



Between abstinence and relapse: the role of “Pre-relapse abstinence” in drug rehabilitation in Hong Kong

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Abstract

This study examined the relationship between the amount of drug-free time achieved before relapse (pre-relapse abstinence) and the amount of drug-free time achieved in the next posttreatment period after relapse, a neglected issue in relapse studies. It was hypothesised that the former would have a significant, causal and positive effect on the latter. Data were extracted from the three-year Longitudinal Study of Chronic Drug Abusers in Hong Kong conducted from 2000 to 2003. The survey of the study involved three interviews, yielding two 12-month intervals and one retrospective six-month interval. Altogether 178 subjects who were in treatment at the time of the 1st and 2nd interviews were selected for analysis. Pre-relapse abstinence in the first and second intervals were each examined to see if it could affect the total drug-free time in the next interval. Pre-relapse abstinence and total drug-free time were measured by the percentage of drug-free weeks in an interval in which the subject was not in treatment. In order to test the spuriousness of the relationship between pre-relapse abstinence in an interval and total drug-free time achieved in the next interval, which was the new posttreatment period, two psychological variables (self-efficacy and life satisfaction), three social capital variables (family support, support of non-drug-using friends, and association with drug-using friends), and one treatment variable (number of treatments after relapse) were introduced as independent variables. Multiple regression results confirmed that, even after controlling for these other independent variables, pre-relapse abstinence in an interval was still significantly related to total drug-free time in the next interval. Findings of this study suggest that the conventional “failure” view of relapse should be replaced

with a more constructive view that attaches importance to the amount of drug-free time achieved before relapse. The emphasis on pre-relapse abstinence also has relevance to the popular harm reduction approach in the drug field.

Key words: Relapse, abstinence, chronic drug abuse, rehabilitation, Hong Kong

INTRODUCTION

The high prevalence of relapse among drug addicts after receiving treatment services has been a common finding in studies in the drug field. Although drug treatment programmes help their clients to initiate behavioural change and cease dependence, a majority of treated addicts, including those who seek treatment voluntarily, would return to drug use in their posttreatment periods. Sustaining abstinence appears to be a lofty goal for even addicts most motivated to receive treatment. A great deal of research efforts have been devoted to exploring the psychological, social and treatment factors contributing to posttreatment relapse (Marlatt & Gordon, 1985; Daley, 1989; Hubbard et al., 1989; Simpson and Sells, 1990; Tims et al., 2001; Cheung, 1997). Much less attention, however, has been paid to the length of time that the treated person is able to remain drug-free after treatment. We believe that the length of the posttreatment drug-free period before relapse is an important piece of information in our understanding of relapse or recovery. The objective of this study is to examine how the length of posttreatment drug-free period achieved before relapse, or “pre-relapse abstinence,” may affect the lengths of future drug-free periods achieved after subsequent relapse and treatments.

PRE-RELAPSE ABSTINENCE AS A PROTECTIVE FACTOR IN DRUG REHABILITATION

Before we discuss the concept of pre-relapse abstinence, we will briefly review the phenomenon of relapse. In simple terms, relapse may be defined as “use after treatment of a specific pretreatment drug” (Hubbard et al., 2001:111). It is “the reinstatement of addictive behaviour, thoughts, and feelings after a period of abstinence” (Chiauzzi, 1991:13). The first use in the posttreatment period may be only an occasional episode, and that itself is a lapse (or a slip) rather than relapse (Marlatt & Gordon, 1985). When the re-use of drug becomes regular, relapse has occurred.

Relapse is commonly regarded as an indication of failure of either the treatment programme or the individual, or both. This “failure” view of relapse is understandable, given that the goal of treatment



is recovery of the treated person from drug addiction. If our focus is on relapse as failure, then the length of abstinence preceding relapse is not relevant. A relapse is a failure regardless of the length of time it takes to relapse. The “failure” approach to relapse looks at relapse as a cross-sectional and static event. Relapses after subsequent treatments are just a collection of failures.

However, there is more to the phenomenon of relapse than failure. Between the time the treated person leaves the treatment programme drug-free and the time of relapse, there can be a whole period of abstinence, or different cyclical periods of use and abstinence (Maddux & Desmond, 1974). Regardless of the pattern of use in this pre-relapse period, the length of abstinence achieved is relevant to drug rehabilitation. For example, a relapse that occurs shortly after treatment is qualitatively different from a relapse that occurs a long time after treatment. Although in both cases the treated individuals return to drug use, the latter individual demonstrates a greater ability to resist drug re-use than the former. In addition to the greater ability to remain drug-free, the longer duration of “pre-relapse abstinence” may also produce a psychological boost to the person’s confidence in resisting drug re-use in future. Thus, if we look at relapse from a more longitudinal and dynamic perspective, pre-relapse abstinence could be a positive factor that helps the person to achieve longer periods of posttreatment abstinence in future. In other words, we may hypothesise that pre-relapse abstinence could, over time, be one of the protective factors against posttreatment relapse.

ANALYTICAL FRAMEWORK

The main focus of this paper is on the possible influence of pre-relapse abstinence on the next posttreatment drug-free period. Pre-relapse abstinence will be the major independent variable, and the length of the drug-free period after another treatment will be the major dependent variable. In addition to pre-relapse abstinence, a number of other independent variables will also be introduced in the analysis. The purpose of including other independent variables is twofold: (1) to use them as controls for testing the spuriousness of the relationship between pre-relapse abstinence and length of drug-free status in the subsequent posttreatment period, and (2) to compare the strength of pre-relapse abstinence and those of the other independent variables in explaining subsequent posttreatment abstinence. Among these additional variables, two are psychological variables, three are social capital variables, and the last one is a treatment variable.

The two psychological variables are (i) self-efficacy and (ii) life satisfaction. Self-efficacy refers to

the individual's perceived ability to perform a coping response to deal with a high-risk situation (Marlatt, 1985). It is the extent of an individual's confidence in resisting the urge to consume drugs. The higher the degree of self-efficacy, the greater the likelihood of remaining drug-free. Life satisfaction is a person's overall evaluation of his/her satisfaction with a variety of life circumstances (Diener et al., 1985). A higher degree of life satisfaction is associated with a greater likelihood of remaining drug-free.

The three social capital variables are based on the social capital perspective which discusses how social relations are able to generate resources for the individual to facilitate social action or achieve goals (Coleman, 1988). Social capital can be either positive or negative, depending on the nature of the social network that one is embedded in (Portes, 1998). In this study, social capital that contributes to the continuation of drug-free status is *positive social capital*. By the same token, social capital that is conducive to relapse is *negative social capital*. Of course, in the case of negative social capital, the meaning of "capital" is more of a liability than an asset.

In the social capital domain, we derive our variables from two major deviance theories. Control theory (Hirschi, 1969) posits that social bonds established between the actor and his/her significant others exert informal social control that restrains him/her from committing deviant behaviour. For a treated addict, the re-establishment of social bonds with family members and non-drug-using friends will generate positive social capital in the form of informal social control. Conversely, renewal of bonds with drug-using friends will bring about negative social capital that is conducive to relapse (Cheung and Cheung, 2000, 2003).

Differential association theory (Sutherland and Cressey, 1978) suggests that deviant behaviour results from the learning of values, motives and techniques associated with the commitment of deviant behaviour from intimate persons. Family members and non-drug-using friends can offer opportunities for the treated addict to re-learn the normal way of life, and hence they can be sources of positive social capital. Re-association with addict friends, however, produces negative social capital, as it reinforces the addict way of life (Cheung and Cheung, 2000, 2003).

Based on the above-mentioned theories, the three social capital variables are: (i) family support, (ii) support of non-drug-using friends, and (iii) association with drug-using friends.



After relapse occurs, the individual may sooner or later seek treatment again. In the new posttreatment period, we need to differentiate between the effect of the new treatment and the effect of pre-relapse abstinence, on the maintenance of drug-free status. Thus, we introduce the variable “treatment after relapse” as another control in the analysis.

DATA AND METHOD

The Longitudinal Study of Chronic Drug Abusers in Hong Kong

Data used in this analysis were extracted from the “Longitudinal Study of Chronic Drug Abusers in Hong Kong” (LSCDA), of which the author was a principal investigator. Funded by the Hong Kong SAR Government through the Action Committee Against Narcotics and the Narcotics Division in 2000, the LSCDA was a three-year longitudinal study that examined the demographic, social, psychological and treatment factors affecting the path to relapse/recovery of chronic drug abusers (For details of the study, see Cheung et al., 2003). The survey of the study involved three interviews conducted at two 12-month intervals. In the 1st interview, information pertaining to the six months prior to the interview was also collected. This has allowed the study to have an extra interval for analysis. The three waves of interviews and the three intervals (A, B and C) covered in the study are shown in Figure 1.

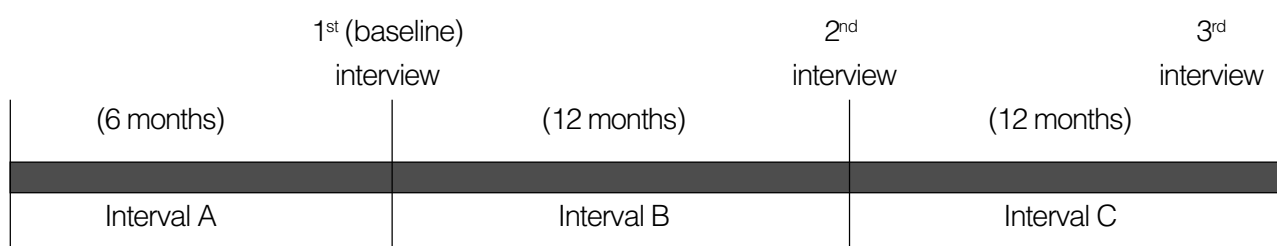


Figure 1:
The Three Waves of Interview and the Three Intervals

Subjects for the survey interviews were recruited from various drug treatment and rehabilitation programmes in Hong Kong. Altogether 547 subjects were successfully interviewed in the 1st (baseline) interview, 401 in the 2nd interview, and 319 in the 3rd interview. The overall retention rate of subjects from the 1st interview to the 3rd interview was 58.3%.

Selection of Subjects for the Present Analysis

Subjects for the present analysis are selected from the final panel of 319 subjects, who had gone through all the three waves of interviews. The selection criteria are as follows. First, to measure pre-relapse abstinence, it is not enough to take a single episode of relapse and then note the length of the drug-free period prior to the relapse. This is because the length of this drug-free period can be long or short, and if it is too short, its impact on future abstinence may not be significant. To ensure that the length of pre-relapse abstinence would not be too short, we use the two 12-month intervals (Intervals B & C) and the retrospective six-month interval (Interval A) in the LSCDA project as time frames, and count the total length of drug-free episodes in each interval. In other words, we use the amount of drug-free time in an interval as the length of pre-relapse abstinence.

Second, to ensure that the drug-free time in an entire interval is recorded, we select subjects who were in a treatment programme at the time of the interview, so that all the drug-free time concerned would be “pre-relapse” abstinence. This means that we select subjects who were both (1) in treatment during the 1st interview, so that the total drug-free time in the six-month Interval A was pre-relapse abstinence with respect to Interval B, and (2) in treatment during the 2nd interview, so that the total drug-free time in the 12-month Interval B was pre-relapse abstinence with respect to Interval C. Also, since we want to find out whether or not pre-relapse abstinence will be conducive to the length of the drug-free period in the next interval, the length of pre-relapse abstinence of an interval and the total amount of drug-free time in the same interval are, in fact, the same thing. More specifically, total drug-free time in Interval B serves to test the effect of pre-relapse abstinence in Interval A, and it is also the pre-relapse abstinence for Interval C (see Figure 2).

| | In treatment at 1 st interview | In treatment at 2 nd interview |
|--|---|--|
| Interval A (6 months) | Interval B (12 months) | Interval C (12 months) |
| Pre-relapse abstinence in Interval A | Total drug-free time in Interval B (Also Pre-relapse abstinence in Interval B) | Total drug-free time in Interval C |

Figure 2:
Pre-relapse Abstinence and Total Drug-free Time of the Intervals



Altogether 178 subjects were in treatment during the 1st and 2nd interviews. They are selected for the present analysis. Among this group of subjects, 79% were male, 51% were under the age of 30, 57% were never married, 52% lived in public housing, 90% were having only lower secondary school education or less, and 44% had 5 to 10 years of addiction history.

Data analysis will be divided into two parts. In the first part, the effect of pre-relapse abstinence in Interval A on total drug-free time in Interval B will be examined. Along with pre-relapse abstinence, the psychological variables (self-efficacy and life satisfaction), social capital variables (family support, support of non-drug-using friends, and association with drug-using friends), and the treatment variable (number of treatments after relapse) pertaining to Interval B will be introduced into the multiple regression analysis. The model for the regression analysis is shown in Figure 3.

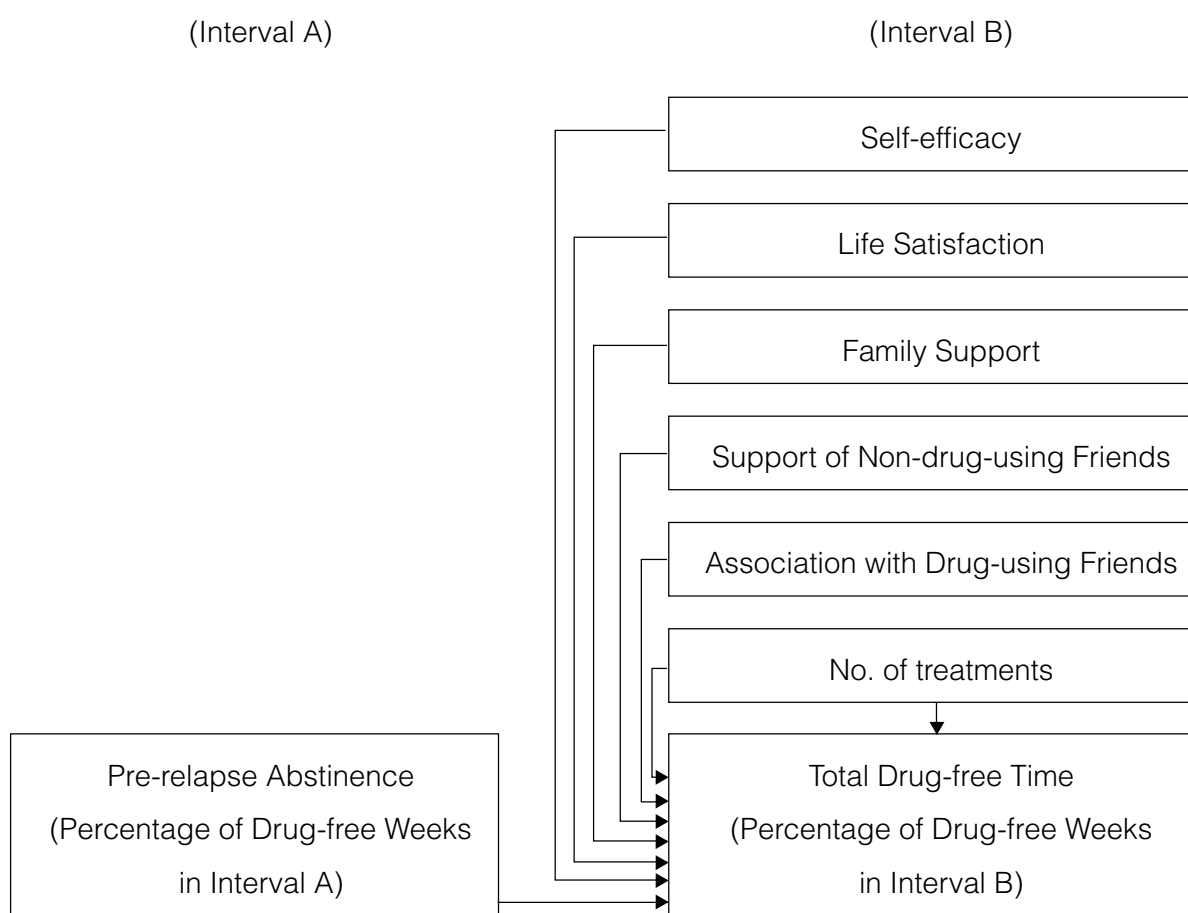


Figure 3:
Multiple Regressions for Total Drug-free Time in Interval B with
Pre-relapse Abstinence in Interval A and Other Independent Variables

The relationship of pre-relapse abstinence in Interval A to total drug-free time in Interval B, if not spurious, will be causal, as the former occurs before the latter. However, the relationships of the psychological variables, social capital variables and treatment variable in Interval B to total drug-free time in Interval B will be associational rather than causal, since they were all in the same interval as total drug-free time.

In the second part of data analysis, the same multiple regression analysis will be performed for total drug-free time in Interval C, which will be regressed on pre-relapse abstinence in Interval B, and self-efficacy, family support, support of non-drug-using friends, association with drug-using friends and number of treatments in Interval C.

Measurement of Variables

Pre-relapse Abstinence and Total Drug-free time

Pre-relapse abstinence and total drug-free time in an interval, which, as mentioned earlier, belong to the same variable, are measured by the “percentage of drug-free weeks” in the interval that a subject was drug-free. Stopping use for one whole week is used as the criterion for registering a unit of drug-free time. This is because a subject could stop use for a day or two, and then resume regular use. Such a short drug-free time would not truly reflect the ability to abstain from drug use. Also, since a subject might be in treatment for some of the time in an interval, the amount of drug-free time during treatment should not be taken into account. Thus, it is necessary to standardise the number of drug-free weeks with the amount of time that the subject was not in treatment in the interval concerned. As a result, the percentage of drug-free weeks in an interval is the number of drug-free weeks divided by the total number of weeks that the subject was not in any treatment programme in the interval.

Self-efficacy

A short form of the Situational Confidence Questionnaire which consists of 42 items (Annis, 1987) was used. The original scale had been validated in Annis and Davis (1988). In the final panel of the LSCDA subjects, the alpha value (Cronbach, 1951) of the self-efficacy scale was .981 in the 1st interview, .984 in the 2nd interview, and .987 in the 3rd interview, indicating that the scale has a very



high degree of reliability.

Life Satisfaction

The six-item life satisfaction scale developed by Diener et al. (1985) is used. The scale had been validated in Chang et al. (2003). The alpha value of the scale was .810, .838 and .869 in the 1st, 2nd and 3rd interviews respectively, indicating a very high degree of reliability.

Family Support

Family support consists of four items asking about whether family accepted subject, offered help when needed, gave emotional support, and discussed subject's problems. The alpha values for the three interviews were .717, .798 and .842, indicating a very high degree of reliability.

Support of Non-drug-using Friends

Like family support, support of friends who do not use drugs (including friends who have never used drugs and ex-addicts) consists of four items viz acceptance, offer of help, emotional support, and discussion of problems. The scale has a high degree of reliability, as the alpha values were .821, .834 and .826 for the three interviews respectively.

Association with Drug-using Friends

This variable is measured by two items asking about the frequency of seeing such friends and whether help was sought from them. It has sufficiently high alpha values of .597, .639 and .735 for the three interviews respectively.

Treatment after Relapse

Treatment after relapse is measured by the number of treatments the subject had received in the interval after relapse had occurred, the same interval as total drug-free time.

RESULTS

As mentioned earlier, we will divide our data analysis into two parts. We will examine firstly the effect of pre-relapse abstinence in Interval A on total drug-free time in Interval B, and then the effect of pre-relapse abstinence in Interval B on total drug-free time in Interval C.

Pre-relapse Abstinence in Interval A and Total Drug-free Time in Interval B

Let us first examine the bi-variate correlations among the variables in this analysis (Table 1).

Table 1

Bi-variate Correlations

| Independent variables: | Dependent variable: Total drug-free time in Interval B |
|---|---|
| | r |
| Pre-relapse abstinence in Interval A | .524** |
| Self-efficacy in Interval B | .523** |
| Life satisfaction in Interval B | .223** |
| Family support in Interval B | .220** |
| Support of non-drug-using friends in Interval B | .286** |
| Association with drug-using friends in Interval B | -.388** |
| Number of treatments in Interval B | -.376** |

** $p < .001$

From Table 1, it can be seen that all independent variables were significantly correlated with total drug-free time in Interval B. The correlation between pre-relapse abstinence in Interval A and total drug-free time in Interval B ($r = .524$, $p < .001$) was, in fact, greater than those between the psychological, social capital, and treatment variables and total drug-free time in Interval B.

We next control for the other independent variables to test the spuriousness of the relationship between pre-relapse abstinence in Interval A and total drug-free time in Interval B. To do this, we perform a multiple regression and regress total drug-free time in Interval B on the independent variables. Results are indicated in Table 2.



Table 2

Multiple Regression of Total Drug-free Time in Interval B on the Independent Variables

| Independent variables: | Dependent variable: Total drug-free time in Interval B | | | |
|---|---|--------|-------------------------------|-----------|
| | Unstan- dardised beta beta | SE | Stan- dardised beta (β) | t |
| Pre-relapse abstinence in Interval A | .325 | .073 | .294 | 4.467*** |
| Self-efficacy in Interval B | 18.475 | 4.281 | .305 | 4.315*** |
| Life satisfaction in Interval B | -.517 | 4.302 | -.008 | -.120 |
| Family support in Interval B | .528 | .988 | .035 | .534 |
| Support of non-drug-using friends in Interval B | .880 | .558 | .099 | 1.577 |
| Association with drug-using friends in Interval B | -2.738 | 1.393 | -.126 | -1.965* |
| Number of treatments in Interval B | -10.977 | 2.911 | -.232 | -3.771*** |
| <i>Constant</i> | -38.590 | 23.025 | | -1.676 |

Multiple R = .686

$R^2 = .471$

$F = 20.355^{***}; df = 167$

* $p < .05$; *** $p < .001$

Results in Table 2 show that, after controlling for other variables, pre-relapse abstinence in Interval A was still significantly related to total drug-free time in Interval B ($\beta = .294$; $p < .001$). This supports the major thesis of our present study that pre-relapse abstinence is a causal and positive factor in the amount of drug-free time that can be achieved in the next posttreatment period.

In Table 2, self-efficacy, association with drug-using friends and number of treatments in Interval B were also significantly related to total drug-free time in Interval B, after other independent variables were controlled for. The higher the degree of self-efficacy, the longer the total drug-free time achieved. However, association with drug-using friends and number of treatments were inversely related to

total drug-free time. The more the subject was in contact with drug-using friends, the less the amount of drug-free time that can be achieved. The more the number of treatment programmes that the subject had gone through in the interval, the less the amount of drug-free time in the same interval. One reason for the inverse relationship is that the need for more frequent treatments was a reflection of the lack of ability to refrain from drug reuse.

Self-efficacy yielded the largest standardised regression coefficient in the regression ($\beta=.305$), followed by pre-relapse abstinence in Interval A ($\beta=.294$), number of treatments in Interval B ($\beta=-.232$), and association with drug-using friends in Interval B ($\beta=-.126$). Altogether, the independent variables explained 47.1% of the variance of total drug-free time in Interval B.

In the regression, life satisfaction, family support and support of non-drug-using friends in Interval B were not significantly related to total drug-free time in Interval B after controlling for other variables. This does not mean that these variables did not have any influence on total drug-free time. The results suggest that they did not have direct effects on total drug-free time. They could still have indirect effects that passed through other independent variables before reaching total drug-free time. The examination of indirect effects could be facilitated by statistical methods such as path analysis, which are not performed here.

We next examine variables in Interval B and Interval C.



Pre-relapse Abstinence in Interval B and Total Drug-free Time in Interval C

Again, let us first look at the bi-variate correlations among the variables (Table 3).

Table 3:

Bi-variate Correlations

| Independent variables: | Dependent variable: |
|---|------------------------------------|
| | Total drug-free time in Interval C |
| | r |
| Pre-relapse abstinence in Interval B | .553** |
| Self-efficacy in Interval C | .591** |
| Life satisfaction in Interval C | .482** |
| Family support in Interval C | .334** |
| Support of non-drug-using friends in Interval C | .186* |
| Association with drug-using friends in Interval C | -.532** |
| Number of treatments in Interval C | -.370** |

* $p < .05$; ** $p < .01$

Table 3 shows that, like the case of Interval A—Interval B, total drug-free time in Interval C was significantly related to pre-relapse abstinence in Interval B ($r = .553$; $p < .01$) and all the other independent variables in Interval C.

We next perform a multiple regression analysis of the variables (Table 4).

Table 4

Multiple Regression of Total Drug-free Time in Interval C on the Independent Variables

| Independent variables: | Dependent variable: Total drug-free time in Interval C | | | |
|---|---|--------|-------------------------------|-----------|
| | Unstan- dardised beta | SE | Stan- dardised beta (β) | t |
| Pre-relapse abstinence in Interval B | .259 | .063 | .260 | 4.089*** |
| Self-efficacy in Interval C | 14.234 | 4.129 | .247 | 3.447*** |
| Life satisfaction in Interval C | 1.720 | .840 | .133 | 2.046* |
| Family support in Interval C | 1.429 | 3.292 | .026 | .434 |
| Support of non-drug-using friends in Interval C | 3.118 | 4.525 | .038 | .689 |
| Association with drug-using friends in Interval C | -10.006 | 2.413 | -.251 | -4.146*** |
| Number of treatments in Interval C | -7.038 | 2.577 | -.156 | -2.731** |
| <i>Constant</i> | -21.775 | 22.338 | | -.975 |

Multiple R = .738

$R^2 = .544$

$F = 26.979^{***}$; $df = 165$

* $p < .05$; ** $p < .01$; *** $p < .001$

The results in Table 4 largely resemble those obtained in the multiple regression results in Table 2. After controlling for other independent variables, pre-lapse abstinence in Interval B was still significantly related to total drug-free time in Interval C, suggesting that pre-relapse abstinence was a significant, causal and positive factor in the amount of drug-free time that can be achieved in the next posttreatment period.

As in Table 2, self-efficacy in Interval C was positively related to total drug-free time in Interval C, whereas association with drug-using friends in Interval C and number of treatments in Interval C were inversely related to total drug-free time in Interval C. Unlike the case in Interval B, life satisfaction



in Interval C was significantly and positively related to total drug-free time in Interval C.

Similar to regression results for Interval A and Interval B, family support in Interval C and support of non-drug-using friends in Interval C were not significantly related to total drug-free time in Interval C when other independent variables were controlled for. Again, this does not necessarily imply that these variables have no influence on total drug-free time. They might have indirect effects which were not assessed in this analysis.

Altogether, the independent variables explained 54.4% of the total variance of total drug-free time in Interval C.

SUMMARY AND DISCUSSION

This study examined the relationship between pre-relapse abstinence and the amount of drug-free time achieved in the posttreatment period after relapse, a neglected issue in relapse studies. It was hypothesised that the former would have a significant, causal and positive effect on the latter.

Data were extracted from the three-year Longitudinal Study of Chronic Drug Abusers in Hong Kong conducted by the author from 2000 to 2003. The survey of the study involved three interviews conducted at two 12-month intervals. In the 1st interview, information pertaining to the six months prior to the interview was also collected. This has allowed the study to have an extra interval for analysis, and this was Interval A. The 12-month interval between the 1st and 2nd interviews was Interval B, and that between the 2nd and 3rd interviews was Interval C. Altogether 319 subjects successfully went through the three interviews. Among them, subjects who were in treatment at the time of the 1st and 2nd interviews were selected, and the final number of subjects selected for the analysis was 178. The total drug-free time in Interval A was pre-relapse abstinence in Interval A with respect to Interval B, and total drug-free time in Interval B was pre-relapse abstinence in Interval B with respect to Interval C. Pre-relapse abstinence in both intervals were each examined to see if it could affect the total drug-free time in the next interval. Pre-relapse abstinence and total drug-free time were measured by the percentage of drug-free weeks in an interval in which the subject was not in treatment.

In order to test the spuriousness of the relationship between pre-relapse abstinence and total drug-free time achieved in the next interval, which was the new posttreatment period, two psychological variables (self-efficacy and life satisfaction), three social capital variables (family support, support of non-drug-using friends, and association with drug-using friends), and one treatment variable (number of treatments after relapse) were introduced as independent variables. Multiple regression analyses were performed firstly for Interval A and Interval B, and then for Interval B and Interval C. Results confirmed that, even after controlling for the other independent variables, pre-relapse abstinence in Interval A was still significantly related to total drug-free time in Interval B, and pre-relapse abstinence in Interval B was still significantly related to total drug-free time in Interval C. As to the other independent variables, self-efficacy, association with drug-using friends, and number of treatments were significantly related to total drug-free time in their respective intervals, after controlling for other variables. Life satisfaction was not significantly related to total drug-free time in Interval B, but it was in Interval C.

Findings of this study have demonstrated that the length of abstinence achieved in a period will have a causal and positive effect on the length of abstinence that can be achieved in the next period, and subsequent ones as well. We think this is an important footnote in the study of drug rehabilitation.

There is no shortage of debates on the effectiveness and success of treatment programmes (Goode, 1998). One of the views sets a high standard for evaluating the effectiveness or success of treatment, requiring the posttreatment maintenance of continuous, long-term abstinence by the treated addict. This view is, unfortunately, also quite prevalent among service providers. Abstinence of a client means progress, and hence rewarding, but relapse means “back-to-square-one”, a failure. While long-term abstinence is always a desirable goal, the overwhelming emphasis on abstinence may mask a lot of the dynamics of the relapse/recovery process.

In our earlier discussion of social capital, we mentioned that a process of social learning is involved when the treated addict either re-associates with his/her former drug-using peers, or re-establishes a network of non-drug-using friends. In the former scenario, the treated addict re-learns pro-drug values and the addict way of life. The treated addict in the latter scenario re-learns pro-social values and the drug-free way of life. Re-learning pro-drug values and the addict way of life is easy, since that was the treated addict's way of life before treatment. To re-learn drug-free values and



way of life is, however, a much more difficult task. To chronic drug abusers, the normal and drug-free way of life has long become alien. This process of re-learning, or what we may call “reverse learning,” will not only require persistent determination and strenuous efforts, but also involve many trials and errors, and vicissitudes of abstinence and relapse.

Moreover, each drug-free period achieved, no matter how short, may be viewed as a useful experience that facilitates the next drug-free period. This is like the case of a toddler having to repeat many times of tumbling before he/she finally could walk properly. Viewed from this perspective, many drug abusers would need to go through a fair number of treatments, in order to slowly develop, and accumulate, the ability to achieve longer drug-free episodes in the long and winding pathway to recovery.

Our results confirmed that the length of drug-free time achieved in a previous interval would directly affect the length of drug-free time in the following interval, and possibly subsequent ones as well. The remark of one of the male focus group subjects in the LSCDA study triangulates our view with his experience:

Previous experiences of failure could indeed help to achieve abstinence in future, as when I encounter similar high-risk situations in future, I would be more able to prevent relapse.

Therefore, we recommend that the more positive and brighter side of pre-relapse abstinent episodes should be acknowledged by service providers, policy makers in the drug fields, and the public as well. Achieving an amount of pre-relapse drug-free time should be welcomed rather than rejected. As pointed out by Shaw when he discussed the career perspective on substance abuse and intervention, “...each intervention may already help users to pick up something in their mind and build some latent motivation for change. Health professionals therefore should not judge individual interventions by their immediate effect and become disappointed when they see inattention, failure, and relapse after their particular programme efforts...” (Shaw, 2002). The “failure” view of relapse should be replaced with a more constructive one that acknowledges the amount of drug-free time before the next relapse as an accomplishment.

Lastly, to attach importance to the achievement and accumulation of short-term drug-free episodes is a view that coincides with the now internationally popular “harm reduction” approach in the drug field. Harm reduction acknowledges that most problem drug users would not be able to achieve long-term abstinence in the near future. Thus, at a pragmatic level, efforts should be made to help them to reduce or minimise the harms of current drug use, such as avoiding needle sharing among intravenous drug addicts and stabilising on methadone as a substitute for heroin use (Erickson et al., 1997; Cheung, 2000). Our findings suggest that achieving gradual increases in the amount of drug-free time in posttreatment periods could be a harm reduction goal in drug treatment and rehabilitation. Within a 12-month posttreatment period, for example, if abstinence for the whole period could not be achieved, maintaining a certain percentage of drug-free weeks in the period could have the merit of reducing some drug-related harm.

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