Trajectories, from addiction to reintegration

Study of drug addicts social trajectories after therapeutic process

(PTDC/CS-SOC/099684/2008)

Report I

"Trajectories, from addiction to reintegration"

Study of drug addicts social trajectories after therapeutic process

Progress Report

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Introduction

The knowledge of the complex reality of the social reintegration of drug abusers as well as the characterization of phenomena that occur in this area, is a cornerstone and a prerequisite for the success for designing policies and intervention programs. However, the available knowledge about this phenomenon is clearly incomplete, limiting and weakening the policies and strategies for action related to this theme.

The studies on this issue are scarce, especially in Portugal. Their analytical approaches have a fragmented and not integrated view of reality. These studies focus mainly on the register of individuals' own experience about their strategies of social integration e.g. Torres *et al* (2008).

Thus, the present study, based on a conceptual matrix that brings together different theoretical perspectives, aims to fill these gaps and contribute to the understanding of the complex reality of the social reintegration of (ex-)drug abusers. In which are analysed the trajectories of reintegration of drug addicts who have gone through a therapeutic process.

It is intended to account reinforcement vs. vulnerability factors that may influence the trajectories of these individuals, as well as identify trends and factors that lead to effective social reintegration, with effective renunciation of drug abuse.

Promoting a depth and systematic strategic thinking on this issue, it is expected to promote understanding and support decision-making, meeting the priorities identified by national and international reference in this field.

Thus, the aims of this research are to capture regularities and singularities present in the strategies of social reintegration of this individuals. These are patterns associated with social, family and individual skills that were acquired during the therapeutic process, or arising from the application of institutional measures. That is, the aim is to do a systematic comparison of the trajectories of social reintegration, in an attempt to capture differentiating factors in their life courses, as well as their social support networks.

To this end, we chose to conduct this study based on individuals who have completed the therapeutic process for some time in an institution whose therapeutic program provides some empirical guarantees of control on quality indicators. Namely: **Therapeutic Community *Quinta das Lapas* of Associação Dianova Portugal**.

In this first phase, on which the present report was done, it is made a first approximation to the empirical reality of the study, in order to carry out a social characterization of the study

object. It will be based on this characterization that in a later stage of the study, one can perform a comparative analysis of these data, and investigate and evaluate the path taken by individuals, as well as the impact of the therapeutic process.

Thus, after the presentation of methodological notes, data for socio-demographic characteristics of individuals are presented. There will be analysed their social networks and their economic resources, data regarding hospitalization (motivation and history) and drug abuse, in order to trace a profile of the individuals and its arrival at the treatment.

Method

The theoretical and strategic concerns above cited have important consequences at a methodological level. Firstly, the aim of collecting and analysing data on the reintegration of drug addicts in order to promote the knowledge and support decision making, involves an empirical basis from which individuals have completed the therapeutic process (clinic departure). On the other hand, considering that the treatment is assumed to be an essential variable to impact on the results, it became necessary to ensure and control this factor. To do that it was chosen only one institution (thus isolating the factor treatment) whose therapeutic program guarantees control on quality indicators.

Thus, we chose to conduct the study with drug abusers who have completed the therapeutic process on the Therapeutic Community *Quinta das Lapas* of Dianova Portugal.

Dianova Portugal, and its Therapeutic Community *Quinta das Lapas*, is a Private Institution of Social Solidarity, Public Utility Association and Non-Government Development Organization. It specializes in the prevention, treatment and rehabilitation of drug abusers, community development, social inclusion, psychosocial support and training, and has been the first therapeutic community in Portugal with a Quality Management System implemented and certified by SGS-ICS according with ISO 9001:2008 norms. This gives as described above an empirical control over quality indicators. It is also worth mentioning that this therapeutic community is part of the Dianova international network, that have Special Consultative Status to the Economic and Social Council of the United Nations and in Operational relationships with UNESCO, among other international public affairs organizations.

Thus, the first empirical approximation to the empirical object of the study was conducted among users of this Therapeutic Community who were discharged between 1999 and 2009. The field work took place between 23 February and 3 March 2010. It consisted in the analysis of all the administrative processes of the Therapeutic Community users; it included individual records filled by the various technical and medical with information regarding life history, criminal records, and medical examinations of users with clinical departure. Therefore, discharges regarding transfers, abandonment and expulsions were not considered. From the administrative files was taken all the relevant information for this first socio-economic and demographic characterization of individuals in our sample.

It should also be noted that most of the categories of the variables presented in this report consists of pre-defined categories, as a result of the answer fields available in the forms of the therapeutic community.

1. Socio-demographic characterization

Geographical origins

Due to the international scope of the therapeutic community in study there is some heterogeneity in users' nationalities, however, most of them have Portuguese nationality. The foreign nationalities most represented are the Slovenian, Swedish, Spanish and Italian respectively. Still, there are some cases of nationals of countries of South America, Northern and Eastern Europe.

Figure 1: Nationality of users (total values)
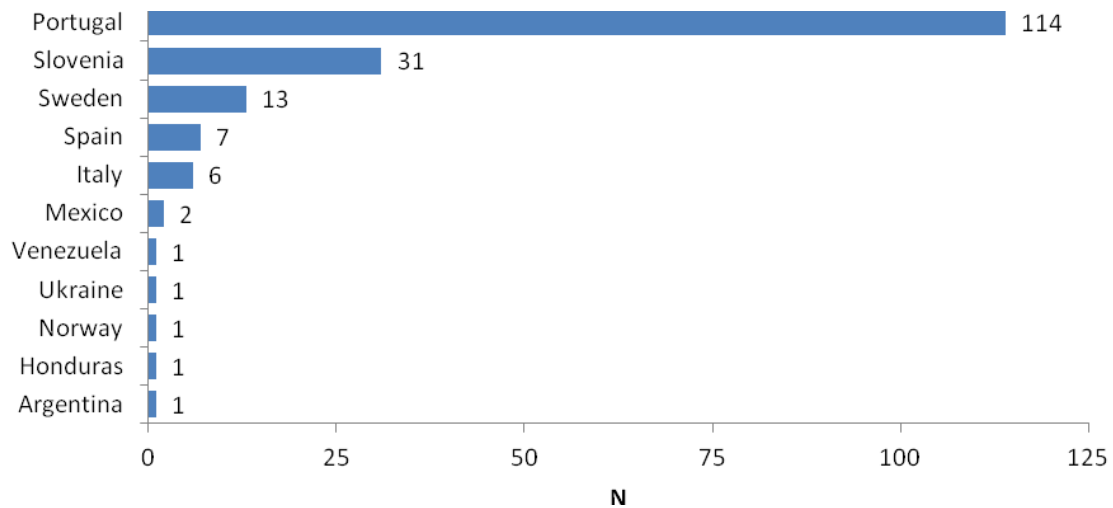
From the users living in Portugal, it dominated as districts of residence the two bigger cities, Lisbon and Oporto. At the opposite, the least represented zones are Alentejo, Beira Interior and Algarve.

Figure 2: District of residence of the Portuguese users (total values)
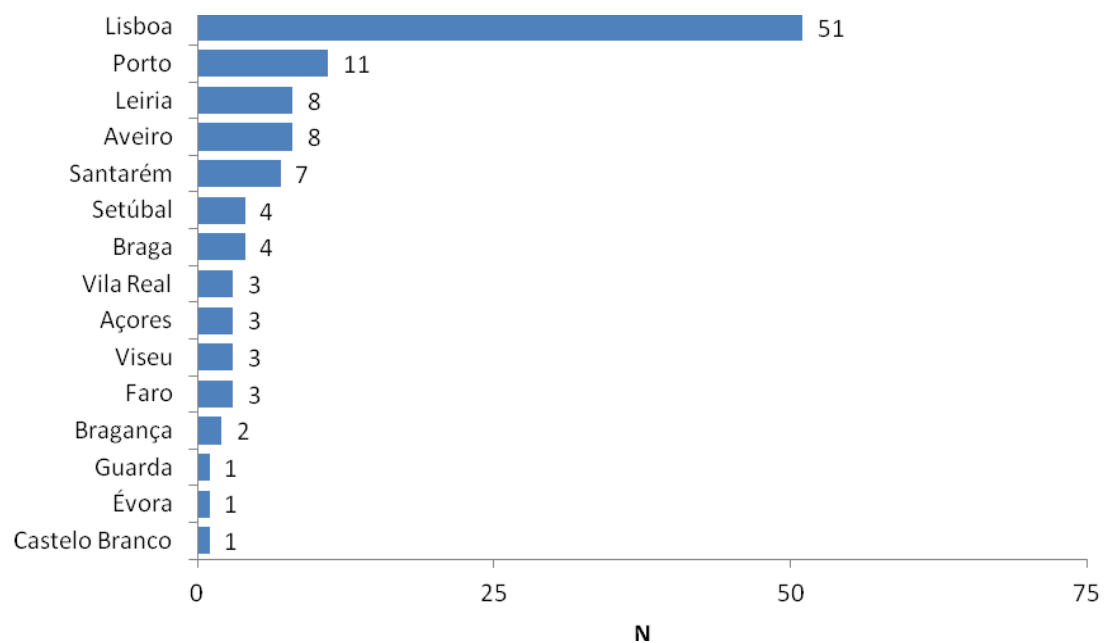
Since the majority of the therapeutic community users came from the district of Lisbon, we did a segmentation of municipalities to unravel the areas of origin. Thus, it appears that the majority of users are from the municipality of Lisbon, followed by Torres Vedras. The high

number of users resident in the municipality of Torres Vedras can be explained by greater geographic proximity to the therapeutic community under study.

Figure 3: Municipality of residence of users in the district of Lisbon (total values)
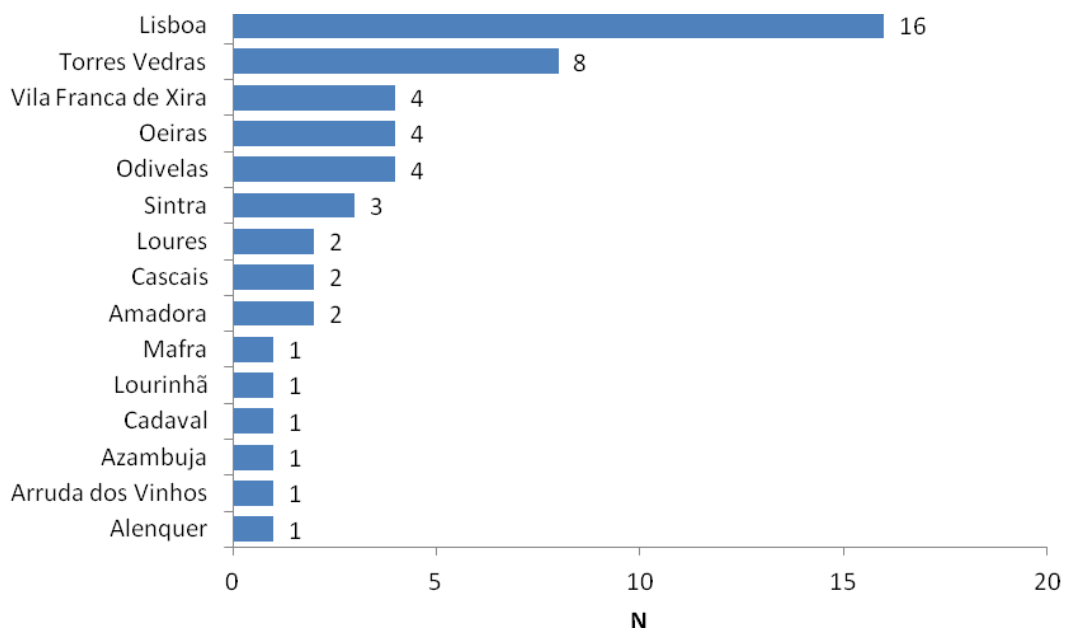
Sex ratio

The vast majority of users are male; there is an average of 7.5 men for every woman. Comparing the difference between the number of men and the number of women in our study with the total of therapeutic communities in Portugal it is found that the disparity is similar. In 2008, the percentage of men in therapeutic communities in Portugal was 81.8% (IDT, 2009:

36). However, it should be noted that we are comparing databases with different time amplitudes, 10 years for our case, one year to the official data, and that during these years, sexual structure of the therapeutic community users may have been changing.

The gender differences found may be explained by two reasons: The socialization differentiated based on patterns of "hegemonic masculinity" and "femininity adequate" that makes drug abuse an activity practiced more by men than by women (Torres et al, 2008). The existence of a speech "on a pathologizing of women drug abusers" (Waldorf cited by Vasconcelos, 2003: 19) and a greater centrality given to man in the organization of therapeutic communities (*ibid*.).

Figure 4: sex ratio (%)

Age structure

Data on the age structure relate to the time of admission of the users. The vast majority of the users were already adult when admitted. About 76% were between 21 and 35 years old when entered the community. The most common age group is the one between 31 and 35 years.

Figure 5: Age structure (%)
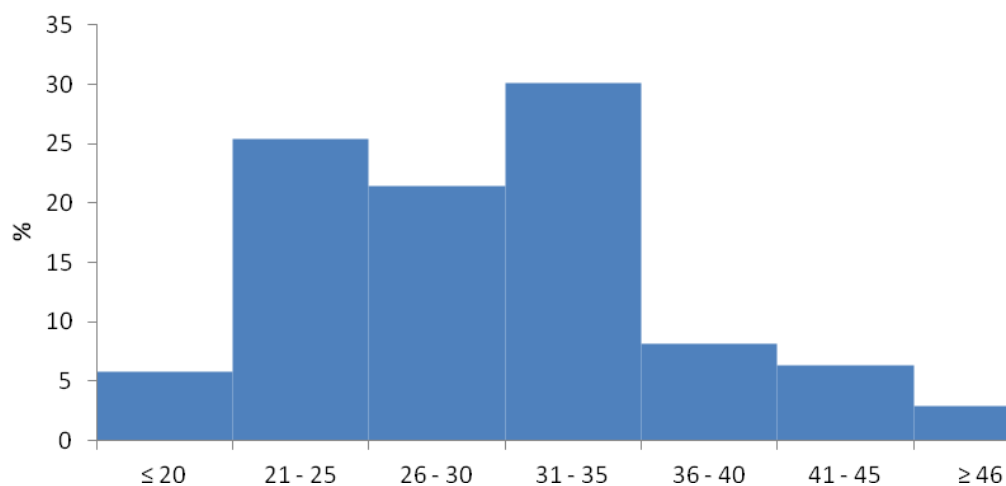
Education level

The education level of the therapeutic community users is low taking into account the relatively young age structure. In terms of education, predominates among the users the general lower secondary, followed by primary education (6 years) and the general upper secondary. The number of users with a higher education degree is residual.

There are several possible explanations for this school profile, such as that advanced by Torres et al (2008: 34) which relates the low educational levels of the users in their study with a "tendency to school dropout driven by consumption and dependency." Without knowing whether there is coincidence between the age of onset of consumption and dropping out of school we cannot confirm this hypothesis.

Figure 6: Education level (%)
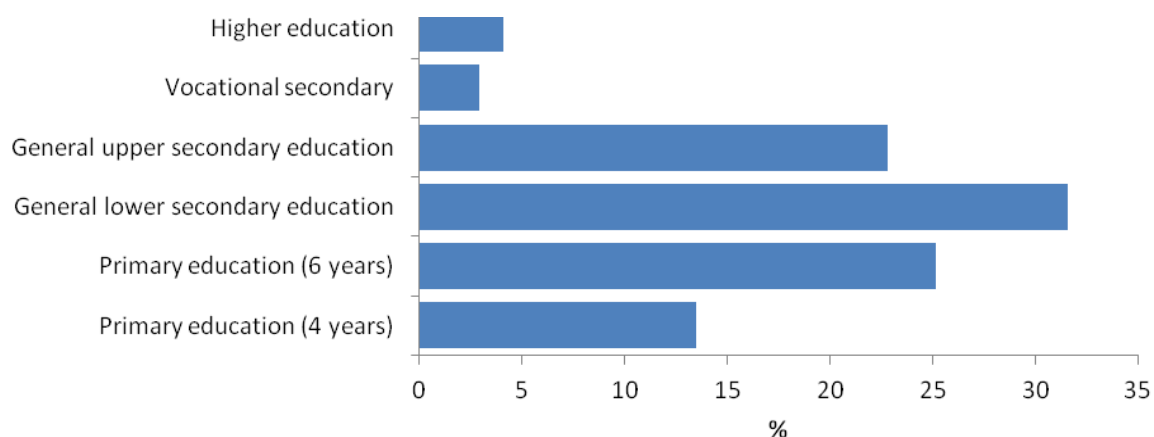
Work situation

Regarding the profession at the time of admission, it appears that about a third of users fall into the category of "craft and related trades workers", there is also a large number of "service workers & shop & market sales workers" and "plant and machine operators and assemblers". The professional groups more common are mostly low-skilled occupations. Despite this, the percentage of users under the category of "elementary occupations" is very low. It should be noted that the high number of "craft and related trades workers" and "plant and machine operators and assemblers" is much higher than registered in the Lisbon region.

The high number of less qualified professions on drug abusers can be explained by a greater consumption hiding in the upper classes (Fernandes and Carvalho, cited by Torres et al, 2008: 22). Another explanation advanced by this team is that the high number of users in unskilled occupations studied is a result of early school leavers, which implies a less qualified professional integration (ibid, 37). However, as has been said earlier regarding schooling, the data that we have will not allow us, at this stage, to know these aspects.

Table 1: Occupational groups (ISCO)

Occupation	N	%
Managers	2	1,6
Professionals	7	5,5
Technicians and associate professionals	10	7,9
Clerical support workers	6	4,7
Service and sales workers	29	22,8
Skilled agricultural, forestry and fishery workers	5	3,9
Craft and related trades workers	42	33,1
Plant and machine operators, and assemblers	23	18,1
Elementary occupations	3	2,4

	N	
Total	127	100

Regarding job situation, it appears that the majority of users were unemployed when entered in treatment, which could be indicative of a situation of extreme social exclusion that did not allow them to perform work tasks. It is important to realize, at this level, if unemployment is, in most cases prior to this situation of social exclusion.

Table 2: Job situation

	N	fi
Work in a fixed place	18	0,23
Work in precarious place	3	0,04
Unemployed	56	0,7
Retired	2	0,03
Arrested	1	0,01
Total	80	1

Clinical status

The clinical situation of many users when the entry into the therapeutic community was serious: 57 users indicated they had health problems, whether they were consequences of the drug abuse or not. Hepatitis C (HCV) was the most frequent disease, following 13 cases of patients with human immunodeficiency virus (HIV +), 3 cases of hepatitis B virus (HBV) and 2 cases of syphilis (VDRL).

Figure 7: Clinical status when entering treatment (total values)

Clinical status	N
HCV +	44
HIV +	13
HBV	3
VDRL	2
Others[1]	23

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[1] Other medical conditions declared: hepatitis (3 cases), bronchial asthma (2 cases), epilepsy (2 cases), cognitive impairment, attention deficit disorder, mild weakness, hypofunction of the thyroid with hypocalcemia, asthma, liver cirrhosis, eye infection, poor thyroid gland function, herniated disc, leg cast, leg prosthesis, allergic rhinitis, allergies, hepatitis, sinusitis.
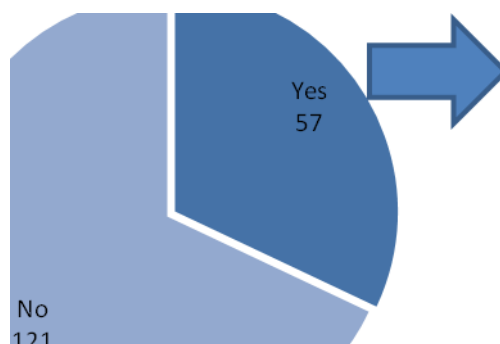
Judicial situation

More than half of the therapeutic community users reported having a criminal record. It should be noted that the vast majority had already entered into treatment after the approval of the law no. 30/2000 which decriminalize drug use.

Table 3: Judicial situation

	N	fi
No criminal record	39	0,48
Criminal record or convictions already met	31	0,38
Probation	3	0,04
Suspended sentence	9	0,11
Total	82	1,01[2]

Asked about the existence of legal matters pending, more than half reported that did not have unpaid issues with the justice.[3]

Table 4: Pending legal matters

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[2] The sum of the ratios is greater than 1 due to the possibility of multiple responses, total=81.

[3] The variable presents the legal situation declared on treatment entry, this does not invalidate that later came to light unresolved court cases. In some cases, clients who claimed not to have cases pending had courts communications attached. Thus the amount of users with pending legal matters should be under-represented.

	N	fi
With pending legal matters	29	0,38
No pending legal matters	47	0,62
Total	76	1

2. Social networks and resources

Cohabitation

Most therapeutic community users (71%) lived with his family of origin at the time of admission, less frequent where the cases of users with their own family (20%). Situations of sharing housing with friends, living alone and using other family members are residual.

Also in the study of Torres et al (2008: 40) majority of users lived with their families of origin, which, according to these authors is the result of difficulties in the process of empowerment and independence. In this case, with no further data at this stage, we cannot confirm this hypothesis.

Table 5: Cohabitation

	N	%
Family of origin	74	70,5
Own family	21	20,0
Friends	7	6,7
Alone	7	6,7
Other relatives	3	2,9
Unstable	2	1,9
Homeless	2	1,9
Penitentiary institutions	1	1,0
Halfway house	1	1,0
Total	118	112,4[4]

Relations with family

Likewise, most therapeutic users resort to his family for support and shelter. On the other hand, there are a small percentage of those who resort to the family to get only support (without shelter). Situations of total isolation of the family are reduced.

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[4] The sum of the percentages is higher than 100 due to the possibility of multiple responses, total=105.

Table 6: Family relationships

	N	fi
Family provides support and shelter	59	0,80
Family provides only support	13	0,18
Family provides neither support nor shelter	2	0,03
Total	74	1

Financial resources

Since the majority of users were unemployed when admitted to treatment, it was expected that their sources of income not derived from the work. Thus, seems to be with the family that most users could get their revenue. These data are consistent with those presented before and that indicated the family as a vital support network.

Figure 8: Sources of income (total values)
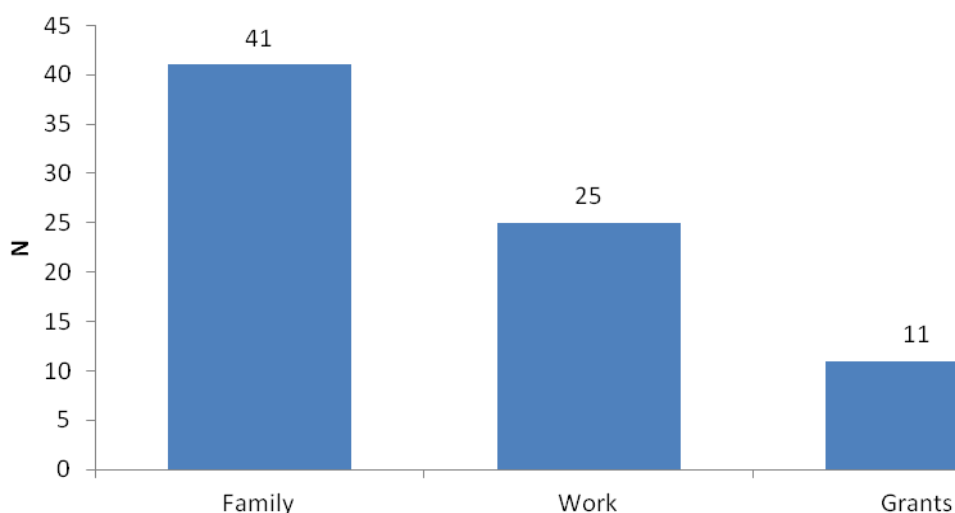
Although family is the primary means to obtain income, in many cases there are multiple sources of income, sometimes income obtained from the relatives are in conjunction with working (8 cases) or grants (3 cases), sometimes also work is combined with grants (3 cases).

Table 7: Sources of income

	N	fi
Family	30	0,48
Family + grants	3	0,05
Grants	4	0,06
Grants + work	4	0,06

Work	14	0,22
Work + family	8	0,13
Total	63	1

Proximity to drug abuse environments

Regarding proximity to drug abuse environments, the majority of the therapeutic community users indicated that they relate to *some* drug abusers. Featuring almost identical quantitative existed users who indicated the extremes, i.e., that only they related to drug abusers or who had no contact with any drug abuser. So there seems to be diversity in terms of proximity to drug abuse environments.

Figure 9: Groups affiliation (total values)
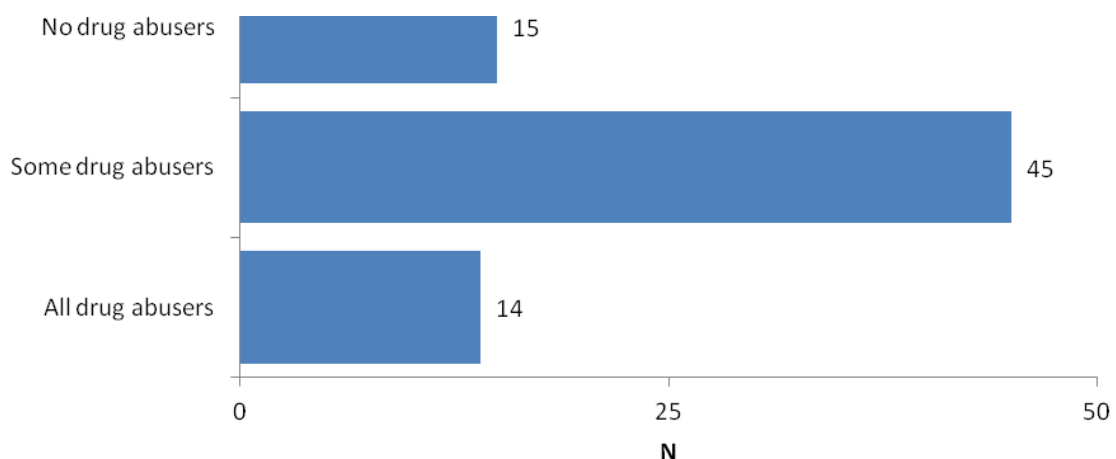
Mediators in the first contacts with drugs

When asked about the mediator in the first contact with drugs, the majority of the subjects indicated that it was through friends they got their first experience. Peer groups are important for socialization and to that extent are vehicles for the inculcation and reproduction of norms, consumption patterns and lifestyles. For example, in the specific case of heroin, the perception of the risk associated with their use can be deterred by high levels of trust in the peers. In this sense, Pearson et al (1987: 38) reported that the first contacts with heroin are always made within a circle of friends.

Table 8: First contact with drugs

	N	fi
Friends	86	0,96
Family	5	0,06
Job colleagues	1	0,01
Total	92	1,02[5]

3. Internment | Clinical Inpatient (motivations and history)

Clinic departure

The number of clinic departure completed by year has been changing, notably a high peak in 2001 and a reflux in the years 2004 and 2005.

The high quota in 2001 can be explained by a large number of processes available from other therapeutic communities in the same group (Casa Azul, Quinta da Remelha, Quinta do Paço, Quinta do Paral).

Figure 10: Clinic departure by year (total values)

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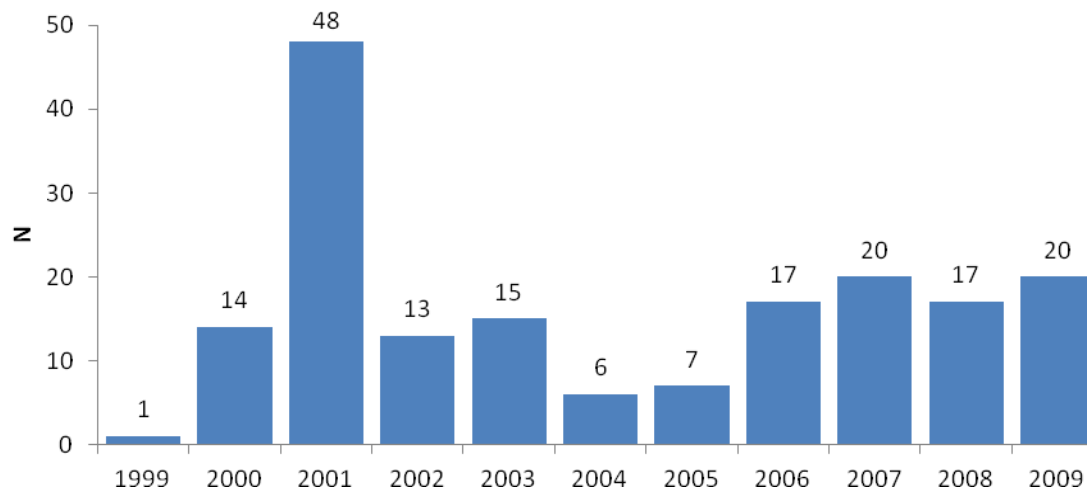
[5] The sum of the ratios is greater than 1 due to possible multiple responses, total=90.

Reasons for rehabilitation

Most users points personal reasons for their rehabilitation, often in conjunction with family reasons. The category of personal motivations includes very general grounds as "being sick of the lifestyle that leads" "feel like changing life" or "stop being a burden to family." The legal or medical reasons are residuals.

Table 9: Reasons for rehabilitation

	N	fi
Personal	79	0,95
Family	18	0,22
Medical	3	0,04
Judicial	2	0,02
Total	102	1,23[6]

Treatment history

More than an half of the therapeutic community users indicated they had tried earlier treatments, whether in inpatient or outpatient, both drug treatments and replacement free of drugs (cold turkey).

According to Pearson et al (1987) there is a high number of relapses in former heroin users because it is easier to quit consuming temporarily than to keep the new way of life for a long time - "many ex-addicts seem to say that "coming off" is easy, but that "staying off" is the most difficult part of the abstinence "(pp.35).

Figure 11: Treatment history (%)

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[6] The sum of the ratios is greater than 1 due to the possibility of multiple responses, total=83.

4. Psychoactive Substances

Main substance

The vast majority of the patients said that heroin was their main substance, followed by alcohol and cocaine. Substances indicated less frequently were cannabinoids, amphetamines and (psycho)pharmaceuticals. The average age at which they started use was 18, while the youngest age was 9 and the oldest was 44.

If we compare the data from our study to the universe of therapeutic communities in Portugal, we find that, although heroin was also the main substance, it was so to a lesser degree. The number of users entering therapeutic communities whose main substance was heroin had been decreasing at least in the three years for which we have records (65% in 2006, 59% in 2007 and 58% in 2008)(IDT 2009 p.93).

When we analyse the data on admission to therapeutic communities in Europe, the conclusions are similar. In 2007, 56% of the patients admitted to therapeutic communities said that opiates were their main substance (EMCDDA 2009 p.32). It is important to note that there are differences in the use of opiates between European countries. In some countries there has been an increase, while the major trend has been for a decrease in the last 10 years (p.77).

According to Torres et al (2008 p.23), the decrease in heroin use can be explained by two factors: ignorance of the destructive properties of the substance when it emerged in Portugal and dissemination of the negative consequences of using widespread it in the media in recent years. However, Pearson et al (1987) do not agree with this opinion on the dissemination of the harmful effects of heroin in the media and awareness campaigns. They warn of the possibility that this type of campaign "offers a 'macho' challenge to some young men that they can 'handle it' and so prove their manhood through a mortal contest with the demon drug" (Pearson et al. 1987 p.28).

There were some differences between the therapeutic community studied and the total for therapeutic communities in Portugal regarding patients who said that cocaine was their main substance. According to official statistics (IDT 2009 pp.105-108), cocaine was given as their main substance by 18% of patients in 2008 and 16% in 2007 and 2006. If we compare these figures with the 9% at the therapeutic community in question, it is obviously much lower. However, this inconsistency may be due to a difference in the timeframe of the figures.

Ecstasy, which has been gaining some visibility as the main substance of patients at therapeutic communities in Portugal, was not mentioned by any of the patients as their main substance, as opposed to 1.1% for the national total in 2008, 1.3% in 2007 and 0.8% in 2006 (IDT, 2009: 105-108). However, we must bear in mind that these figures are still very low and, although they are relevant at national level, they do not seem to be of special significance in one therapeutic community in particular.

Figure 12: Main drug (%)
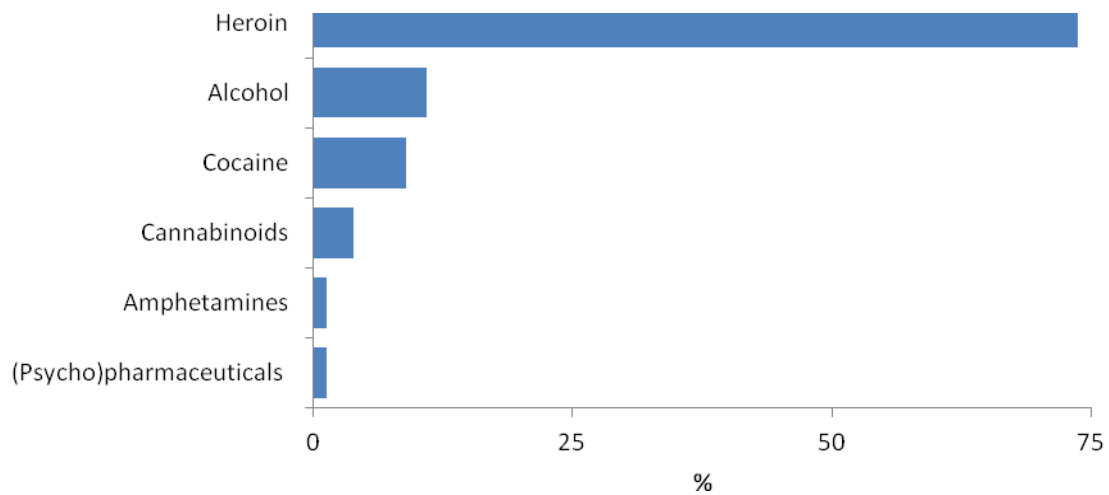
If we compare the figures for main substances used by Portuguese and foreign patients, we find that although the rankings are similar, there were more heroin and cannabinoid users among foreign patients. Where the Portuguese patients were concerned, there were more alcohol abusers. The few cases in which substances like amphetamines and (psycho)pharmaceuticals were indicated as the main substance involved foreign patients.

Figure 13: Main drugs used by nationality (percentages)
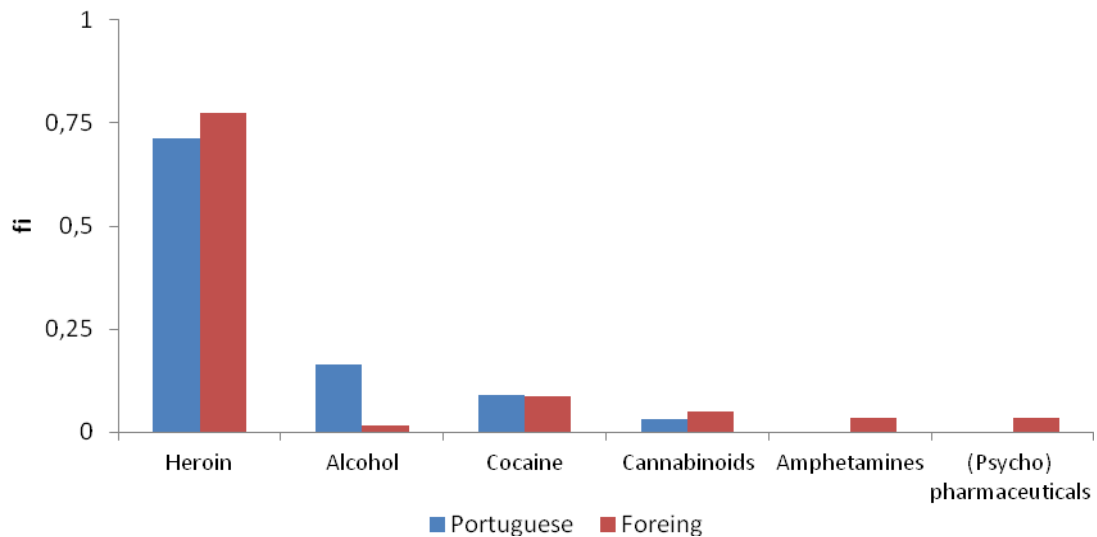
The main substances indicated by the patients at the time of admission were similar in the different age groups. However, there were a lower percentage of heroin users in the oldest group than in the other two. There was also a higher percentage of alcohol and cocaine users among the older patients, though none of them have referred cannabinoids, amphetamines or (psycho)pharmaceuticals as their main substances.

Figure 14: Main drug by age group (percentages)
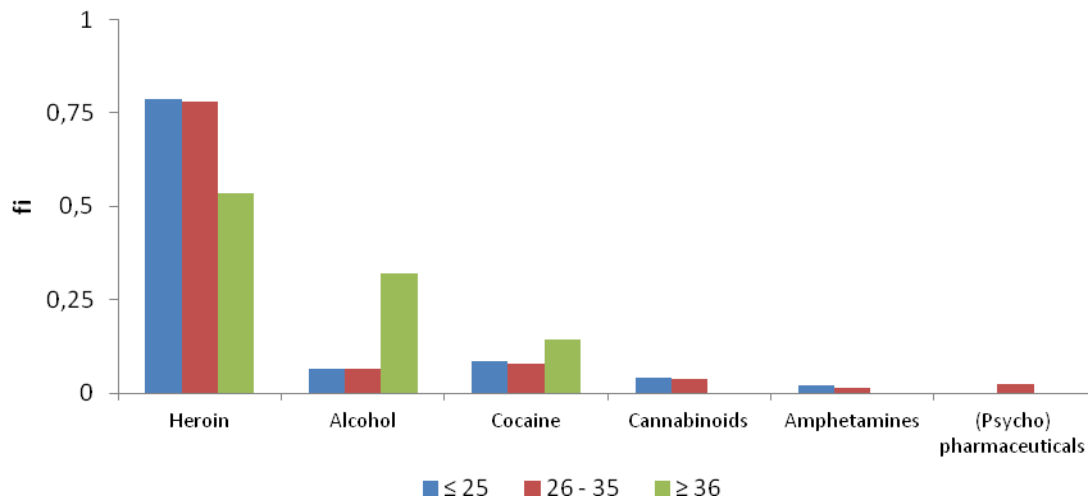
Frequency of use of main drug

Most of the patients who indicated the frequency with which they used their main drug said that they took it on a daily basis.

Table 10: Frequency of use of main substance

Frequency [7]	N	fi
Daily	85	0,92
Occasionally	4	0,04
Sporadically	3	0,03
Total	92	1

Ways of administration

We proceeded to ascertain the ways of administration for the main substance used (heroin). Although the most common method was injection, there were many different methods and injection was often combined with smoking or inhaling.

Some studies have found that the route of administration of heroin varies geographically (Pearson et al, 1987: 5; EMCDDA, 2009: 82). According to the study of Pearson and colleges, heroin tends to be consumed via injection because it is a more efficient and economical, hence the lower frequency mode smoked. Sometimes, some injectors turn to smoking because is no longer possible to inject heroin, due to a scarcity of injectable veins in the body (pp.14).

Table 11: Routes of administration of heroine as main substance

Route of administration	N	%
Injected	61	65,6
Smoked	51	54,8
Inhaled	8	8,6
Total	120	129,0[8]

Total of drugs used

Now looking at all the drugs used by the users, the category heroin and other opiates stands out as the most used, followed by cannabinoids, cocaine and alcohol.

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[7] The frequency of substance was aggregated in the following way: *Daily*: daily, habitual, regular, everyday, every other day, regularly, almost daily, more or less daily, periodical, ever. *Occasionally*: weekend, a few times per week, more than once a week, sometimes, at times, twice a week or so, when goes out at night, at the meal, 3 times per week, sometimes for weeks, average, weekly, sporadic, unusual, variable, sporadic, rarely, once a month, when it appears. *Tried*: does not consume, 3 times, tried 1/2 times.

[8] The sum of the percentages is higher than 100 due to the possibility of multiple responses, total=93.

The use of cannabinoids is extremely widespread throughout Europe, although it reached its height in the 1990s, when the EMCDDA report said that ¼ of the adult population had used it at least once in their lives. These figures have been stabilizing or even decreasing, the same trends have been noted in the USA and Australia (EMCDDA 2009).

Concerning alcohol, it is important to remember that it is a substance that is very common and its consumption is relatively socially encouraged. Probably because it is a substance sold legally, there is a tendency for its use not to be declared in the admission for treatment (EMCDDA 2009 15). Quantities of alcohol use may therefore be underestimated.

Figure 15: Drugs used (total values)
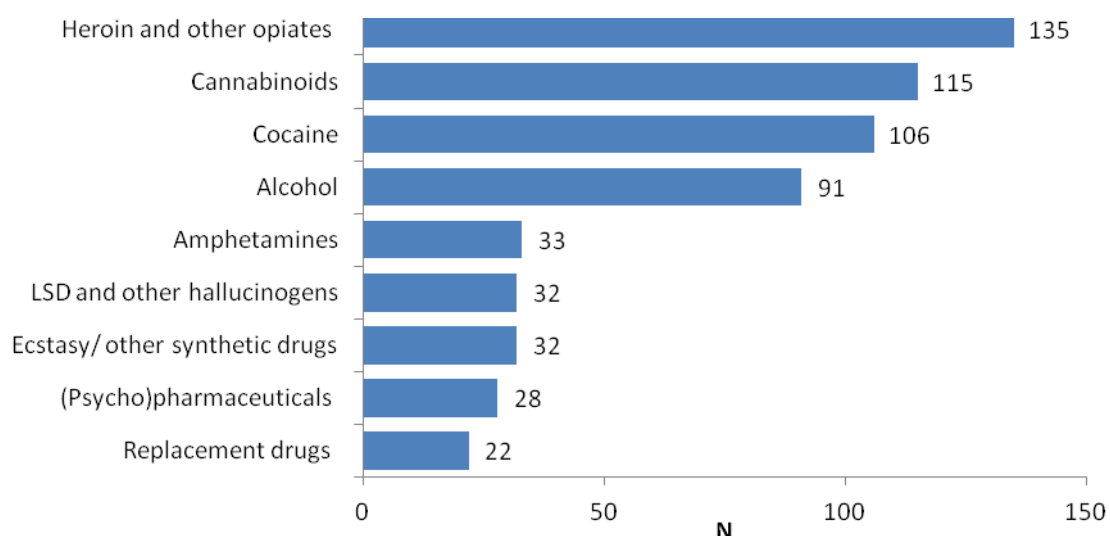
**Age at the beginning of the drug use**

The average age for starting using drugs varied between 15 and 24 years old. Alcohol and cannabinoids were the earlier substances used. In parallel, it is the replacement drugs that are used mostly later in life, which is to be expected, as they are substances that presuppose dependency on others. With the exception of replacement drugs, the substance that the patients started using the latest, on average, was cocaine, heroin and other opiates, which they began using at an average age of 18. Although there are some extreme cases, it seems that the starting age for drug use occurred at a specific time in life, between the ages of 15 and 18, in adolescence.

Torres et al. (2008) put forward several hypotheses for explaining why people begin substance abuse in adolescence. One of them is based on the "centrality of identity transformation processes in adolescence" (p.20). Another considers that adolescence is a "phase of life in which a person is particularly vulnerable and confused and willing to accept something that makes him/her feel better" (p.26) or because it is a time in life "particularly favourable to new experiences" (p.63).

It is important to relate this data to those mentioned above on the importance of friends in the initiation to drug abuse (Table 8: First contact with drugs). This trend is found in the combination of risk factors and protective factors associated with drug abuse (Ferreira-Borges and Filho 2004; Winters et al. 2002), which highlight the importance of peer groups in networks of influence.

Figure 16 shows the average ages and extreme cases, i.e. the youngest and oldest ages for starting the use of each group of drugs. Stands out that the use of substances such as amphetamines, ecstasy and LSD are reduced to a narrow age group, while alcohol seems to be the substance that people may start using at any stage in their life cycle.

**Figure 16: Age at the beginning of the drug use**
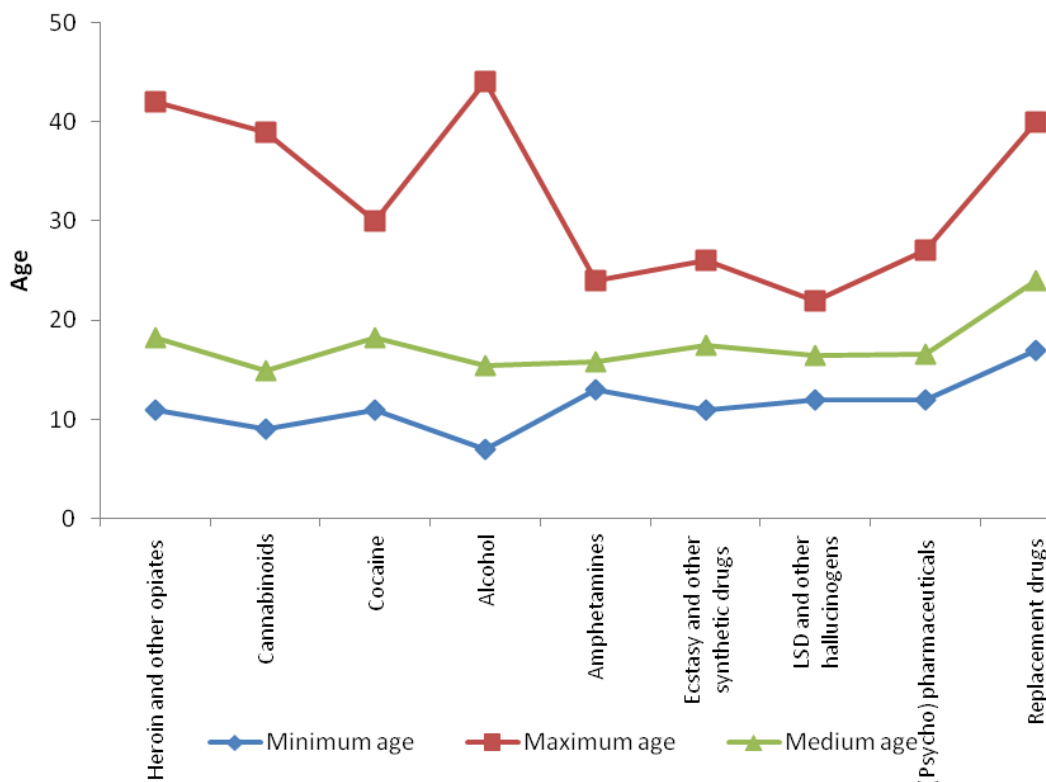
Duration of the consumption

If we look at the number of years in which the patients consumed drugs, we find that alcohol was the one with the longest period of use (average 14 years), followed by cannabinoids, cocaine and "heroin and other opiates" (average 11 years). At the other extreme are replacement drugs, LSD and other hallucinogens, which are the substances with the shortest length of use.

Figure 17: Time of drug use in years
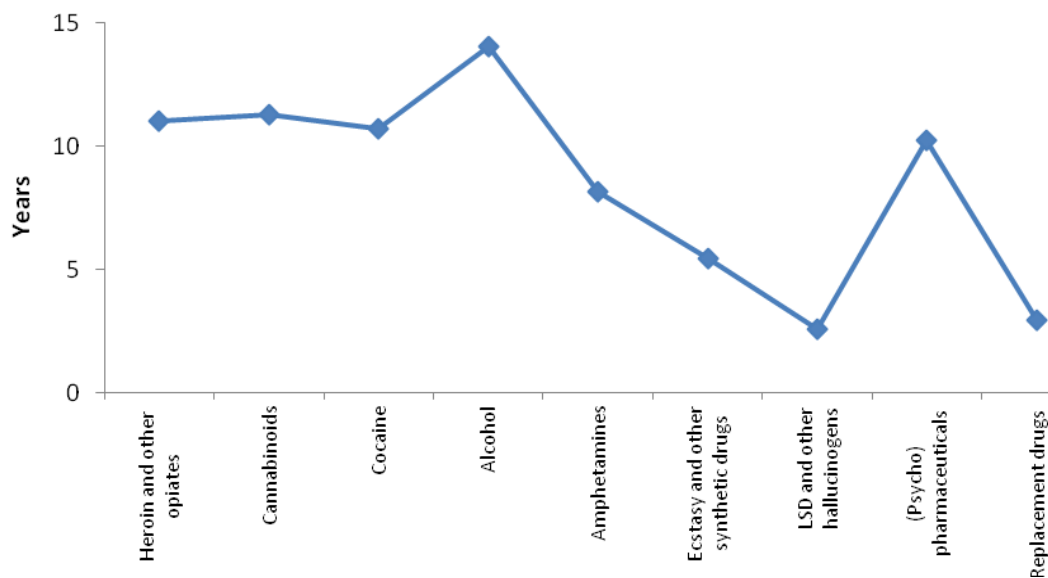
On the basis of the information given, it is possible to see whether the drugs in question were being used at the time of the admission or whether the therapeutic community users had used them previously in their lives, which means that the use of the drug was not the reason for their seeking treatment. More than half of the substances had been used in the period immediately before the admission, and cocaine and "heroin and other opiates" were the categories most often mentioned as being used at the time of the admission. This may indicate that they are substances that involve higher dependence and greater difficulty in keeping their use down at an experimental level or only in a particular time of life.

**Figure 18: Consumption of drugs at the time of admission (percentages)**
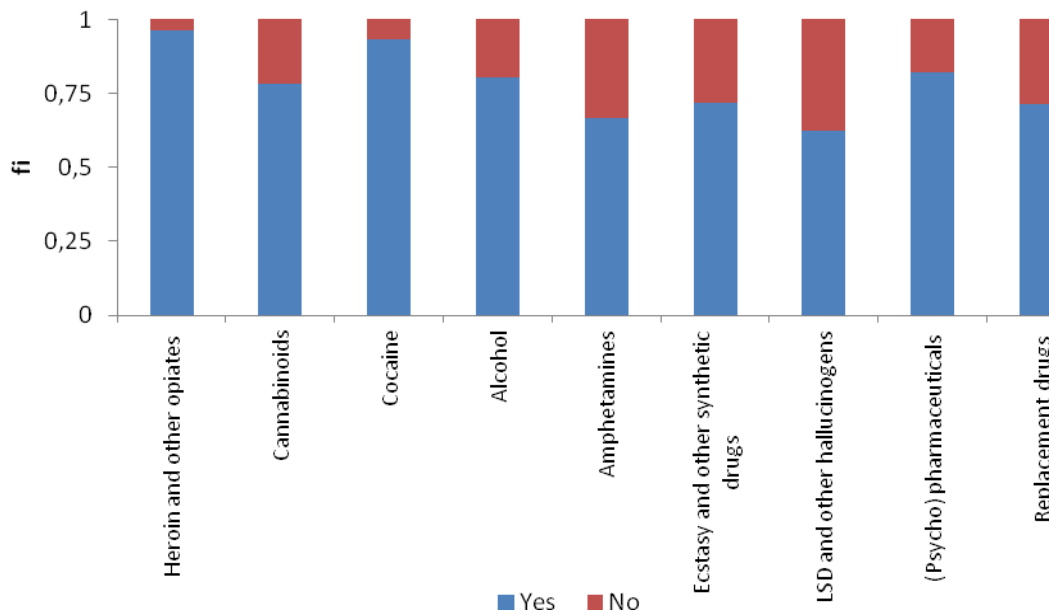
Frequency of use

Not all substances are used with the same intensity, so we conducted an analysis of the frequency of their use. Substances such as "heroin and other opiates", cannabinoids, cocaine, alcohol and replacement drugs tended to be used on a daily basis. Substances like amphetamines, "ecstasy and other synthetic drugs", "LSD and other hallucinogens" tended to be used more sporadically. Finally, cannabinoids and "heroin and other opiates" were the least mentioned substances which have only been experimented.

However, the data interpretation of "heroin and other opiates" should take into account that we had a universe, in which the majority was heroin users, hence low percentages of the "tried it" and "sporadically" ones. Pearson et al. (1987) claim that there is no single type of heroin user and that there are many people who just try it and others who use it only occasionally. These users tend to stay in the shadows, as they do not feel the need to publicly admit their relationship with the substance or to seek treatment at a therapeutic community.

Figure 19: Periodicity in the drug use (percentages)
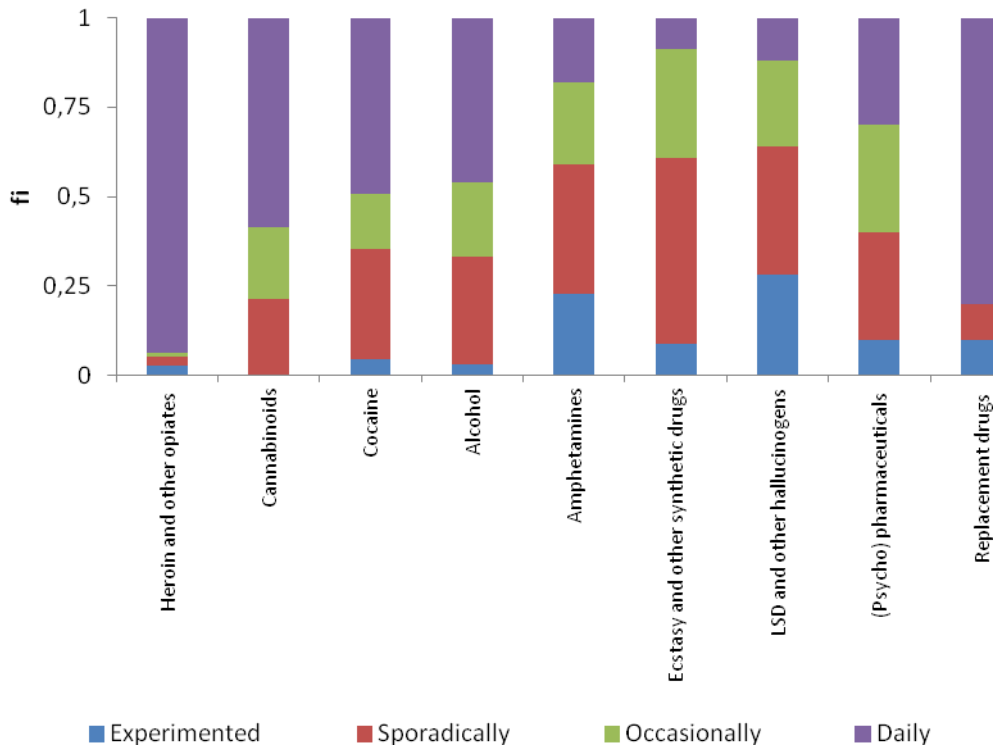
If we analyse the used substances based on the nationality, we find that there was a higher percentage of users of cocaine, alcohol and "heroin and other opiates" in the portuguese therapeutic community users, while the foreigners used more cannabinoids, amphetamines, ecstasy and other synthetic drugs.
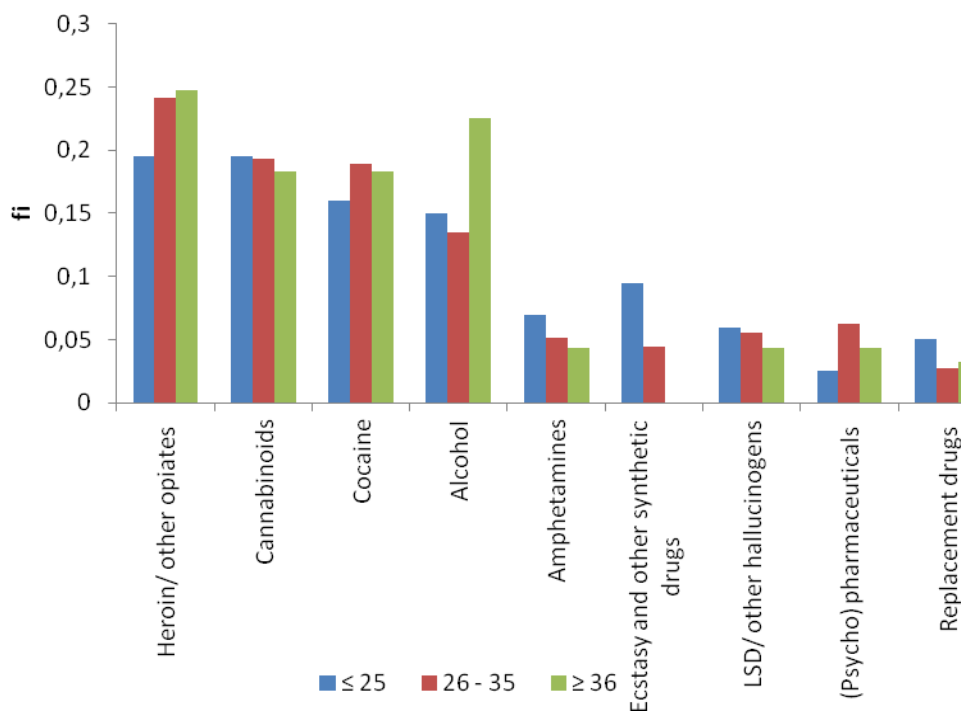
The data that we gathered on cocaine and amphetamine use confirm the theory that there is a kind of competition in the European stimulants market, in which the countries in Southern and Western Europe have a higher use of cocaine than amphetamines, while the pattern is the opposite in the interior and in the Eastern European countries (EMCDDA 2009).

Figure 20: Drugs used by nationality (%)
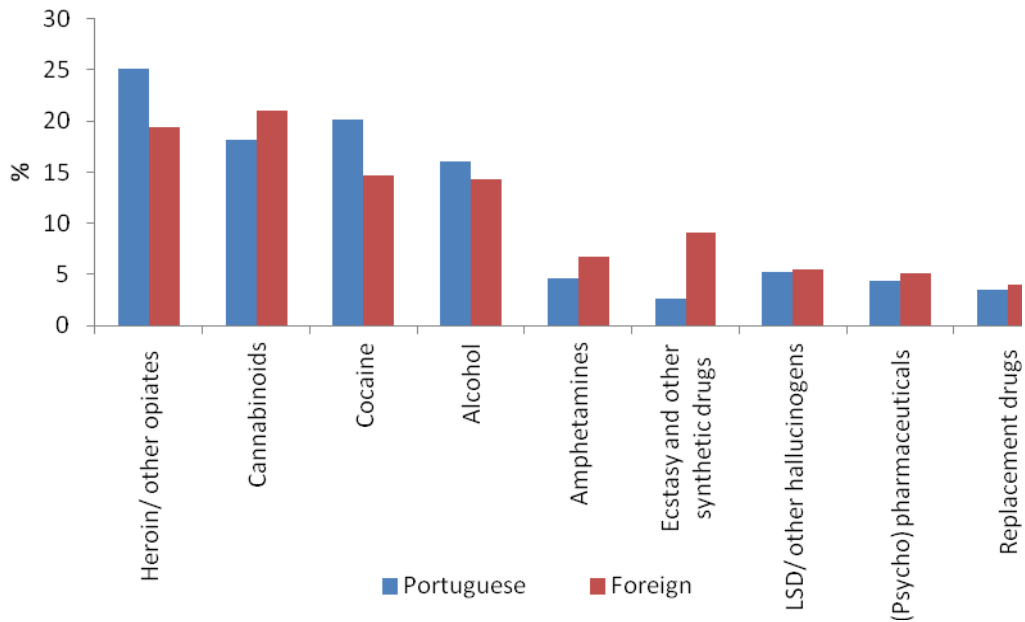
If we classify the therapeutic community users into three age groups and analyse the drugs used by them, we find some differences, such as a higher percentage of "heroin and other opiates" and cocaine in the two older groups. Also, alcohol tended to be used more among the oldest group of patients, who did not use ecstasy or other synthetic drugs, substances that tended to be used by the youngest group of therapeutic community users. This use may have been occurred in any other time before the age of the admission.

Figure 21: Drugs used by age groups (percentages)

fi

0,3
0,25
0,2
0,15
0,1
0,05
0

Heroin/ other opiates
Cannabinoids
Cocaine
Alcohol
Amphetamines
Ecstasy and other synthetic drugs
LSD/ other hallucinogens
(Psycho) pharmaceuticals
Replacement drugs

■ ≤ 25   ■ 26 - 35   ■ ≥ 36

We carried out also a segmentation of drugs used according to the occupation of the therapeutic community users with the aim to identify the existence of groups of substances associated with some professional categories[9]. For example, some studies have associated the cocaine consumption with members of the class medium/high (EMCDDA, 2009: 65; Elder, 1998). However, in our study, no pattern was found. This may be explained by the high homogeneity in the profile of the user studied. Although studies at the level of the general population can identify these patterns of consumers, it seems to be the consumers who do not resort to therapeutic communities, since the treatment of these models continue to be directed more towards the rehabilitation of heroin users (EMCDDA, 2009 : 72) and notorious with this type of population.
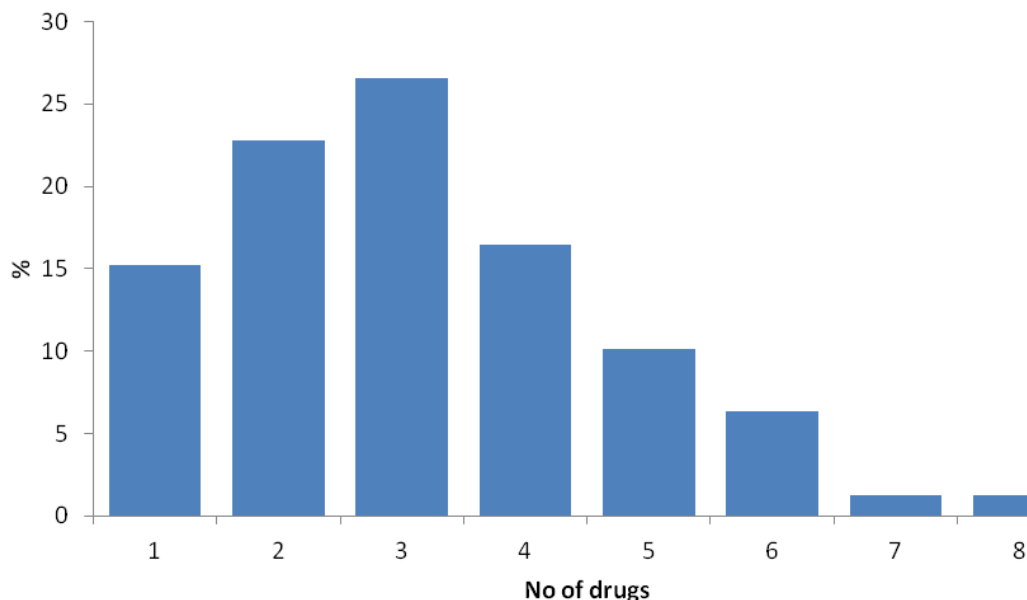
Polydrug use

Based on the drugs used at the entrance of the treatment was possible to quantify the number of drugs (or groups of drugs) that each therapeutic community user consumed, thus identifying polydrug use situations. It was found that almost half of users on which information

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[9] See appendix 1: Substances consumed by occupational group (absolute values).

is available consumed two to three drugs simultaneously. The maximum possible cases (7 and 8 substances simultaneously) are less frequent.

Figure 22: Number of drugs used at treatment entrance (%)

Theoretically, it would be expected to find different patterns of polydrug use associated with certain lifestyles or social status, such as the cocaine use associated with consumption of cannabinoids and alcohol by regulars of recreational night (EMCDDA, 2009: 69) or consumption of ecstasy and hallucinogens associated with the rave movement (Chaves and Fernandes, 2008). However, given the homogeneity of the profiles of users under study, it was not possible to set different standards of polydrug use because much of our universe consists of former heroin addicts who pooled consumption of heroin with other secondary substances.

Conclusion

After being presented the analysis of data characterizing socio-demographic, social networks and resources, admission and drugs consumed by the users of the Therapeutic Community Quinta das Lapas of Dianova Portugal with clinic departure for at least one year, we get a first picture of the individuals in our group study. This picture indicates that we are facing a population that seeks the answers therapeutic communities apparently distinct from other population that show different consumption patterns of these (Henriques, 2003; Carvalho,

2007) and which still seems to be no answers capable of meeting these emerging requirements.

But this study intends to focus on the social trajectories of reintegration after the therapeutic process. In this sense, we will prepare a questionnaire by telephone to apply to these therapeutic community users, in order to ascertain information about their trajectories in the period after the treatment. Trajectories that may be of reinstatement or relapse, but that are important to know and map.

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Appendices

Appendix 1: Substances consumed by occupational group (absolute values).

Drugs	Managers	Professionals	Technicians and associate professionals	Clerical support workers	Service and sales workers	Skilled agricultural, forestry and fishery workers	Craft and related trades workers	Plant and machine operators, and assemblers	Elementary occupations	Total
Heroin and other opiates	1	7	8	5	23	5	30	18	2	99
Cannabinoids	1	5	8	3	16	4	27	15	2	81
Cocaine	2	6	9	1	15	3	25	16	1	78
Alcohol	2	2	4	2	10	4	25	14	2	65
Amphetamines	-	-	2	2	1	-	14	3	1	23
Ecstasy and other synthetic drugs	-	1	1	-	4	-	8	4	-	18
LSD and other hallucinogens	-	1	1	2	3	1	7	6	-	21
(Psycho) pharmaceuticals	1	-	3	2	4	1	12	1	-	24
Replacement drugs	1	-	-	1	3	1	4	3	2	15
Total	8	22	36	18	79	19	152	80	10	424