INTRODUCTION
CHAPTER I

INTRODUCTION

A GENERAL BACKGROUND TO DRUG PROBLEM

Drug problem has become so pervasive that it poses a great challenge to people all over the world. A million people die every year because of smoking, drinking and illicit drug use. The fact remains that between 3-4 percent of the world population still regularly consumes illegal substances and that the number of countries affected continues to grow; that intravenous drug use is still one of the leading causes of the spread of AIDS with devastating consequences across the globe among young people and that criminal organizations have no scruples in taking advantage of globalization and technological advances in transport and telecommunications.

Drugs continue to damage and indeed destroy human lives. The costs associated with their use continue to impose a heavy burden on the social infrastructure of numerous countries, whether developed or developing. The valuable human and financial resources continue to be diverted away from productive activities, which are essential for development and prosperity. Drug trafficking also continues to ferment corruption, one of the most formidable obstacles to good governance.

Kofi Annan, (1999)

The devastating impact of drug abuse by young students appears very familiar today. This problem can largely be attributed to a strategy, which has ignored the medical and social aspects of the problem and has instead almost exclusively law enforcement solution. Drugs affect the nervous system, brain, lungs, psychomotor skills and mental health of a person. There are basically
three approaches to dealing with the drug problem try harder, get tough and get soft. The first proposes continuing with more-or-less the present system of restricting the use of “control substances” by a combination of education, medical provision, miscellaneous taxation, and occasional criminal sanctions for unauthorized distribution and use. Despite repeated failures, it is believed (or hoped) that improvements in the system can be made and the problem can be contained.

The second approach proposes “cracking down” on drugs, eliminating the problem “once for all”. The rhetoric (though not the practice) of the so-called “war on drugs” falls in this camp. Greater police power and tougher sentencing, it is claimed, will put all the dealers behind bars and save our children from the menace of illicit drugs.

The third approach proposes legalizing the sale of drugs across the board, in the belief that this will save the problem. It’s not the drug that’s the menace, it’s the law against them if we didn’t have the laws, and we wouldn’t have a problem.

Hence there have always been drug problems, but they were seldom, if ever, menacing before. And there have been diverse laws and exhortations against the misuse of drugs since the beginning of civilization, but there have never been so many laws and regulations as there are today. There was never a golden age of pure substance innocence; yet we did at least enjoy a sheltered childhood, to which we can never return. The genie, to switch metaphors, is not of the bottle.

It was during the nineteenth century, a period of rapidly increasing prosperity that drug addiction started to become a major social problem both in England and America. The proliferation of patent medicines and opiates like laudanum and paregoric, and an amazingly complacent and liberal approach to
the prescribing of morphine by the new medical profession, brought addiction to
the masses and the opium drunkard to the attention of both newspaper
columnists and social reformers. The pendulum swung back. New regulation
reduced the availability of the opiates, and of cocaine, and induced a greater
degree of responsibility among doctors and pharmacists. This was instrumental
in curing the immediate epidemic and in keeping lid on the problem until after
the Second World War.

In the twentieth century, as rising prosperity introduced even more potent
preparations to wider market, artificial drugs like PCP and LSD began to be
manufactured and distributed among new categories of users. The so-called
problem is the growing incidence of HIV/AIDS cases amongst injecting drug
destroying their productive life and seriously impairing the social and economic

   Most of the time, governments wish to restrict, control or eradicate the
abuse of drugs within their own territories. How do they attempt to do this? The
answer varies from country to country, some are strict, some are less strict;
some are sympathetic to users, some less so; some are more consistent, some
less. In the Third World especially, corruption is rife. In Europe, actual
corruption is comparatively rare; but inadequate enforcement of existing law is
common. In Netherlands, for instance, laxity to the point of an almost complete
failure to prosecute has become official policy, what is misleadingly known as
decriminalization. By contrast, the fact of the Orient is stern; on the Pacific rim,
the penalty prescribed for drug trafficking is often death, though performance
seldom matches the promise, with the abandonment of the rule of law and the
provisions of the constitution, to downright with a moderate, civilized and
occasional consistent policy on drug control in the United Kingdom and
perhaps that is why the problem is less pressing here than elsewhere. Specifically then, how have successive British governments attempted to deal with the drug problem? Partly by taxation or excise duty (in the case of alcohol; and tobacco); partly by regulation (in the case of prescription drugs) partly by decriminalization (in the case of illicit drugs including marijuana); partly by medical treatment (especially for opiate and cocaine addiction—and of course for alcoholism); and partly by education and propaganda (both in the schools and in the media).

It would be unfair to accuse government of dogmatic adherence to a single strategy, since official policy has been characterized by a pragmatic willingness to try a little of everything; but at the same time it is arguable that this plethora of approaches has itself contributed to the scale of the problem and the difficulty of solution. Perhaps it has not been a total failure, but it has certainly not proved to be a complete success. The problem have existed for so many years despite hard work of government as well as private organizations to combat this evil. A number of addicts have increasingly grown day by day. The most worrying scenario of this problem is that it spreads to schools where students, the great source of human power & future citizens and hope of a nation shall become its victims.

Even with drugs like heroin, where overdosing is common, the death rate is likely to be dominated by the long-term damage resulting from repetition, just as with tobacco. The difficulty here is that it is very hard to reliably associate long-term medical or psychological problems with the antecedent drug use. It took centuries of widespread use and the collection of immense amounts of data before the dangers of tobacco smoking were recognized and quantified. Comparable data for illegal drugs do not even begin to exist; and there is no mechanism by which it could be gathered; in a regime in which the use of such
Introduction
drugs is banned, large-scale adequately controlled experiments or survey are impracticable.

It is certainly true that many of the presently observed risks of drug taking are simply the result of the activity's illegality. There can be no guarantee of purity, strength, consistency, quality or safety of products bought in the black market. Potentially dangerous impurities and uncertain doses are the rule, not the exception, add to that the appalling circumstances in which addicts “shoot up” and their understandable unwillingness to seek help for any resulting medical problems and we can see the force of the argument for legalization. But it ought to be realized that there are similar if lesser risks intrinsic to the activity Itself; even if heroin is legalized there will still be overdose deaths, as with barbiturates today.

By the very nature of the problem, the dangers are frightening and unknown, and may indeed prove catastrophic. It is true that the introduction of new drugs in medicine faces much the same difficulties; but there are clear benefits to offset the risks, and usage can be more easily controlled and monitored.

IMPACT OF DRUG ADDICTION

There’re certain features of drug addiction that differentiate drugs and make some drugs more likely than others to be widely used for non-therapeutic purpose. Most obviously different classes of drugs have different effect on the nervous system. Some produce stimulation and feeling of excitement, some are used as painkillers and often produce tranquility and drowsiness. Many drugs produce stronger effects when first used, however, the body slowly accommodates to the drug and develops tolerance so that much larger doses are
required to produce the effect originally produced by the same drug. The drug, if not taken regularly will lead to withdrawal symptoms. Certain types of drugs induce tolerance and physiological dependence as well as psychological craving, others produce tolerance without physical dependence and yet others produce neither physical nor psychological dependence but may be sought for psychic effects. The characteristics of drug addiction depend on the amount of drug taken, route of the administration, chemical structure and on the social definition of the circumstance of the situation in which the drug is used. Part of the increase is drug abuse in related to great scientific advancement in the field of pharmacology in the last 50 years cover the whole spectrum of human behaviour. We have pills to sedate us, we have drugs to sleep. Beside these, we have drugs to enhance our ability to function and on the contrary to carry our minds out of real in of reality into loneliness. It is, however, important to keep a proper use of drugs, which both solve and create problems. Given the sophistication of drugs and their positive use achieves a high level of acceptance.

Availability of drugs is one reason believed to be the cause of drug addiction. One cannot be addicted to something, which he has not experienced. It is suggested that if drugs are banned addiction will cease but this is too simple a solution to work (Wills, 1974). One way is to ban substances. When, once, the properties of a substance are known it becomes available to the vulnerable population. The new discovery of drugs no doubt has brought relief to mankind but it can have harmful effects if drugs are not used judiciously. Self-medication and easy availability of drugs without prescription have further worsened the position.
PROBLEM OF DRUG ADDICTION IN THAILAND

Drug addiction in Thailand since 1950, has been regarded as a significant public health problem by the authorities. Opium abuse persists and heroin addiction is spreading. Heroin abuse is prevalent both in rural and urban areas. In 1958, Thailand proclaimed the abolition of opium smoking and selling throughout the kingdom by 1959. All opium-smoking utensils were seized and burnt. The narcotics control Act was promulgated in 1976. As a result, the Narcotics Control Board and the Office of Narcotics Control Board was established. The Office of Narcotics Control Board (ONCB) is an agency under the office of the Prime Minister acting as the central coordinating body for narcotics prevention and suppression, as well as for carrying out assignments of the Board.

Thailand is one of many countries where problems of narcotics drug exist. Difficulty was experienced in giving the exact number of current drug addicts in Thailand. But this was estimated from the number of drug addicts, who voluntarily apply for treatment both at private and government treatment centres that have been increasing. There has been an increase in arrests of narcotic offenders. The number of narcotic offenders in 1977 was 11,803. In 1985, it has increased to 34,618. There was a corresponding increase in the amount of narcotics seized. In 1977, 120.67 Kg. of opium was seized. By 1985, it had increased to 1,450.28 Kg. The figure for heroin in the corresponding period was 380.89 Kg. compared with 1,282.1 Kg. In 1985 Thersteerasukdi, (1987) a total 43,914 opiate addicts were admitted for treatment Office of the Narcotics Control Board (1988).

Chupikulchhai (1990) studied “The increasing number of narcotic drug abuse of adolescents in slums at Bangkok, Thailand”. It was found that
boys, who were educated under VI, and with average age 16, had the highest number of narcotic drug abusers. They started to use narcotic drugs at average age between 11-16.

Drug addiction of adolescents is a serious problem, which affects not only a user but also others. It directly affects oneself, parents, siblings, close friends and workers. Even though several preventive measures have been initiated to minimize/eliminate the problem of drug addiction not much progress has been made either in prevention or minimizing the malady. The consumption of drug is a common feature both during occasions of joy and sorrow. The search for pleasure and fun, attempts at driving out pain and displeasure, the illusion of promoting one’s self-esteem, peer group interaction are the important factors, which lead a person towards consuming drugs. The factors associated with drugs and the extent to which it affects the life of an individual vary according to his/her social class, sex and region. Drugs appear to be a great threat to those of lower economic and social strata because these are generally more vulnerable than others.

Moreover, the problems encountered by women seem to be more alarming than those encountered by men. It is a popular belief that the narcotics are dangerous to us but this no more remains the basic concept, as majorities of people are already neck deep in addiction to narcotic drugs. The main factor is its easy accessibility through agents, which more often misguide the people/students knowing very well the strict punishments or provision of law. The narcotic drug agents have formed a network of their trade all over the nation and in all directions that infiltrate, penetrate, insinuate in different ways making it difficult for officials to follow them.

A survey by Thailand Development Research Institute (2000) made an analysis of the number of drug users different types of drugs in 2000 and were
supported to use the same 2002. It is likely that Solvent users will increase from 500,000 + to 700,000 +, Marijuana users will increase from 400,000 + to 600,000 + and Methamphetamine users will increase from 2,400,000 + to 4,000,000 +. Heroin users will increase from 200,000 + to 400,000 + and Opium users will increase from 80,000 + to 90,000 + considering the total 20,790,000 + persons in the year 2002 as given in the table 1.1.

**Table 1.1**

**Narcotic Drug users in 2000, 2002** (Survey by TDRI)

<table>
<thead>
<tr>
<th>Drugs</th>
<th>Number of Drug User</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2000</td>
</tr>
<tr>
<td>Solvent</td>
<td>500,000+</td>
</tr>
<tr>
<td>Marijuana</td>
<td>2,400,000+</td>
</tr>
<tr>
<td>Methamphetamine</td>
<td>400,000+</td>
</tr>
<tr>
<td>Heroin</td>
<td>200,000+</td>
</tr>
<tr>
<td>Opium</td>
<td>80,000+</td>
</tr>
<tr>
<td>Tobacco</td>
<td>3,580,000+</td>
</tr>
<tr>
<td>Total</td>
<td>15,580,000+ persons</td>
</tr>
</tbody>
</table>

(TRDI = Thailand Development Research Institute, Bangkok, Thailand, 2000)
In 2001, the number of drug addicts, who voluntarily applied for treatment, Office of the Narcotics Control Board is given in table 1.2

Table 1.2

The number of drug addicts, who voluntarily applied for treatment in Thailand

<table>
<thead>
<tr>
<th>Age/Period</th>
<th>2000 (January – December)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>15 below</td>
<td>831</td>
</tr>
<tr>
<td>15 – 19</td>
<td>8,513</td>
</tr>
<tr>
<td>20 – 24</td>
<td>9,600</td>
</tr>
<tr>
<td>25 – 29</td>
<td>6,805</td>
</tr>
<tr>
<td>30 – 34</td>
<td>4,393</td>
</tr>
<tr>
<td>35 – 39</td>
<td>3,433</td>
</tr>
<tr>
<td>39 up</td>
<td>5,821</td>
</tr>
<tr>
<td>Total</td>
<td>39,396</td>
</tr>
</tbody>
</table>

(Office of the Narcotics Control Board 2001)
A Daily newspaper in Thailand dated 28 March 2001, reported to Liumchaikul, a Secretary – General Office of the Narcotics Control Board, pointed out, that amphetamines from Va-Dang (Burma border) and Lao were trafficked to Thai market. It pointed and 2.5 million people in Thailand were consuming those about 700 million tablets. “Thai-rate” Thai newspaper dated 31 July 1999, reported that the police had arrested drug trafficking near Bangkok more than 500 million of amphetamines tablets, estimated to be worth US. $ 50 million in international market had been seized.

The Department of Elementary Education discovered that out of 400 schools in Northern Thailand 1 percent of the school students are addicts of narcotic drugs. The narcotic drugs have affected more than 100,000 students from amongst 954,339. It is interesting to note that there are 40,000 to 50,000 students out of 600,000 in the sixth level alone who are into drug addiction. It is also observed that the tendency to get addicted to drugs is higher at young age and 60 percent of them change/convert to sellers Daily news version on 18901 p. 7, July 13, (2001)

The present government has a strong policy to fight drug abuse and trafficking. Therefore, narcotic problems have been designed as one of the first priorities to be urgently solved. Thai government spends huge amounts of money collected from taxes to contain this malaise every year.

Public education is important to disseminate correct information about the physical dangers of drugs with negative social and economic effects in order to enhance the development of individuals who are not tempted to abuse drugs.

For teenagers, preventive activities for young should include a comprehensive educational programme within the school system, dissemination of information to the parent, support of extracurricular sports activities, and co-
ordination between school and control agency.

However, there are many minority groups trafficking in narcotics on Thai border. The influential ones are the Karen and Khun-Sa. These groups make contact with the Thai people in the lowland and also have contacts with the outside world and overseas markets.

Some countries support a community-based programme to make people aware of the danger of drug use. Rehabilitation is carried out in treatment centres, in the home and in prison. One participant suggested that the growing area should not be given exotic or attractive-sounding names like the “Golden Triangle”. It would be better to call them, the “Hell Triangle” Thersteerasukdi, (1987).

Like other countries worldwide, Thailand has been facing the drug problem for so many years despite hard work of government as well as private organization to combat this evil. The number of the addicts has increasingly grown day by day. The most worrying scenario of this problem is that is spreads to teenagers who, a great source of human power, become its victims.

CONCEPT OF DRUG AND DRUG ADDICTS

Drug is a wider term and can be used for both medicinal and non-medicinal purpose. Drug in the context of phrases like drug problem or drug abuse is really shorthand for socially disapproved drugs or drugs, which are used in the socially disapproved ways.

The drugs obtained from a doctor and used under the auspices of medicinal treatment are seen as less dangerous and more socially acceptable than otherwise would be the case. Further, in view of the medicinal and non-medicinal use of drugs, each society develops rules and guidelines for such use.
The rules cover wide ranging aspects of drug use and drug abuse, defining the uses and behaviour that are acceptable or disapproved or which drugs may be self-administered or which may be taken only on the advice of a socially or legally authorized person or the drugs which are not authorized under any circumstances.

The basic pharmacological or scientific definition of a drug is "a substance that by its chemical nature, effects the structure or function of the living organism". The mode of action and the nature of the effects of drug is the subject matter of pharmacology. It will take only a moment's thought to realize that this definition covers virtually everything that people ingest, inhale, inject, absorb. It includes medicines, over the counter drugs, illegal drugs, drugs that are commonly referred to as beverage or cigarettes, food additives and preservatives, many industrial chemicals, pollutants and even food itself. An immediate reaction is certain to be that this is not a very useful definition. It is certainly not the way most people think of and respond to the term "drug". From many points of view, it is so general as to be of little use, but it highlights the important fact that something more than pharmacology is necessarily involved in most current definitions of drugs. These definitions have more to do with the purpose for which substance is used than with any characteristic of the substance itself or the way in which it interacts with the living organism. These purposes vary from time to time and from place to place.

There is no such thing as the effect of any drug. All drugs have multiple effects and these vary from dose level to dose level, from individual to individual, from time to time and from setting in the same individual. Drug effects are a function of the interaction between the drug and the individual physiologically, psychologically and socially defined. Individuals are complex and varied. Drug effects must, therefore, be complex and varied

Marin and Cohen (1971) have pointed out that drug in its broader sense may be defined as any compound that affects the functioning of the organism. Drugs may cause changes in both the bodily process and behaviour.

Krivanek (1972), while defining drug, observes that drug is chemical, but all chemicals are not drugs. The popular definition of drugs normally excludes substances naturally present in the body, though some of these, for example, the hormones, may be used medically. The drugs, therefore, are the substance introduced into the body but such substances do not include food or necessary components of diet such as vitamins, even though these may be taken in forms and ways unrelated to ordinary eating. The chemicals used to flavor, colour and preserve food are also excluded from the category of drugs.

Helen (1975) pointed out that drug phenomenon like any other phenomenon cannot be explained or understood outside social and cultural contexts. Every issue about the drugs beginning even with the question as what is a drug is interpreted and mediated by social and cultural factors. Even different cultures attach widely divergent and some time contradictory meanings to a given drug and expect different experience and behaviour from it. The drug for many people means simply something which a doctor prescribes for treatment of a disease or which one can buy for the same purpose from a drug store without prescription. The drugs include within their ambit substances such as heroin and morphine, which were originally and are still used medically for treatment or pain but are now also manufactured and sold illegally for pleasure producing agents.

Plicher (1988) observed that the drug is a chemical, which interacts with body chemistry. Sometimes it substitutes for chemicals which the body lacks such as insulin, opiates, depressants, tranquilizers, stimulants, marijuana and
hallucinogens are classified as drugs. The basic pharmacological or scientific definition of drug is a substance that by its Chemical nature affects the natural behaviour of those who use such drugs. The mode of action and nature of effects of drugs is the subject matter of pharmacology and varies from individual to individual.

Alcohol as a substance is a drug. Under the name ethyl alcohol, it appears in most pharmacological and medical texts. To label it a beverage in no way changes the way in which it interacts with the organism. It is stilling a central nervous system depressant Parikh and Krishna, (1981).

Drugs mean any chemical that modifies the function of living tissues resulting in physiological or behavioral change. In the ordinary sense drug means any substance, other than food, which is used to change the taste of an individual and has some direct or indirect impact upon the overall behaviour of such a person. The impact of such drugs may be either physiological or psychological.

The drugs liable to abuse are usually put into the two classifications of "narcotics" and "dangerous drugs" and the people who abuse them are usually called "addicts" and "users". The terms have been used carelessly and have gathered around them many subjective associations. Some precision is necessary if they are to be used as instruments of analysis. All drugs, even food and water, are dangerous for some individuals at some dosage level under some circumstances. Some are more dangerous at lower levels for more individuals than are others. Use of any drug involves risks. But, most of what people do, if they do anything, involves some degree of risk and is done because of some perceived benefit. People still drive powerful cars despite the terrible toll of life and property, including their own. The ability of all to move quickly would seem to be valued more than conserving the life and property of some. Who
may take what risks for what benefits is a basic problem both for individuals and for societies.

THEORETICAL ISSUES

Theories help practitioners to describe, explain, predict and control phenomena. Theories are made up of concepts and propositions. Concept is abstract properties of the phenomena that are being studied.

Theories of addiction reflect prevailing attitudes, practice and knowledge. For the sake of description, addiction theories are organized broadly according to these attributes. Contemporary theories of addiction include biological, psychological, socio-cultural, and transcendental/spiritual theories.

Addiction theories provide frames of reference that help practitioners understand the etiology, expression and course of addiction. Practitioners use theories to guide treatment, promote presentation, conduct research and develop policy. Each addiction practitioner typically grounds his or her practice in dominant theory. To utilize theory effectively, a practitioner must understand its origins, examine its characteristics, its adequacy (strengths and limitations) and determine its clinical and social relevance. What assumptions support the theory? What is knowledge base? What practice skills are associated with the theory? Sandra, (2000)

BIOLOGICAL THEORY

Recent research has demonstrated neurobiological, neurobehavioural and genetic bases for addictive disorders. Neurobiological theory focuses on neuroadaptive processes and the role they play in the etiology of substance use
Introduction

Genetic predisposition plays a large role in this theory. Neurobehavioral theory attributes alcohol and other drug used disorders to a link between certain behavioral disturbances and neural system dysfunction, interpreted within a neuropsychological framework. Genetic predisposition also plays a large role in neurobehavioral theory. Sandra, (2000)

GENETIC THEORY

Genetic theory emphasizes the role of heredity in the development of addictive disorders. The apparent vulnerability of some people to addictions has prompted researches to search for factors that may contribute to heightened susceptibility. Genograms often reveal the history of alcoholism in families. Among certain ethnic groups, genetic factors are theorized to increase individual’s likelihood of becoming an alcohol dependent. Individuals within other ethnic groups appear to have protective genetic factors that make it doubtful they will ever abuse alcohol. Molecular biology techniques have isolated and identified genes that may confer vulnerability for alcohol dependence and other addictive processes. It is possible that the enzyme monoamine oxidizes and aden late cycles are biochemical markers to predisposition to alcoholism. Genetic factors alone, however, do not account for the development of alcohol abuse. A host of environmental factors shape individuals’ thinking about alcohol and affect use, including family dynamics, peer influences, everyday stresses and cultural values. Drinking to states of abuse or dependence represents a complex interplay between genetic and environmental factors.

Alcohol and other drugs produce brain changes. As the research examined in the 1998 public television series Meyers on Addiction; Close to
Home emphasizes, addiction a chronic and relapsing brain disease. A sight or a smell can trigger brain circuits altered by drug abuse and spur a relapse. Yale Schools of Medicine scientists have found that the protein delta-fobs stimulate mice brain genes that intensify the craving for cocaine. If a similar process occurs in humans, this could help explain why cocaine addiction is so difficult to arrest. Brain changes have also been identified in individuals with pathological gambling, compulsive shopping, sex addiction, and eating disorders. Some of these changes compromise the individual’s decision-making ability, including the capacity to make rational choices about substance use and its consequence. Addicts experience dysphasia and craving; craving is relieved with another drink, drug, or behaviour.

Brain reward helps explain why a drug or addictive behaviour is self-administered. The effects are pleasant. The individual experiences a feeling of well-being or reduced anxiety. Researchers have identified a D2 dopamine receptor for alcoholism in mice. Alcohol and other drug use and addictive behaviours such as gambling, shopping, sex or eating increase pleasure and/or reduce pain. Heroin addicts often report that they use “just to feel normal”. Neuroscience theory helps clinicians and clients understand that the intense drug seeking, profound denial, and extreme manipulation that characterize addictive behaviour may in part be caused by drug-induced brain changes. Biological research is trying to discover the precise neurotransmitters and processes associated with specific substance use. Related research seeks to develop medications to treat withdrawal, reduce craving and prevent relapse.

Sandra, (2000)
PSYCHOLOGICAL THEORY

For many years, psychologists considered alcoholism and other drug problems as symptoms of mental illness, not as diseases or disorders. Today, both the American Psychiatric Association and the American Psychological Association recognize addiction as a disease.

Many psychological theories extend our understanding of addiction and expand treatment skills. There are two kinds of the psychodynamic theories that explain addiction. First, addiction develops when individuals use alcohol, drugs, or behaviour to experience pleasure or escape pain. Second conflicts among the id, ego, and superego can lead to use and abuse of substances to relieve anxiety.

Other psychodynamic manifestations of addictive disorders include impulsivity, self-centeredness, self-destructiveness, responsibility poor judgment, regression, irritability and labile mood. Denial helps clinicians understand how clients can persist in such self-defeating behaviour. Clients also employ other defense mechanisms, especially rationalization, projection, and minimization, to reject diagnoses of addictive disorders and resists treatment. In addition, infantile narcissism (self-pathology) typifies addiction. What Alcohol Anonymous call “character defects” Psychodynamic theory view as infantile narcissism. A.A suggest replacing the “big ego” with a more humble self. Even the “twelvetraditions” of A.A emphasize avoiding the egocentric pitfalls of individual leader. Psychodynamic clinicians recognize that psychopathology can precede the development of addiction or predispose the individual to addiction. They were some of the first mental health professionals to treat clients with dual disorders. Psychopathology can coexist with follow addiction Sandra, (2000).
STRESS-MANAGEMENT THEORY

Stress-management theory recognized the need for people to reduce the tension and anxiety that is often associated with stress. People with addictive disorders report high stress levels and may, in fact, be more vulnerable to stress than other individuals. Alcohol and other drugs (or gambling, shopping, eating, or sex) reduce tension and stress for many people. Individuals can address the sources of their stress—the difficult job, the dysfunctional marriage, a delinquent child—but it is usually quite difficult and time consuming to do so. Most people with stress-related tension can manage stress. Even relaxation exercises, meditations, and other non-pharmacological techniques take longer to provide relief than a drug. In the United States, the pharmaceutical industry aggressively markets products that promise quick relief for tension related problems. Fortunately, clinicians and clients are beginning to use more non-pharmacological therapies to prevent and manage stress Sandra, (2000).

SOCIAL LEARNING THEORY

Social learning theory is a self-efficacy paradigm that posits personal factors, environment, and behavior as interlocking determinants of on another. The principles of learning, cognition, and reinforcement are important. Substance use and other addictive behaviors are socially learned, purposeful behavior resulting from interplay between social-environmental factors and personal perceptions. What is the individual’s social learning history? What is his or her cognitive set? Such as expectation or beliefs about the effects of use
or behaviour? What are the physical and social settings in which use or behaviour occurs? Sandra, (2000).

SOCIO-CULTURAL THEORY

Drug use is not a physiological and medical problem only. It is also an important social problem. As a medical problem, it is to be dealt through the doctor-patient relationship, while as a social problem, it is not only a matter for criminal procession but a matter of understanding as to what type of social and cultural forces generate tendencies toward its use.

The analysis of drug problem in this study is primarily the analysis of social cultural aspects of the drug use problem. In order to attempt an answer to the following questions: what is the role of the family, environment, culture and others socio-economic factors in the development and expression of addiction?

- What is the role of the family, environment, culture and others socio-economic factors in the development and expression of addiction?
- What kind of adolescents use drugs?
- Why do the adolescent take drugs?
- Why don't the adolescent take drugs?
- What are their sources of getting drugs?
- How does their drugs use come about?
- What are the consequences of using drugs?
- What efforts do they make to withdraw from drugs?
- What are the consequences of using drugs?
Introduction

• How can we control or prevent drug use among youth?
• What alternative approach exists?
• What are the socio-cultural and economic factors affecting The drugs addict?

The current status of family theory, system theory, and anthropology theory deals with socio-cultural theoretical approach to taking drugs Sandra, (2000).

FAMILY THEORY

Family theory challenges the premise that addiction is an individual problem or disease. This theory examines how the family contributes to the addiction, how the problem affects each family member and the impact of the addiction on the family as a whole. Addiction is one-way a family attempts to adapt to life's needs and challenges. Addiction is a coping mechanism. Enabling behaviour on the part of the family sustains the addiction. Over time, family "rituals" develops that determine behaviour and define roles for all family members vis-à-vis the addiction. Ineffective communication and limited expression of feelings characterize families with addiction. Parental interactions and expectations are inconsistent and vicarious behaviour by children is common. Negativity, denial, and anger are high and self-medication is common Sandra, (2000).

DRUG ADDICTS

The word addiction evolved from the Latin term 'adducer' which, in Roman law, meant the giving or binding over of a person to one thing
Introduction

or another, such as a judge assigning a debtor to his creditor. By the late 16th Century, ‘to addict’ had apparently assumed a broader meaning: to devote, give up or apply habitually to a practice. One writer suggests that the word was generally identified with bad habits or vices.

Some drugs are addicting and some persons are addicted by one definition but not by another. The World Health Organization Expert Committee on Addiction Producing Drugs has recommended that the term ‘drug dependence’, with a modifying phrase linking it to a particular type of drug, be used in place of the term ‘addiction’. But ‘addiction’ seems too deeply embedded in the popular vocabulary to be expunged. Most frequently, it connotes physical dependence, resulting from excessive use of certain drugs. However, it should be noted that one could become physically dependent on substances, notably alcohol that are not considered part of the drug abuse problem Wills (1974). It should be noted also that psychic or emotional dependence could develop to any substance not only drugs, that affect consciousness and that people use for escape, adjustment or simple pleasure.

Addiction was defined as ‘a condition developed through the effects of repeated actions of a drug such that its use becomes necessary and cessation of its action causes mental or physical disturbances. Addiction was further subdivided into ‘true addiction’ which involved the ‘physical disturbances’ associated with the withdrawal syndrome and ‘psychic addiction’ which was associated with the ‘feeling of exhilaration and euphoria (constituting) and almost irresistible goad to its continued use’ Mitchell (1974).

With the emergence of public and scientific interest in the opium problem, ‘addiction’ and ‘mania’ were commonly used in the press to describe this ascendant vice Isbell (1981).
There is no settled definition of addiction. Sociologists speak of ‘assimilation into a special life style of drug taking’. Doctors speak of ‘physical dependence’ an alteration in the central nervous system that results in painful sickness when use of the drug is abruptly discontinued; of ‘psychological or psychic dependence’ an emotional desire, craving or compulsion to obtain and experience the drug; and of ‘tolerance’ physical adjustment to the drug that results in successive doses producing smaller effects and, therefore, in a tendency to increase doses. Statutes speak of habitual use; of loss of the power of self-control respecting the drug; and of effects detrimental to the individual or potentially harmful to the public morals, safety, health or welfare.


The WHO Expert Committee on Addiction Producing Drugs attempted to formulate a definition of drug addiction applicable to drugs under the international control. The committee defined drug dependence rather than drug addiction. The term addiction has come to be used in medicine less often and with a more restricted meaning. The Expert Committee also sought to differentiate addiction from habituation and provided the definition of the habituation, which, however, failed in practice to make a clear distinction Harm (1985).

Within the American Scientific community, the terms most commonly employed during the 19th and early 20th centuries to describe the condition were opium (or morphine) habit’ and ‘morphinism’. In 1903, for example, the American Pharmaceutical Association established a Committee on the Acquisition of Drug Habits. By 1920, however, the scientific community had given the term addiction it’s blessing, a development paralleling the popularization of the word ‘narcotics’ and the entry of government into the field “narcotic addiction’ become a household phrase Long 1986).
The definition of addiction no doubt gained some acceptance, but confusion in the use of terms addiction and habituation and misuse of former continued. Further, the drug abuse increases in number and diversity. These difficulties have become increasingly apparent and various attempts have been made to fine a term that could be applied generally to drug abuse. Uddin (1997).

**DRUG USERS**

Whenever there is concern with deviant or destructive behaviour, there is often an attempt to identify physical, psychological or social background factors and characteristics of those who engage in these behaviours on the assumption that others who share the same characteristics and background are more likely to become involved in the same deviant or destructive behaviour. Efforts to prevent intervene or isolate, may then be concentrated on those so identified.

No such factors have as yet been clearly identified as either necessary or sufficient to serve as a basis for reasonably accurate prediction. Availability of drugs, a situation in which drug use is perceived as safe and association with friends who use drugs seem to be the only factors that can be identified as necessary for drug use.

To put drug use in perspective it is necessary to make at least some gross distinctions. These are usually made on the basis of either type of substance used or of different levels of frequency of use Bell (1970). Such levels often include:

1. Experimental use often defined as once to three times
2. Casual or occasional use which may not be more than once or twice a month
3. Regular use, which may be weekly or several times a week, depending on the particular substance used
4. Heavy or compulsive use which usually implies daily use, although it may occur on a spree basis with extremely heavy use for several days on periodic basis as with the occasional or repeated alcoholic

On the whole, differences between users and non-users of this or that drug or of psychoactive drugs in general are small though in some cases statistically significant. They are often specific to the sample studied both in terms of socio-economic and cultural characteristics, type of drug used, and pattern of use. Just as it was necessary to distinguish among types of drug use, it is even more necessary to distinguish among types of drug user and used. This adds another dimension of complexity to a picture that is already very complex. This complexity presents the greatest difficulties for those who insist on simple, universal answers. Acceptance of such complexity enables one to begin to define a particular problem in a particular community and to begin to solve it.

It is much easier to address the problems posed by a group of socially and economically privileged high-school students using marijuana occasionally because they are bored, are experimenting with independence and rebellion as well as drugs, than it is to solve the drug problem at a national level. It is easier to address the problems created by economically, educationally and socially deprived 9, 10 and 11 years old sniffing glue as perhaps the only momentary escape from an almost unbearable existence available to them than it is to develop nationally a social or educational policy and addresses the problems associated with non-medical drug use. Bean (1974).

Drug users are experimenters or casual or occasional users or regular users, or they may be periodic or regular heavy users or compulsive users of an
increasing array of substances. Drug using often appears to be a fairly simple phenomenon, which can be defined in simple terms, either one uses or one does not use. Unfortunately, use is not simple but is nevertheless often described in simple terms. To categorize all people as users or non-users of certain substances for certain reasons may derive some purpose, but it is not at all useful in understanding drug use or as a basis for modifying drug use behaviour. A majority of people in many cultures does use one or more of a wide variety of psychoactive substances. Different people use different substances in different amounts for different reasons under different circumstances. The majority of people do not use substances prescribed by their culture or for reasons unacceptable in their culture. If the majority did, it is probable that the culture would be modified to include use of such substances. Customs, mores, and laws in general represent consensus in a given culture. Both increasing use of a new a new drug and its users represent a threat to he consensus. Auld (1981.)

Biological and medical scientists have searched for physiological, genetic or biochemical factors; behavioural scientists have searched for specific character disorders or psychopathology, for arrested stages of growth and development, for influences on development of such factors as broken homes, permissive or laissez-faire parents, patterns of child-rearing, social, religious and political attitudes of parents. Social scientists have sought explanations in terms of deprivation, poverty, poor housing, inadequate educational and occupational opportunities, prejudice, and discrimination, as well as such factors as cultural pressures supporting drug use, advertising and content of mass media. That is found that is often a function of what was sough. Risshi (1995).
HABITUAL DRUG USERS AND DRUG ADDICTS

The term 'habituation' Ahuja (1982) is used in the neutral sense that one can make a habit of doing or using anything; for example, smoking a cigarette after every meal, going for a morning walk, wearing a particular style of dress, taking bed-tea in the morning, watching television in the evening and so forth. Once the habit of doing something or using or taking some substance is acquired, one comes to think that it is harder to quit it. However, if one fails to get it or do it, he doesn't feel restless, uneasy or agitated as he feels in 'addiction' Thus one comes to develop a psychological dependence on a particular thing that is he does not physically need to satisfy that habit he becomes so used to the habit that he feel he cannot live without it. In psychological dependence on a drug (i.e. being habituated to taking a drug) the abuser likes the feeling of getting satisfaction from the use of drug and wants to re-experience it. He feels a definite need for the exacted drug effects, a need which may be mild or intense. The drug enables him to escape from reality—from these causes the user to use the drug. Thus, habit is not compulsive as addiction is. ‘Addiction’ to a drug means that the body becomes so dependent to the toxic effects of the drug that one just cannot do without it. We could say, addiction is the state of chronic intoxication produced by the repeated consumption of a drug and involves physical dependence and an overwhelming compulsion to continue using the drug. These characteristics are overwhelming compulsions to continue using the drug.

The characteristics of drug addiction are Edwin (1965): (i) an overpowering desire or need (compulsion) to continue taking the drug and to obtain it by any means. (ii) a tendency to increase the dose, (iii) a psychological and generally a physical dependence on the effects of the drugs
and (iv) an effect detrimental to the individual and to society.

The continued use of a substance for a purpose other than food amounts to ‘addiction’. However, every use of a substance may not amount to ‘addiction’ unless such a use is of such a type or level that it is difficult or painful for the user to withdraw or stop it. According to the traditional medical usage, addiction refers to a condition brought about by the repeated administration of any drug, whereby the continued use of such a drug is necessary to maintain normal physiological function and discontinuance of the drug results in abnormal physical and mental symptoms.

Laurie (1969) is of the opinion that “Addiction is a condition induced in certain higher mammals by chronic administration of central nervous system depressants like alcohol, barbiturates, and opiates, in which a gradual adaptation of the nervous system to the drug causes a latent hyper-excitability that becomes manifest when the drug is withdrawn and produces physiological symptoms that are interpreted as a physical need for the drug”.

This definition implies no moral or political attitude and it does not intimate anything implausibly horrible and debasing. Pharmacological tolerance is another symptom that often accompanies addiction. It is usually described as an adaptation of the nervous system to the effects of a given amount of drug that makes it necessary to keep taking more to get the same effect.

Addiction is thus habituation involving certain physiological qualities or a type of habituation with distinguishable properties. The qualitative difference between ‘habituation’ and ‘addiction’ can be explained in terms of the detrimental effects and the consequences of the two. Detrimental effects of addiction are on both the individual and the society while detrimental effects of habituation are primarily on the individual. The consequences of ‘drug
habituation' depend on the personality of the user while the consequences of 'drug addiction' depend not only on the properties of the drug itself but also on the factors like the setting in which the drugs are taken, reliability of supply and vagaries of personal background, drug user's physical and psychological condition, the amount of drug being taken and the frequency with which the drug is being used Love (1971).

Marin and Cohen (1971) observed that addiction although similar to physical dependence, is not synonymous to psychological dependence. He observed that it is often used in reference to narcotics. Other drugs such as barbiturates can produce physical dependence. The narcotic addiction also involves an overwhelming craving for an involvement with drug to such an extent that getting and using it pre-empts all other interest and activities. Addiction involves a totally drug-centered life style. The compulsive getting and using of narcotics completely pervades the addict's life.

Delong (1972) expressed that he has failed to perceive any value in this distinction. He observed that physical or psychological habituation, after all, best describes the condition that develops during the course of drug addiction and which is responsible for mental and physical symptoms that usually arise when the drug is discontinued. Further, many habitual users of tobacco, coffee, alcohol and other drinks, experience profound physical and psychological discomfort when they voluntarily or otherwise forego there. He further maintained that it would be quite correct to use the term 'habit-forming' and 'addicting' synonymously and to refer to common habit-forming drugs as addictive in nature.

Drug addiction is a term, which cannot be defined in isolation. It, besides various other factors, also depends upon the nature of the drug used. Moreover, it has been customary to distinguish between drugs that are 'habit
Introduction

forming’ and drugs that are ‘addicting’. The former groups of drugs are said to induce a condition in which the user desires a drug but suffers no ill effects on its discontinuance. The drugs in tobacco, coffee, Coca-Cola and other drinks are frequently termed as ‘habit forming’ but not as addiction Helen (1975).

Weissman (1978) has defined addiction as the periodic or chronic abuse of drugs characterized by physical dependence and psychological dependence and tolerance. Physical dependence is altered; physiological state of body and mind is caused by repeated consumption of a drug. The drug is therefore needed to maintain normalcy and abstinence there from results in the withdrawal syndrome. This is called as addiction. The psychological dependence, sometimes also known as habituation, is a psychological state characterized by preoccupation with the drug procurement and compulsive drug use necessary to wellness, this is addiction. Further tolerance a concept central to addictive process is the phenomenon explaining the diminishing effects of a given dose of the drug upon repeated administration. If a drug precipitates user’s tolerance, the dose is to be increased gradually to achieve the desired effects; this stage of drug abuse is called as addiction.

This very distinction may, of course, seem to be logical one, but many writers do not agree with this type of classification. Ausube (1980)

Cancrini (1985) and others have attempted to define the term drug addiction:’ It consists in a state of intoxication provoked by the repeated and voluntary use of natural or synthetic drugs’. The following features characterize this type of intoxication:

1. The compulsive need (physical or psychological) to confine use of the drug

2. The irresistible craving for the drug and consequent necessity to procure it at all costs
3. A general loss of interest in other pursuits and other relationships
4. The acceptance of social role of drug addict.

The definition of drug addiction given by Cancrini seems to be a scientific one. It also provides a clear distinction between ‘drug addiction’ and drug habit, as the latter, although characterized by a state of intoxication provoked by the repeated and the voluntary use of drugs, similar to that which determines addiction, differs from addiction as in case of ‘habit’ the drug user is capable of resisting the urge to procure the drug and continues to pursue other interests and maintain significant relationships with others, avoiding total dedication to drug use and rejecting the social role of a drug addict.

Secondly, actual addiction is characterized by the existence of an active conflict in the younger people’s social environment that gives rise to a feeling of uneasiness and inadequacy. Moodiness, various idiosyncrasies, reduction of activities, and demonstrative attitudes. The addicts often demonstrate that they use a drug (usually heroin) because of its hypnotic rather than euphoric effects. The young person usually shows expressions of challenge and intolerance directed primarily towards those persons who are perceived as responsible for the conflict, usually parents but often therapists and others who try to help the addicts.

Thirdly, transitional addiction is characterized by various psychological disorders that go with the onset of drug addiction. Among such disorders repeated maniac states, more often in young addicts, have been reported Ansudel (1958). Addicts report honeymoon states with sudden and wonderful effects of drug, which as per their perception control personal pain that existed before the use of a drug.

Fourthly, sociopath addiction is characterized by psychosocial conflict,
which is expressed in the manner of ‘action out’, and by a number of personality disorders. There is usually evidence of anti-social behaviour in the past history of the addict. The persons affected by the socio-pathic addiction are usually defiant, act with coldness and show inconsiderate behaviour to other people. They are unable to give or accept love and are unable to establish meaningful and lasting relationships. They often perceive their social environment as cold and hostile. They are usually involved in the multiple drug abuse. The addicts of this type are characterized by marked psychological, social immaturity and troubled family life, which is often a source of disorder for the youth. Theft, prostitution and homosexual behaviour are common disorders among persons with this type of addiction. Lack of self-confidence and an accumulation of self-destructive aggression are also characteristics of majority of these individuals.

Keeping in view the different types of addiction and their varying impact upon the different individuals, Mac (1987) pointed out that addiction couldn’t be defined as a physical dependence or chemical dependence or as a psychological dependence. Addiction has to be defined in relation to the impact the drug has on the behaviour of a person. The relationship between the person and the substance determines how that person functions socially.

In other words, addiction means such a use of a substance, which is harmful, but at the same time the user feels difficult to stop or withdraw from such drug. The addicts, even though, are getting into trouble because of being drunk or high, yet they continue to use it despite all the negative effects in all areas of life.

In all concepts mentioned above, the meaning of the word, drug often varies with the context in which it is used. From a strictly scientific point of view, a drug is any substance other than food, which by its chemical nature
Introduction

affects the structure of function of the living organism. From this perspective, the term includes some agricultural and industrial chemicals. The physician might define a drug as any substance used as a medicine in the treatment of physical or mental disease; when treatment of illness is the retreat, the lay public may use the word in the same sense. However, when used in the context of drug ‘abuse’ or the drug ‘problem’ the meaning of ‘drug’ becomes social rather than scientific. In its social sense, drug is not a neutral term. This point is best illustrated by the fact that ‘drug problem’ is frequently used not as a descriptive phrase, but substitute for the word drug.

TYPOLOGY OF ADDICTS

Drug addicts can be classified on the basis of the frequency of drug taken per day:

1. Chronic Addicts – These are the people in the condition of chain intoxication
2. Adolescent Initiates – This refers to those in 12 to 17 years of age and implies the initial or early exploratory use of a drug in order to form an attitude that will result either in rejection of that drug or its adoption
3. Intermittent User – those who are not completely hooked to drugs and have limited supply and money to afford drugs.
4. Relapsed Addicts – These are the ones who are always trying to give up drugs but not quite succeeding
5. Ex-addicts – These represent the brighter side of the picture. These have overcome their habit and have no intention of going back to it.
Drug abuse is one of the most complex and baffling of vices. There is no one given set of circumstance or no one combination of factors that invariably assures that someone will turn to drug. Though we can neither pinpoint the causes of drug abuse nor predict with accuracy that will and who will not turn to drug; one can always suggest a number of factors that contribute to an individual’s abuse of drug WHO,(1973).

CLASSIFICATION OF THE DRUGS

The drug abuse in the recent years has increased not only in their magnitude but new drugs have emerged on the scene and more synthetic drugs are appearing in the market almost in every season. It is difficult to give a detailed account of all such drugs. However, the drugs have been classified in the following pattern.

1. Marijuana

Cannabis is also known as marijuana or hashish and is famous throughout the world for its psychoactive properties. Marijuana is a tall leafy weed, which grows best in hot dry climate like Central Asia, where it probably originated, but also grows wild in most parts of the world. The plant has a widespread distribution in Asia and is found growing in abundance in the territories of the South on the Caspian sea, in Siberia, in the desert of Kirghiz in Russian Kurdistan, in Central and Southern Russia and along the lower slopes of Caucasus mountains. It has a wild growth in Iran and India, the plant is found growing in a state of nature throughout the Himalayan foothills and the adjoining plains, from Kashmir in north to Assam in the east. It has become acclimatized to the plains of India producing its narcotics in the area.
Marijuana is probably the oldest cultivation of non-food plant, which has a valuable source of products for man’s commercial, medical religious and recreational use for thousands of years. It has been a source of fiber for rope and cloth for centuries. In the countries such as India and Nepal, the plant has been also used as a drug for hundreds, perhaps thousands of years. In the recent years a new class of users has developed, first in the prosperous societies of the West and then, by a reverse influence, in the countries from which drug itself has traditionally come Uddin (1997).

The earliest known written reference on Marijuana occurs in a Chinese pharmacological treatise dating from 2737 BC and attributed to the Emperor Sheen Nun, according to tradition, was the first to teach his people the medical value of cannabis. In India the first known reference on marijuana is found in the Atharva Veda, which probably dates back to the second millennium BC. The references on marijuana are also believed to be in the Bible, Homer, Arabian Nights and Marco Polo’s writings. Marijuana was in early use in all parts of Africa and references on the drug in Germany have been found as early as 500 BC. The first record of Marijuana in the New World dates from 1545 A.D, when the Spaniards introduced it to Chile. The plant was introduced to Virginia in 1611 and cultivated for its fiber. It was brought to New England in 1629 and until the end of civil war; it was a major crop in North America and played an important role in colonial economic policy. In 1765, George Washington was growing hemp at Mount Vernon, presumably for its fiber, though it is also believed that Washington was also interested in the medical and intoxicated qualities of his plants.

Herbal marijuana or grass is a mixture of crushed leaves, flowers and often twinges of Cannabis sativa. Its principal psychoactive ingredient, delta (THC), is the most heavily concentrated in the plant’s resin. The concentrated
(THC), is the most heavily concentrated in the plant’s resin. The concentrated dark, tarry resin is called ‘hashish’ and its usual form cannabis is consumed generally by mixing it with tobacco. A percolation process can produce a still more concentrated form of the drug, hashish oil. The leafy mixture contains the smallest amount of THC, usually from 1-10 percent. The THC contained in cannabis preparation dexterities especially when exposed to heat and light, a given sample of marijuana or hashish may vary quite a bit in psycho activity over a period of time. THC is no doubt the most important single cannabis ingredient, but there are more than one hundred chemicals, which play a very vital role in modifying the effects of the drug. Only a few of the other components have been studied and their complex reactions are not yet understood. Cannabis, the plant that produces hemp as well as hashish, is now known primarily as one of the leading psychoactive substance in the world. It follows tobacco and alcohol in popularity. The cannabis products are also used in the following forms:

**Bang** consists of dried leaves and flowering of fruiting shoots. It is common in the state of Jammu and Kashmir, particularly in Kashmir valley.

**Ganja** consists of flowering or fruiting tops of the female plant of the cannabis. It has a particular colour. The users wet it a little with water and rub it on the palm till it becomes soft and then smoke it in a chillum or pipe after mixing it with tobacco.

**Charas** or hashish is concentrated resin oozed from the leaves and stems of the plants and is dark green or brown in colour. It is smoked with tobacco in a pipe or hookah and is the most potent of all these forms.

This form of cannabis was commonly abused in ‘Takayas’. Kashmir produces worth crores of rupees and is smuggled to international market. It has also infected local population and is widely consumed. Marijuana has wild
growth in the Kashmir valley from which high quality of hashish is produced Uddin (1997).

2. LYSERGIC ACID DIETHYLAMIDE (LSD)

LSD is derived from lysergic acid, a constituent of ergot, which is a parasitic fungus. Or rust that grows on rye and other grains. LSD was originally synthesized in 1983 by two chemists. Five years later in the spring of 1943 one of its co-discovers (Unger 1966), inadvertently ingested some of the drug. He experienced restlessness and dizziness followed by a mind delirium in which he also experienced fantastic visions of extraordinary vividness accompanied by a kaleidoscopic play of intense coloration. It was first used medically in 1950’s and 60’s as an aid to psychotherapy particularly in those patients who had difficulty in freely communicating or associating. Further in this period LSD was widely used by those interested in mysticism and exploration consciousness and with other drugs it became a part of hippy culture of that time.

LSD effects are usually felt within an hour, when had taken orally. It is considered the king of psychedelics because it produces the most intense effects. The subjective experiences that LSD induces can be spectacular. Sensory perceptions are altered and intensified so that colours appear brighter and sounds become magnified. The user may experience as being both within and without himself or as merged with an object or another person. The majority of users have both pleasant and unpleasant reactions to the drugs. But for those whose overall reactions to the drugs have been positive; the unpleasant side effects are seen as transitory and valuable in terms of self-knowledge Wiener (1970).
Drug users regard cocaine with its romantic history and its high cost, as the status drug. Cocaine is basically an alkaloid found in the leaves of coca bush, erthroxylon coca. cocaine falls in the family of stimulants, but unlike other stimulants, cocaine is a naturally occurring substance and has been chewed by Indians from time immemorial. Cocaine has been used since the time of the Inca Empire, which flourished for hundreds of years in the Andean Mountain region of Peru until the arrival of the White man in 1500’s. Inca priest chewed Coca leaves in order to achieve and enhance their understanding of religious rituals and experiences. Using coca leaves was originally a mark of the aristocracy, but gradually other members of Inca male population took up the habit. The attitude of the Spanish conquerors towards Coca was decidedly mixed. On one hand their religious zeal dictated that they eliminate the persistent symbol of Inca idolatry, but on the other hand they also realized that coca enabled the Indians to work-harder in the mines and elsewhere, making it an important economic asset and at the end, the latter consideration prevailed. Harm (1985).

Coca attracted little serious medical or scientific attention outside the territory of Spain, until the latter half of the 19th century, but at the end of the century, it gained its importance and when cocaine became available, there was an era of great medical excitement over the drug’s therapeutic potential. It was used for treating digestive disorders so-called wasting disease (such as cancer), as an aphrodisiac, a general stimulant and as a local anesthetic especially for dye surgery. The last two decades of 19th century were the climax of the patent medicine era. Cocaine today has two main medical uses. Firstly, it is still used in nose-throat surgery because of its unique properties as an excellent local anesthetic and as an agent which contract blood vessels, reducing
bleeding at the operation site. Secondly, its present and widest use is an ingredient in the Brampton Cocktail. This is a combination of alcohol, heroin or morphine and cocaine, *Beschner and Friendman (1979)* which is used as a painkiller and tonic for patients with terminal cancer however, with use of Coca and cocaine its abuse also emerged.

There are several methods of taking cocaine, The most common is by snoring it into nostrils through a straw, a rolled paper or form a tiny coke spoon deposited on the nasal membranes, the drug is rapidly and efficiently absorbed into the blood stream. Another method, favored by some heavy users, is to inject the substance directly into the blood stream, sometimes following it up with a shot of heroin. Cocaine is also taken by applying it to the mucus lining of the mouth, rectum or vagina. *Long (1986).*

Cocaine in its normal streak from cocaine hydrochloride is not effective when smoked. To make it effective, an alkali and solvent is required to convert cocaine into cocaine alkaloid, called ‘free base’. The process involves heating lighter fluid or a similar flammable solvent with cocaine, a potentially dangerous process that could lead to burns.

Free base has lower vaporizing temperature than cocaine hydrochloride; therefore smoking does not destroy it, but produces a sudden and intense high that lasts for less than two minutes. It is rapidly absorbed by the lungs and carried to the brain only in a few seconds. The brief euphoria that results is quickly replaced by a feeling of restless irritability. In order to maintain the high, users often continue smoking until they either run out of cocaine or until they are completely exhausted. The cocaine abuse has spread to almost all the segments of the society and has been used even in the soft drugs, for instance coca extracts are used in Coca cola. Cocaine directly affects the central nervous system, causing a definite simulative sensation. The effects include the
Introduction

universally acknowledged euphoria and a general feeling of well being. The high-reduced tiredness, diminished appetite and sexual stimulation are found in small minority of users. The most obvious physiological effects of cocaine and other stimulants mainly include the increase in heart rate and blood pressure.

4. OPIUM

Opium is the dried milky exudes obtained from the unripe seed pods of poppy plant, which grows extensively in Turkey, India, Pakistan, Iran, Nepal, Yugoslavia and Bulgaria. Opium is the coagulated dried latex juice obtained by incision of the unripe capsules of while; poppy, air-drying the juice. Uddin (1997).

Raw opium comes in a solid mass of varying shape weighing from one-half to five pounds. It is processed in several ways. Though now rarely used, granulated opium is a medically approved drug for treating diarrhea. Powdered opium is more effective than granulated variety and is used in the manufacture of few prescriptive drugs. It is processed in several ways. Dissolved in water, filtered, then boiled down into sticky paste, the substance becomes a preparation used by opium smokers. Dissolved in alcohol, the substance becomes the tincture of opium used in making the laudanum and paregoric. Broken down chemically into its alkaloids, the substance fields’ morphine and codeine. Long (1986).

Opium is a drug of pleasure, which was originally eaten or drunk as an infusion. Later on smoking of opium also found its way along with tobacco in the countries of South East Asia for smoking purposes Kuruvilla (1978). There is evidence that opium has been used since prehistoric times. The opium poppy is thought to have originated in Asia and was first used medically in Egypt then from there it spread to Greece. Arab traders carried opium to India and China,
where it was used to control dysentery and for its euphoric and sedative effects. Chinese emigrants carried the habit of opium smoking to the United States and elsewhere. In Europe laudanum was used to relieve pain and control dysentery, as a cough suppressant and sedative. It became a standard drug until the end of the 19th century; its use began to decline. During the major part of the 19th century, opiates, in the form of patient medicines, were widely used in Europe, England and United States. Mc Coy (1972), is of the opinion that opium is one of the common drugs selected by suicides. Unhappy women are known to have taken opium either to frighten their relatives or escape from their worries.

5. MORPINE

The principle alkaloid of opium is known as ‘morphine’. It is a pure drug giving opium its characteristic action. Morphine constitutes by weight about 10 percent of opium, the coagulated exudes of the poppy plant, palaver somniferous, which also contains codeine and about 20 other alkaloids. Since pure morphine is slightly soluble in water, morphine soleplate is the foremost commonly used both medically and recreationally; it appears as; odorless white crystals or white poder. It loses water on exposure to air and light. Morphine hydrochloride is also occasionally used in injections. Imlah (1980).

Morphine was introduced to the medical profession as a powerful analgesic effective in the relief of all kinds of pain; it was also regarded as a cure for opium addiction. Opium, which no doubt was regarded as a popular remedy for every imaginable ailment and some imaginary ones also. Morphine quickly replaced opium in any application, though it did not cure opium addiction. It has been also used for suspension of cough, reduction of movements of intestine and induction of a state of indifference to threatening situations. The undesired effects include nausea and vomiting, the development
of tolerance, physical dependence and depression of breathing. Typical adverse effects also include nausea, vomiting and sweating. Further, yawning, lowered body temperature, flushing of the skin, a heavy feeling in the limbs and itchiness around the face and nose are also usually present. On injecting morphine intravenously, users experience an organism rush beginning in the upper abdomen and spreading to other parts of the body. In overdose, the effects described above are magnified. The respiratory depression can be severe enough to cause coma and death.

6. HEROIN

Heroin is a synthetic alkaloid derived from morphine, which was once used as a medicine for suppressing cough. Even at that time, for years together physicians were unaware of its potential for addiction. Heroin, (diacetylmorphine or dia-morphine), which is prepared from morphine, was first marketed in 1989, when it was claimed to be the heroin cure for morphinism, providing a safe and effective cure with no danger of dependence. This claim was soon proved to be false and heroin steadily replaced opium and morphine on the street. An international black market with underground laboratories and well-organized smuggling operations grew rapidly. Two main factors namely, the comparatively simple equipment needed to convert morphine to heroin, and the reduced bulk of heroin, compared to morphine, made the operation very simple. Pearson (1987).

The process by which heroin is manufactured, although very simple in theory, yet requires a considerable skill and a quality of equipment in practice. Heroin is a white crystalline powder with a better taste and is very easy to carry from one place to other place. Heroin passes down the distribution chain. Therefore, it is progressively diluted with a variety of substances including
Introduction

sugar, starch powdered milk and quinine. Heroin, which is usually in two forms viz, Brown sugar and smack is available in every part of the world. Until recent years, most of the heroin smuggled into the United States was supplied from South East Asian opium sources and was converted to heroin in clandestine laboratories in the area of Marseilles and France. After this supply was curtailed, production of the drug increased in Mexico, which remained the major source for several years.

Heroin depresses the central nervous system in a way similar to alcohol and barbiturates, but unlike those drugs, it also relieves pain. The alcohol and barbiturates abuse increases belligerent behaviour by removing inhibitions, but heroin acts to depress aggression as well as appetite and sexual drive. Other effects include constipation and suppression of coughing relief. After a ‘fix’ a sense of well-being replaces feelings of depression or low self-esteem and this is followed by sleep ‘going on the nod’

Heroin is either taken orally or administered by intravenous or sub-coetaneous injection. The common way of taking it at present is called chasing the dragon, in which a flame heats powder on a piece of paper and the resultant fumes are inhaled. It is also taken by intravenous injection (main lining), which delivers the entire available drug right into the blood stream, while providing the addict with a kick (rush or high) associated with a number of serious complications. This drug is commonly used in USA, UK, Soviet and Bavarian countries, Japan, China, Afghanistan, Pakistan and India. Dishware, (1997).

7. BARBITURATES

Barbiturates are hypnotic and sedative derivative of barbituric acid, which depresses the central nervous system. The barbiturate fall within the family of
depressant drugs and the first barbiturate was synthesized in 1864 from barbituric acid (malouanylureal). It was first manufactured and used in medicine in 1882 as barbiturate and released in the year 1903 under the trade name, veronal. Initially, barbiturates were used to induce sleep, replacing such kinds as alcohol, bromides and opiates. Since the appearance of lamina in 1921, several thousand barbituric acid derivatives have been synthesized. Singh, Ravindra (1979).

Barbiturate until recently were the most widely used drugs in retain and many other countries, and were mainly used under the cover ‘sleeping pills’. The fact that these drugs were obtainable legitimately on a doctor’s prescription made them to be regarded as an acceptable and relatively harmless medicine, compared with known addictive drugs like heroin, which were not available in the same way. Barbiturate is extremely dangerous drug when the prescribed dose is exceeded and particularly when combined with alcohol. A lethal dose need not be much more than double the prescribed dose in some cases. As drugs, which depress the central nervous system and slow down vital functions such as breathing and heart rate, barbiturates are potentates by alcohol, which is also, a central nervous system depressant. The combined effect is considerably more powerful than that of it amount of the drug or alcohol taken separately. Gold (1991).

Barbiturate users often take other drugs as well. A common abuse pattern is to take ‘amphetamines’ to wake up and offset the morning-after barbiturate hangover. With the passage of time more barbiturates are needed to fall asleep and as the dose increases so does the need for more amphetamines until vicious circle develops. Other drugs, which interact with barbiturate, are tranquilizers, antihistamines, and opiates, which also depress the brain’ control over breathing, and increase the risk of respiratory failure.
ROLE OF GOVERNMENT IN DEALING WITH DRUG PROBLEM

The Ministry of Education was responsible for taking measures with regard to prevention of drug abuse among adolescents. It has been realized that it is not only the duty of government but also the private organizations like school, family and community should collectively take this special activity of life skill thinking, to awareness of right and wrong and bring discipline among the adolescents. Various strategies have been recommended that these agencies and organization may adapt to affect this problem:

1. To introduce project and workshops by the schools for better co-operation and protection of students.
2. The religious institutions should support the juvenile by contacting them through schools and inculcate moral values.
3. To entrust the juvenile with responsibility and to make them feel a part of society by involving them in various activities of school, religion and society.
4. To involve the juvenile in sports and other health activities so that they can be made aware of their health.
5. To introduce the various modes of entertainment and refreshment.
6. Promotion of art and insight into nature so that they can develop creative thinking.
7. To involve juveniles in local cultural programmes and other community programmes to inculcate a feeling of self – belongingness and pride.
8. Most importantly, schools should hold awareness camps to teach skills and to prevent drug addiction and avoid getting tempted to drug building a network in the school.

9. Cooperation from the parents to cure and prevent students from getting into drug addiction.

Moreover, prevention problem is the main aim of the Ministry of Education. The main plan for preventing drug addiction in school is applied at every level of education and aimed at students and youth by providing them with the knowledge to make their own decision to practice the right way and develop a permanent habit in avoiding narcotic drug. (ONPEC, Document No.16-1994X An order by the Prime Minister’s 141 - 1999 letter dated April 19 - 1999 had this slogan on drug problem “Private Government Committee Together To Do Away With Drug Problem”. It means all mentioned above should work as unit to cooperate and to prevent drug problem.

The main recommendation of Prevention and Eliminator Drug Committee, (1999) under the national policy scheme is as follows:

1. To make strategies for prevention by making more stringent laws, bringing awareness in educational institutions and preventing use of drugs in the entertainment areas.

2. To strengthen awareness programme amongst the parents, community, education and religion institutes.

3. To frame rules against the production and selling of narcotic drugs.

Since the rapid expansion of drug problems have become threatening situation deterioration peace of all Thai societies, this critical issue has invoked public awareness on the exigency needs of the effective counter measures against drugs. Especially, at present, H.E. Pol. Lt. Col. Thaksin
Shinawat’s administration has proclaimed drug control policy as the urgent policy of the nation with an immediate action. As to share a common brain–storm, the first national workshop on the strategy to overcome drug has been held in Chiang Rai during March 10 – 11, 2001. As a result, the Prime Minister’s Order No. 119-2001 and 120/2001 (issue dated May 31, 2001) on the guideline on the Strength of the nation to Overcome Drug have been imposed. In addition, the 9th National Economic and Social Development Plan B.E 2002-2006 has been deliberately designed to facilitate and mobilize all drug control measures correspondingly.

GOVERNMENT POLICY

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

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

2. Strictly control the importation of chemicals, which may be used in the production of drugs. Strengthen the mechanisms of the public sector as well as legal measures so that they may be able to keep up with the evolution in technology involved in the production of drugs.
3. Foster cooperation with the international organization and the international community in order to control and eradicate drug production bases as well as transnational networks for the distribution of drugs.

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

KNOWLEDGE AND PREVENTION FOR DRUG ADDICTION

Knowledge and prevention are better than cure, so this awareness and preventive work should aim at both short-term and long-term benefits of the population. In Thailand enormous amounts of money has been spent by the government every year on this seemingly impossible task. The 1996-2000 statistics show that the problem of narcotic drug seems to remain the same and not even a small decline in drug abuse has been witnessed. The picture is very dark on the curative side of the task. So, it is really a serious and fathomless social setback as far as human welfare is considered.

Today, the most widely used types of treatment to combat narcotic addiction in this country are the following:

1. Communities: Prioritize the wisdom and energy of survivors and their communities at the grassroots. Community organizing empowers activists to incorporate an ethic of self-determination when they address sexual and therapeutic domestic violence. Community taking leadership to develop values
and strategies for safety and accountability on their own terms not only addresses rape and abuse, but also builds opportunities for long-term social change. Narcotic Control Board, (2002)

2. Methadone maintenance and detoxification centres: For users who have tried treatment and filed, methadone maintenance programme have been a popular way to control the negative effects of opiate dependence Page Wise, (2001).

3. Force institutionalization: Drug-involved offenders generally exhibit complex needs which likely involve housing, education, vocational rehabilitation and opportunities, health care needs and mending of the family unit. Coordination mechanisms among all service agencies must be in place for managing such comprehensive problem. Meeting these needs, with the goal of reducing relapse and recidivism rates, will require probation/parole officers to be cognizant of all resources within the community. Agencies must further effect cooperation and communication in order to avoid fragmented approaches which have little chance of success Oakland, (1997-2001).

4. Drug-Free for Out Service: The Drug Free Ambulatory Substance Abuse Treatment Programme is a medically supervised programme providing services to males and female from the ages of 18 and older (including HIV counseling, Testing and AIDS treatment therapies). Promesa, (2002)

5. Narcotic Antagonist: They are especially useful in cases of overdose where they can reverse the CNS depression caused by opiate antagonists. Naloxone is the most often used, most effective, and prototypal narcotic antagonism. Naloxone, Nalmefene and Nadine are among several other compounds used to antagonize morphine receptors. Besides, Narcotic antagonists (Naloxone) do not have against activity at any of the opined

6. Center for treatment of non-narcotic drug abuse; Services may be organized around the Drug of abuse, as is the case in many methadone clinics. Or they may be organized around the needs of the programme. Alex Brumbaugh, (1999).

According to statistics, the problem of narcotic drug tends to increase although the government has put much emphasis on preventive measures. Looking at the seriousness of the problem of drug abuse, it is important that the Thai government adopts some measures to prevent this problem.

Looking at the seriousness of the problem of drug abuse, it is important and necessary to study the effect of drugs on mental health of secondary school students and their academic achievement.

MENTAL HEALTH

Mental health covers an elusive and diffusive field and the term itself encompasses a multiplicity of meanings. Jahoda (1958) who made comprehensive survey of the criteria suggested in the literature and the solutions proposed by her or the criterion problem meant step forward.

However her truly important contribution is her synthesis resulting in the formulation of six criteria of positive mental health, which she describes as follows;

1. Attitudes towards the self; they’re the accessibility of the self to consciousness; the correctness of the self-concept; its relation to the sense of identity and the acceptance by the individual of his own self.
2. Growth, development, and self-actualization; the extent the individual utilizes his abilities; his orientation towards the future and his investment in living.

3. Integration: the extent to which the psychic forces are balanced; a unifying outlook on life and resistance to stress.

4. Autonomy: the aim here is to ascertain whether the self-reliant person is able to decide with relative ease and speed what suits his own needs best.

5. Perception of reality: a relative freedom from need-distortion and the existence of empathy. Environmental mastery under this heading is listed: Ability to love work and play adequacy in interpersonal relationships; adaptation and adjustment; and efficiency in problem solving.

Skinner (1960), quoting UNESCO documents writes, “the whole mental health turns upon the solutions sought and found to the twin problems of maintaining personal security and moving found to resolve the continual challenges presented by the environment”. 

According to Auckerman (1961), “positive mental health is a process not a static quality in the possession of anyone. It is not self-sustained. It can be maintained only by continuous striving, an the emotional support of others is needed to keep it.”

Allport (1961) describes that a mature personality is synonymous with soundness of health as having six salient qualities:

1. Extension of human endeavour beyond immediate self-interest.
2. Warm relating to others. Because of self-extension, the mature person is more capable of intimacy and also of respect and comparison.
3. Emotional security (self-acceptance). This is reflected both in frustration, tolerance and in trust.

4. Realist perception skills assignments. This includes not only accurate judgment, but also the capacity to lose oneself in one’s work.

5. Self-objectification; insight and humour. To know oneself and to laugh at oneself requires mature detachment.

6. A unifying philosophy of life. The mature person has a sense of direction and purpose and a broad personal philosophy.

*Peck and Mitchel (1962)* mental hygienists, feel that characteristics like rationality, autonomy, initiative, emotional maturity, self-realizing drive, self-acceptance and respect for others must be included in a definition of mental health. *Engle (1968)*, has emphasized in the shift from static disease state to the processes which move human adaptation from a pole of mental health towards one of mental illness.

Opposing a discrete disease orientation, *Menninger et al. (1963)*, proposed that psychological diseases are the same in quality though differing in quantity. They represent positions towards health or towards illness along a single scale. At the extremes, between life and death, position is determined by stresses, internal and external acting upon the person and his coping resources. Neither is there a fixed state of mental health nor disease entities but rather degrees of effectiveness (or contra wise disorganization, dysfunction or decontrol) of the adaptation processes.

*Dunn (1964)* suggests that mental health or well-being must involve a balance among several components (neuromuscular, chemicals, mind, and body) of the individual and the society in which he lives.
The National Association for Mental Health of America (1964) describes a mentally healthy person as “one who feels comfortable about himself, feels right about other people and is able to meet the demands of life”.

Various researchers like Schroeder (1965), (Bennett(1973), Vandewiele (1979), Sharma (1984) and Brown (1985) have explored the area and concluded that mental health and mental illness are dynamic concepts and to a large extent are culturally determined and are defined differently in different parts of the world.

Mereness and Karnosh (1966) wrote that, to diagnose mental illness the individual must be studied in a totality as he is engaged with varying degrees of success in adjusting to his environment and as his environment affects him.

Offer and Sabshin (1966) have surveyed the many meanings of normality which have arisen in psychology, psychiatry, sociology and anthropology. Normality is then the wide range of functioning, which has in common that it does not represent a disease state.

Bower (1966) relates mental health to the competence with which an individual lives in his environment and the competence of social institutions (home, school, work, recreation etc.) to make this living as effective as possible. This approach considers mental health in terms of the quality of interaction between an individual and his environment rather than its interpsychodilic manifestations.

Kaplan (1971) writes, “Mental Health involves a continuous adaptation to changing circumstances, a dynamo process where a living reacting being strives to achieve a balance between internal demands and the requirements of a changing environment”.

According to Wolman’s B.B (1973) “Mental Health is a state of relatively good adjustment, feeling of well-being and actualization of one’s
potentialities and capacities”.

According to WHO (1973), in developing countries infectious diseases, parasitic diseases and malnutrition lead to many cases of mental disorder.

Townsend (1975) states “It is an established fact that cultures vary in the way they view mental disorders”.

Websters International Dictionary (1976) states; “The science of preventing the development of psychosis, neurosis or other personality disturbances is called mental health”.

According to the International Dictionary of Education(1977), “Mental health or mental hygiene is the maintenance of satisfactory personality adjustment and a relative absence of mental disorder”.

The Working Group on Health Education of children and young people (1978) pointed out that “school teachers are ill-prepared on health issues”.

The Word Health Organization (1981) points out that a nation’s greatest asset is its people, the more so when they are endowed with the highest attainable standard of health, which promotes creativeness, dynamism, determination, productivity and the self-confidence to move ahead. Health is basic requirement, not only for the fulfillment of human aspirations but also for the enjoyment by all mankind of a better quality of life.

Tsung-Yi Lin (1983) pointed out that mental health programme which aim to cultivate and promote human development should take the family and school as strategic targets, for these two social institutions represent the foci of the work intensive human interaction where conduct and learning are fostered modified.

Longman’s Dictionary of Psychology and Psychiatry (1984) states; “mental health is a state of mind characterized by emotional well-being.
relative freedom from anxiety and disabling symptoms and a capacity to establish constructive relationship and cope with ordinary demands and stress of life”.

Advisory Committee on Medical Research Sub committee (1985) concluded not only the hazards of the physical environment but also those that were a consequence of human behaviour in the term “environmental”. The influences determined by behaviour were very important in some of the diseases of poverty, especially in relation to the diseases of maladaptation and developed countries today they are probably the major determinants of ill health.

Verma (1986) states that “mental health sustaining influences of culture are characterized by social roles and institutions which reduce uncertainties and channelize gratification and by customs and rituals, sanctions and prohibitions, symbolism and folkways which serve culturally sanctioned defensive functions in the face of anxiety and guilt”.

Davis (1987) states that answer given nowadays to the question “What are the characteristics of a mentally healthy person?” are likely to refer to such signs as the capacity to co-operate with others and suction a close, loving relationship and the ability to make a sensitive, critical appraisal of oneself and the world about one and two cope with the every problem of living.

Appel (2000) states mental health as psychological well-being or adequate adjustment, particularly as such adjustment conforms to the community-accepted standards of what human relations should be. Among characteristics of mental health, he includes reasonable independence, ability to take responsibility and make needed efforts; ability to get along with others; ability to work under authority, rules and difficulties: tolerance of others and of frustration and sense of humour.
Mental health is a psychological state of well-being, characterized by continuing personal growth, a sense of purpose in life, self-acceptance and positive relations with others. Some people define mental health as the absence of mental illness, but many psychologists consider this definition too narrow. Mental Health can also refer to a field of study encompassing mental health, mental illness and mental care. Richard H. Price, (2002).

Definitions of mental health can be grouped into three categories as medical, psychological and social phenomenon.

Mental Health as a Medical Phenomenon: Those who view mental illness in disease terms believe that constitutional factors are largely responsible for many mental conditions and that genetic and biological factors play an important, if not prominent part in exploring the causes of mental illness.

Mental Health as a Psychological Phenomenon: Those who view mental illness as primarily disturbances of the personality conceive of such problems as repertoires of behaviour and patterns of feeling which have become deeply rooted as a result of the Childs social development and which persist through time, although they are inappropriate to effective social functioning and personal comfort.

Mental Health as a Social Phenomenon: Such theorists maintain that persons are labeled mentally ill because they fail to conform to certain social standards either because of their own unique understanding and viewpoints or because of their failure to develop certain social skills which others define as necessary. They argue that such difficulties are problems in living, which develop because of confusion in communication, maintenance of particular social rules, and enforcement of certain moral standards. The social-stress perspective is not based on an elaborate theory or concept. It is increasingly used as a rationale for public policy in mental health. This perspective assumes
that every person has breaking point and that mental illness and psychiatric
disability are products largely of the commutation of stress in people’s lives.
This perspective does not draw clear distinction between psychoses and other
kinds of problems causing psychological and social disability but great weight
is given to the idea that mental illness is environment caused.

ELEMENTS OF MENTAL HEALTH

Psychologist have identified a number of distinct dimensions of mental
health. These include self-esteem, characterized by a positive evaluation of
oneself and one’s past experiences; personal growth reflected in one’s sense of
continued psychological growth and development; a sense that one’s life has
purpose and meaning; positive relations with others; environmental mastery, the
capacity to manage effectively in the surrounding world; and autonomy, a sense
of self-determination and the ability to control one’s own life, self and
autonomy usually improve as a person ages and gains life experiences.
However, many people find that these personal growth and sense of purpose in
life begins to decline in midlife. Some psychologists regard mental health as the
ability to maintain a balance between positive and negative emotions, such as
elation and sadness. A person who displays emotional extremes in his direction
is less well adjusted. Other psychologists emphasize the role of one’s
environment influencing well being. This perspective sees mental health
reflected in a person’s overall happiness with various domains of life, such as
social relationships, work, and community life. Psychiatrists agree that
environmental influence have an importance impact on the development and
cause of some mental illnesses. They differ, however in theories of how
environmental force influence and interaction its biological and personality
influences.

The inter-relationship of the medical, psychological, social, psychiatry there is the rapidly growing field of social psychiatry. Persons working in this field usually take a broad perspective and make effort to include concepts of social role as well as personality in their thinking about mental health. Leighton (1960).

Mental Health problems of secondary school students are commonly related to their school achievement and the use to which they put themselves in their daily living, but at the secondary school level, perhaps a greater percentage of emotional problems are “Free Floating” in that they may not reflect scholastic and achievement problems as directly as they did in the elementary school. However, the firming up of one’s life in relation to schoolwork and achievement often assists in the improvement of general morale. The class room teacher and the school counselor or psychologist can often help the ailing secondary student by observing when the student is failing to live up to his or her own expectations seeing how other achievement problems often involving social accomplishment, or peer group acceptance-resemble problems of the student in the classroom can frequently help the student greatly in coming to grips with difficulties.

FACTORS, WHICH INFLUENCE MENTAL HEALTH

A number of different aspects of life can influence mental health, In mid-1970s study of people living in the United States, researchers identified critical areas that influence mental health. These areas are working life, family life, and the social role that one occupies in the community. Negative experiences in these areas, such as an unreasonable boss or a turbulent family life, can reduce
overall sense of well being.

Another important influence on mental health in stress. In general, people experience when the demands placed on them exceed the resources available to meet those demands. Significant sources of stress include major life events, such as divorce, death of a spouse, loss of a job and illness in the family. These events can overwhelm a personal ability to cope and function effectively. In addition, one source of stress may lead to another, as when financial hardship follows job loss. People who experience unusually traumatic events, such as rape and natural disasters, may develop post-traumatic stress disorder.

People may experience chronic stress when confronted with a continuing set of demands that reduce their ability to function. Examples of demands include working long hours under difficult circumstances and caring for a chronically ill relative. Economic hardship, unemployment, and poverty can also produce chronic stress and undermine mental health. Some studies suggest that genetic factors may partly determine one level of happiness and mental health. People seem to display a characteristic level of well being, with some people usually feeling happy and others typically feeling sad or unhappy. Researchers have found that although events, the effect wears off over time. Research suggests that genetic background that is, the genes inherited from parents explain more than half of the differences in people characteristic mood levels. Genes may also partly determine the range of ups and downs that people feel, including whether people have large mood swings or remain stable from day to day.
POLICY ON MENTAL HEALTH AND SUBSTANCE ABUSE

WHO (2002) has supported and concentrated on Mental Health and Substance Abuse projects as to a number of neuropsychiatries disorders among people, have increased worldwide. It is emphasized that the magnitudes of neuropsychiatry disorders in South-East Asia Region because 450 million people overall are affected due to neuropsychiatries conditions. One in four people will suffer from mental health or neurological disorders in their life. Globally, 12 percent of the total burden of disease is due to neuropsychiatric conditions.

WHO POLICIES ON MENTAL HEALTH AND SUBSTANCE ABUSE ARE

1. Mental Health Legislation, Policy and service Development, collaborative programme between SEAR and HQ
   - Faculty training workshop, USA, 1-3 July 2002
   - Policy-markers workshop, Tunisia, November 2002
   - National workshop in Indonesia
   - Sub-national workshop in Indonesia

2. Development of community-based neuropsychiatry services.
   - All member countries participating
   - Epilepsy and Psychoses
   - Workshop on Epilepsy in Yang on, September 2003
   - Workshop on Psychoses, early 2003
3. Community-based rehabilitation of the mentally challenged
   - Basic ADL rural programme
   - Advanced institution-based urban programme
   - Reintegration of long-stay patients

4. Mental health needs of vulnerable groups
   - Disaster victims (disaster mental health) (Natural disasters, war refugees)
   - Adolescent mental health
   - Elderly (mental and neurological needs)
   - Woman’s mental health

5. Assessment of magnitude of neuropsychiatry disorders in community
   - Bhutan (BHU), Indonesia (INO), Nepal (NEP)—complete
   - Indonesia (INO), Maldives (MAV)—planned
   - Inter-country workshop to discuss results
   - HQ sponsored project
   - Indonesia (INO), Srilanka (SRI), Thailand (THA)

6. Prevention of harm from alcohol
   - Inter-country workshop in Bali, Indonesia, Japan
   - Community-based projects: Bhutan, Indonesia, Nepal, Srilangka
   - Joint programme with CASH (SEARO and HQ)
   - Joint workshop in October-prevention of harm from substance abuse amongst adolescence
ACADEMIC ACHIEVEMENT

Academic achievement comprises of two words academic and achievement. The term academic has been derived from the term academy. The meaning of term academy is “a school where special type of instructions are imparted”.

Academic achievement has always been a crucial point and main focus of educational research. Among the various aims of education is academic development of the pupil which continues to be the primary concern and most importance goal of education. Secondary Education Commission, (1952-53).

According to Good (1959) the term academic means pertaining to the fields of english, foreign language, history, economics, mathematics, science, pertaining to the liberal arts field; pertaining to the realism of ideas or obstruction.

According to the Oxford Advanced Dictionary of Current English (1959), meaning of the term academic is” of teaching and studying in schools, college, scholarly, literacy or classical (contrasted with technical or scientific); too much concerned with theory and logic, not sufficiently practical.

The operational definition of term academic with reference to the study was any activity pertaining to scholastic in nature or any scholarly activity.

According to Good (1959), the term academic means pertaining to the fields of english, foreign language, history, economics, mathematics, science, pertaining to the liberal arts fields; pertaining to the realism of ideas or obstruction and the term achievement is an “accomplishment or proficiency of performance in a given skill or body of knowledge”. The same definition was accepted as operational definition in the study.
Academic achievement is the status level of person’s learning and the ability to apply what he has learned. Its means the extent to which teaching and study have resulted in mastery. It is the outcome of general and specific learning experiences. Academic achievement of pupils, refer to the subject knowledge attained and skills developed during their academic career in the subjects, which are assessed by the school authorities with the help of achievement tests, which may be either standardized or teacher made. In other words, Academic Achievement means the achievement of pupils in academic subjects, such as reading, writing, arithmetic, history, etc. Pressey, Robbinson and Horracks, (1959).

The justification of measuring academic achievement is based on the fundamental assumptions of psychology; namely, there are differences within an individual from time to time, from one class to another and from one educational level to other. Academic achievement has been assessed in variety of ways such as Grade Point Average (GPA), performance on standardized tests as the Stanford Achievement Test (SAT), the Science Research Associate Test (SRA) and scores on essay type examination etc. In many studies, performance in various courses, such as mathematics, science, reading and other areas, has been linked with another aspect of performance in the classroom, the verbal behaviours of high achievement and low achieving children.

Academic achievement is the proficiency of performance in a given skill or body of knowledge. It covers up all the fields where learning takes place. Good (1959), describes achievement of individual in a given skill or body of knowledge.

Academic achievement is a part of the wider term, education growth. It includes knowledge attained or skills developed in the school subjects that are usually evaluated by test scores or marks assigned by teacher or both Good.
Introduction

(1959). Thus academic achievement is the knowledge and skill obtained by a student in various subjects taught at school.

Trow (1960) defined academic achievement as the attained skills ability or degree of competence in school tasks usually measured by standardized tests and expressed in age or grade units based on norms derived from a wide sampling of pupil performance.

Crow and Crow (1969) defined achievement as the extent to which learner is profiting from instruction in a given area of learning.

“Achievement encompasses student ability and performance, it is multidimensional, it is intricately related to human growth and cognitive, emotional, social, and physical development; it is not related to a single instance, but occurs across time and levels, though a student’s life in school and on into post secondary years and working life”.

Academic Achievement is often referred to as the degree or level of success or proficiency attained in some academic work. Good (1973) defines academic achievement as “knowledge attained or skill developed in the school subject, usually designates by the test scores or by marks assigned by the teacher or both. In the present study academic achievement has been operationally defined as the works obtained by the students in theirs previous final class. According to Christian (1980), the word achievement indicate the learning outcome of students. As a result of learning different subjects, the behaviour patterns of the students change. Learning affects three major areas of behaviour of students (I) cognitive (ii) affective (iii) psychomotor. Christian (1980) is of the view that these three levels are not affected in equal measures at a time; a student may be at a higher level in one domain and lower in another. Cognitive area is primarily concerned with intellectual growth of an individual. It involves acquisition of basic intellectual skills, such as reading, ability to add,
subtract, learning of facts etc. The present study concerns itself with only the Academic Achievement of the students. It is known through experiences and experiments that Academic Achievement is affected by different variables.

According to Kohli (1973), academic achievement is the level of proficiency attained in academic work or as formally acquired knowledge in the school subjects which is often represented by percentage of marks obtained by students in the examination.

Achievement is defined as successful accomplishment or performance in particular subjects, areas or courses usually by reasons of skill, hard work and interest. It is summarized in various types of grades, marks, scores or descriptive commentary The Concise Dictionary of Education, Hawes and Hawes, (1987). Academic Achievement has been considered as an important factor in the educational life of the students. It encourages the students to work hard and learn more. Also it helps the teachers to know whether teaching methods are effective or not and helps them in bringing improvement accordingly. High academic achievement in school builds self esteem and self-confidence, which leads to better adjustment with the group. It is the prime and special responsibility of a school or any other educational institution established by society to promote a wholesome scholastic growth and development of a child.

The Concise Dictionary of Education (1987) stated that academic achievement means successful accomplishment or performance in particular subjects, areas or course usually by reasons of skill, hard work and interest and typically summarized in various types of grade, marks, scores or descriptive commentary.
According to Taneja’s Dictionary of Education (1989), academic achievement refers to performance in school or college in standardized series of educational sets.

In new Webster’s Dictionary and Thesaurus (1992) Achievement means to bring to a successful performance.

Achievement means successful accomplishment or performance in a particular subjects area or course, usually by reasons of skills, hard work and interest, typically summarized in a various types of grades, marks, scores or descriptive commentary Encyclopedia Dictionary of Education, (1997)

According to Oxford Advanced Learners Dictionary (2000), achievement is a thing that somebody has done successful, especially using his/her own effort and skill.

Landson Billing (1999) states that its best, academic achievement represents intellectual growth and the ability to participate in the production of knowledge. At its worst, achievement represents inculcation and mindless indoctrination of the young.

According to Megaragee (2002), achievement test is how well students have mastered the subject matter in a course of instruction.

In short, academic achievement is a measure of understanding or skills in a specified subject or group of students. The achievement may be for a particular subject or a total score of several subjects combined. Hence achievement is concerned with the quantity and quality of learning attained, in a subject of study after a period of instruction. Academic Achievement: refers to the degree or level of success or that of proficiency attained in some specific area concerning scholastic or academic world.
OFFICE OF THE NATIONAL PRIMARY EDUCATION COMMISSION (ONPEC)

ONPEC, the largest Department in Ministry of Education of Thailand is primarily responsible for management and administration of state primary schools throughout Thailand. Since 1990, ONPEC was currently responsible for the provision of basic education at three levels: pre-school, primary school and lower-secondary school. By 1994, there has been at least one ONPEC School offering nine years of basic education in each school cluster. By 1996, over 5,000 ONPEC schools offer the lower-secondary education classes. The number of schools increasing annually is known as Expansion Opportunity School. They use curriculum designed by the curriculum and instruction Development Department. The total number of lower-secondary school students under ONPEC is 494,942 (Introduction ONPEC, Ministry of Education, 1997)

However, narcotic drug problem still exists not only at the primary level, but also at all levels of education institutes, especially at the secondary education level when the students are at the beginning of adolescence. These students spend 8 hours per day and 200 days per year, or more than half the year in school.

The prevention of drug dependence in the younger generation could be a part of a wider programme of providing services for the child in his early school education. The school should become a "Therapeutic community" for drug prevention. It is so believed that success of any treatment programme can create knowledge, changes and may involve teacher, curriculum guide, former users and other professionals. Lower-Secondary Curriculum is aimed for the learners to improve their life quality or to acquire basis for further education to be able to choose ways of making themselves responsible and playing their roles and
duties efficiently under the democratic system. The learners are expected to acquire sufficient knowledge and skills to choose and develop required competencies to be successful in the world of work.

CURRICULUM FOR THE LOWER SECONDARY STUDENTS IN THAILAND


Since the promulgation of the secondary school curriculum by the Ministry of Education in 1978, there have been continuous efforts to monitor and evaluate curriculum implementation of various agencies in order to facilitate curriculum development.

Evaluation indicated that the 1978 curriculum was not responsive to the rapid changes in socio-economic conditions and the scientific and technological progress. It did not adequately enhance people's knowledge, morality and ability to become self-reliant in keeping with those changes and to apply appropriate technology in improving their quality of life. In the light of the above findings the Department of Curriculum and Instruction Development (DCID), which is responsible for the development of primary, and secondary school curricula has therefore taken steps to make the lower secondary school curriculum more relevant to the changing conditions as well as the present and future economic and social needs of the country.

The 1990 Revised Edition of the 1978 Lower–Secondary School Curriculum put more emphasis on the thinking process and actual practice. The curriculum structure constitutes a reduction in the number of periods of
compulsory courses and an increase in the number periods of free elective courses in order to provide opportunity for learners to broadly select studying general subjects and vocational subjects and to have some place for activities, which develop and discover their abilities, aptitudes, and interests. To make possible easier application of the curriculum to the teaching and learning, guidelines for implementing the curriculum have been incorporated so that effective provision of education in accordance with the aims of the curriculum could be arranged. Chamreun Sekhthecra, (1991).

CURRICULUM GOALS

To ensure that basic education management is in line with the national policy for education management:

1. Education shall aim at unity of the nation, emphasizing Thai-ness and integration international consciousness.

2. Education shall be for all Thai citizens who shall have equal rights to be educated, where as social institutions shall be invited to be state partners in education provision.

3. Learners shall be supported in order that they develop continuously and as lifelong learning, taking into consideration that learners are the most important and learners are capable of self-development and self – realization.

4. The curriculum structures, substance, time – frame and learning management processes shall be flexible.

5. The curriculum shall be applied to all education systems. For all target groups the learning result and experience shall be equated and transferred.
CURRICULUM AIMS

Lower Secondary School level education shall aim at the full development of Thai people in all aspects: morality, intellect, and happiness, Thai-ness potential in furthering education and securing careers. To implement these ideals the following goals and standards are stipulated:

1. Self-esteem, self-disciplines, strict observance of religious teaching and practice, morality, right behaviour, and desirable virtue.

2. Creative thinking, thirst for knowledge and learning, acquiring reading, writing and research habits

3. Universal Knowledge, keeping pace with changes and advancement in academic world, skills and potential for communication and technology management, adjustment of thinking and working processes to encounter changing situations


5. Physical exercise for good health and personality.

6. Efficiency in producing and consuming preference for producing than consuming.

7. Knowledge of Thai history, pride in being a Thai, a good citizen who strictly observes democratic ways of life, under a regime of constitutional monarchy.

8. Consciousness in the preservation of Thai language, art, culture, customs, sports, local wisdom, natural resources and environmental development.
9. Love and dedication to the country, community and contributions to the society’s prosperity.
{See curriculum in appendix (B) for details}.

NEED OF THE STUDY

Drug abuse is one of the most complex and baffling of vices. There is no one given set of circumstance or no one combination of factors that invariably assures that someone will turn to drugs.

Drugs continue to damage and indeed destroy far too many human lives. The costs associated with their use continue to impose a heavy burden on the social infrastructure of numerous countries, whether developed or developing. The devastating impact of drug abuse by young student appears very familiar today.

The present study is mainly designed to investigate the drug abuse in Thailand among young students at the age 13-16 years. Thailand is one of the many countries where problem of narcotic drugs exists. Drug addiction in Thailand since 1950 has been regarded as a significant public health problem.

The present study lays its stress on drug addiction of adolescent, which affect the users but also others like parents, siblings, close friends and workers. The subject of the present thesis is a comparative study of mental health and academic achievement of student as drug users and non-drug users in secondary schools in Thailand.

The present research is confined to secondary school student in class 3 (Mata Yom suksa3) in the Department of General Education Schools in Lampang Province, Thailand.
Introduction

STATEMENT OF THE PROBLEM

“COMPARATIVE STUDY OF MENTAL HEALTH AND ACADEMIC ACHIEVEMENT OF DRUG USERS AND NON-DRUG USERS IN SECONDARY SCHOOL STUDENTS OF THAILAND”

OBJECTIVES OF THE STUDY

The objectives of this study are as follows:

1. To identify drug users in secondary school students of Thailand.
2. To study the mental health of drug users and non-drug user students in secondary schools.
3. To study the academic achievement of drug users and non-drug user students in secondary schools.
4. To study the relationship between mental health and academic achievement of secondary school students.

HYPOTHESES

Following hypotheses have been formulated for the study.

1. There will be a significant difference between drug users and non-drug user students in respect of mental health.
2. There will be a significant difference between drug users and non-drug user students in respect of academic achievement.
3. Drugs will have a significant negative effect on the mental health of drug user students of secondary school.
4. There will be significant relationship between mental health and academic achievement.
DELIMITATIONS OF THE STUDY

1. The present research is confined to secondary students in class ninth (Mattayom suksa 3) in the Department of General Education Schools in Lampang province, Thailand.

2. The drug users sample is confined to secondary students in class ninth (Mattayom suksa 3) in Drug Narcotic Control Centre Lampang Province, Thailand.

3. Non-drug users sample is selected from Secondary education level of four districts in Lampang Province, Thailand.

4. A Purposive sample of 400 students has been considered for present study. Half of them are drug users and another half are non-drug users.

5. The study is confined to the following tools:
   b. Academic achievement test from Ministry of Education of Thailand (2001)
   c. Survey questionnaire of students Salapan, (2001)

DEFINITION OF IMPORTANT TERMS

1. Drugs means substance used as a medicine of in medicine that stimulates the system especially, one that is addictive. e.g. alcohol, cocaine, heroin or Ya ba (Encyclopedia of psychology, 2000).
2. Academic means institutional system of formal education within a school, college or university *Panda, Bhugendra and Samal*, (1995)

2.1 Referring to the institutional system of formal
2.2 Theoretical and not of practical importance
2.3 A scholarly person who works in higher education as


3. Achievement means successful accomplishment or performance in a particular subject area or courses, usually by reasons of skills, hard work and interest, typically summarized in various types of grades, marks, scores or descriptive commentary. *Encyclopedia of Education*, (1977).

4. Academic Achievement refers to the degree of level of success of that of proficiency attained in some specific area concerning scholastic or academic work.