terms of the youths' relationships with drug use/deviance/risky behavior and family structure, gender role, and peer group behavior. This suggests that the cultural meanings associated with family, gender role, peer group, educational levels, income, marital status of parent, and risk behavior influence deviant outcomes.

4) Within an overall aspect of activity, it was found that the majority of sample had expressed their opinion on benefit assessment from the rehabilitation activities against drug addict in the center as overall was at a level as high level (mean = 3.96). This result had consistent with the study of Ratchanee Leiuwleanthana (2542 B.E.) that focused on results of the group participation toward the motivation to drug rehabilitation and as considering by the item orderly as mean from agree to disagree the sample had their opinion as activity 4 athletics against drug addict was at a level as highest level (mean =4.21).

In addition, it was found that the majority of sample had expressed their opinion on benefit assessment from the rehabilitation activities against drug addict in the center as overall was at a level as high level (mean = 4.09) . Within the issue of activity management, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on activity management as overall was at a level as high level (mean = 4.18). This result had consistent with the study of **Sinyor, Brown, Rostant and Seraganian** (1982), in a study of the role of recreation in an addiction treatment facility, found that those who took part in a fitness program during treatment had greater abstinence rates and experienced healthy changes in their fitness levels. Although not being able to provide a definitive reason for the results.

A part from this, it was found that the majority of sample had expressed their opinion on Activity for drug rehabilitation in the center on the relationship with other rehabilitations as overall was at a level as high level (mean = 4.13). Within the issue of results of activity procedure, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on results of activity procedure as overall was at a level as highest level (mean = 4.46).Meanwhile the issue of results of activity for behavioral changes, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on results of activity for behavioral changes as overall was at a level as highest level (mean = 4.39). This result had consistent with the study of **Schaef (1987)** describes a process addiction as an addiction to relationships or to certain patterns of behavior. Within the issue of on need for more activities, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on need for more activities as overall was at a level as highest level (mean = 4.47). This result had consistent with the study of **Austin and Crawford (1991)** state that therapeutic recreation plays an important role in addiction treatment because of the emphasis on treating the whole person. Then the more activates should tend to focus on recreation within.

5) Within appropriated with the activity management, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on appropriated with the activity management as overall was at a level as highest level (mean = 4.27). As for the continuing benefits with social and family, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on continuing benefits with social and family as overall was at a level as highest level (mean = 4.49). Within the issue of development of rehabilitation activity, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on development of rehabilitation activity as overall was at a level as highest level (mean = 4.35). This result had consistent with the study of Hood,(1995) had focused addiction treatment programs are very intense and often overwhelming for the client who is trying to gain insight into themselves and their behaviors while experiencing withdrawal symptoms.

This process often consumes clients physically, emotionally and cognitively, leaving them with an overwhelming amount of information to digest and practice. The recreation therapist's role is to create a balance in their program to increase the overall effectiveness of treatment.

5.1 Hypothesis Testing

1. Youth in the observation and protection center in Bangkok and its vicinity that had different sex getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample both male and female had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (t-test = 0.569, Sig. = 0.570) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample both male and female had opinion on results of activity for behavioral changes different with as statistically significant as 0.05 (t-test = 1.993*, Sig. = 0.047) that coincident with the setting hypothesis. This result had consistent with the study of Austin and Crawford (1991) state that therapeutic recreation plays an important role in addiction treatment because of the emphasis on treating the whole person. It is the therapist's job to help recovering clients develop functional leisure activities and behaviors that are in tune and in balance with other lifestyle needs, and discover the good things in life that were missing in an intoxicated state. Meanwhile the others were not different as statistical significant that not consistent with the hypothesis testing.

2. Youth in the observation and protection center in Bangkok and its vicinity that had different age getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different age had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (t-test = 1.406, Sig. = 0.161) that not consistent with the hypothesis testing and when considering an opinion drug

rehabilitation activity in the center in each items, it was found that the sample who had different age had opinion on activity management different with as statistically significant as 0.05 (t-test = 2.085*, Sig. = 0.038) that coincident with the setting hypothesis. As for the rest others were not different as statistical significant that not consistent with the hypothesis testing

3. Youth in the observation and protection center in Bangkok and its vicinity that had different geographical domicile getting any different opinions regarding the football gambling

As for hypothesis testing, it was found that the sample who had different domiciles had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (t-test = -1.319, Sig. = 0.188) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had different domiciles had expressed their opinion on relationship with other rehabilitation conducts different with as statistically significant as 0.05 (t-test = -2.441*, Sig. = 0.015) that coincident with the setting hypothesis. This result had consistent with the study of Dusanee Chanpreecha(2541B.E.) was refered to the effectiveness of group therapy and social support towards knowledge attitudes and drug treatment. As for the rest others were not different as statistical significant that not consistent with the hypothesis testing.

4. Youth in the observation and protection center in Bangkok and its vicinity that had different school based education getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different educational background had expressed their opinion on activity for drug rehabilitation in the center as overall different with as statistically significant as 0.05 (F-test = 5.264*, Sig. = 0.006) that coincident with the setting hypothesis and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had different educational background had expressed their opinion on results of activity procedure (F-test = 4.921*, Sig. = 0.008), need for more activities (F-test = 5.092*, Sig. = 0.007)and development of rehabilitation activity (F-

test = 5.813*, Sig. = 0.003) different with as statistically significant as 0.05 that coincident with the setting hypothesis. This result had consistent with the study of Areerat Panthong(2535) which refluxed that the education background as related with social and family supports will help the drug addict can recovery and set up good attitudes in rehabilitation. As for the rest others were not different as statistical significant that not consistent with the hypothesis testing

In addition, it was found that the sample who had different educational background as junior secondary school level had expressed their opinion on activity for drug rehabilitation in the center on development of rehabilitation activity different from the sample who had different educational background as secondary school level as statistically significant as 0.05. This result had expressed that educational level will lead anyone to think more on the effects of any committing and tend to improve their way of life.

5. Youth in the observation and protection center in Bangkok and its vicinity that had different marital status of parent getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different opinion on activity for opinion on activity for drug rehabilitation in the center on marital status of the parents had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (F-test = 0.177, Sig. = 0.838) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had different marital status of the parents had opinion on relationship with other rehabilitation conducts(F-test = 3.271*, Sig. = 0.039) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing. This result had consistent with the study of The Social Justice Policy Group’s interim report (published in December 2006) implicated debt, economic dependency, failed education, drugs and alcohol addiction as contributors to family breakdown, which in turn is implicated so often in criminality.

Moreover, it was found that the sample who had different on marital status of the parents, marriage and live together had expressed their opinion on activity for drug rehabilitation in the center on relationship with other rehabilitation conducts different from the sample who had different Father/mother died, others as statistically significant as 0.05. This result had consistent with the study of Rodgers, B. and Prior, J.,(1998) In terms of early indicators of criminal behavior, children who experience family breakdown in all its forms are twice as likely to have behavioral problems, perform less well in school, suffer depression and turn to drugs, smoking and heavy drinking.

6. Youth in the observation and protection center in Bangkok and its vicinity that had different income getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different current income had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (t-test = -0.842, Sig. = 0.400) that not consistent with the hypothesis testing and when considering an opinion on drug rehabilitation activity in the center in each items, it was found that the sample who had different current income also had opinion on activity management (t-test = 2.459*, Sig. = 0.016) results of activity for behavioral changes (t-test = -2.006*, Sig. = 0.046) Need for more activities (t-test = -3.599*, Sig. = 0.000) and development of rehabilitation activity (t-test = -3.649*, Sig. = 0.000) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing.

7. Youth in the observation and protection center in Bangkok and its vicinity that had different peer group getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different associated peers had different opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (t-test = -0.508, Sig. = 0.612) that not consistent with the hypothesis testing and when considering an opinion drug

rehabilitation activity in the center in each items, it was found that the sample who had different associated peers had different opinion on development of rehabilitation activity (t-test = -2.035*, Sig. = 0.043) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing.

8. Youth in the observation and protection center in Bangkok and its vicinity that had different access to drug abuse getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different any reasons for drug addict had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (F-test = 0.944, Sig. = 0.390) that not consistent with the hypothesis testing. This result had consistent with the study of Health Canada(1991) Structured treatment characterizes services that are based on a formal assessment, the development, monitoring and review of individual plans for client care and a programme of medical treatment and/or counseling services. Some therapeutic programmes, in particular those delivered in a residential setting, are highly structured and involve an intensive schedule of individual and group-based educational, therapeutic and training sessions to promote rehabilitation. When considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had any reasons for drug addict had different opinion on continuing benefits with social and family (F-test = 3.516*, Sig. = 0.031) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing

A part from this, it was found that the sample who had any reasons for drug addict need to try had expressed their opinion on activity for drug rehabilitation in the center on continuing benefits with social and family different from the sample who had different Family problems, others as statistically significant as 0.05.

9. Youth in the observation and protection center in Bangkok and its vicinity that had different reasons to consume drug getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different sources of drug had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (F-test = 1.088, Sig. = 0.354) that not consistent with the hypothesis testing.

When considering an opinion on drug rehabilitation activity in the center in each items, it was found that the sample who had different sources of drug had different opinion on appropriated with the activity management (F-test = 4.257*, Sig. = 0.006) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing

A part from this, it was found that the sample who had different sources of drug on purchase or getting from friends had expressed their opinion on activity for drug rehabilitation in the center on appropriated with the activity management different from the sample who had ever to be sale agent and also consumed as statistically significant as 0.05.

10. Youth in the observation and protection center in Bangkok and its vicinity that had different risk conditions to drug circle getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different motivation or contribution for drug addict had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (F-test = 2.082, Sig. = 0.126) that not consistent with the hypothesis testing and when considering an opinion on drug rehabilitation activity in the center in each items, it was found that the sample who had different motivation or contribution for drug addict had different opinion on results of activity procedure (F-test = 10.219*, Sig. = 0.000) and results of activity for behavioral changes (F-test = 12.364*, Sig. = 0.000) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing. The sample who had different motivation or contribution for drug addict, family and community, others had expressed their opinion on activity for drug rehabilitation in the center on results of activity procedure

different from the sample who had different motivation or contribution for drug addict, associated peers and curiosity or personal motivation as statistically significant as 0.05

11. Youth in the observation and protection center in Bangkok and its vicinity who had different access to drug rehabilitation getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center.

As for hypothesis testing, it was found that the sample who had different knowing or ever receive drug treatment had expressed their opinion on activity for drug rehabilitation in the center as overall different with as statistically significant as 0.05 (t-test = 3.057*, Sig. = 0.002) that coincident with the setting hypothesis and when considering an opinion on drug rehabilitation activity in the center in each items, it was found that the sample who had different knowing or ever receive drug treatment had different opinion on rehabilitation activity management (t-test = 2.045*, Sig. = 0.041), relationship with other rehabilitation conducts (t-test = 2.580*, Sig. = 0.010), results of activity procedure (t-test = 2.179*, Sig. = 0.030), appropriated with the activity management (t-test = 4.910*, Sig. = 0.000) including continuing benefits with social and family (t-test = 3.334*, Sig. = 0.001) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing.

CHAPTER VI
SUMMARY AND RECOMMENDATION

6.1 Summary

The objective of this study was to analysis the activity development processes use for rehabilitation of the youth drug addicts in the Juvenile Observation and Protection Center, and factors related to activities. The sample consisted of four hundred youths in the juvenile observation, and its vicinity. The tool used to collect data was questionnaire, and SPSS was used to program determine ANOVA for statistical analysis.

The results of this study were revealed as follows,

1) Personal data; the majority of sample were male, age between 16-18 year old; separated parent; and family income were between 10,000 – 30,000 Baht. Additionally, they had a routine group of friends, and reasons for drugs consuming was to meet their need to try illegal drugs, received from their friends.

2) Benefit evaluation of the benefits from activity in the Juvenile Observation and Protection Center, the majority of teens in the sample were in the risk juvenile group had expressed their assessment opinion for benefit at the highest level on the sports for combating the drug. As while the drug addicted groups had revealed on assessment opinion on benefit at the high level in all activities obviously.

3.) Factors affected for the rehabilitation activity were obviously gender, age, old domicile, educational levels, income, marital status of parent, reason to drug abuse including access to drug abuse.

4) Within an overall aspect of activity, it was found that the majority of sample had expressed their opinion on benefit assessment from the rehabilitation activities against drug addict in the center as overall was at a level as high level (mean = 3.96) and as considering by the item orderly as mean from agree to disagree the sample had their opinion as activity 4 athletics against drug addict was at a level as

highest level (mean =4.21). In addition, it was found that the majority of sample had expressed their opinion on benefit assessment from the rehabilitation activities against drug addict in the center as overall was at a level as high level (mean = 4.09) . Within the issue of activity management, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on activity management as overall was at a level as high level (mean = 4.18).

A part from this, it was found that the majority of sample had expressed their opinion on Activity for drug rehabilitation in the center on the relationship with other rehabilitations as overall was at a level as high level (mean = 4.13). Within the issue of results of activity procedure, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on results of activity procedure as overall was at a level as highest level (mean = 4.46).Meanwhile the issue of results of activity for behavioral changes, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on results of activity for behavioral changes as overall was at a level as highest level (mean = 4.39). Within the issue of on need for more activities, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on need for more activities as overall was at a level as highest level (mean = 4.47).

5) Within appropriated with the activity management, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on appropriated with the activity management as overall was at a level as highest level (mean = 4.27). As for the continuing benefits with social and family, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on continuing benefits with social and family as overall was at a level as highest level (mean = 4.49). Within the issue of development of rehabilitation activity, it was found that the majority of sample had expressed their opinion on activity for drug rehabilitation in the center on development of rehabilitation activity as overall was at a level as highest level (mean = 4.35).

6.2 Hypothesis Testing

1) Youth in the observation and protection center in Bangkok and its vicinity that had different sex getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample both male and female had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (t-test = 0.569, Sig. = 0.570) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample both male and female had opinion on results of activity for behavioral changes different with as statistically significant as 0.05 (t-test = 1.993*, Sig. = 0.047) that coincident with the setting hypothesis. Meanwhile the others were not different as statistical significant that not consistent with the hypothesis testing.

2) Youth in the observation and protection center in Bangkok and its vicinity that had different age getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different age had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (t-test = 1.406, Sig. = 0.161) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had different age had opinion on activity management different with as statistically significant as 0.05 (t-test = 2.085*, Sig. = 0.038) that coincident with the setting hypothesis. As for the rest others were not different as statistical significant that not consistent with the hypothesis testing

3) Youth in the observation and protection center in Bangkok and its vicinity that had different geographical domicile getting any different opinions regarding the football gambling

As for hypothesis testing, it was found that the sample who had different domiciles had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (t-test = -1.319, Sig. = 0.188) that not

consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had different domiciles had expressed their opinion on relationship with other rehabilitation conducts different with as statistically significant as 0.05 (t-test = -2.441*, Sig. = 0.015) that coincident with the setting hypothesis. As for the rest others were not different as statistical significant that not consistent with the hypothesis testing

4) Youth in the observation and protection center in Bangkok and its vicinity that had different school based education getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different educational background had expressed their opinion on activity for drug rehabilitation in the center as overall different with as statistically significant as 0.05 (F-test = 5.264*, Sig. = 0.006) that coincident with the setting hypothesis and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had different educational background had expressed their opinion on results of Activity procedure (F-test = 4.921*, Sig. = 0.008) Need for more activities (F-test = 5.092*, Sig. = 0.007)and development of rehabilitation activity (F-test = 5.813*, Sig. = 0.003) different with as statistically significant as 0.05 that coincident with the setting hypothesis. As for the rest others were not different as statistical significant that not consistent with the hypothesis testing

In addition, it was found that the sample who had different educational background as junior secondary school level had expressed their opinion on activity for drug rehabilitation in the center on development of rehabilitation activity different from the sample who had different educational background as secondary school level as statistically significant as 0.05

5) Youth in the observation and protection center in Bangkok and its vicinity that had different marital status of parent getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different opinion on activity for opinion on activity for drug rehabilitation in the center on

marital status of the parents had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (F-test = 0.177, Sig. = 0.838) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had different marital status of the parents had opinion on relationship with other rehabilitation conducts(F-test = 3.271*, Sig. = 0.039) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing

Moreover, it was found that the sample who had different on marital status of the parents, marriage and live together had expressed their opinion on activity for drug rehabilitation in the center on relationship with other rehabilitation conducts different from the sample who had different Father/mother died, others as statistically significant as 0.05

6) Youth in the observation and protection center in Bangkok and its vicinity that had different income getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different current income had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (t-test = -0.842, Sig. = 0.400) that not consistent with the hypothesis testing and when considering an opinion on drug rehabilitation activity in the center in each items, it was found that the sample who had different current income also had opinion on activity management (t-test = 2.459*, Sig. = 0.016) results of activity for behavioral changes (t-test = -2.006*, Sig. = 0.046) Need for more activities (t-test = -3.599*, Sig. = 0.000) and development of rehabilitation activity (t-test = -3.649*, Sig. = 0.000) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing

7) Youth in the observation and protection center in Bangkok and its vicinity that had different peer group getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different associated peers had different opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (t-test = -0.508, Sig. = 0.612) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had different associated peers had different opinion on development of rehabilitation activity (t-test = -2.035*, Sig. = 0.043) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing

8) Youth in the observation and protection center in Bangkok and its vicinity that had different access to drug abuse getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different any reasons for drug addict had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (F-test = 0.944, Sig. = 0.390) that not consistent with the hypothesis testing and when considering an opinion drug rehabilitation activity in the center in each items, it was found that the sample who had any reasons for drug addict had different opinion on continuing benefits with social and family (F-test = 3.516*, Sig. = 0.031) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing

A part from this, it was found that the sample who had any reasons for drug addict need to try had expressed their opinion on activity for drug rehabilitation in the center on continuing benefits with social and family different from the sample who had different Family problems, others as statistically significant as 0.05

9) Youth in the observation and protection center in Bangkok and its vicinity that had different reasons to consume drug getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different sources of drug had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (F-test = 1.088, Sig. = 0.354) that not consistent with the hypothesis testing and when considering an opinion on drug rehabilitation activity in the center in each items, it was found that the sample who had different sources of drug had different opinion on appropriated with the activity management (F-test = 4.257*, Sig. = 0.006) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing

A part from this, it was found that the sample who had different sources of drug on purchase or getting from friends had expressed their opinion on activity for drug rehabilitation in the center on appropriated with the activity management different from the sample who had ever to be sale agent and also consumed as statistically significant as 0.05

10) Youth in the observation and protection center in Bangkok and its vicinity that had different risk conditions to drug circle getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center

As for hypothesis testing, it was found that the sample who had different motivation or contribution for drug addict had expressed their opinion on activity for drug rehabilitation in the center as overall not different as statistical significant (F-test = 2.082, Sig. = 0.126) that not consistent with the hypothesis testing and when considering an opinion on drug rehabilitation activity in the center in each items, it was found that the sample who had different motivation or contribution for drug addict had different opinion on results of activity procedure (F-test = 10.219*, Sig. = 0.000) and results of activity for behavioral changes (F-test = 12.364*, Sig. = 0.000) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not

consistent with the hypothesis testing. The sample who had different motivation or contribution for drug addict, family and community, others had expressed their opinion on activity for drug rehabilitation in the center on results of activity procedure different from the sample who had different motivation or contribution for drug addict, associated peers and curiosity or personal motivation as statistically significant as 0.05

11) Youth in the observation and protection center in Bangkok and its vicinity who had different access to drug rehabilitation getting any different opinions regarding the rehabilitation activities in the juvenile observation and protection center.

As for hypothesis testing, it was found that the sample who had different knowing or ever receive drug treatment had expressed their opinion on activity for drug rehabilitation in the center as overall different with as statistically significant as 0.05 (t-test = 3.057*, Sig. = 0.002) that coincident with the setting hypothesis and when considering an opinion on drug rehabilitation activity in the center in each items, it was found that the sample who had different knowing or ever receive drug treatment had different opinion on rehabilitation activity management (t-test = 2.045*, Sig. = 0.041), relationship with other rehabilitation conducts (t-test = 2.580*, Sig. = 0.010), results of activity procedure (t-test = 2.179*, Sig. = 0.030), appropriated with the activity management (t-test = 4.910*, Sig. = 0.000) including continuing benefits with social and family (t-test = 3.334*, Sig. = 0.001) different with as statistically significant as 0.05 that coincident with the setting hypothesis as while the rest of others had no different as statistical significant that not consistent with the hypothesis testing.

6.3 Recommendations

6.3.1 Recommendations from the study

1) The study found that the sample had expressed their opinion on the activity that likes most due to its valuable was the activity within the sport inside. Then the concerned agencies such as Department of Juvenile justice or the centers have to adjust or insert the content to chance sport design activities.

2) The study found that the sample had expressed their opinion to design activity with content to accommodate future plans.

3) The study found that the sample had expressed their opinion that they need the officials who tech or lead in activity insert or allow anytime consulting or having consultation program in the activities. Therefore, before teaching any activities, there should be coaching the officials on how to help or allow the risked groups or the drug addicted groups to consult on their problems or any matters that they need.

4) The study found that the sample had expressed their opinion on how they set up their life in the right way. Then, the official as a teacher should contribute content for life expectation in all activities and try to encourage anyone to fight for success in the future or take any success bibliographical books for them to read and insert in activity conduct as much as possible.

5) The study found that the sample had expressed their opinion that some activities were not met need for them due to the program had sat up from the formal officials. Then, in development of activity should be allowing the risked groups or the drug addicted groups to join as the youth participation in activity planning.

6.3.2 Recommendation for Future Research

1) In development of activities for drug rehabilitation, there should be studying need assessment for youth activities for using as essential data for activities design.

2) There should be conducting on vertical approach included quality research regarding impact of such activities for understanding the impact of activity toward the risked groups or the drug addicted groups.

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Internet resources

National treatment policies and strategies

National Drug Strategy, Australia

http://www.nationaldrugstrategy.gov.au

National Illicit Drug Strategy, Australia

http://www.health.gov.au/pubhlth/strateg/drugs/illicit/index.htm

Drug Strategy, Canada

http://www.hc-sc.gc.ca/hppb/cds-sca/cds/pdf/englishstrategy.pdf

http://www.hc-sc.gc.ca/hppb/cds-sca/cds/pdf/profile.pdf

(Profile substance abuse treatment and rehabilitation in Canada)

National Narcotics Control Council (CONACE), Chile

http://www.conace.cl

National Strategy, Spain

http://www.mir.es/pnd/presenta/html/national.htm

Consensus Statement on Drug Treatment, Finland

http://www.aka.fi/users/132/1623.cfm

Three-Year Plan to Fight against Drug Use and to Prevent

Dependence, France
http://www.drogues.gouv.fr/uk/index.html
Treatment and Rehabilitation in Hong Kong
http://www.info.gov.hk/ne/text/treat/index.htm
National Drug Strategy, Ireland
Drug Policy, Thailand
http://www.oncb.go.th/e1-frame02.htm
Home Office, Drugs Prevention, United Kingdom
http://www.homeoffice.gov.uk/atoz/drugs.htm
II.17
Developing a strategic framework for treatment
Government Strategy on Drug Abuse Treatment, United Kingdom
http://www.archive.official-documents.co.uk/document/cm39/3945/3945.htm
http://www.archive.official-documents.co.uk/document/cm39/3945/aim-3.htm
Changing the Conversation, A National Plan to Improve Substance
Abuse Treatment, United States
http://www.natxplan.org
Drug Strategies of European Countries, EMCDDA
http://www.emcdda.org/policy_law/national/strategies/strategies.shtml

APPENDIX

แบบสอบถาม (สำหรับเด็กและเยาวชน)

แนวทางพัฒนาการจัดกิจกรรมบำบัดฟื้นฟูด้านยาเสพติดในสถานแรกรับเด็กและเยาวชน

ตอนที่ 1 : ปัจจัยภูมิหลังหรือข้อมูลส่วนบุคคล

คำชี้แจง : โปรดทำเครื่องหมาย /ลงใน ( ) หรือหน้าข้อความ หรือเติมข้อความในช่องว่างที่ตรงกับข้อเท็จจริงเกี่ยวกับตัวท่านมากที่สุด

สำหรับผู้วิจัย

☐ 1 ☐ 2 ☐ 3

1). เพศ ☐ 4

( ) 1. ชาย ( ) 2. หญิง

2). อายุ ☐ 5

( ) 1. ต่ำกว่า 13 ปี ( ) 2. ระหว่าง 13-15 ปี

( ) 3. ระหว่าง 16-18 ปี ( ) 4. มากกว่า 18 ปี ขึ้นไป (โปรดระบุ).....

3). ภูมิลำเนาเดิม ☐ 6

( ) 1. เขตกรุงเทพมหานครและปริมณฑล ( ) 2. ภาคเหนือ

( ) 3. ภาคตะวันออกเฉียงเหนือ ( ) 4. ภาคใต้

( ) 5. อื่นๆ (โปรดระบุ).....

4). พื้นฐานการศึกษา ☐ 7

( ) 1. ไม่ได้เรียนในโรงเรียนมาก่อน ( ) 2. ชั้นประถมศึกษา

( ) 3. ชั้นมัธยมศึกษาตอนต้น(ม.1- 3) ( ) 4. ชั้นมัธยมศึกษาตอนปลาย(ม.4-6)

( ) 5. อื่นๆ (โปรดระบุ) .....

5). สถานภาพสมรสของบิดามารดาปัจจุบัน ☐ 8

( ) 1. สมรสถูกต้องและยังอยู่ด้วยกัน ( ) 2. บิดา/มารดา เสียชีวิต

( ) 3. ยังคงสภาพสมรส แต่แยกกันอยู่ เพราะเรื่องงานหรือความจำเป็นอื่นๆ

( ) 4. หย่าร้าง/แยกทางกัน

( ) 5. อื่น ๆ (ระบุ) .....

6). รายได้ปัจจุบัน / ต่อเดือน (รวมทั้งครอบครัว) ☐ 9

( ) 1. ระหว่าง 10,000 – 30,000 บาท ( ) 2. 30,000 – 50,000 บาท

( ) 3. 50,000 บาทขึ้นไป

7). เพื่อนที่ท่านคบหาสมาคมด้วยส่วนใหญ่ ☐ 10

( ) 1. เกเรและไม่สนใจเรียน ( ) 2. ทั่วไปและหลากหลาย

( ) 3. ใช้ยาเสพติดและเล่นการพนัน ( ) 4. อื่น ๆ (โปรดระบุ) .....

8). เหตุผลในการใช้ยาเสพติด ☐ 11

( ) 1. การมีปัญหาครอบครัว ( ) 2. ชอบความท้าทายและแรงจูงใจจากเพื่อนๆ

( ) 3. ต้องการการอยากรู้ อยากลอง ( ) 4. อื่น ๆ (โปรดระบุ) .....

9). ท่านหายาเสพติดได้จาก ☐ 12

( ) 1. ซื้อหรือได้จากเพื่อน ( ) 2. คนที่รู้จัก

( ) 3. ซื้อคนขายที่ไม่รู้จักเป็นส่วนตัว ( ) 4. เคยเป็นตัวแทนขายและเสพเอง

( ) 5. อื่น ๆ (โปรดระบุ) .....

10). สิ่งที่ชักจูงหรือทำให้ท่านอยากเสพยาเสพติด ☐ 13

( ) 1. การอยากรู้ อยากลองหรือแรงจูงใจส่วนตัว

( ) 2. เพื่อนที่คบหาสมาคม

( ) 3. ครอบครัวและชุมชนที่อยู่

( ) 4. อื่น ๆ (โปรดระบุ) .....

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11). ท่านรู้จักหรือเคยเข้ารับการบำบัดยาเสพติด ☐ 14

( ) 1. เคย ( ) 2.ไม่เคย

12) .หากเคยเข้ารับการบำบัด ผู้ที่พาไปบำบัด คือใคร ☐ 15

( ) 1. เพื่อนแนะนำหรือพาไปก่อน

( ) 2. ครอบครัวหรือเครือญาติ

( ) 3. องค์กร/มูลนิธิ/หน่วยงานราชการ

( ) 4. ทางอื่น ๆ (โปรดระบุ) .....

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ตอนที่ 2 : คำถามเกี่ยวกับการประเมินประโยชน์ที่ได้รับในกิจกรรมบำบัดฟื้นฟูด้านยาเสพติดในสถานแรกรับฯที่เข้าร่วม

คำชี้แจง : กรุณาพิจารณาข้อความต่อไปนี้ และทำเครื่องหมาย / ลงในช่องที่ตรงกับความเป็นจริงมากที่สุดเพียงข้อเดียว

ประโยชน์การจัดกิจกรรม บำบัด ฟื้นฟู ด้านยาเสพติดในสถานแรกรับฯ	มากที่สุด	มาก	ไม่แน่ใจ	น้อย	น้อยมาก	สำหรับผู้วิจัย
กิจกรรมเหล่านี้ กิจกรรมแต่ละกิจกรรมได้ประโยชน์สำหรับการแก้ไขฟื้นฟูความเสี่ยงในการติดยาเสพติด/การติดยาเสพติดระดับใด						
ก). สำหรับกลุ่มเสี่ยง (กลุ่มเสพซ้ำไป)						
กิจกรรมที่ 1 เรื่องการให้ความรู้เกี่ยวกับยบุหรี่ ยาเส้นและสุรา						☐ ๑๖
กิจกรรมที่ 2 เรื่องการให้ความรู้เกี่ยวกับยาบ้าและสารเสพติด						☐ ๑๗
กิจกรรมที่ 3 เรื่องการให้ความรู้เกี่ยวกับโรคเอดส์						☐ ๑๘
กิจกรรมที่ 4 เรื่อง เกมส์ ทีฬา ต้านยาเสพติด						☐ ๑๙
กิจกรรมที่ 5 เรื่อง ดนตรี สีสันแห่งชีวิต						☐ ๒๐
กิจกรรมที่ 6 เรื่องศีลปะใจ						☐ ๒1
กิจกรรมที่ 7 เรื่องทักษะการตัดสินใจ						☐ ๒๒
กิจกรรมที่ 8 เรื่องปฏิเสธอย่างไรไม่เสียเพื่อน						☐ ๒๓
กิจกรรมที่ 9 สิ่งที่มีค่าที่สุดสำหรับฉัน						☐ ๒๔
กิจกรรมที่ 10 รู้ไว้ไม่เสียประโยชน์						☐ ๒๕
ข). กลุ่มเสพ (กลุ่มเสี่ยงข้ามไป)						
กิจกรรมที่ 1 เรื่องผลกระทบอันยิ่งใหญ่						☐ ๒๖
กิจกรรมที่ 2 เรื่องตัวกระตุ้น						☐ ๒๗
กิจกรรมที่ 3 ป้องกันการเสพซ้ำ						☐ ๒๘
กิจกรรมที่ 4 เรื่องทักษะการตัดสินใจ						☐ ๒๙
กิจกรรมที่ 5 เรื่องทักษะการแก้ปัญหา						☐ ๓๐
กิจกรรมที่ 6 ทักษะการปฏิเสธ						☐ ๓๑
กิจกรรมที่ 7 เรื่องทักษะคลายเครียด						☐ ๓๒
กิจกรรมที่ 8 เรื่องการสังเสริมความภาคภูมิใจ						☐ ๓๓
กิจกรรมที่ 9 เรื่องข้ามสีทันตรสะท้อนดวงจิต						☐ ๓๔
กิจกรรมที่10 เรื่องการวางแผนชีวิต						☐ ๓๕

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ตอนที่ 3 : คำถามเกี่ยวกับการจัดกิจกรรมบำบัดฟื้นฟูด้านยาเสพติดในสถานแรกรับฯ

คำชี้แจง : กรุณาพิจารณาข้อความต่อไปนี้ และทำเครื่องหมาย / ลงในช่องที่ตรงกับความเป็นจริงมากที่สุดเพียงช่องเดียว

การจัดกิจกรรมบำบัดฟื้นฟูด้านยาเสพติดในสถานแรกรับฯ	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่แน่ใจ	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง	สำหรับผู้วิจัย
ด้านการจัดกิจกรรม ๑. กิจกรรมการบำบัดฟื้นฟูมีกิจกรรมหลากหลายที่เหมาะกับเด็กและเยาวชนแต่ละคนแต่ละคน						☐ ๓๖
๒. กิจกรรมการบำบัดที่จัดแสดงให้เห็นว่ามีความพร้อมในเรื่องอุปกรณ์การ สื่อน ครูผู้สอน						☐ ๓๗
๓.กิจกรรมช่วยเสริมการพัฒนาในด้านอื่นๆด้วย นอกเหนือจากเรื่องยาเสพติด						☐ ๓๘
๔. ที่ผ่านมา มีการประเมินผลกิจกรรมแต่ละอย่างและมีการปรับเปลี่ยนให้เหมาะสมกับแต่ละกลุ่มเรียน						☐ ๓๙
๕. ในการทำกิจกรรมแต่ละด้านมีเวลาที่เพียงพอ						☐ ๔๐
๖. กิจกรรมแต่ละอย่างมีเป้าหมายในการแก้ไขพฤติกรรมและมีการให้การปรึกษาประกอบ						☐ ๔๑
ด้านความสัมพันธ์กับการแก้ไขฟื้นฟูด้านอื่น ๗. มีการให้การรักษาทางยาพร้อมกับการจัดกิจกรรมการบำบัด						☐ ๔๒
๘. กิจกรรมเป็นการดำเนินการที่มีการนำมาใช้ร่วมกันแก้ไขทั้งด้านร่างกายและจิตใจ						☐ ๔๓
๙. การจัดกิจกรรมไม่ได้ให้ท่านเข้าร่วมโดยสมัครใจ						☐ ๔๔
๑๐. มีการติดตามผลของการจัดกิจกรรมอย่างต่อเนื่อง						☐ ๔๕
๑๑.ในการจัดกิจกรรมมีการให้คำปรึกษาร่วมในการทำกิจกรรม						☐ ๔๖

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ด้านผลลัพธ์ของการจัดกิจกรรม						
๑๒. กิจกรรมการช่วยบำบัดต้องดำเนินการที่ต่อเนื่องและยาวนานเพื่อให้เห็นผลรัดเจน						☐ ๔๗
๑๓. กิจกรรมที่จัดช่วยให้ท่านมีความเข้มแข็งทาง ร่างกายและจิตใจ						☐ ๔๘
๑๔. กิจกรรมทั้งหมดช่วยให้ท่านเสริมสร้างการรู้ จักคิดและตัดสินใจอย่างมีเหตุผล						☐ ๔๙
๑๕.การเข้าร่วมกิจกรรมช่วยให้ท่านกระตุ้นความรับผิดชอบต่อตนเอง ครอบครัว และสังคม						☐ ๕๐
๑๖. หลังการเข้าร่วมกิจกรรม กิจกรรมช่วยให้ท่านเกิดการรักตนเอง ครอบครัวและหมู่คณะ						☐ ๕๑
๑๗. การเข้าร่วมกิจกรรมช่วยให้ท่านสามารถวางแผนในการดำเนินชีวิตต่อไปได้อย่างถูกต้องและเหมาะสม						☐ ๕๒
การจัดกิจกรรมบำบัดฟื้นฟูด้านยาเสพติดในสถานแรกรับฯ	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่แน่ใจ	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง	สำหรับผู้วิจัย
ผลของกิจกรรมที่ช่วยปรับพฤติกรรม						
๑๘. กิจกรรมต่างๆช่วยให้ท่านเข้าใจอย่างถ่องแท้เกี่ยวกับเป้าหมายชีวิตและพฤติกรรมของตนเอง						☐ ๕๓
๑๙. กิจกรรมบำบัดยาเสพติดมีกิจกรรมที่ช่วยเสริมสร้างความรู้และทักษะในด้านต่างๆ ได้แก่ ด้านการสื่อสาร การแก้ปัญหาและการแก้ไขความขัดแย้ง						☐ ๕๔
๒๐. เนื้อหากิจกรรมช่วยให้ท่านเพิ่มความสนใจทางสังคมและการติดต่อสัมพันธ์ทางบวกกับบุคคลอื่น						☐ ๕๕
๒๑. กิจกรรมส่วนใหญ่ช่วยให้ท่านมีความตั้งใจมั่นที่จะพัฒนาตนเองให้เจริญงอกงามและเปลี่ยนแปลงไปในทิศทางบวก						☐ ๕๖
๒๒. สถานแรกรับฯเปิดโอกาสให้ท่านสามารถเลือกการเข้าร่วมกิจกรรมได้อย่างอิสระ						☐ ๕๗

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ด้านความต้องการกิจกรรมเพิ่ม						
๒๓. ท่านต้องการกิจกรรมที่มีโอกาสได้พัฒนาทักษะชีวิต						☐ ๕๘
๒๔. กิจกรรมบำบัดยาเสพติดควรเพิ่มการสนับสนุนการพัฒนาความรู้ความสามารถเกี่ยวกับการประกอบอาชีพ						☐ ๕๙
๒๕. ท่านต้องการกิจกรรมที่ช่วยเพิ่มความสามารถของท่านในการเป็นที่ยอมรับของครอบครัวและสังคม						☐ ๖๐
๒๖. ท่านต้องการมีอิสระในการกำหนดกิจกรรมด้วยตนเอง						☐ ๖๑
๒๗. ท่านต้องการกิจกรรมที่ช่วยให้ท่านมีสัมพันธภาพที่ดีกับผู้อื่น						☐ ๖๒
ด้านความเหมาะสมในการจัดกิจกรรม						
๒๘. ช่วงเวลาและตารางการจัดกิจกรรมมีความเหมาะสม						☐ ๖๓
๒๙. ท่านไม่มีปัญหาในเรื่องความเข้าใจในเป้าหมายและวัตถุประสงค์ของแต่ละกิจกรรม						☐ ๖๔
๓๐. ท่านต้องการให้มีกิจกรรมลักษณะนี้เพิ่มมากขึ้น						☐ ๖๕
๓๑. กิจกรรมหลายอย่างทำให้ท่านรู้สึกผิดต่อตนเอง และครอบครัว						☐ ๖๖
ด้านประโยชน์ต่อสังคม และครอบครัว						
๓๒. ท่านรู้สึกมีค่าต่อครอบครัวหลังเข้าร่วมกิจกรรม						☐ ๖๗
๓๓. กิจกรรมที่ท่านเข้าร่วมทำให้ท่านรู้สึกว่าต้องแก้ไขในสิ่งที่ผิดและรักเข้าใจครอบครัวมากขึ้น						☐ ๖๘
๓๔. ครอบครัวและญาติของท่านเห็นความเปลี่ยนแปลงหลังจากท่านเข้าร่วมกิจกรรม						☐ ๖๙
๓๕. เมื่อผ่านกิจกรรมต่างๆแล้ว ท่านเกิดความรู้สึกว่าต้องหาโอกาสช่วยเหลือและทำประโยชน์ที่ดีแก่สังคมบ้าง						☐ ๗๐

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การจัดกิจกรรมบำบัดฟื้นฟูด้านยาเสพติดในสถานแรกรับฯ	เห็นด้วยอย่างยิ่ง	เห็นด้วย	ไม่แน่ใจ	ไม่เห็นด้วย	ไม่เห็นด้วยอย่างยิ่ง	สำหรับผู้วิจัย
แนวทางการพัฒนากิจกรรมเพื่อการบำบัดฟื้นฟู ๓๖. กิจกรรมในการฟื้นฟูฯควรดำเนินการต่อเนื่อง						☐ ๗๑
๓๗. กิจกรรมฟื้นฟูฯควรเพิ่มในด้านแรงจูงใจภายในตัวท่าน						☐ ๗๒
๓๘. ท่านคิดว่ากิจกรรมในการฟื้นฟูฯควรปรับปรุงจากการประเมินความพึงพอใจ						☐ ๗๓
๓๙. กิจกรรมในการฟื้นฟูฯควรพัฒนาเน้นการแก้ไขหลายอย่างพร้อมกัน						☐ ๗๔
๔๐. กิจกรรมในการฟื้นฟูฯควรให้ครอบครัวมีส่วนร่วมในการกำหนดขั้นตอนในการจัดกิจกรรมฟื้นฟูบำบัดยาเสพติด						☐ ๗๕
๔๑. กิจกรรมในการฟื้นฟูฯควรมีการประเมินผลสำเร็จร่วมกันทั้งครอบครัวและเจ้าหน้าที่จากสถานแรกรับ						☐ 7๖
๔๒. กิจกรรมในการฟื้นฟูฯควรมีการปรับรูปแบบของกิจกรรมโดยใช้กิจกรรมกลุ่มมาร่วมกับเนื้อหาการสอน						☐ 7๗

4. คำถามปลายเปิด

กรุณาตอบคำถามเหล่านี้ตามความเป็นจริงมากที่สุดเกี่ยวกับตัวท่าน

3.1 ท่านเห็นว่าการจัดกิจกรรมบำบัดฟื้นฟูด้านยาเสพติดในสถานแรกรับฯเป็นอย่างไร ? (มีความเหมาะสม ยังต้องปรับปรุง หรือไม่ได้ผลเท่าที่ควร ไม่สามารถทำให้ท่านปรับเปลี่ยนพฤติกรรมได้ หรือช่วยให้ท่านเกิดการจูงใจได้ระหนักหรือยิ่งดี ฯลฯ)

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3.2 สิ่งที่ท่านได้การจัดกิจกรรมบำบัดฟื้นฟูด้านยาเสพติดในสถานแรกรับฯ มีความเหมาะสมหรือไม่มีความเหมาะสม ท่านเห็นว่ามีอะไรบ้าง และมีความเหมาะสมหรือไม่เหมาะสมอย่างไร ?

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3.3 ท่านคิดว่าการพัฒนาการจัดกิจกรรมบำบัดฟื้นฟูด้านยาเสพติดในสถานแรกรับควรจะทำอย่างไร เพราะเหตุใด

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3.4 ความคิดเห็นอื่น ๆ (ถ้ามี)

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BIOGRAPHY

NAME	Miss Thidarat Aranyasot
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