dianova
aprender | crescer | concretizar

cies centro de investigação e estudos de sociologia
iscte
centre for research and studies in sociology

"Trajectories, from addiction to reintegration

Study of drug addicts social trajectories after therapeutic process"

(PTDC/CS-SOC/099684/2008)

Report II

FCT Fundação para a Ciência e a Tecnologia
MINISTÉRIO DA CIÊNCIA, TECNOLOGIA E ENSINO SUPERIOR

“Trajectories, from addiction to reintegration

Study of drug addicts social trajectories after therapeutic process”

Progress Report

Contents

Figure index

Table index

Introduction

The present report aims to present and discuss the empirical material collected in the second phase of the research project "Trajectories, from addiction to reintegration - Study of drug addicts' social trajectories after therapeutic process". This data results from a telephone questionnaire survey applied to ex-users of the **Therapeutic Community *Quinta das Lapas* of Associação Dianova Portugal**.

The exposure of the material is structured as follows: a first section describes the strategies implemented during the fieldwork; the remaining chapters refer to thematic sections. The first section presents the sample studied in terms of gender, age and residential situation. A second block deepens the issue of schooling and lifelong learning. Later we explore some factors related to the labor market. A fourth section presents the family situation of respondents. A fifth chapter is devoted to the drug use situation. Subsequently, we analyze several indicators of the social reintegration process. A final chapter presents a short assessment of the therapeutic community treatment services. In the conclusion is indicated the future directions of the research project in progress.

Method

The collection of empirical material for this phase of the project followed this methodology: In the first phase of the project, when was collected the information present in the processes of the therapeutic community users, were also collected all the available contacts, both for users as for friends, relatives or technicians that gave assistance to the user. The subjects in study have been informed by staff from the therapeutic community (by mail, e-mail or telephone) that they would be contacted by members of the research team; informing them of the nature of the study and requesting their participation.

The first approach consisted of a telephone contact with the former therapeutic community users, in the impossibility of this contact; we used the contacts of friends, relatives or technicians associated with the user. If these contacts also were not successful, we tried to get new contacts, through the telephone information services (1820), searching by name and/or addresses of users, or the name and/or address of friends and family of the users. It was also made some approaches via email, which allowed the subsequent realization of one (1) telephone interview. In short, often contacts were established through chains of contacts more or less distant. The fieldwork took place between September 20 and December 2 of 2010.

Contacts performed

From the database of 115 users, it was possible to know the whereabouts of 80 of them.

Table 1: Contacts performed

	n
Contact done	80
Contact not done	35
Total	115

Being that of these 80 contacts, 63 led to an interview.

Table 2: Interviews done

	n
Interview done	63
Interview not done	17
Total	80

There were only registered six explicit denials, other cases of difficulty or inability to contact where due to the death of the ex-user (6), with emigration projects (5) or relapses (4). Nevertheless, in some situations of absence from the country or relapse, it was possible to interview the user (cases not shown in table 3).

Table 3: interviews not achieved, n=17

	n
Refusal[1]	6
Deceased	6
Relapse	3
Away from the country	4

Note: possible multiple situations

In most cases where the contact was made, it was possible to establish contact with the user himself, but often this contact has not been established at the first attempt, table 4 shows the last person contacted to each user. Only in 37 cases we could not establish any contact, usually because the phone number was currently nonexistent; or the phone was not answered, despite several attempts in different times of day; other reasons were that the contact we had didn't match the name, or that there were no phone number attached to the address we had.

[1] Of these six denials two of them were made by the ex-users, and four by family.

From the list below (Table 4) two of the interviews were administered to family members (fathers) who agreed to respond to the survey, one case because the subject as relapsed, so his whereabouts were unknown; another one because as migrate, and where also unaccounted for.

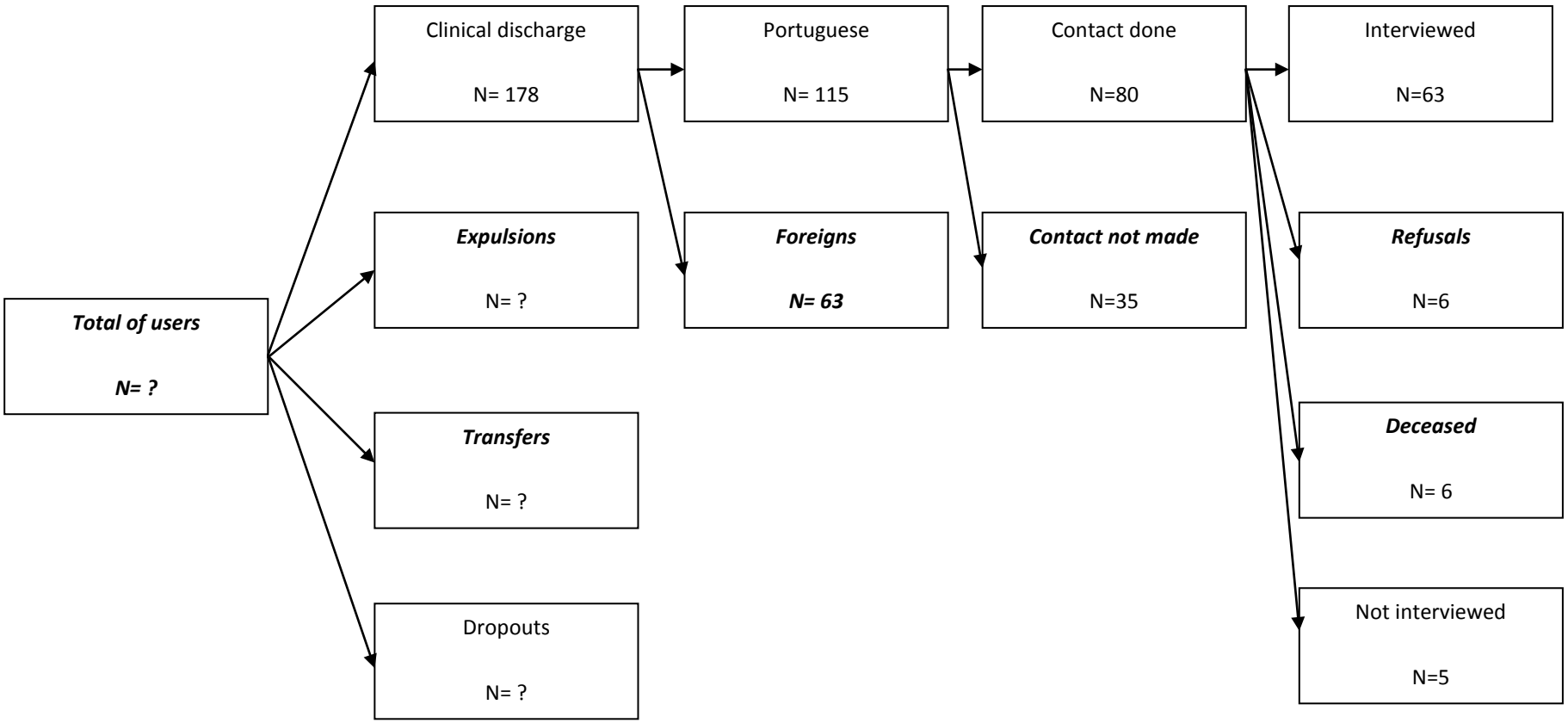
Of the six former users who died, two deaths were due to problems related to drug abuse, two of them died due to other health problems. It is assumed that the death was not directly related to drug abuse, since they didn't relapse after treatment. In two other ex-users the reason of death is unknown.[2]

Table 4: Contacted person

	N
Himself	63
Relatives	13
Person who created him	1
Social worker	1
Unable to establish any contact[3]	37
Total	115

[2] The cause of death of two ex-users is unknown since it has been notified by the therapeutic community.
[3] The difference between these 37 cases and 35 contacts not performed was due to the death of two ex-users who were aware in advance.

Figure 1: Contact model



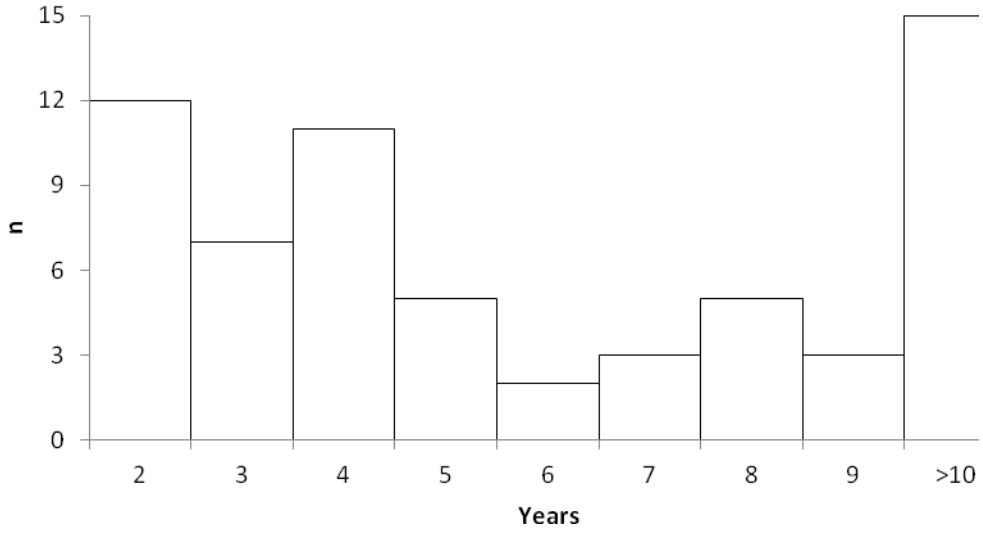
Duration of the interview

On average, the application of each telephone survey lasted 12 minutes (SD = 6) having the shorter interview the duration of 6 minutes and the longer 34 minutes.

Time since treatment

The subjects interviewed completed the treatment for about 5.79 years. Being more frequent those who finished treatment for 2, 3 and 10 years, as shown in Figure 2.

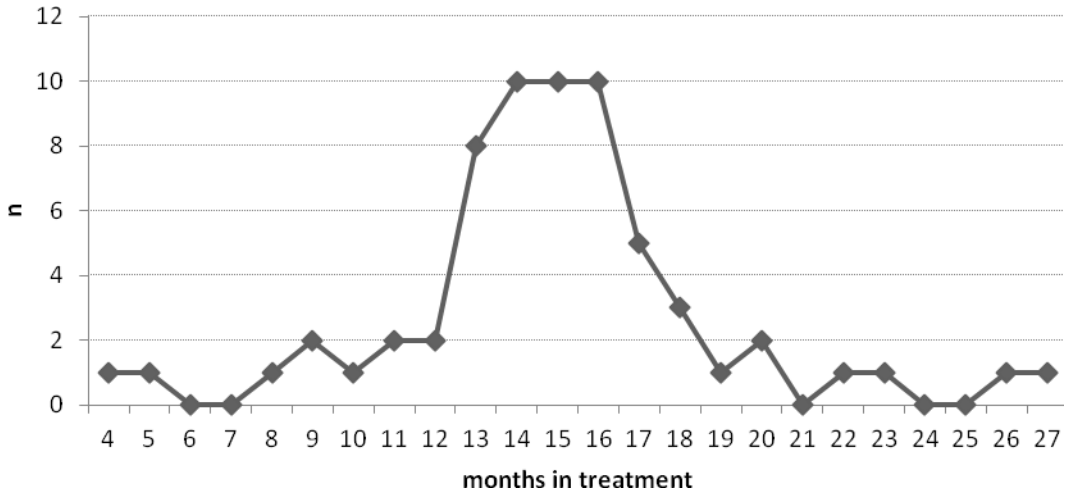
Figure 2: Years since discharge



Duration of treatment

According to the literature, there is a relationship between the duration of the treatment program in therapeutic communities and the probability of success (Leon in Vieira 2008 p.28). It thus seems important to know the duration of therapeutic treatments. The duration of these vary between 4 and 27 months, with an average 15 months and variability (SD) of about 4 months (Figure 2). That is, there appears a high uniformity in the duration of treatments, which may make unfeasible the establishment of this as an independent variable.

Figure 3: Treatment duration (months)



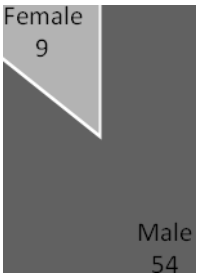
Socio-demographic

In this section, is briefly presented some of the socio-demographic characteristics of the subjects, namely sex, age and place of residence. Other items related to socio-demographic will be analyzed in greater depth in subsequent chapters.

Sex

In terms of sex ratio were interviewed 54 men and 9 women. There are on average about 6 men for each woman.

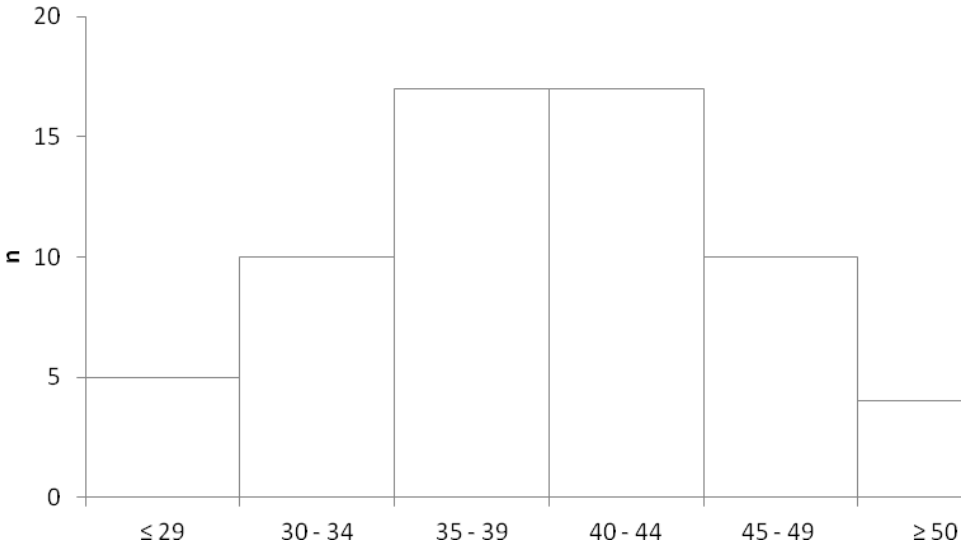
Figure 4: Sex ratio (n)



Age

In terms of age distribution, a large part of the subjects had between 35 and 44 years old.

Figure 5: age groups (n)



Residential situation

It was intended to meet the residential mobility of subjects in the study, since it could be a strategy, whether to break with formers drug abuse environments, or as an attempt to start a new life project. It became known that less than half of respondents (27) changed their residence since the end of treatment in the therapeutic community.

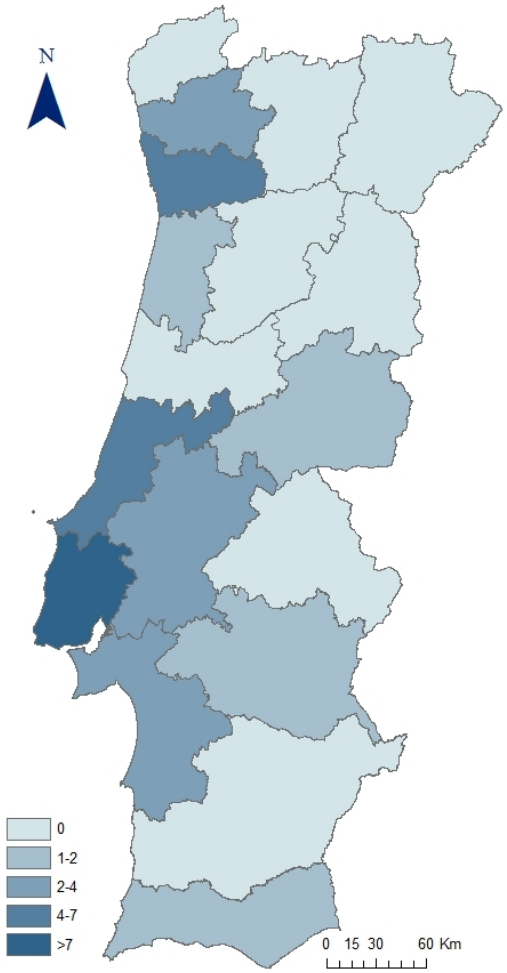
Table 5: Currently living in the same address as when was admitted in the treatment

	n
Yes	27
No	35
Didn't answer	1
Total	63

Regarding the place of residence (Figure 6) a bigger part of the subjects (26) lives in the district of Lisbon. Currently, more than half (35) no longer resides in the same address than when entered in the therapeutic community. It should be noted that some subjects (6) probably intimidated by the question,

chose not to reply. It should also be noted that two of the subjects were admitted to therapeutic communities when interviewed.

Figure 6: Current residence of subjects by district



If we compare only the residences of ex-users who have changed the place of residence, we note that there are departures from districts like Aveiro, Bragança, Viseu, Vila Real and Lisbon, one change to Faro and Braga and two projects of emigration. Often these changes are intra-district or intra-municipalities, thus escaping this broader analysis at the district level.

Table 6: Place of residence of subjects who changed residence, before treatment and nowadays, by district (n)

	Before treatment	Nowadays
Aveiro	4	-
Braga	2	3
Bragança	1	-
Faro	-	1
Leiria	3	3
Lisbon	16	14
Oporto	3	3
Santarém	1	2
Setúbal	1	1
Viseu	1	-
Vila Real	3	-
Oversea	-	2
Didn't answer	-	6
Total	35	35

Reasons for the change of residence

It was asked to ex-users what where the reasons that justified their change of residence (Table 7), the most common case was the marriage or of civil union (10), however, the reverse situation is also observed, i.e., by dissolution of marriage or of civil union (2). Also common was to be assigned as a reason the old residence being the residence of relatives (9), the work-related reasons and fear of relapse were identified by four respondents, respectively.

Table 7: Reasons attributed to the change of residence

	n
Got married/went live together	10
Got divorced/separated himself	2
At the time of admission was living with relatives	9
At the time of admission was living in a sober house	1
Work-related reasons	4
Don't want to return to former place of residence/fear of relapse	4
Desire for independence	2
Wanted to stay near to the therapeutic community	1
Relapsed and was admitted in a therapeutic community in Setubal, then stayed there	1
Came to an sober house in Lisbon and stayed there	1
Moved but continues to live with the family	1

Note: response treated as multiple, total = 35

School situation

In this block is intended to ascertain the present situation of ex-users with respect to the acquisition of training, either scholar or professional. Given the low educational level observed in the first phase of the study, it was assumed that the acquisition of training could be a strategy activated in order to achieve a better social reintegration.

Educational level

Analyzing the education levels of the subjects at the time of the interview (Table 8), almost half of them (28) completed the general lower secondary education, and almost a quarter (14) finished general upper secondary education.

Table 8: Current educational level

	n
Primary education (4 years)	8
Primary education (6 years)	9
General lower secondary education	28
General upper secondary education	14
Vocational Secondary	1
Higher education	3
Total	63

When we compare the levels of education that the subjects had prior to treatment with the current situation (Table 9), is noticeable that that the major changes occurred mainly at the primary education of 6 years and general lower and upper secondary. There was a decrease in graduates with the primary education with 6 years of schooling and an increase on both lower and upper general secondary education. The frequencies of graduates of higher education are reduced: only one subject obtained a diploma in higher education, and another is currently attending a course with a university degree. These slight increases in educational levels after treatment had been shown in previous studies carried out in Portugal (Torres, Lito, Sousa and Maciel 2008 p.45).

Table 9: Comparison of educational level before treatment and nowadays

	Before treatment	Nowadays	Change
Primary education (4 years)	8	8	=0
Primary education (6 years)	18	9	-9
General lower secondary education	25	28	+3
General upper secondary education	8	14	+6
Vocational Secondary	2	1	-1
Higher education	2	3	+1
Total	63	63	

Post treatment training

For this study, was important to know if the subjects had received training either educational, or more practical (Table 10). This strategy was activated by about half (32) of former therapeutic community users contacted.

Table 10: Training after treatment

	N
Yes	32
No	31
Total	63

Completion of training

It was important for us to know if such training had been completed or discontinued (Table 11). When surveyed, 19 of the 32 subjects reported having attended and completed the training. Only two respondents did not complete the training and nine were at the time of inquiry to attend any type of training. It is also important to note that two of the respondents are expected to begin some kind of training (not counted in the subsequent section "type of training").

Table 11: Completion of training

	n
Yes	19
No	2
Currently attends	9
Hopes to start soon	2
Total	32

Type of training

When we analyze with some depth the type of training received by the subjects we realize that often are/were small training practices and not so much academic training. One subject had attended and completed university degrees, two have completed secondary education and two others obtained training at the 3rd cycle level. In what concerns the formations with lower levels of qualification, 4 subjects attended and completed the Novas Oportunidades (New Opportunities) program and two courses EFA (Education and Training for Adults).

The rest of the formations refer largely to smaller training courses very diversified. Stand out the computer courses that are available through various institutions like the Job Center, Vida Emprego (Employment and Life) and in some therapeutic communities.

Table 12: Types of training received

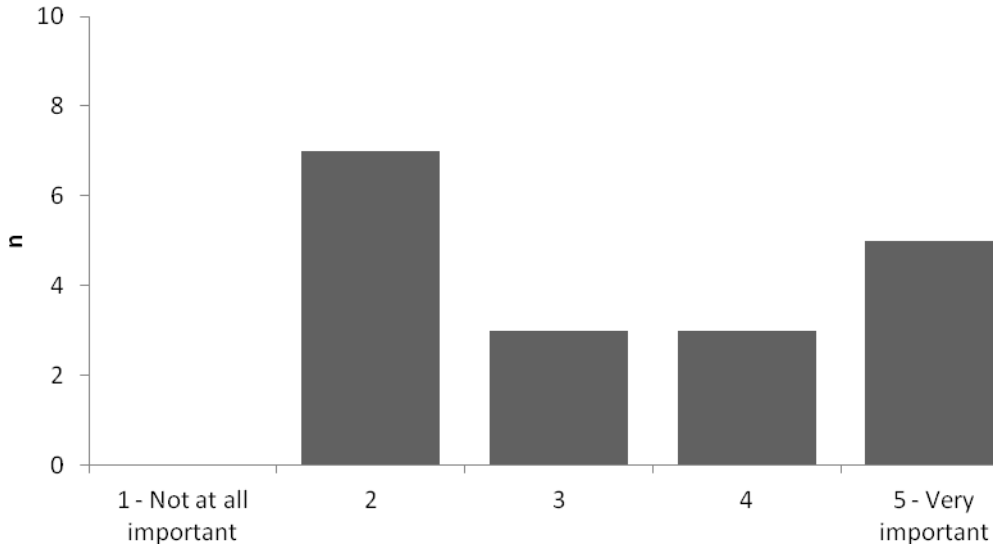
	n
Graduation	1
General upper secondary education	2
General lower secondary education	1
Novas Oportunidades (new opportunities)	4
Logistics and transportation	1
Organization of events	1
Electricity technician	1
Computers	7
Training of trainers	1
Geriatrics	2
Management	1
Hotel management	1
Conservation and restoration of patrimony	1
Catering	1
Handler of fish and birds	1
Music	1
Mechanics	1
Kindergarten	1
Advanced Microsoft Office Excel	1
Logistics	1
Olive culture	1
Customer management	1
Citizenship	1
Portuguese language	1
Drawing	1
Security and alarms	1
Driving license for trucks	1

Note: only selected the cases were the formation was completed or currently attending, responses treated as multiple, total=28.

Importance attributed to the training

Subjects was asked about the importance they attributed to the training they get, especially at the professional level, since the aim was to understand the importance of training in the insertion in the labor market and not other situations like self-realization or curiosity. Looking at the responses was calculated an average of 3.33 in a 1 to 5 scale. Although no one has assigned the minimum value, the most frequent case was the second, considered a negative evaluation.

Figure 7: Importance attributed to training at a professional level



Work situation

We propose the hypothesis that labor integration is essential for a successful social reintegration, since this is the way most of the adult population occupies much of his time. [4] Bearing in mind that the labor component was something overlooked by most of these subjects in the period prior to treatment, it is important to explore this component.

Economic activity status

Regarding to the condition of economic activity in the period previous to treatment (Table 13) almost half of subjects (35) found themselves unemployed. This pattern in common in studies of drug users in Portugal (IDT 2010 p.35; Torres, Lito, Sousa, and Maciel 2008 p.36). However, we should note that although this situation is dominant is not unique, since 23 out of 63 subjects found to work before entering treatment. In what concerns the condition of economic activity at present, the proportion of assets profession increases to 42. Although the unemployment decreased, it still affects about a quarter of respondents. Similar migration had also been observed in the follow-up study previously mentioned (Torres, Lito, Sousa, and Maciel 2008 p.46).

[4] According to the official statistics data, the employment rate (15 + years) in the first quarter of 2011 was 53.9%.

Table 13: Economic activity before the treatment and nowadays (n)

	before treatment	Nowadays
Unemployed	35	16
Employed	23	41
Retired or disabled	2	2
Student	-	2
Interned	-	2
Arrested	2	-
Didn´t answer	1	-
Total	63	63

Occupation

Regarding occupation it´s considered important to know it in three key moments, before admission, after treatment and at the time of application of the survey (Table 14). Generally, at the period prior to the treatment entrance, dominated the group of the "craft and related trades workers" (17) the "service workers & shop & market sales workers" (9), and also some clerks (6). Looking at the first job after leaving treatment is noticeable that the number of "craft and related trades workers" decreases (17 to 8), increasing the number "service workers & shop & market sales workers" (9 to 13) and clerks (6 to 9). Looking at the current profession and comparing it with the first job after treatment is possible to verify that the proportion of "service workers & shop & market sales workers" and clerks remain similar (13 to 12 and 9 to 10 respectively). The number of "craft and related trades workers" and "technicians and associated professionals" decreases (8 to 6 and 7 to 3 respectively) and the class of "professionals" slightly increases (3 to 5).

Table 14: Occupation at the time prior to treatment, after the treatment, and nowadays (n)

	Occupation previous to treatment	First occupation after treatment	Occupation nowadays
Legislators, senior officials & managers	4	4	5
Professionals	2	3	5
Technicians and associated professionals	4	7	3
Clerks	6	9	10
Service workers & shop & market sales workers	9	13	12
Skilled agricultural & fishery workers	4	5	5
Craft and related trades workers	17	8	6
Plant & machine operators & assemblers	5	6	9
Elementary occupations	3	6	6
Can´t remember/never worked	9	2	2
Total	63	63	63

Professional status

Now, is observed the professional status in two moments: before treatment and at the time of the survey interview. The vast majority of respondents (46) used to work for others, there was however a small quantity of self-employed (6) and informal workers (3). Comparing with the professional status nowadays, we find that there aren't relevant differences, only the increase in the number of self-employed without employees, which can indicate some upward social mobility.

Table 15: Professional status before treatment and nowadays (n)

	Before treatment	Nowadays
Employed by others	46	45
Self-employed without employees	3	8
Self-employed with employees	3	2
Casual labor	3	1
Not applicable/no answer	8	7
Total	63	63

Type of contractual relationship

Regarding the type of contractual relationship that the subjects had prior to admission it is clear that much of this was characterized by a formal relation. The number of workers with a contract with term almost matched with the number of workers employed without term (22 *vs*. 20).

Comparing the type of contractual relationship in the two moments in time is observed that the proportions of informal situations (working without a contract, family business, worker at task) remain (4), but the proportion of contracted without duration decreases (22 to 15). That is, it is assumed that subjects who had greater employment stability, eventually lose it during drug abuse, and now migrate to a situation of contract term, with less stability.

Table 16: Contractual relation before treatment and nowadays (n)

	Before treatment	Nowadays
Hired with a term	22	28
Hired without a term	20	15
Worker without a contract	1	2
Family business	1	1
Worker at task	2	1
Not applicable/no answer	17	16
Total	63	63

Organization type

Most subjects (40), at the time previous to the admission, worked in private companies. When the types of organization where subjects work are compared in time, there are no relevant differences; the private companies dominate (40 and 38). There is only a higher quantity of subjects working on reintegration companies.

Table 17: Type of organization where subjects used to work and work nowadays (n)

	Before treatment	Nowadays
Private company	40	38
Public company	4	1
Reintegration company	2	4
Private institution of social solidarity	2	1
Central government agency	1	2
Local government agency	2	2
Cooperative	-	1
Informal company	-	1
Not applicable/no answer	12	13
Total	63	63

Number of jobs

In an attempt to measure employment stability we the ask subjects how many jobs they had, before and after treatment (Table 18). It seems that the job volatility was higher in the period prior to the treatment, although it must be borne in mind that many of these subjects were admitted for treatment as adults, being understandable the plurality of jobs. On the other hand, there are subject who completed treatment recently (12 subjects had completed the treatment for 2 years when interviewed),

which will influence the mean values. Keeping in mind the reservations above, the subjects interviewed have had, on average, about 4 jobs before admission. However, there is some dispersion (SD = 6). After treatment, the maximum number of jobs was 5 and on average, the deviations to this value are close to 1.

Table 18: Number of jobs before and after treatment

	Maximum	Mean	SD
Number of jobs before treatment	30	4,05	5,78
Number of jobs after the treatment	5	1,65	1,14

Strategies for job finding

This section seeks to understand what are the resources mobilized to get a job and if these resources are likely to change over time (Table 19). The most common way to get the first job after treatment is to answer to an ad, over the internet or in a newspaper (11). The public employment services also assume considerable importance alongside more informal ways such as relatives (8 in both). If we consider the formal/semi-formal means to get a job (response to ad, job center and temporary employment agency) we sum 23 of the responses. Of the respondents who got their first job through friends, their origin is diverse: contact made during treatment, a former co-worker, some people who met at the café, and the case of a contact made at the job center. When we compare the former strategies with the strategic activated in obtaining the current job we realize there is a decrease in formal means, and is now more common the self-initiative (10), followed by relatives (8). What may be an indicator of some individualization and autonomy in relation to public services. It is still important to clarify that a considerable proportion of respondents (19) only had one job since completed the therapeutic treatment.

Table 19: Strategies to obtain the first job after treatment and the current job (n)

	First job after treatment	Current job
Ad reply	11	5
Employment service	8	4
Relatives	8	8
Friends/acquaintances	6	5
Own initiative	6	10
Therapeutic community	6	3
Self-employment	2	5
Public tender	2	3
Temporary work company	2	2
Invitation	1	3
Internship	1	-
Not applicable/no answer	10	15
Total	63	63

It seemed important to know how often these subjects came into contact with friends or relatives through whom they got their job, this to realize how much their network of contacts could be dispersed and broad, testing the theory of the weak ties of Granovetter (1995). It seems that, largely, the jobs that were obtained through friends or relatives referred as strong ties, since it where people with whom contact was frequent, which can indicate a less extensive network of contacts, both regarding the first job after treatment as the current job.

Table 20: Frequency of contact with the link in obtaining job (n)

	First job after treatment	Current job
We saw each other frequently (once a week or more)	10	9
We spoke by phone/by text frequently (once a week or more)	1	-
We spoke by phone/by text occasionally (less than once a week)	1	-
Someone put us in contact	2	1
Total	14	10

Note: question applied to subjects who answered that got their job through relatives or friends/ acquaintances.

Periods of unemployment

With the aim to know the stability or insecurity of the subject's jobs we sought to characterize the existence of unemployment situations (Table 21). At a ratio of almost 60/40 the majority of respondents have experienced periods of unemployment at some time since completing treatment.

Table 21: Unemployment situations since treatment completion

	n
Yes	37
No	25
Not applicable/no answer	1
Total	63

Reasons for the unemployment situation

Respondents who said they had experienced periods of unemployment were asked them the reasons that led to this situation (Table 22). The most frequent answers (7) where due to termination of the contract term with the employer, or the closure of the company in which they worked. Also common was the number of subjects who reported that could not find any job (5). By an identical amount are the subjects who found themselves unemployed, but only for a short period of time, because it was a situation of job changing, change of residence, or exit from the therapeutic community. It should be noted that only two of the subjects were unemployed as a result of a relapse.

Table 22: Reasons attributed to unemployed

Reasons	n
Termination of the contract/closure of the company where he worked	7
Cannot find work	5
Was unemployed but only for a short period of time	5
Quit the job he had	2
Relapsed	2
He went to study	1
The state of the economy	1
Is self-employed, is job is unstable	1

Note: question only applied to those subjects who answered have already been unemployed after treatment, treated as multiple response, total=37

Duration of unemployment situations

It was important to know how long where the periods of unemployment which subjects were passed (Table 23). There is a high level of heterogeneity, since there were some subjects who were unemployed for days, while the most extreme case refers to six years. On average, subjects who were unemployed found themselves in this situation for about 15 months, however, there is a high dispersion (SD = 18).

Table 23: Duration of unemployment periods

	Minimum	Maximum	Mean	SD
Months	0,2	72	15,2	17,7

Family situation

It was considered important no know the family status of subjects, since it was known, through the previous report, that at the entrance to the treatment, the majority of subjects relied on their family of origin. Thus, it seemed important to know if the family situation of subjects at the present, whether they still dependent on their relatives or if it was part of its plans an autonomization over the household. At a more empirical level, we tried to know the subjects marital status and the changes in this condition. Also theirs residential situation, that is, who they currently resides, the composition of their household, as well as the cohabitation with the family of origin.

Marital status

The more common marital status of the subjects is to be single (28). When in situations of cohabitation there are more frequent civil unions than marriage (14 vs. 6) i.e., it seems that the relations are driven by greater informality. There is also a considerable quantity (14) of divorced, the equivalent of unmarried couples.

Table 24: Actual marital status

	n
Single	28
Married	6
Civil union	14
Divorced	14
Widower	1
Total	63

Changes in marital status

However, more important than to know the marital status of subjects after treatment was if this situation had changed in the meantime. It is found that a quarter of respondents changed their marital status during the period between the end of the treatment and nowadays.

Table 25: Changes in marital status

	n
Yes	16
No	47
Total	63

When we compare the current marital status with the one at the period before treatment, it seems that the main transition is from living single to living in civil union, greater than the number marriages. There are also some cases of dissolution of marriages and civil unions.

Table 26: Comparison between marital status (n)

Marital status	Before treatment	Nowadays
Married	2	3
Divorced	2	3
Single	9	1
Civil union	3	9
Total	16	16

Note: included only respondents who changed marital status since the end of treatment.

Residential situation

Regarding the residential situation (Table 27), the most common case is to live with the family (43), whether in an own home, or in a combination, that is, in families with more than one core. A fifth of respondents live alone. Sharing housing with friends or colleagues is present in only two cases.

Table 27: Current residential situation

Residential situation	n
Alone	13
With relatives	46
With friends/colleagues	2
With family and alone (alternates)	1
Unknown	1
Total	63

Regard the households, the most common cases are situations of cohabitation with the spouse or partner and/or children. This is the dominant situation in almost half of respondents living with relatives. In situations of living with children we have a small number of children between one and two. There are also some situations in which respondents live with their parents, being more common to live

alone with their mother (12) than with both (7). Situations in which respondents live with siblings are also relatively common. Less common are the wider family groups.

Table 28: Household

	n	Mean
Spouse/partner	22	
Children/stepchildren	21	1,74
Mother	19	
Father	7	
Siblings	6	1,17
Grandparents	1	
Stepfather	1	
Niece	1	
Aunt	1	

Note: Applied to those who answered question that lived with their relatives, total=47

Another relevant dimension to consider is the cohabitation with the family of origin, table 29 shows that almost one third of the subjects lives with his family of origin, which can be considered a quantitative high if we consider that, regarding age, we are dealing with an adult population. What can be considered evidence of difficulty of autonomy towards the family of origin.

Table 29: Living with family of origin

	n
No	44
Yes	19
Total	63

To the 44 subjects who do not reside with the family of origin they were asked to maintain contact with them, it largely held to maintain contact, only in two cases revealed complete disconnection of relationships with the family.

Table 30: Contact with the family of origin

	n
Yes	39
Yes, but only indirectly	1
No	2
Has no family of origin	1
Both parents died, maintains contact with sisters	1
Total	44

Note: question only applied to respondents who do not live with the family of origin.

Situation towards drug use

A dimension present in almost any follow-up study of therapeutic community users relates to their situation in terms of drug abuse. Thus, it is presented the current situation of the subjects in relation to drug consumption. It is also examined the existence of relapses, the reasons given to that relapse and the time interval between the conclusion of treatment and the relapse.

Current situation towards drug consumption

When asked about the situation towards drug consumption at the present, the majority of respondents (35) claimed to have completely abandoned the use of any drug. When comparing these results with the responses of the follow-up of Torres and colleagues (2008 p.49) the results are relatively similar, although, in the cited study, the response options were dichotomous in a yes/no format, with percentages of 61.4 and 32, 5%, respectively.

Table 31: Situation towards drug consumption

	n
Continues to consume	3
Continues to consume but sporadically	11
Stopped completely consume	35
Ceased to consume some	10
No longer consume the previously and consumes other	2
Does not apply to be interned	2
Total	63

Drugs consumed

When asked about the drugs consumed nowadays highlights the prevalence of alcohol consumption. In the case of occasional consumption these tend to be of cannabinoids and alcohol. Situations that some of the substances were abandoned to the detriment of others only have been declared by two subjects that begin the consumption of methadone and alcohol. The case of the consumption of new substances was only declared by two subjects, one of them went on to attend a program for opiate substitution (methadone) and one consumes anxiolytics.

Table 32: Drugs used according to the situation towards the consumption

	Cannabinoids	Methadone	Tobacco	Heroin	Cocaine	Ecstasy	Alcohol	Coffee	Anxiolytics
Continues to consume	2	-	-	2	2	1	2	-	-
Continues to consume but sporadically	5	-	1	-	-	-	6	-	-
Ceased to consume some	1	3	3	-	-	-	5	1	-
No longer consume the previously and consumes other	-	1	-	-	-	-	-	-	1

Relapses

When asked about relapses, little over a quarter of respondents (17) reported that ever had a relapse after completing treatment in the therapeutic community. However should note that this is a delicate matter, and that the phenomenon in question can be under-counted.

Table 33: Relapses

	n
Yes	17
No	46
Total	63

Duration between clinical discharged and relapse

Of the 16 clients who reported having relapsed there seems to be a great heterogeneity, not being possible to find a pattern supporting studies that have dedicated themselves to infer the average time to relapse. The average number of months for the 16 patients is 19.88 months

Table 34: Time until relapse

	n
Immediately	1
≤ 6 months	5
1 year	2
1,5 year	2
2 years	1
2 to 3 years	3
≥ 3 years	3
Total	16

Reasons for relapse

Few respondents were able to assign a motive to relapse. Some showed more individual reasons such as lack of motivation or feeling ill. Others reported more external factors such as problems with a relationship or loss of employment.

Reintegration process

The dimension related to the reintegration process seeks to identify two kinds of factors, on one hand the difficulties, on the other the factors that potentiated an effective social reintegration.

Experience of difficulties

In this block it was interesting to know what kinds of difficulties are experienced by ex-users when the end of treatment. In this sense they were asked what the greatest difficulties experienced during the reintegration process (Table 35). More than one quarter of respondents reported not having felt any kind of difficulties in their reintegration process.

Table 35: Experience of difficulties during reintegration

	n
Yes	46
No	17
Total	63

Type of difficulties

In general, the kind of difficulties described refers largely to problems of socialization; re-establish social relationships abroad, and in the same way, to feel stigmatized (14). Following are difficulties to the adaptation to life outside the therapeutic community (6), to get a job and the feeling of loneliness (both 5). Some respondents also expressed financial difficulties, fear of relapse, leaving the therapeutic community without felling adequately prepared, or the difficulty in making new friendships (3 each).

Table 36: Types of difficulties experienced

	n
Relate to people, feeling stigmatized	14
The impact of leaving the therapeutic community/adaptation to the life outside of the therapeutic community	6
Getting a job	5
Loneliness	5
Financial distress	4
Fear of relapse	4
Having to leave the therapeutic community	4
Create new friendships	3
Being closer to contexts of drug abuse	3
Lack of support / problems with the therapeutic community	3
Adapting to the life in the city	2
Have autonomy	2
Dealing with bureaucracies	1
Being dependent on parents	1
Cognitive difficulties	1
Lack of motivation	1
Recover lost material possessions	1

Note: question applied to subjects who say they have felt some kind of difficulties during the reintegration process, response treated as multiple, total=46

Supports

It was intended to know what kinds of assistance where mobilized, that is, if we are dealing with formal or informal support, being this support of small or large amount. There were asked to subjects if after leaving the treatment they had requested help from someone. 44 of the subjects responded affirmatively. It should be to safeguard the position of a respondent who asked for help, but was not helped.

Table 37: Request for support

	n
Yes	44
No	19
Total	63

Interveners in the support

These supports where more frequently requested near relatives (28), and secondly from staff of the therapeutic community or the halfway house (10). It also assumes some significance the help of technicians, doctors, psychologists or social workers (8). The dominance of family support networks is transversal in Portuguese society, being the family the main donor support, both with regard to small aids for daily use, as for larger assistance (Vasconcelos 2005 pp.610-611).

Table 38: Interveners in the support

Interveners	n
Family	28
People from the therapeutic community	10
Technicians	8
Friends who met after leaving the therapeutic community	2
Friends	2
Work colleagues	1
Narcotics Anonymous	1

Response treated as multiple, total=44

Types of support

It was also asked what kind of help that was obtained. The low frequency in this response is due to the fact that it was not possible to collect practical answers, often being said that the interveners had helped in "everything".

Table 39: Types of support obtained

	n
Money	4
Psychological help	2
Moral support	2
Work	2

Contact with old friends drug abusers

In this section, interested us to know how the social networks established during the periods of drug abuse remained after treatment, both for the group of drug abusers as for contacts with non-

consumers, used as an indicator of social capital. In terms of friends or acquaintances that where drug abusers half of the respondents declared that no longer have contact with them, but almost 1/5 says that maintain a more superficial contact (12), others reported taking a selection of these contacts (7) while others only relate to other ex-consumers (6).

Table 40: Contact with drug abusers

	n
No	32
Yes	5
Yes, but only "good morning, good afternoon"	12
With some	7
Only with a few that are in the same situation	6
Very sporadically	3

Response treated as multiple, total = 63

Contact with old friends not drug abusers

In respect to former friends/acquaintances outside the group of drug abusers the trend is reversed. Most of the subjects (38) reveal that maintain these networks active. Some of the subjects who cannot keep these contacts are due to the changes of residence listed above.

Table 41: Contact with old friends not drug abusers

	n
Yes	38
No	10
Some	10
Sporadically	3
Did not answer	2
Total	63

New friendships

A final dimension in this section relates to the establishment of new friendships after the therapeutic treatment. We wanted to know if the reintegration process went through a resocialization in a new peer

groups. What is found in almost all subjects contacted reported having made new friends after leaving the therapeutic community (58).

Table 42: Establishment of new friendships after the treatment

	n
Yes	58
No	5
Total	63

Means to establish new friendships

Since the vast majority of respondents reported having established new friendships after treatment it is relevant to know what where the means and places more prone to these contacts were established (Table 43). Thus, most subjects (24) named the workplace as the most suitable, then, the place of residence is mentioned by 10 respondents, the therapeutic community was, as well, considered relevant by 8 respondents.

Table 43: Locations / situations of formation of new friendships

	n
Workplace	24
Place of residence	10
Therapeutic community	8
Through family	6
Bars, night out	5
School	5
Cafes	4
Everywhere	4
Gym	3
Through friends	2
Through their children	2
In the halfway house	2
In situations of leisure	2
Beach	1
Narcotics Anonymous	1

Note: question only applied to subjects who said they had created new friendships after the end of treatment, response treated as multiple, total=58

Associativism

Social capital is not limited to interpersonal relations, so it was also included the associativism dimension to see if the subjects had an established network in this dimension. It was concluded that

associativism has a residual expression since only nine respondents revealed belong to an association. However, if we compare the data collected by us with studies of the representative samples of the Portuguese population the results are not very different (even higher in proportion to our sample, despite the small size), according to the European Social Survey (ESS) of 2008 2.7% of the Portuguese claimed to have worked in an organization or association that is not a political party or civic movement in the 12 months preceding the implementation of the survey concerned. In the European Value Studies (EVS) applied in the same year, the questions concerning the associations are broken down by type of association, and in this case the ratio varies between movements for peace (1.4%) and social services (6.1 %).

Table 44: Engagement in civil society associations

	n
Yes	9
No	54
Total	63

Given the small amount we would not expect a clear pattern in the associations joined. The only exception is the participation in local sports clubs, a group that also had a considerable percentage of members in the value study mentioned above (EVS) (4.1%).

Table 45: Associations

	n
Sports club	5
Motard club	1
Portuguese League for Animal Rights	1
Portuguese Federation of Muay Thai	1
Evangelical Church	1
Group of amateur theater	1

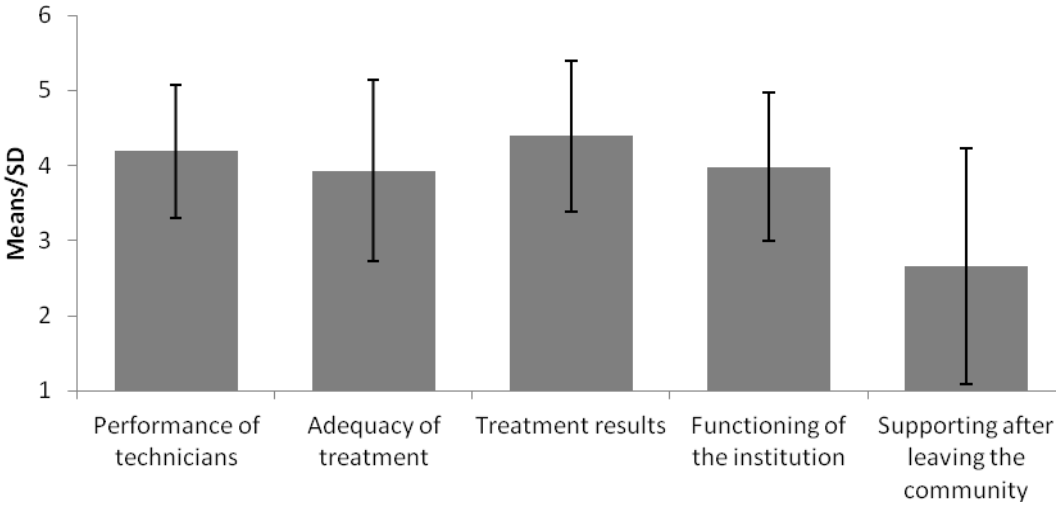
Note: question applies to subjects who said they belonged to any association or group, treated as multiple response, total=9

Treatment evaluation

Finally, we asked subjects to evaluate the service provided by the therapeutic community in five aspects, the performance of technicians, the adequacy and treatment outcome, the general functioning of the institution and the support that is given to the user after the treatment. With the exception of this last item the average response are located above the midpoint 3, which is considered a positive evaluation. In the case of technician's performance and the result of the means are located above the

value 4. The support given after leaving the therapeutic community is the only dimension evaluated negatively, although it is also the variable with higher dispersion (SD = 1.6).

Figure 8: Treatment evaluation



Conclusion

This report allowed to answer the question "what has changed in the life of ex-users of a therapeutic community a few years after the treatment?" In general terms was presented the current situation and, where relevant, compared with the situation previous to the treatment.

It is intended, in the third phase of this project, to understand how these processes of reintegration have gone. Through a biographical perspective will be possible to establish the existence of the risk factors or protective factors for social reintegration.

References

Granovetter, Mark S. 1995. *Getting a job: a study of contacts and careers*. Chicago: University of Chicago Press.

IDT. 2010. "Relatório Anual • 2009 - A Situação do País em Matéria de Drogas e Toxicodependências." Instituto da Droga e da Toxicodependência, I. P., Lisbon.

Torres, Anália, Ana Marques Lito, Isabel Sousa, and Diana Maciel. 2008. "Toxicodependentes: trajectórias sociopsicológicas e nós problemáticos." in *Consumos de Drogas: Dor, Prazer e Dependência*, edited by A. Torres and A. M. Lito. Lisbon: Fim de Século.

Vasconcelos, Pedro. 2005. "Redes sociais de apoio." Pp. 599-631 in *Famílias em Portugal*, edited by K. Wall. Lisbon: Imprensa de Ciências Sociais.

Vieira, Rita Isabel Fazenda. 2008. "Trajectórias e Estilos de Vida Familiar de Ex-residentes de uma Comunidade Terapêutica - A influência do tratamento em comunidade terapêutica e a relação com o passado de toxicodependência na vida familiar actual." Master Theises in Family and Society , ISCTE, Lisbon.

Sources

INE – National Institute of Statistics [http://www.ine.pt]

ESS – European Social Survey [http://www.europeansocialsurvey.org/]

EVS – European Value Studies [http://www.europeanvaluesstudy.eu/]

Appendix

Telephone survey applied to the therapeutic community use