香港賽馬會藥物資訊天地
Hong Kong Jockey Club Drug InfoCentre

RESEARCH REPORT

ON

A STUDY ON THE NEEDS OF EX-ADDICTS

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Research report on a study
on the needs of ex-addicts

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Executive Summary

1. Rationale and Objectives of the Study

1.1 As the service needs of 'ex-addicts' who have completed the treatment programmes, the availability of relevant support services and the adequacy of these services have been scarcely studied, in response to the invitation of the Research Sub-committee of the Action Committee Against Narcotics, the present study was conducted.

1.2 The Objectives of the present study include:

(1) To explore different service needs of ex-addicts after completing the treatment programmes;
(2) To identify types of support services currently available to ex-addicts;
(3) To match these support services with the needs of ex-addicts at individual and community levels;
(4) To recommend additional services for helping ex-addicts reintegrate into the society; and
(5) To recommend a stage model of service provision to ex-addicts aiming for facilitating their reintegration into the society.

2. Research Design

2.1 "Ex-addicts" is operationally defined as those who had/have completed drug detoxification treatment programmes.

2.2 "Needs" are further classified into three domains, namely, (1) Biological, (2) Psychological and (3) Social.

2.3 A bio-psycho-social approach, which is believed to be able to comprehend the phenomenon of drug abuse and relapse more comprehensively, is adopted as the theoretical framework in the present study.

2.4 This study was commenced in July 1997 and completed by September 1998 (a total of 15 months).

2.5 Two study targets were approached: (1) Ex-addicts (service consumers) and (2) Experienced Workers in Counselling and Guidance Services for Ex-addicts (service providers).

2.6 Ex-addicts: The samples of this target group were drawn from four sources: 1. Compulsory Treatment Programmes (CTPs), 2. Voluntary Treatment Programmes (VTPs), 3. Methadone Clinics (MCs) and 4. Mutual Help Networks (MHNs).

2.7 Trained interviewers with a pre-set questionnaire were responsible for the individual interviews with the 'Ex-addicts'.

2.8 As the sampling procedure required a high degree of cooperation from all concerned parties and would induce a high administrative cost for the agencies, convenience sampling method was adopted.

2.9 Finally a total of 145 'Ex-addict' respondents were interviewed with 55 'New Ex-addicts' and 90 '1-year Ex-addicts'.

2.10 Sixteen interviews with Experienced Counselling Workers were successfully conducted with 6 from CSD and 10 from NGOs.

2.11 The investigators themselves were responsible for conducting the interviews with an interviewing schedule.

3. Research Findings and Analysis

3.1 Profile of Respondents

3.1.1 Among the 145 'Ex-addict' respondents interviewed, 55 (37.9%) were 'New Ex-addicts' and 90 (62.1%) were '1-year Ex-addicts' (Table 1.1).

3.1.2 A majority of the 'Ex-addict' respondents (114, 78.6%) was male and 21.4% (31) of them was female (Table 1.2).

3.1.3 A majority of the respondents was in their young adulthood (20-39) (72, 49.6%) (Table 1.3).

3.1.4 Most of the respondents had their education attainment at junior secondary (63, 43.4%), while 30.3% (44) attained the primary level. Sixty-three (22.8%) had attained the senior secondary level (Table 1.4).

3.1.5 Most of the respondents did not have any religion (67, 46.2%). However, as most of the VTPs and MHNs which provided respondents are Protestant organizations, nearly 40% (57, 39.3%) of the respondents was Protestant (Table 1.5).

3.1.6 Eighty percent (116) of the respondents was born in Hong Kong while 18 (12.4%) were born in Guagdong province of the mainland (Table 1.6).

3.1.7 Most of the respondents was single (82, 56.6%) while over one-fifth (33, 22.8%) was married. However, 27 (18.6%) of them were either separated or divorced (Table 1.7).

3.1.8 Nearly half of the respondents was employed (69, 47.6%) and half was not (76, 52.4%) (Table 1.8).

3.1.9 For those who were working, the types of work they engaged in were mostly of labour nature. Over half of them (37, 53.6%) was in the service/ transportation work. One-third (24, 34.8%) was in construction work. So totally, nearly 90% (61, 88.4%) of them were in jobs that required manual labour (Table 1.9).

3.1.10 Over half of the '1-year Ex-addicts' (50, 55.6%) reported that they had relapsed to drug addiction. The relationship between the Ex-addict Status and the Relapse Status is significant as revealed by the X^2 test (Table 1.10).

3.2 Service Needs of Ex-addicts

3.2.1 Biological

3.2.1.1 Thirty to forty percent of the ex-addicts reported minor health problems including insomnia, lacking concentration, physical fatigue, lack of appetite, etc. (Table 2.1).

3.2.1.2 The 'New Ex-addicts' were generally more satisfied with their overall health condition than were the '1-year Ex-addicts' (Table 2.3).

3.2.1.3 The relapsed ex-addicts reported much worse overall health satisfaction than did the non-relapsed (Table 2.4).

3.2.1.4 Over 50% of the respondents reported that they had experienced at least one time in more than three health problems in the list in the questionnaire (Table 2.2).

3.2.1.5 Smoking and drinking habits were similar across our main variables; except that more of the relapsed group reported to have smoking habit than the non-relapsed group.

3.2.1.6 A mix of unhealthy outlook, unfavorable appearance and smell affect the social life and job seeking of the ex-addicts that may add difficulties during their rehabilitation process.

3.2.1.7 Although the ex-addicts did not experience much great physical health problems, general health education and education on personal hygiene are needed both for the addicts and ex-addicts.

3.2.2 Psychological

3.2.2.1 In terms of self-esteem, although the respondents overall had a positive evaluation on themselves, 50% inclined to feel that they were failure and 80% at times thought that they were no good at all (Table 3.1.1). EWs also agreed that having low self-esteem is a common phenomenon among the ex-addicts.

3.2.2.2 The old ex-addicts are comparatively having a lower self-esteem than the younger ones. A trend was observed that the younger the ex-addicts were, the higher were their self-esteem scores (Table 3.1.2). Service workers should keep in mind the relation between self-esteem and the age of the ex-addicts during the rehabilitation process. Psychological support is very essential in helping ex-addicts who reach mid-age or beyond as they appear to have comparatively negative evaluation on themselves as well as on their future.

3.2.2.3 The relapsed ex-addicts reported a significantly low self-esteem when compared with the non-relapsed ones (Table 3.1.2). Continuous support by service workers should be given to those relapsees in the rehabilitation services. As relapses are common before a full rehabilitation can be achieved, counsellors should prepare to support and sustain the self-image of those exhibit relapses in the process.

3.2.2.4 Although the present findings indicate that self-mastery was perceived not as a problem for the ex-addicts (Table 3.2.1), this was a subjective expression of the ex-addicts themselves. EWs had reminded that the emotional state of the ex-addicts would fluctuate easily and it often affects their self-mastery abilities.

3.2.2.5 Relapse Status of the ex-addicts is found to have significant relationship with their perception of self-mastery. Relapse seems to have strong impact to the ex-addicts and weakens the relapsees' sense of self-mastery (Table 3.2.2).

3.2.2.6 The ex-addicts are generally satisfied with their life and possess a positive attitude on their life and future (Table 3.1.1). However, differences appear to be significant among their different Ex-addict Status, Age Group, and Relapse Status. The 'New Ex-addicts' are more satisfied than the '1-year Ex-addicts'. The younger ex-addicts are more satisfied with life than the older ex-addicts. The non-relapsed also scored a significantly high in life satisfaction than the relapsed (Table 3.3.2).

3.2.2.7 The EWs opined that the ex-addicts usually carry psychological burdens due to their previous addiction. A sense of guilt and failure is prevalent among the ex-addicts. It seems that the ex-addicts' perceptions of their life and future might be easily affected by their overall psychological condition.

3.2.2.8 Several service needs of the ex-addicts could be drawn for assisting their reintegration process. Self-esteem, self-image, and self-confidence are various psychological aspects that should be promoted through aftercare counselling, group and educational programmes.

3.2.2.9 Helping the ex-addicts work through their sense of guilt and failure caused by their past addiction history is an important job for aftercare workers. The ex-addicts should be trained to handle appropriately their emotions and situation of relapse. Since Relapse Status is associated strongly with all psychological variables, relapse prevention is extremely important in the reintegration process of the ex-addicts.

3.2.3 Social

3.2.3.1 The EWs opined that family support is of utmost importance for assisting the reintegration of the ex-addicts. Respondents had

expressed a positive view on the support of their families (Table 4.1.1), but at the feeling level, they could not really get adequate support from the families especially when faced with emotional difficulties (items 5 & 6). The lacking support from family is believed to be detrimental for the reintegration of the ex-addicts as expressed by several EWs. Family members should be assisted to increase their understanding and acceptance of their rehabilitating members in order to enhance the effectiveness of their support to the ex-addicts. Teaching them skills to support the ex-addicts especially in times of their needs is essential.

3.2.3.2 Many ex-addicts seemed to lack confidence on assuming the role of taking care of the family members (Table 4.1.4). Assistance is needed to help them develop abilities to meet different family roles.

3.2.3.3 Support from friends is satisfactory among the ex-addicts. However, marked differences are observed in terms of their Ex-addict Status, Age Group and Relapse Status. 'New Ex-addicts' are more satisfied with their support from friends than the '1-year Ex-addicts'. The younger the ex-addicts, the greater the perceived social support from friends. The non-relapsed ex-addicts perceive greater support from friends than the relapsed ones (Table 4.2.2).

3.2.3.4 The EWs had indicated that peer support is an influential factor for the rehabilitation of the ex-addicts. The success of reintegration lies on the attitude and behaviors of the peer groups that the ex-addicts associate with. Services to provide opportunities for desirable peer association and services to foster positive peer culture are extremely vital for the rehabilitation of the ex-addicts.

3.2.3.5 Over one-fifth of the respondents (23.5%) reported an inability to interact with strangers and 45% of them indicated incompetence in talking with the opposite sex (Table 4.3.1). In line with the EWs' opinions, some ex-addicts do lack appropriate social skills to develop new friendship that eventually affects the outcome of their reintegration. Good social skills can help them enlarge their social circle as well as enhance their sense of overall competence.

3.2.3.6 The '1-year Ex-addicts' had expressed a lower level of social competence than the 'New' ones. While the relapsed ex-addicts also have significantly lower level of social competence than the non-relapsed ones (Table 4.3.2). A continuous effort to assist them in the development of social skills is essential for preparing them to engage in normal social life.

3.2.3.7 A few number of ex-addicts expressed gratification on their jobs (Table 5.2). Assisting ex-addicts to engage in employment is important, furthermore, counselling workers should put effort to help ex-addicts identify the meanings of work. Some EWs mentioned that ex-addicts often needed to be reminded to develop realistic

expectations of their job.

3.2.3.8 Ex-addicts are lacking information of available help and services (Table 6.6). To provide them with adequate information of different kinds of available services and helping sources is necessary.

3.2.3.9 Ex-addicts considered the receiving of social services as a kind of social stigma (Table 6.7) and they had an idea that they should take care of their own problems. Educating them their right of using the services as consumers is important.

3.3 Support Services for Ex-addicts

3.3.1 There are quite a number of different kinds of services available for addicts/ ex-addicts. However, the adequacy of quantity and quality of available services need to be further investigated.

3.4 Adequacy of Support Services for Ex-addicts

3.4.1 Ensuring of Service Quality

3.4.1.1 Some EWs commented that there is not enough office space in their agencies to conduct different service programmes (e.g. group programmes) for the clients. This has affected the quality of their services.

3.4.1.2 Many NGOs have not employed professionally trained staff to carry out their services. This has affected the quality of their services.

3.4.1.3 Inadequate (or no) financial subvention provided to the agencies by the government is commented. Without adequate financial assistance, qualified professionals cannot be employed to deliver the services. All these will further affect the provision of quality services to the ex-addicts.

3.4.2 Inadequacy of Present Services

3.4.2.1 Heavy caseload was mentioned. 'Normally', a caseworker has to take care of 80-100 cases at the same time. Workers admitted that it is unrealistic for them to provide adequate guidance and aftercare to their clients with this caseload.

3.4.2.2 Some EWs suggested that methadone clinics (MCs) should be better utilized since they are locations where 'ex-addicts' can be gathered. A multiple service approaches (e.g. casework service, group programmes, educational programmes, etc.) should be adopted in the MCs so that the needs of the ex-addicts can be better served.

3.4.2.3 A majority of EWs has commented the inadequate provision of half-way house and accommodation services to the ex-addicts. The

remote location and shortage of half-way houses are unfavourable for the service provision. Furthermore, the length of stay in the half-way houses should be made more flexible as some ex-addicts might need a longer time to settle their accommodation after their leaving of the treatment programmes. Also, the professional input in the half-way houses is rather weak.

3.4.2.4 Some NGOs have provided hotline service to addicts/ex-addicts but it is not subvented and the output is not recognized in the service standard. This has impeded the NGOs to energetically pursue the hotline service that might have popular demand due to its convenience and concealed identity of the callers.

3.4.2.5 Existing service programmes have focused much on detoxification. Equal emphasis should be put on relapse prevention and aftercare services.

3.4.2.6 Working with the families of the ex-addicts is also an area that needed to be strengthened. Practically ex-addicts found it difficult to gain support from their family members. Most EWs also commented that family acceptance and support are crucial for successful rehabilitation of the ex-addicts.

3.4.2.7 The lack of mutual understanding, communication, cooperation and coordination, and hence trust, among different concerned agencies (both governmental and non-governmental organizations) has been critically commented by the EWs interviewed. The diverse orientations of different service agencies have made cooperation and coordination difficult. To promote commonly shared missions of the services for ex-addicts is important.

3.5 Additional Services for Ex-addicts

3.5.1 Multi-modality Clinics: A clinic service which is set up to address the unique health problems of the ex-addicts (e.g. physical illness, personal hygiene, health and diet education, dental problems) may channel their health complaints to proper and controlled means.

3.5.2 Expanding Service Scope of Methadone Clinics: A multiple approach which combines individual counselling, job placement, group training, drugs and health education, and personal growth activities should be considered to be included in the services of methadone clinics.

3.5.3 Reintegration Training Programme: Relapses are common among ex-addicts. Therefore, a systematic reintegration programme should be organized. This programme should be offered both to ex-addicts who relapse and who do not. Contents should include social skills training, stress management, independent livings and relapse prevention and cognitive-behavioural skills to handle cues and risks for relapse.

3.5.4 Supported Employment: Vocational rehabilitation for ex-addicts which focuses on three areas: education of positive job attitudes, development of interpersonal skills, and placement service should be emphasized.

3.5.5 Services for Family of Ex-addicts: It is stressful to the whole family having a drug using member. However, there is another story that living in an unhappy family may trigger out the relapse of a rehabilitating person. Therefore, it is always an emphasis for aftercare workers to assist ex-addicts in tuning in their families.

3.5.6 Hotline Service: Hotline service is useful in addressing the emotional crisis of the ex-addicts so that they can have an alternative way of getting help in case of stress. It is recommended that subvention to the service should be seriously considered.

3.5.7 Long-term Hostel: The provision of long-term hostels especially for those ex-addicts who need longer time to find proper places to stay is needed.

3.6 Assisting Ex-addicts' Reintegration

3.6.1 'Relapse Status' has been identified to be significantly associated with the biological, psychological and social needs of 'Ex-addicts'.

3.6.2 Conducting relapse prevention and relapse education programmes for addicts and ex-addicts is urgently needed.

3.6.3 Relapse prevention connotes the teaching of ways to identify triggers and conditions that may lead to re-addiction. The teaching of ways for strengthening coping skills with different life stress and assertive skills for resisting drug temptations is also stressed. The enlargement of supporting social network, the acquiring of appropriate inter-personal skills and development of healthy hobbies should all be included in the programmes of relapse prevention.

3.6.4 Relapse education implies a genuine acceptance of relapses during the rehabilitation process of ex-addicts. Ex-addicts should be made aware that complete abstinence is a difficult but achievable process which requires a strong determination with a restructuring of a healthy life style. Ex-addicts should also be educated to look for help in case of relapse.

3.7 A Stage Model of Service Provision to Ex-addicts

3.7.1 As there are no statistically significant difference found between different needs of 'New Ex-addicts' and '1-year Ex-addicts', a stage model of service provision to ex-addicts, as originally proposed to be developed, cannot be recommended.

4. Limitations

4.1 As those addicted to drug might easily relapse into multiple addiction even after detoxification, a clear definition of 'Ex-addict' does not exist in the literature. As an operational definition for facilitating the present study, the current definition of 'Ex-addict' has to be adopted.

4.2 Due to the skepticism of the ex-addicts and the difficulty of directly getting their consent, the samples obtained is relatively limited. So, a vigorous statistical analysis of the data could not be pursued.

5. Recommendations

5.1 In order to fully comprehend the needs of the ex-addicts, a longitudinal study on the same topic for tracing the path of reintegration of the ex-addicts after their discharge is recommended.

5.2 As the support from families is a significant factor for assisting the reintegration of ex-addicts into normal social life, a thorough study on this aspect is recommended. The study could include investigating the different types of families that ex-addicts are living in and the roles that different family members play in the reintegrating process of the ex-addicts.

5.3 Energetic effort on community education to promote public acceptance of the ex-addicts is needed so that their reintegration process can be facilitated.

5.4 Participation of frontline practitioners in concerned government bodies (e.g. Action Committee Against Narcotics) should be promoted so that the government can be more efficiently attuned to the pulse of drug addiction and the treatment scenes.

I. Research Background

Practitioners in the field of drug abuse treatment are well aware of the difficulties encountered by ex-addicts in the reintegration process. Studies have shown that the relapse rate for ex-addicts after their detoxification treatment was rather high. The study by Hunt, Barnett and Branch (1971), which was a classical investigation, revealed that over 65% of all participants relapsed by the 90-day follow-up assessment after the termination of treatment. A more recent study (Wallace, 1989) even showed that 76% of the clients relapsed within the first 90-day post-detoxification treatment.

The encountering of intrapersonal and interpersonal high risk situations is suggested to be a cause for relapse of ex-addicts (Barber, 1994; Marlatt and Gordon, 1985). Summarizing from different researches, Botvin (1995) has pointed out three factors that have been identified as contributing to drug abuse (and relapse). These include social influence, individual personality characteristics and developmental factors. Conditions under two domains - psychological and environmental domains - have also been proposed as factors associating with the relapse of ex-addicts (Wallace, 1992). The psychological difficulties of ex-addicts identified include painful emotional states, weak motivation, and failure and refusal to aftercare services; while the environmental factors identified include exposure to stimuli of people, places and things; interpersonal difficulties and lack of family support, etc..

Aftercare services, which emphasize the provision of support services to ex-addicts for facilitating their reintegration into the society after their detoxification treatment, are regarded as an integral part of the rehabilitation programmes. These services include both tangible ones (such as financial assistance, housing, employment, etc.) and intangible ones (such as personal guidance, emotional support, counselling, etc.). As a whole, these services aim to provide support and opportunities for enhancing ex-addicts to reintegrate into the society and to resume a normal and healthy life. In fact, the existence of social support is regarded as essential for reducing deviance and creating conformity (Stacy and Newcomb, 1995).

Although local practitioners in the field of drug abuse treatment are clear about the importance of aftercare services to ex-addicts, systematic information on the needs of this clientele is extremely limited. Statistics from the government show that from 1991 to 1995, on the average, there were 3,839 newly reported cases of drug abusers each year (Narcotics Division, 1996). This shows that the problem of drug abuse in the territory is quite unfavourable. Locally, there are a number of local agencies providing aftercare support services to ex-addicts (Action Committee Against Narcotics, 1995), however, their adequacy in assisting the rehabilitation and reintegration process of ex-addicts has been scarcely studied.

Most previous indigenous studies on drug abuse had their focuses on the causes and prevention of drug abuse and the effectiveness of different treatment programmes for drug abusers. However, the service needs of ex-addicts who have completed the treatment programmes, the availability of relevant support services and the adequacy of these services, if available, have been scarcely studied. All these aspects, in fact, have significant bearings on the successfulness of assisting the ex-addicts to reintegrate into the society that is the ultimate goal of different treatment programmes.

With the awareness of the above phenomena, and in response to the invitation of the Research Sub-committee of the Action Committee Against Narcotics, the present study was conducted.

II. Research Objectives

The objectives of this study are:

(1) To explore different service needs of ex-addicts after completing the treatment programmes;

(2) To identify types of support services currently available to ex-addicts;

(3) To match these support services with the needs of ex-addicts at individual and community levels;

(4) To recommend additional services for helping ex-addicts reintegrate into the society; and

(5) To recommend a stage model of service provision to ex-addicts aiming for facilitating their reintegration into the society.

III. Definitions of Concepts

A clear definition of "Ex-addict" does not exist in the literature. In most international studies, ex-addiction is usually associated with 'drug-free', 'drug abstinence' and 'non-relapse'. Although 'drug free' or 'abstinence' can be employed as a defining criterion, the period of its achievement varies for different people. Furthermore it's intrusive, and in fact unrealistic, to request respondents to take drug free test. So it could not be a good operational definition of 'Ex-addict'. Also relapse is common among drug addicts/ex-addicts even they have gone through detoxification programmes. In order to create a more practical definition of "Ex-addicts", the following one is adopted as an operational definition.

"Ex-addicts": Those who had/have completed drug detoxification treatment programmes.

"Needs": These are further classified into three domains, namely, (1) Biological, (2) Psychological and (3) Social.[1]

[1] For further elaboration of the items of different domains, please refer to Appendix 1: Questionnaire for 'Ex-addicts'.

IV. Theoretical Framework

Different models have been proposed to account for substance abuse relapse (Tucker and Vuchinich, 1992).[2] However, a bio-psycho-social approach (Chiuzzi, 1991)[3], which is believed to be able to comprehend the phenomenon of drug abuse and relapse more comprehensively, is adopted as the theoretical framework in the present study for investigating the needs of ex-addicts. This approach suggests the need to consider the biological, psychological and social domains that play important roles in preventing relapse of ex-addicts and assisting their reintegration.

Under this theoretical framework, to explore the biological (physical) conditions of ex-addicts that might lead them to abuse drug again and see if relevant services are available to them are essential for preventing their relapse. As it is understood that ex-addicts will encounter lots of psychological problems in their reintegration process, to explore the problems they encounter in this dimension is important for understanding their needs in this domain. The degree of satisfaction or stress that ex-addicts experience in different aspects in their social environment is also critical for preventing their relapse. So, an understanding of their situation in this social domain is necessary for exploring their needs in this area.

Factors in the three domains proposed in this approach are interactive and mutually reinforcing. Equal attention should be paid to each of them so that relapse prevention and reintegration of ex-addicts could be more promising.

V. Research Methodology

This study was commenced in July 1997 and completed by September 1998 (a total of 15 months).

For exploring the needs of the ex-addicts and the availability and appropriateness of relevant support services, two study targets were approached.

Study Targets

The two groups of people targeted for this study were:

(1) Ex-addicts (service consumers), and
(2) Experienced Workers in Counselling and Guidance Services for Ex-addicts (service providers).

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[2]Tucker, J. A. and Vuchinich, R. E. (1992) Substance Abuse Relapse : Theory and Clinical Application. In Watson, R. R. (ed.) ***Drug Abuse Treatment***. New Jersey: Humana Press (P.71-98).

[3] Chiuzzi, E. J. (1991) ***Preventing Relapse in the Addictions : A Biopsychosocial Approach***. New York: Brunner/Mazel.

(1) Ex-addicts

As it has been defined that 'Ex-addicts' are those who had/have been in drug detoxification treatment programmes, the samples of this target group were drawn from four sources : 1. Compulsory Treatment Programmes (CTPs), 2. Voluntary Treatment Programmes (VTPs), 3. Methadone Clinics (MCs) and 4. Mutual Help Networks (MHNs).

1. Compulsory Treatment Programmes (CTPs)[4]

The compulsory treatment programmes are those of the Drug Addiction Treatment Centres (DATCs) of the Correctional Services Department (CSD) which are of a custodial nature.

Eligible respondents were recommended from these custodial institutions. Since during their treatment process, they had been segregated from the society, this makes the need of their reintegration into the society after the treatment more apparent.

For identifying and comparing the needs of the 'Ex-addicts' at different stages after treatment, two groups of respondents in this kind of programme were approached for data collection through individual interviews. The first group was those who had just completed the treatment programme (discharged) within the past 3 months when the interviews were conducted (New Ex-addicts). The second group was those who had completed the treatment programmes (discharged) for 12 months when the interviews were conducted (1-year Ex-addicts).

Originally, 15 new discharge cases (New Ex-addicts) from Hei Ling Chau Addiction Treatment Centre (for male) and 15 of those from Chi Ma Wan Correctional Institution (for female) were collected. Another 15 cases who had just completed the aftercare period (discharged for 12 months: 1-year Ex-addicts) from Hei Ling Chau Addiction Treatment Centre and 15 of those from Chi Ma Wan Correctional Institution were also collected for the study. All these eligible respondents had signed consent forms for the interviews voluntarily. Trained interviewers with a pre-set questionnaire (Appendix 1) were responsible for the individual interviews. However, at the deadline of the data collection period (i.e. June 15, 1998), only 18 of them had participated in the interviews.

2. Voluntary Treatment Programmes (VTPs)[5]

The voluntary treatment programmes are those run by the non-governmental organizations (NGOs) with a residential nature.

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[4] There are 2 CTPs (DATCs) under CSD. They are Hei Ling Chau Addiction Treatment Centre (for male) and Chi Ma Wan Correctional Institution (for female).

[5] As listed in the handbook by HKCSS (1996), there were 10 NGOs which ran VTP of different service capacity for the ex-addicts. They included Wu Oi Christian Centre; Society for the Aid & Rehabilitation of Drug Abusers; Finnish Missionary Society; Operation Dawn, Hong Kong; Dacars Limited; Barnabas Charitable Service Association Limited; Christian Zheng Sheng Association Limited; The Christian New Being Fellowship Limited; St. Stephen's Society and World Vision Lily's Home.

Eligible respondents were recommended by the staff of these residential programmes. Same as the above argument, since during their treatment process, they had been segregated from the society, their need of reintegration into the society is more apparent.

Also, two groups of respondents in these programmes were approached for individual interviews. The first group was those who had just come out their treatment programmes within the past 3 months when the interviews were conducted (New Ex-addicts). Definition of completion of treatment programmes had not been made since the definition varied among different programmes. However, respondents who had stayed in their treatment programme for less than two weeks were excluded so that full detoxification among all respondents could be more assured. The second group was those who had graduated from their treatment programmes for 12-15 months when the interviews were conducted (1-year Ex-addicts).

Based on the data provided in a handbook on drug abuse treatment and rehabilitation published by HKCSS in 1996, a total of 10 NGOs were running VTPs with different service capacity for drug abusers. Among the 10 NGOs, the VTP run by SARDA had the largest capacity for male drug abusers. Its capacity equalled approximately 45% of all VTPs run by other NGOs in Hong Kong. Therefore, half of the male VTP 'Ex-addict' respondents were intended to be collected from SARDA while another half from the other NGOs. With reference to government's statistics, the male-female ratio among drug abusers is approximately 6 : 1, but the number of female respondents in this study was set to one third of all respondents. The main reason for using disproportionate sampling arrangement was to make sure the obtaining of an adequate number of female respondents for analysis.

However, the sampling procedure required a high degree of cooperation from all concerned NGOs and would induce a high administrative cost for the agencies. So ultimately, the convenience sampling method was adopted.

Again, trained interviewers with a pre-set questionnaire (Appendix 1) were responsible for the individual interviews.

3. Methadone Clinics (MCs)[6]

As revealed from the statistics of the Narcotics Division of the Government, the number of users admitted in all methadone clinics of the territory in 1996 was 10,924. It is known that most of them had been in other forms of detoxification programmes. Since the population of the methadone users is quite enormous, their opinions on their needs as "Ex-addicts' are valuable. Therefore, they were also approached as respondents of this study.

Also, two groups of respondents were sampled for individual interviews. The first group was those who had been admitted into the clinics within 3 months at the

[6] From the information of the Department of Health of the Government, at present, there are totally 21 methadone clinics in the territory. Four in Hong Kong Island, 10 in Kowloon and 7 in the New Territories.

time of the interviews (New Ex-addicts), while the second group was those who had been admitted for 12 months at the time of the interviews (1-year Ex-addicts). Among the 21 methadone clinics in different districts of different regions of the territory, 1 clinic from each region (i.e. Hong Kong Island, Kowloon and New Territories) were randomly sampled for this study. It was expected that in each sampled clinic, 15 users who had been admitted within 3 months at the time of the interviews and 15 who had been admitted for 12 months at the time of the interviews could be approached.

4. Mutual Help Networks (MHNs)[7]

As members in these networks are those who have gone through the experience of drug addiction and rehabilitation, their opinions on their needs as "Ex-addicts' also have good reference value for the present investigation. Same as above, two groups of people in these networks were approached. The first group was those who had joined the networks within 3 months at the time of the interviews, while the other group was those who had joined the networks for 12 months at the time of the interviews.

With reference to the size of network of the related NGOs, eligible 'Ex-addicts' from Pui Hong Self-Help Association (5 networks); Society for the Rehabilitation of Offenders, Hong Kong (4 networks) and Wu Oi Christian Centre (2 networks) were approached.

Size of Respondents

After a great deal of effort in contacting, liaising and soliciting cooperation from different target sources for eligible respondents, the actual number of the respondents obtained from different sources was as follows:

Programmes	New Ex-addict	1-year Ex-addict	
CTPs	8	10	
VTPs	25	24	
MCs	10	43	
MHNs	12	13	
Total	55	90	**145**

(2) Experienced Workers in Counselling and Guidance Services for Ex-addicts

For collecting opinions on the availability and appropriateness of support services for ex-addicts, some experienced workers in agencies which provide counselling and guidance/aftercare to ex-addicts were invited to be interviewed. The investigators themselves were responsible for conducting the interviews with an interviewing schedule (Appendix 2). Based on their working experience, these personnel are in the best position to comment on the suitableness of the available

[7] From the information in the Directory of Social Services 1995 (HKCSS), there are currently 6 NGOs in Hong Kong running this kind of network with various size.

support services for ex-addicts and recommend the implementation of new and appropriate ones.

Besides, the Aftercare Sections of the 2 DATCs, 10 such agencies[8] were identified in the Directory of Social Services 1995 of HKCSS. Originally 20 of such workers were expected to be approached and interviewed. However after various attempt, 16 were interviewed.

Organization	Experienced Worker Interviewed
CSD	6
NGOs	10
Total	**16**

Content analysis of the different opinions of the 16 EWs can be consulted in Appendix 3.

VI. Research Findings

The following sections present the different relevant findings of this study.

1. Profile of Respondents

Table 1.1: Sources of Respondents

Source / Type	New Ex-addict	1-year Ex-addict	
Compulsory Treatment Programme	8 (5.5)	10 (6.9)	
Voluntary Treatment Programme	25 (17.2)	24 (16.6)	
Mutual Help Network	12 (8.3)	13 (9.0)	
Methadone Clinic	10 (6.9)	43 (29.6)	
Total	55 (37.9)	90 (62.1)	145 (100.0)

Among the 145 'Ex-addict' respondents interviewed, 55 (37.9%) were 'New Ex-addicts' and 90 (62.1%) were '1-year Ex-addicts'.

Table 1.2: Gender

Male	114 (78.6)
Female	31 (21.4)
Total	145 (100.0)

[8] These agencies include : Barnabas Charitable Service Association; Caritas-Hong Kong; Community Drug Advisory Council; Dacars, Limited; Finnish Missionary Society; Hong Kong Christian Service; Operation Dawn, Hong Kong; Society for the Aid & Rehabilitation of Drug Abusers; Society for the Rehabilitation of Offenders, Hong Kong and St. Stephen's Society.

A majority of the 'Ex-addict' respondents (114, 78.6%) was male and 21.4% (31) of them was female.

Table 1.3: Age

15 - 19	21 (14.5)
20 - 29	46 (31.7)
30 - 39	26 (17.9)
40 - 49	30 (20.7)
50 - 59	16 (11.0)
60+	6 (4.1)
Total	145 (100.0)

A majority of the respondents was in their adulthood (30-49) (56, 38.6%). Nearly one third of the respondents (46, 31.7%) was in their late adolescence/early adulthood (20-29).

Table 1.4: Education

No formal education	2 (1.4)
Primary (P.1-6)	44 (30.3)
Junior secondary (F.1-3)	63 (43.4)
Senior secondary (F.4-5)	33 (22.8)
Matriculation (F.6-7)	2 (1.4)
Post-secondary	1 (0.7)
Total	145 (100.0)

Most of the respondents had their education attainment at junior secondary (63, 43.4%), while 30.3% (44) attained the primary level. Sixty-three (22.8%) had attained the senior secondary level.

Table 1.5: Religion

Catholic	8 (5.5)
Protestant	57 (39.3)
Buddhist	10 (6.9)
Taoist	2 (1.4)
Other	1 (0.7)
No religion	67 (46.2)
Total	145 (100.0)

Most of the respondents did not have any religion (67, 46.2%). However, as most of the VTPs and MHNs which provided respondents are Protestant organizations, nearly 40% (57, 39.3%) of the respondents was Protestant.

Table 1.6: Place of Birth

Hong Kong	116 (80.0)
Guagdong	18 (12.4)
Other provinces	8 (5.5)
Foreign countries	3 (2.1)
Total	145 (100.0)

Eighty percent (116) of the respondents was born in Hong Kong while 18 (12.4%) were born in Guagdong province of the mainland.

Table 1.7: Marital Status

Single	82 (56.6)
Married	33 (22.8)
Widowed	3 (2.1)
Separated	6 (4.1)
Divorced	21 (14.5)
Total	145 (100.0)

Most of the respondents was single (82, 56.6%) while over one-fifth (33, 22.8%) was married. However, 27 (18.6%) of them were either separated or divorced.

Table 1.8: Employment

Yes	69 (47.6)
No	76 (52.4)
Total	145 (100.0)

Nearly half of the respondents was employed (69, 47.6%) and half was not (76, 52.4%).

Table 1.9: Types of Employment

Clerical	5 (7.2)
Service/Transportation	37 (53.6)
Construction work	24 (34.8)
Factory	3 (4.3)
Total	69 (100.0)

For those who were working, the types of work they engaged in were mostly of labour nature. Over half of them (37, 53.6%) was in the service/transportation work. One-third (24, 34.8%) was in construction work. So totally, nearly 90% (61, 88.4%) of them were in jobs that required manual labour.

Table 1.10: Relapse to Drug Addiction

Relapse	New Ex-addict	1-year Ex-addict
Yes	16 (29.1)	50 (55.6)
No	39 (70.9)	40 (44.4)
Total	55 (100.0)	90 (100.0)

(X^2=9.64 p=0.0000)

It can be seen from Table 1.10 that over half of the '1-year Ex-addicts' (50, 55.6%) reported that they had relapsed to drug addiction. The relationship between the two variables is significant as revealed by the X^2 test.

Table 1.11: Problem Behaviours in Last 3 Months

Problem Behaviour	Yes	No
Borrowing money from others	59 (40.7)	86 (50.3)
Getting into troubles with police	11 (7.6)	134 (92.4)
Fighting	18 (12.4)	127 (87.6)
Stealing	3 (2.1)	142 (97.9)
Trading sex for money	1 (0.7)	144 (99.3)
Associating with drug abusing peers	47 (32.4)	98 (67.6)

Among the list of problem behaviours asked, 40.7% (59) of the ex-addicts had borrowed money from other people in the last three months. Nearly one-third of them (47, 32.4%) had associated with drug abusing peers in the last three months (Table 1.11).

2. Health (Biological) Condition of Ex-addicts

Four main independent variables, namely, Ex-addict Status, Gender, Age Group and Relapse Status, of the respondents are used in analysing the biological condition of the 'Ex-addicts'. The biological condition of the respondents are measured by their general health situation, smoking and drinking habits.

Table 2.1: Health Condition in Previous Month

Health Condition	Never	1 –2 Times	3 - 4 Times	5 Times +
Sleeplessness	74 (51.0)	15 (10.3)	24 (16.6)	32 (22.1)
Lack concentration at work	60 (42.1)	30 (20.7)	22 (15.2)	31 (21.4)
Easily become tired	39 (26.9)	25 (17.2)	27 (18.6)	54 (37.2)
Consulting doctor due to sickness	100 (69.6)	31 (21.4)	8 (5.6)	4 (2.8)
Cannot go to work due to physically weakness	92 (71.0)	8 (6.2)	8 (6.2)	8 (6.2)
Lack of appetite	82 (56.6)	17 (11.7)	10 (6.9)	36 (24.8)
Feel lack stamina/want to faint	94 (64.8)	13 (9.0)	13 (9.0)	25 (17.2)
Feel accelerating of heartbeat unreasonably (Cardiac arrhythmia)	91 (62.8)	15 (10.3)	17 (11.7)	22 (15.2)
Feel back pains	64 (44.1)	27 (18.6)	19 (13.1)	35 (24.1)

Table 2.2: Number of Health Problems in Previous Month

Number of Health Problem	Frequency	Valid Percentage
0	11	8.5
1	14	10.8
2	23	17.7
3	14	10.8
4	17	13.1
5	16	12.3
6	13	10.0
7	12	9.2
8	5	3.8
9	5	3.8
Total	130	100.0

Feeling fatigue, lacking concentration, disturbing sleep and having back pains were the most frequent physical problems in the past month reported by the respondents (Table 2.1). Over 50% of the respondents reported that they had experienced at least one time in more than three health problems in our list (Table 2.2).

Table 2.3: Satisfaction with Overall Health Condition

Satisfaction	New Ex-addict	1-year Ex-addict
Very Satisfied/Satisfied	44 (80.0)	49 (54.4)
Unsatisfied/Very Unsatisfied	11 (20.0)	41 (45.6)
Total	55 (100.0)	90 (100.0)

(X^2=9.69 p=0.0019)

It can be seen from Table 2.3 that generally 'New Ex-addicts' were more satisfied with their overall health condition than '1-year Ex-addicts'. The statistical test (X^2) also indicates that the relationship between the variables is significant.

Table 2.4: Satisfaction with Overall Health Condition by Relapse Status

Satisfaction	Relapsed	Non-relapsed
Very Satisfied/Satisfied	27 (40.9)	66 (83.5)
Unsatisfied/Very Unsatisfied	39 (59.1)	13 (16.5)
Total	66 (100.0)	79 (100.0)

(X^2=28.42 p=0.0000)

Table 4.2 reveals that the non-relapsed ex-addicts were more satisfied with their overall health condition than the relapsed ones. This observed difference is also statistically significance.

Analysing the opinions from the 'Experienced Workers' (EWs), it can be concluded that they felt that generally the health condition of the ex-addicts should not have much problem. It all depends on their addiction history. For those who have taken drugs for a longer period of time, they would have certain physical problems even they have quitted the habit. Physical problems such as lung/respiratory problems, circulation problem, tooth pain, bone pain, insomnia, sweating and smell are common among the ex-addicts who have long history of addiction.

Smoking Situation

Table 2.4.1: Smoking by Ex-addict Status

Smoking	New Ex-addict	1-year Ex-addict
Yes	35 (63.6)	66 (73.3)
No	20 (36.4)	24 (26.7)
Total	55 (100.0)	90 (100.0)

(X^2=1.52 p=0.22)

Over 70% (66, 73.3%) of the '1-year Ex-addicts' had smoking habit while over 60% (35, 63.6%) of the 'New Ex-addicts' had smoking habit (Table 2.4.1); however, the difference is insignificant. So, it seems that smoking is a popular habit among the ex-addicts.

Table 2.4.2: Smoking by Gender

Smoking	Male	Female
Yes	83 (72.8)	18 (58.1)
No	31 (27.2)	13 (41.9)
Total	114 (100.0)	31 (100.0)

(X^2=2.51 p=0.11)

From Table 2.4.2, it can be seen that male tended to smoke more than female. Over 70% (83, 72.8%) of the male respondents reported to have smoking habit. However, the difference is not significant.

Table 2.4.3: Smoking by Age Group

Smoking	Group 1 (15-19)	Group 2 (20-29)	Group 3 (30-49)	Group 4 (50+)
Yes	10 (47.6)	34 (73.9)	39 (69.6)	18 (81.8)
No	11 (52.4)	12 (26.1)	17 (30.4)	4 (18.2)
Total	21 (100.0)	46 (100.0)	56 (100.0)	22 (100.0)

(X^2=6.76 p=0.80)

Although it is not statistically significant, from Table 2.4.3, there seems to be a phenomenon that more older people smoked.

Table 2.4.4: Smoking by Relapse Status

Smoking	Relapsed	Not Relapsed
Yes	64 (97.0)	37 (46.8)
No	2 (3.0)	42 (53.2)
Total	66 (100.0)	79 (100.0)

(Corrected X^2=40.42 p=0.0000)
(Note: No cell has expected count of less than 5)

Table 2.4.4 shows that 'Relapsed Ex-addicts' tended to smoke more than those who have not relapsed. It is also statistically significant.

Drinking Situation

Table 2.5.1: Drinking by Ex-addict Status

Drinking	New Ex-addict	1-year Ex-addict
Yes	12 (21.8)	18 (20.0)
No	43 (78.2)	72 (80.0)
Total	55 (100.0)	90 (100.0)

(X^2=1.65 p=0.44)

Most of respondents did not have a drinking habit (Table 2.5.1). The drinking pattern between the 'New ex-addicts' and '1-year ex-addicts' did not differ significantly.

Table 2.5.2: Drinking by Gender

Drinking	Male	Female
Yes	24 (21.1)	6 (19.4)
No	90 (78.9)	25 (80.6)
Total	114 (100.0)	31 (100.0)

(X^2=0.29 p=0.87)

Only about one-fifth of the male respondents (24, 21.1%) and female respondents (6, 19.4%) had drinking habit (Table 2.5.2). It is statistically insignificant.

Table 2.5.3: Drinking by Age Group

Drinking	Group 1 (15-19)	Group 2 (20-29)	Group 3 (30-49)	Group 4 (50+)
Yes	7 (33.3)	6 (13.0)	10 (17.9)	7 (31.8)
No	14 (66.7)	40 (87.0)	46 (82.1)	15 (68.2)
Total	21 (100.0)	46 (100.0)	56 (100.0)	22 (100.0)

(X^2=7.70 p=0.26)

Although it is not statistically significant, it seems that relatively more 'Ex-addicts' in the youngest age group and the eldest age group drank (Table 2.5.3).

Table 2.5.4: Drinking by Relapse Status

Drinking	Relapsed	Not Relapsed
Yes	9 (13.6)	21 (26.6)
No	57 (86.4)	58 (73.4)
Total	66 (100.0)	79 (100.0)

(X^2=4.05 p=0.13)

It is interesting to note that relatively more 'Non-relapsed Ex-addicts' drank than the relapsed ones (Table 2.5.4), though the difference is not significant statistically.

From the above data, it seems that smoking has a stronger relationship with relapse.

3. Psychological Condition of Ex-addicts

Again, the four main independent variables (Ex-addict Status, Gender, Age Group and Relapse Status) of the respondents are used in analysing the psychological condition of the 'Ex-addicts'. Psychological condition of the 'Ex-addicts' includes the degree of their '*Self-esteem*', '*Self-mastery*' and '*Satisfaction with life*'.

Adopted from Rosenberg Self-esteem Scale, here '*Self-esteem*' is measured by an inventory of five questions:

1. I feel that I'm a person of worth, at least equal to others.
2. I am inclined to feel that I am a failure.
3. I am able to do things as well as most other people.
4. On the whole, I am satisfied with myself.
5. At times, I think I am no good at all.

For '*Self-mastery*', it is measured by an inventory of seven questions:

1. There is really no way I can solve some of the problems I have.
2. I have little control over the things that happen to me.
3. I can do just about anything I really set my mind to do.
4. I often feel helpless in dealing with the problems of life.
5. What happens to me in the future depends on me.
6. I can manage things as well as other people.
7. I can't overcome my own difficulties.

For '*Satisfaction with life*', it is measured by an inventory of five questions:

1. I feel that I am living happily.
2. Life is very stressful.
3. My life is fully engaged.
4. I have great hope about my future.
5. I feel that life is meaningless.

Self-esteem

Table 3.1.1: Rosenberg Self-esteem Scale of Respondents

Rosenberg Self-esteem Scale	SA	A	DA	SD	Corrected Item-total Correlation
I feel that I'm a person of worth, at least equal to others.(R)	13 (9.0)	109 (75.2)	21 (14.5)	2 (1.4)	0.52
I am inclined to feel that I am a failure.	9 (6.2)	67 (46.2)	61 (42.1)	8 (5.5)	0.62
I am able to do things as well as most other people.(R)	18 (12.4)	111 (76.6)	16 (11.0)	0 (0.0)	0.33
On the whole, I am satisfied with myself. (R)	8 (5.5)	99 (68.6)	33 (22.8)	5 (3.4)	0.57
At times, I think I am no good at all.	7 (4.8)	109 (75.2)	26 (17.9)	3 (2.1)	0.36

(Alpha=0.72 Mean=13.33)

(SA=Strongly agree A=Agree DA=Disagree SD=Strongly disagree)

Self-esteem scale measures the extents to which respondents hold a positive evaluation on self. Among the five items measured, over 70% of the respondents endorsed positive direction on three items related to the feelings of self-worthiness. However, about 50% inclined to feel that they were failure and 80% at times thought that they were no good at all. As indicated by the Alpha score, the reliability of the above measurement is moderately (Table 3.1.1).

Most of the EWs also pointed out that having a low self-image/self-esteem is a

common phenomenon of the ex-addicts. They would easily felt being discriminated and would turn to the opposite extreme of indulging themselves in anti-social behaviours. They felt that the main causes of low self-esteem of the ex-addicts include their sense of guilt and lack of self-confidence.

Table 3.1.2: Self-esteem by Main Independent Variables

Independent Variables	**Categories**	**Mean**	**t-value/ F Ratio**	**Significance**
Ex-addict Status	New Ex-addict	13.62	1.38	n.s.
	1-year Ex-addict	13.16		
Gender	Male	13.28	0.59	n.s.
	Female	13.52		
Age Group	15-19	14.05	2.87	0.039
	20-29	13.63		
	30-49	13.14		
	50+	12.50		
Relapse Status	Relapsed	12.38	5.92	0.000
	Non-relapsed	14.13		

(n.s. = not significant)

The mean score on Self-esteem of 'New Ex-addicts' is higher than that of the '1-year Ex-addicts'. This indicates that 'New Ex-addicts' have higher self-esteem than '1-year Ex-addicts'. The mean score on Self-esteem of female ex-addict respondents is higher than that of the male ex-addict respondents. This shows that generally female ex-addicts have higher self-esteem than male ex-addicts. However, for both categories, the statistical tests performed showed no significant relationship between the variables. The mean scores on Self-esteem of younger age groups are relatively higher than those of the older age groups. The statistically test performed also indicates the significance of the relationship. So it can be concluded that the younger the age of the ex-addicts, the higher the self-esteem. The mean score on Self-esteem of 'Non-relapsed Ex-addicts' is higher than that of those relapsed. The statistically test performed also shows a high significance of the relationship. So it can be concluded that 'Non-relapsed Ex-addicts' had higher self-esteem than those relapsed (Table 3.1.2).

Self-mastery

Table 3.2.1: Self-mastery Scale of Respondents

Self-mastery Scale	SA	A	DA	SD	Corrected Item-total Correlation
There is really no way I can solve some of the problems I have.	4 (2.8)	89 (61.4)	52 (35.9)	0 (0.0)	0.52
I have little control over the things that happen to me.	7 (4.8)	79 (54.5)	56 (38.6)	3 (2.1)	0.46
I can do just about anything I really set my mind to do. (R)	15 (10.3)	89 (61.4)	39 (26.9)	2 (1.4)	0.46
I often feel helpless in dealing with the problems of life.	4 (2.8)	67 (46.2)	72 (49.7)	2 (1.4)	0.50
What happens to me in the future depends on me. (R)	6 (4.2)	68 (46.9)	66 (45.5)	5 (3.5)	0.37
I can manage things as well as other people.(R)	14 (9.7)	99 (68.3)	31 (21.4)	1 (0.7)	0.37
I can't overcome my own difficulties.	2 (1.4)	59 (40.7)	80 (55.2)	4 (2.8)	0.36

(Alpha=0.72 Mean=17.96)

The Self-mastery scale measures the extent to which a person perceives his/her own life-chances as being under one's own control or being determined by unexplained forces. Although respectively 71.7%, 51.1% and 78% expressed that 'they can do just about anything they really set their mind to do', 'what happens to them in the future depends on them' and 'they can manage things as well as other people', respectively 64% and 59% agreed (or strongly agreed) that 'there is really no way they can solve some of the problems they have' and 'they have little control over the things that happen to them'. The Alpha score indicates that the above measurement is moderately reliable (Table 3.2.1).

Some EWs expressed that the ex-addicts would become emotional easily that will lower their self-mastery ability.

Table 3.2.2: Self-mastery by Main Independent Variables

Independent Variables	Categories	Mean	t-value/ F Ratio	Significance
Ex-addict Status	New Ex-addict	18.23	0.97	n.s.
	1-year Ex-addict	17.80		
Gender	Male	18.04	0.71	n.s.
	Female	17.67		
Age Group	15-19	18.29	1.44	n.s.
	20-29	18.49		
	30-49	17.58		
	50+	17.50		
Relapse Status	Relapsed	17.12	3.83	0.000
	Non-relapsed	18.68		

(n.s. = not significant)

The mean score on Self-mastery of 'New Ex-addicts' is higher than that of the '1-year Ex-addicts'. This reveals that the sense of self-mastery of 'New Ex-addicts' is higher than that of '1-year Ex-addicts'. Male ex-addicts have a higher mean score on Self-mastery than that of female ex-addicts. So the sense of self-mastery of male ex-addicts is generally higher than that of female ex-addicts. Ex-addicts who were below 30 years of age are having higher mean scores than those who were 30 or above. This also shows that the younger age groups have higher sense of self-mastery than the older age groups. However, the statistical tests performed for all the above categories indicated no significant relationship between the variables. The 'Non-relapsed Ex-addicts' are having a higher mean score than that of the relapsed. It is also statistically highly significant. So, the 'Non-relapsed Ex-addicts' are having a greater sense of self-mastery than those relapsed.

Satisfaction with life (SLIFE)

Table 3.3.1: Satisfaction with life of Respondents

Satisfaction with life	SA	A	DA	SD	Corrected Item-total Correlation
I feel that I am living happily. (R)	16 (11.0)	84 (58.6)	37 (25.5)	7 (4.8)	0.70
Life is very stressful.	8 (5.5)	77 (53.1)	57 (39.3)	3 (2.1)	0.45
My life is fully engaged. (R)	13 (9.0)	70 (48.6)	54 (37.5)	7 (4.9)	0.62
I have great hope about my future. (R)	14 (9.7)	85 (58.6)	42 (29.0)	4 (2.8)	0.75
I feel that life is meaningless.	5 (3.5)	40 (27.8)	78 (54.2)	21 (14.6)	0.67

(Alpha=0.84 Mean=13.31)

Although respectively 69.6%, 57.6% and 68.3% of the respondents agreed (or strongly agreed) that 'they feel that they are living happily', 'their life is fully engaged' and 'they have great hope about their future', 58.6% of them agreed (or strongly agreed) that 'life is very stressful'. Also, nearly one-third of them (45, 31.3%) agreed (or strongly agreed)

that 'they feel that life is meaningless'. The Alpha score for this measurement shows that it is highly reliable (Table 3.3.1).

Table 3.3.2: SLIFE by Main Independent Variables

Independent Variables	Categories	Mean	t-value/ F Ratio	Significance
Ex-addict Status	New Ex-addict	14.02	2.53	0.012
	1-year Ex-addict	12.88		
Gender	Male	13.20	0.93	n.s.
	Female	13.71		
Age Group	15-19	14.48	4.14	0.0076
	20-29	13.68		
	30-49	13.14		
	50+	11.81		
Relapse Status	Relapsed	11.73	7.78	0.000
	Non-relapsed	14.65		

(n.s. = not significant)

The mean score on 'Satisfaction with life in general' of the 'New Ex-addicts' is higher than that of the '1-year Ex-addicts'. The statistically test performed also indicates the significance of the relationship between the variables. It then can be concluded that 'New Ex-addicts' are more satisfied with life than '1-year Ex-addicts'. Female ex-addicts were having a relatively higher mean score on 'Satisfaction with life in general' than male ex-addicts. So female ex-addicts are more satisfied with life than male ex-addicts. But no significant relationship was found statistically. As reveals by the mean scores, the younger the ex-addicts, the more the satisfaction with life in general. The relationship is also statistically significance. As the mean score of the 'Non-relapsed Ex-addicts' is higher than that of the relapsed and the relationship is also statistically highly significant, it can be concluded that the 'Non-relapsed Ex-addicts' are more satisfied with life than those relapsed (Table 3.3.2).

From the above analyses, it can be seen that the relapsed status of the ex-addicts is of utmost importance and is a crucial factor for their psychological condition.

Other opinions on the ex-addicts' psychological condition expressed by the EWs include they lack trust on other people and they also feel the lack of trust from others; they have low will power and avoidance tendency; and they are dependent and have attachment and support needs.

4. Social Condition of Ex-addicts

The social condition of the 'Ex-addicts' is measured by their perceptions of family support, friends' support and social competence.

Family Support

Table 4.1.1: Perceived Social Support from Family (Pss-fa)

Perceived Social Support from Family	SA	A	DA	SD	Corrected Item-total Correlation
My family gives me the moral support I need.	17 (12.3)	93 (67.4)	22 (15.9)	6 (4.3)	0.52
I get good ideas about how to do things or make things from my family.	6 (4.4)	88 (64.7)	36 (26.5)	6 (4.4)	0.53
My family enjoys hearing about what I think.	13 (9.5)	80 (58.4)	40 (29.2)	4 (2.9)	0.64
Members of my family share many of my interests.	9 (6.6)	65 (47.4)	60 (43.8)	3 (2.2)	0.60
I rely on my family for emotional support.	10 (7.4)	72 (52.9)	51 (37.5)	3 (2.2)	0.48
There is a member of my family I could go to if I were just feeling down.	4 (2.9)	61 (44.9)	58 (42.6)	13 (9.6)	0.48
My family is sensitive to my personal needs.	13 (9.4)	83 (60.1)	38 (27.5)	4 (2.9)	0.56

(Reliability Alpha=0.81 Mean of the scale=18.72)

On the whole, respondents expressed that their families were caring and supportive. For example, nearly 80% of the respondents agreed that their family members offered moral support they need and 70% of them agreed that family members were sensitive to their personal needs. Although many respondents (60.3%) indicated their reliance on the emotional supports from family, less than half of them (47.8%) could identify a family member to go to when feeling down. Only about half of the respondents (54%) agreed that their family members shared many of their interests (Table 4.1.1).

Table 4.1.2: Perceived Social Support from Family (Pss-fa) by Main Independent Variables

Independent Variables	Categories	Mean	t-value/ F-ratio	Significance
Ex-addict Status	New Ex-addict	18.79	0.22	n.s.
	1-year Ex-addict	18.68		
Gender	Male	18.65	0.50	n.s.
	Female	18.97		
Age Group	15-19	19.35	0.87	n.s.
	20-29	19.02		
	30-49	18.45		
	50+	18.00		
Relapse Status	Relapsed	18.30	1.35	n.s.
	Non-relapsed	19.03		

A summative scale comprising of the seven items represents an indicator of the perceived social support from family (Pss-fa). The reliability of the scale is high (Alpha=0.81). The means of the Pss-fa have been compared across our main independent variables, namely Ex-addict Status, Gender, Age Group and Relapse Status. Statistical difference has not been identified through either t-test or one-way analysis of variance.

Table 4.1.3:Overall Satisfaction with Family Life

	SA	A	DA	SD
On the whole, I satisfy with my family life.	18 (13.1)	95 (69.3)	17 (12.4)	7 (5.1)

A majority of respondents (82.4%) indicated an overall satisfaction with their family life (Table 4.1.3). Cross-tabulations with the main independent variables indicated no significant difference by using the X^2 test.

Table 4.1.4: Performance of Family Roles

Performance of Family Roles	**SA**	**A**	**DA**	**SD**
I am able to take care of my family members.	2 (1.4)	62 (44.9)	61 (44.2)	13 (9.4)
I can manage household chores.	13 (9.1)	92 (64.3)	36 (25.2)	2 (1.4)

Less than half (46.3%) of the respondents indicated that they could take care of their family members. However, in terms of household chores, most respondents (73.4%) agreed that they could manage their own home (Table 4.1.4).

Based on the sample of items related to family support, ex-addicts who were not satisfied with their family life constituted about 20 to 30 percent among our respondents (Table 4.1.1). Respondents seemed to feel positive about their families and expressed good expectations toward the support from family members. However, at the feeling level, they might not get adequate support especially when faced with emotional difficulties.

Other than the general support from family, respondents were asked about their ability to take care of their family members as well as daily household chores. Seventy-three percent of the respondents agreed that they could manage household matters. However, only 46% of the respondents agreed that they were able to take care of other family members. As indicated from the findings that over 50% (52.2%) of the respondents "Disagree" or "Strongly Disagree" that 'There is a member of (their) family (they) could go to if (they) were just feeling down' (Table 4.1.1).

The opinions from the EWs on the family condition of the ex-addicts have pointed out that family support is a crucial factor for the ex-addicts to start a new life. They have generally expressed that the lack of trust, support and acceptance from the family members, and the lack of communication with the family members are detrimental for the reintegration of the ex-addicts. Ex-addicts have experienced rejection from the families and found it difficult to stay with the families, so their accommodation need is prevalent.

Support from Friends

Table 4.2.1: Perceived Social Support from Friends (Pss-fr)

Perceived Social Support from Friends	SA	A	DA	SD	Corrected Item-total Correlation
I have a deep sharing relationship with a number of friends.	18 (12.5)	88 (61.1)	35 (24.3)	3 (2.1)	0.65
My friends give me the moral support I need.	10 (6.9)	93 (64.1)	39 (26.9)	3 (2.1)	0.68
Most other people are closer to their friends than I am.	4 (2.8)	66 (45.5)	67 (46.2)	8 (5.5)	0.49
My friends enjoy hearing about what I think.	18 (12.4)	99 (68.3)	28 (19.3)	0 (0.0)	0.67
My friends are good at helping me solve problems.	5 (3.4)	76 (52.4)	62 (42.8)	2 (1.4)	0.43
I feel that I'm on the fringe in my circle of friends.	1 (0.7)	41 (28.3)	91 (62.8)	12 (8.3)	0.42
There is a friend I could go to if I were just feeling down.	13 (9.1)	102 (71.3)	28 (19.6)	0 (0.0)	0.71
My friends are sensitive to my personal needs.	10 (6.9)	86 (59.7)	47 (32.6)	1 (0.7)	0.56

(Reliability Alpha=0.84 Mean of the scale=22.06)

The respondents generally agreed that supports from friends were available. Among the items surveyed, around 20% to 30% endorsed negative feelings or perception towards the availability of social support from friends. There were 44.2% of respondents disagreed that their friends were good at helping them to solve problems. Also, one-third of the respondents (33.3%) considered that their friends were not sensitive to their needs (Table 4.2.1).

Table 4.2.2: Perceived Social Support from Friends (Pss-fr) by Main Independent Variables

Independent Variables	Categories	Mean	t-value / F-ratio	Significance (p)
Ex-addict Status	New Ex-addict	22.93	2.53	0.012
	1-year Ex-addict	21.52		
Gender	Male	22.04	0.13	n.s.
	Female	22.13		
Age Group	15-19	23.43	4.35	0.006
	20-29	22.87		
	30-49	21.37		
	50+	20.76		
Relapse Status	Relapsed	20.97	3.80	0.000
	Non-relapsed	22.97		

The 'New Ex-addicts' reported a higher support level from friends than the '1-year Ex-addicts'. Also, the younger ex-addicts scored significantly higher level of support from friends than the older ex-addicts. A linear correlation between age and Pss-fr was also found to be statistically significance (Pearson $r = -0.33$; $p < 0.01$). That is, the perceived social support score is decreasing in accordance with the increasing age among the ex-addicts. The perceived social support from friends was lower among those who had reported to relapse in comparison with those who had not. Sex difference in terms of friends' support has not been identified (Table 4.2.2).

Table 4.2.3: Overall Satisfaction with Friends

	SA	A	DA	SD
On the whole, I am satisfied with my relationship with friends.	22 (15.2)	105 (72.4)	16 (11.0)	2 (1.4)

A majority of respondents (87.6%) reported to have overall satisfactory relationship with friends in a single-item variable (Table 4.2.3). The same variable was compared according to the main independent variables and statistical difference was found only between the relapsed and the non-relapsed cases. Ninety-five percent of respondents who stayed away from drugs agreed that they had satisfactory relationship with friends, while only 79% of the relapsed took the same position ($X^2=14.34$; $p=0.002$).

The EWs pointed out that ex-addicts need peer association as an initial step for their reintegration. However, peer association can be either positive or negative. If they associate with peers with pro-social attitude and behaviours, this would facilitate their reintegration process. However, if the peers they associate with are having much negative elements (e.g. addicts), they would be more likely to relapse. Unfortunately, the latter case is more prevailing.

Social Competence

Table 4.3.1: Indicators on Social Competence

Indicators on Social Competence	SA	A	DA	SD	Corrected Item-total Correlation
I am able to interact with strangers easily.	12 (8.3)	99 (68.3)	33 (22.8)	1 (0.7)	0.34
I have a smooth relationship with my friends.	13 (9.0)	117 (80.7)	15 (10.3)	0 (0.0)	0.48
I have many ordinary friends.	13 (9.0)	103 (71.0)	27 (18.6)	2 (1.4)	0.38
I have very few good friends.*	12 (8.3)	104 (71.7)	28 (19.3)	1 (.7)	NA
I have frequent contacts with my good friends.	17 (11.7)	80 (55.2)	46 (31.7)	2 (1.4)	0.48
I am not good at talking with the opposite sex.	4 (2.8)	61 (42.1)	72 (49.7)	8 (5.5)	0.13
I have some healthy hobbies.	11 (7.6)	98 (67.6)	34 (23.4)	2 (1.4)	0.38

(Reliability Alpha=0.62 Mean of the scale=16.87)
(*: This item has been excluded in forming the composite index due to its extremely low item correlation.)

On the whole, social competence was expressed by most of the respondents. Ninety percent of the respondents agreed that they had smooth relationships with friends and 80% indicated that they had many friends. In terms of interactional skills, 44.9% of the respondents considered that they were not good at talking with the opposite sex. Also, over one-fifth of them (23.5%) reported that they were not able to interact with strangers easily (Table 4.3.1).

Table 4.3.2: Social Competence by Main Independent Variables

Independent Variables	Categories	Mean	t-value/ F-ratio	Significance
Ex-addict Status	New Ex-addict	17.29	1.96	0.051
	1-year Ex-addict	16.61		
Gender	Male	16.81	0.70	n.s.
	Female	17.10		
Age Group	15-19	17.14	1.56	n.s.
	20-29	17.30		
	30-49	16.59		
	50+	16.41		
Relapse Status	Relapsed	16.32	3.05	0.003
	Non-relapsed	17.33		

'New Ex-addicts' scored significantly higher in social competence when compared with the '1-year Ex-addicts'. Also, respondents who reported to relapse into drugs obtained a lower social competence score than those who did not and the difference was statistically significance (Table 4.3.2).

The EWs pointed out that generally ex-addicts are lack of proper social skills, so they cannot build up proper interpersonal relationship with other people and have difficulties in engaging in normal social life.

5. Employment Situation

Table 5.1: Experience in Job Searching after Leaving Last Treatment Programme

	Yes	No
Being rejected in job searching	52 (40.6)	76 (59.4)
Being fired by employer	29 (22.7)	99 (77.3)
Change of employers voluntarily	54 (42.2)	74 (57.8)
Unable to find a job	45 (35.2)	83 (64.8)

Although there were only 22.7% of respondents having experience of being dismissed by employers, negative job experience was common among the ex-addicts. Experiences such as being rejected in job hunting and unable to find jobs were frustrating for our respondents. Although evidence about the frequency of job changes among ex-addicts was not too high, 42.2% of the respondents indicated that, due to various reasons, they had experienced job changes since leaving their last treatment programmes (Table 5.1).

Table 5.2: Satisfaction with Employment Situation

Satisfaction with Employment Situation	**SA**	**A**	**DA**	**SD**	**Corrected Item-total Correlation**
It's not difficult to find an employment	10 (7.0)	77 (54.2)	44 (31.0)	11 (7.7)	
I find my job very interesting	2 (2.2)	10 (10.9)	67 (72.8)	13 (14.1)	0.73
My job gives me chance to do my best	3 (3.2)	23 (24.7)	61 (65.6)	6 (6.5)	0.75
I am satisfied with my current job	2 (2.2)	13 (14.0)	68 (73.1)	10 (10.8)	0.77

(A scale of satisfaction with employment was constructed by using the last three items. Reliability Alpha= 0.87; Scale mean=6.33)

Although 61.2% of the respondents agreed that it was not difficult to obtain a job, as mentioned in the previous section, only 47.6% of respondents engaged in employment.

When asked if they were satisfied with their employment, only a small number of the respondents (16.2%) gave positive answers (Table 5.2).

Table 5.3: Satisfaction with Employment by Main Independent Variables

Independent Variables	Categories	Mean	t-value/ F-ratio	Significance
Ex-addict Status	New Ex-addict	6.00	1.35	n.s.
	1-year Ex-addict	6.50		
Gender	Male	6.26	0.85	n.s.
	Female	6.61		
Age Group	15-19	6.31	1.91	n.s.
	20-29	6.10		
	30-49	6.20		
	50+	7.36		
Relapse Status	Relapsed	7.06	3.45	0.001
	Non-relapsed	5.93		

Although significant differences in employment satisfaction were not found in the comparative analyses of the three independent variables, it was interesting to note that the non-relapsed reported a lower score on job satisfaction when compared with the relapsed ex-addicts. Cautions should be made in interpreting this inconsistent result. As satisfaction with employment is a variable depending on the status of job engagement and since the non-relapsed was more likely to engage in employment than the relapsed (X^2=6.12; p=0.013), the high level of satisfaction score among the relapsed seemed to be a self-selective result. That is, only the willing-to-engage relapsed would answer the question and therefore they might be more likely to report a positive score than the non-relapsed.

Table 5.4: Employment by Relapse Status

Employment	Relapse Status		Total
	Yes	No	
Yes	24 (36.4)	45 (57.0)	69 (47.6)
No	42 (63.6)	34 (43.0)	76 (52.4)
Total	66 (100.0)	79 (100.0)	145 (100.0)

As a support to the above statements, it can be seen that from Table 5.4 only 24 (16.6%) relapsed ex-addicts among the 145 'Ex-addict' respondents had got employment. As willing-to-engage persons, their tendency to report a more positive attitude in employment is understandable.

The EWs suggested that due to the low education standard and 'addict' appearance of the ex-addicts, they would experience difficulty in finding jobs. So unemployment is common among ex-addicts.

6. Utilization of Available Services

The following table (Table 6.1) reveals the situation of services used by the respondents since their leaving of the previous treatment programmes.

Table 6.1: Services Used

Services	Categories	New Ex-addict	1-year Ex-addict	All
Housing	Hostel	14 (25.5)	17 (18.9)	31 (21.5)
Health	Clinic	17 (30.9)	42 (46.7)	59 (41.3)
	Dental	14 (25.5)	36 (40.0)	50 (35.0)
	STD Treatment	2 (3.6)	2 (2.2)	4 (2.8)
	Child Care	5 (9.1)	5 (5.6)	10 (6.9)
Counselling	Family Relationship	7 (12.7)	8 (8.9)	15 (10.4)
	Marital Relationship	4 (7.3)	6 (6.7)	10 (6.9)
	Personal Emotional Problem	15 (27.3)	24 (26.7)	39 (27.1)
Employment	Job Seeking	16 (29.1)	24 (26.7)	40 (27.8)
	Job Re-training	5 (9.1)	3 (3.3)	8 (5.6)
Financial	CSSA	17 (30.9)	27 (30.0)	44 (30.6)
	Other Financial Assistance	4 (7.3)	11 (12.2)	15 (10.4)
Others	Self Help Group/Network	11 (20.0)	9 (10.0)	20 (13.9)
	Legal Aid	6 (10.9)	9 (10.0)	15 (10.4)
	Volunteer Service	10 (18.2)	13 (14.4)	23 (16.0)
	Drug Treatment	9 (16.4)	23 (25.6)	32 (22.2)
	N	[55]	[90]	[145]

The most frequently seek services of the respondents were Health Clinic (41.3%), Dental Clinic (35.0%), and application of Comprehensive Social Security Assistance (CSSA) (30.6%). Statistical differences were not found in the percentages of seeking services when comparing the 'New' and the '1-year Ex-addicts' (Table 6.1).

Table 6.2: Service Needs Expressed

Service Need	New Ex-addict	1-year Ex-addict	All
Accommodation	16 (29.1)	33 (36.7)	49 (34.0)
Employment	26 (47.3)	39 (43.3)	65 (45.1)
Leisure activities	19 (34.5)	24 (26.7)	43 (29.9)
Financial assistance	25 (45.5)	41 (45.6)	66 (45.8)
Physical health	13 (23.6)	35 (38.9)	48 (33.3)
Personal emotion	21 (38.2)	32 (35.6)	53 (36.8)
Interpersonal relationship	18 (32.7)	24 (26.7)	42 (29.2)
Family life	20 (36.4)	16 (17.8)	36 (25.2)
N	[55]	[90]	[145]

Assistance in reducing financial difficulties (45.8%) and employment arrangement (45.1%) were indicated as the services most frequently needed. One quarter to one-third of the respondents found that they were in need of the services listed in our questionnaire (Table 6.2). Statistically, difference in expressing service needs between the 'New' and '1-year Ex-addicts' was found to be insignificant.

Table 6.3: Asking for Assistance when Needed

Yes	66 (62.3)
No	40 (37.7)
Total	106 (100.0)

Table 6.3 shows that among the 106 ex-addicts, who reported that they had experienced problems, a majority (66, 62.3%) had seek for assistance. No statistical significance was found between this help seeking behaviour with the main independent variables (Ex-addict Status, Gender, Age Group and Relapse Status). A majority of those who had not seek help reported that they had no idea of how to get help and considered that they should take care of their own problems.

Table 6.4: Sources of Help Sought

Source	**Often**	**Sometimes**	**Seldom**	**Never**
Family Members	6 (8.3)	30 (41.7)	15 (20.8)	21 (29.2)
Relatives	0 (0.0)	5 (6.9)	15 (20.8)	52 (72.2)
Friends	11 (15.3)	33 (45.8)	15 (20.8)	13 (18.1)
Drug Treatment Agencies/Social Workers	13 (18.1)	26 (36.1)	7 (9.7)	26 (36.1)
Other Welfare Agencies	9 (13.2)	14 (20.6)	8 (11.8)	37 (54.4)

Friends and Drug Treatment Agencies/Social Workers were the helping sources more frequently sought for assistance. Family members were the third frequently sought helping source that respondents would seek at times of need. It is noticed that over 70% of the ex-addicts would not seek help from their relatives (Table 6.4).

Table 6.5: Results of Assistance Sought

Result	**Frequency (%)**
Problem wholly resolved	11 (15.3)
Problem partly resolved	53 (73.6)
Unable to solve the problem	8 (11.1)
Total	**72 (100.0)**

A majority of ex-addicts, who had seek help from others, reported that their problems were partly resolved (Table 6.5).

Table 6.6: Effectiveness of the Helping Sources

Source	Effectiveness				
	Very	Quite	Average	Not at all	Don't know
Family Members	35 (24.1)	31 (21.4)	50 (34.5)	21 (14.5)	8 (5.5)
Relatives	1 (0.7)	2 (6.9)	24 (16.6)	70 (48.3)	40 (27.6)
Friends	16 (11.0)	26 (17.9)	59 (40.7)	28 (19.3)	16 (11.0)
Drug Treatment Agencies/Social Workers	19 (13.1)	40 (27.6)	37 (25.5)	26 (17.9)	23 (15.9)
Other Welfare Agencies	6 (4.4)	10 (7.3)	30 (21.9)	27 (19.7)	64 (46.7)

The ex-addicts considered family members and Drug Treatment Agencies were the most effective sources of help. About half of the respondents indicated that relatives were not an effective source of help. It should be noted that a large number of respondents reported 'Don't know' in evaluating the effectiveness of Other Welfare Agencies. This indicates that they lack the knowledge of the availability of other welfare agencies as sources of assistance (Table 6.6).

Table 6.7: Perceptions of Social Services

	SA	A	D	SD
I can solve my own problem and therefore no need to use social services	5 (3.4)	69 (47.6)	69 (47.6)	2 (1.4)
I think social services cannot help me	5 (3.5)	73 (50.7)	65 (45.1)	1 (0.7)
I feel shame when using services	1 (0.7)	74 (51.4)	64 (44.4)	5 (3.5)
I feel that I can't meet the expectations of the service personnel	2 (1.4)	71 (49.0)	68 (46.9)	4 (2.8)
I'll be looked down when using services	1 (0.7)	65 (45.1)	71 (49.3)	7 (4.9)
I'm afraid to let others know that I'm receiving services	9 (6.2)	71 (49.0)	57 (39.3)	8 (5.5)
It's too troublesome to apply for social services	9 (6.3)	66 (46.2)	67 (46.9)	1 (0.7)
I have no time to make use of the services because of my job	5 (4.0)	52 (41.3)	65 (51.6)	4 (3.2)
My friends will laugh at me if I use social services	0 (0.0)	33 (23.1)	102 (71.3)	8 (5.6)
Using social services may affect my work	3 (2.3)	30 (23.4)	87 (68.0)	8 (6.3)

Although strong feelings about the negative aspects of using social services were not frequent, about half of the respondents agreed that they had somewhat negative feelings on using the services (Table 6.7).

VII. Analysis and Implications of Findings

1. Service Needs of Ex-addicts

Biological

1. 30-40% of the ex-addicts reported minor health problems including insomnia, lacking concentration, physical fatigue, lack of appetite, etc. (Table 2.1).

2. The 'New Ex-addicts' were generally more satisfied with their overall health condition than were the '1-year Ex-addicts' (Table 2.3).

3. The relapsed ex-addicts reported much worse overall health satisfaction than did the non-relapsed (Table 2.4).

4. Over 50% of the respondents reported that they had experienced at least one time in more than three health problems in the list in the questionnaire (Table 2.2).

5. Smoking and drinking habits were similar across our main variables; except that more of the relapsed group reported to have smoking habit than the non-relapsed group.

6. A mix of unhealthy outlook, unfavorable appearance and smell affect the social life and job seeking of the ex-addicts that may add difficulties during their rehabilitation process.

7. The EWs opined that the health condition of the ex-addicts is related with their addiction history. Based on their observation, addicts with longer addiction history would likely to express more physical problems such as bone pain, tooth problems, insomnia, respiratory and circulatory difficulties. The ex-addicts did not take good care of their own health conditions while they were hooked on drugs.

8. As a whole, although the ex-addicts did not experience much great physical health problems, general health education and education on personal hygiene are needed both for the addicts and ex-addicts.

Psychological

1. In terms of self-esteem, although the respondents overall had a positive evaluation on themselves, 50% inclined to feel that they were failure and 80% at times thought that they were no good at all (Table 3.1.1). EWs also agreed that having low self-esteem is a common phenomenon among the ex-addicts.

2. From the findings, the old ex-addicts are comparatively having a lower self-esteem than the younger ones. A trend was observed that the younger the ex-addicts were, the higher were their self-esteem scores (Table 3.1.2). Service workers should keep in mind the relation between self-esteem and the age of the ex-addicts during the rehabilitation process. Psychological support is very

essential in helping ex-addicts who reach mid-age or beyond as they appear to have comparatively negative evaluation on themselves as well as on their future.

3. The relapsed ex-addicts reported a significantly low self-esteem when compared with the non-relapsed ones (Table 3.1.2). It seems that the problems of lapse and relapse seriously affect how rehabilitating ex-addicts evaluate themselves. Continuous support by service workers should be given to those relapsees in the rehabilitation services. As relapses are common before a full rehabilitation can be achieved, counsellors should prepare to support and sustain the self-image of those exhibit relapses in the process.

4. Although the present findings indicate that self-mastery was perceived not as a problem for the ex-addicts (Table 3.2.1), this was a subjective expression of the ex-addicts themselves. EWs had reminded that the emotional state of the ex-addicts would fluctuate easily and it often affects their self-mastery abilities.

5. Again, the Relapse Status of the ex-addicts is found to have significant relationship with their perception of self-mastery. Relapse seems to have strong impact to the ex-addicts and weakens the relapsees' sense of self-mastery (Table 3.2.2).

6. The present findings indicate that the ex-addicts are generally satisfied with their life and possess a positive attitude on their life and future (Table 3.1.1). However, differences appear to be significant among their different Ex-addict Status, Age Group, and Relapse Status. The 'New Ex-addicts' are more satisfied than the '1-year Ex-addicts'. The younger ex-addicts are more satisfied with life than the older ex-addicts. The non-relapsed also scored a significantly high in life satisfaction than the relapsed (Table 3.3.2).

7. Based on the opinions of the EWs, the ex-addicts usually carry psychological burdens due to their previous addiction. A sense of guilt and failure is prevalent among the ex-addicts. Although they had not directly expressed their opinions on the ex-addicts' satisfaction with life, inferring from their opinions, it seems that the ex-addicts' perceptions of their life and future might be easily affected by their overall psychological condition.

8. Based on the above discussion, several service needs of the ex-addicts could be drawn for assisting their reintegration process. Self-esteem, self-image, and self-confidence are various psychological aspects that should be promoted through aftercare counselling, group and educational programmes. Helping the ex-addicts work through their sense of guilt and failure caused by their past addiction history is an important job for aftercare workers in order to assist ex-addicts to rebuild their self-esteem. The ex-addicts should be trained to handle appropriately their emotions and situation of relapse. Since Relapse Status is associated strongly with all psychological variables, relapse prevention is extremely important in the reintegration process of the ex-addicts. Through systematic training on how to calm themselves down and manage their emotions in times of stress, the ex-addicts can be assisted to improve their self-mastery abilities. As self-esteem and self-mastery are essential individual resources to guard a person in case of stress, the life satisfaction of ex-addicts will be

improved once their self-esteem and self-mastery are promoted.

Social

1. Based on the EWs' opinions, family support is of utmost importance for assisting the reintegration of the ex-addicts. Although the EWs mentioned that a lot of families are unsupportive to their ex-addict members, the findings show that the subjective perception of the respondents had revealed a different picture. Respondents had expressed a positive view on the support of their families (Table 4.1.1), but at the feeling level, they could not really get adequate support from the families especially when faced with emotional difficulties (items 5 & 6). In fact, a significant number of respondents indicated the lack of family support. The lacking support from family is believed to be detrimental for the reintegration of the ex-addicts as expressed by several EWs. Family members should be assisted to increase their understanding and acceptance of their rehabilitating members in order to enhance the effectiveness of their support to the ex-addicts. They should be encouraged to develop more emotional ties with their rehabilitating members for developing more understanding. Also, teaching them skills to support the ex-addicts especially in times of their needs is essential.

2. When asked about their abilities to perform different family roles, many ex-addicts seemed to lack confidence on assuming the role of taking care of the family members (Table 4.1.4). In order to develop a better sense of self-competence, assistance is needed to help them develop abilities to meet different family roles.

3. As indicated in the findings, generally support from friends is satisfactory among the ex-addicts. However, marked differences are observed in terms of their Ex-addict Status, Age Group and Relapse Status. 'New Ex-addicts' are more satisfied with their support from friends than the '1-year Ex-addicts'. The younger the ex-addicts, the greater the perceived social support from friends. The non-relapsed ex-addicts perceive greater support from friends than the relapsed ones (Table 4.2.2).

4. The EWs had indicated that peer support is an influential factor for the rehabilitation of the ex-addicts. The success of reintegration lies on the attitude and behaviors of the peer groups that the ex-addicts associate with. A pro-social peer group is extremely important to facilitate the ex-addicts in their reintegration into the society. Services to provide opportunities for desirable peer association and services to foster positive peer culture are extremely vital for the rehabilitation of the ex-addicts.

5. From the findings of this investigation, over one-fifth of the respondents (23.5%) reported an inability to interact with strangers and 45% of them indicated incompetence in talking with the opposite sex (Table 4.3.1). In line with the EWs' opinions, some ex-addicts do lack appropriate social skills to develop new friendship that eventually affects the outcome of their reintegration. As ex-addicts need to develop new relationships other than with their addicted friends in order to sustain their abstinence effectively, offering them the training of appropriate social skills is essential. Good social skills can help them enlarge

their social circle as well as enhance their sense of overall competence.

6. The '1-year Ex-addicts' had expressed a lower level of social competence than the 'New' ones. While the relapsed ex-addicts also have significantly lower level of social competence than the non-relapsed ones (Table 4.3.2). A continuous effort to assist them in the development of social skills is essential for preparing them to engage in normal social life.

7. Although the employment situation of the ex-addicts interviewed seems to be satisfactory (Table 5.1), only a few number expressed gratification on the jobs (Table 5.2). Assisting ex-addicts to engage in employment is important, furthermore, counselling workers should put effort to help ex-addicts identify the meanings of work. Some EWs also mentioned that ex-addicts often needed to be reminded to develop realistic expectations of their job. One EW had strongly emphasized that some ex-addicts may tempt to give up jobs that could offer them a healthy environment as they often evaluate the jobs with unrealistic criteria.

8. Ex-addicts are lacking information of available help and services (Table 6.6). To provide them with adequate information of different kinds of available services and helping sources is necessary so that they can obtain prompt assistance when needed.

9. It can be observed that ex-addicts considered the receiving of social services as a kind of social stigma (Table 6.7) and they had an idea that they should take care of their own problems. Educating them their right of using the services as consumers is important so that they can obtain prompt assistance when needed.

2. Support Services for Ex-addicts

Reviewing the information from the Directory of Social Services (1995) by the Hong Kong Council of Social Service and the Hong Kong Narcotics Report 1996, there seems to be quite a number of different kinds of services for addicts/ex-addicts. These include:

1. Compulsory Treatment Programmes (DATCs)
2. Out-patient Treatment Programme (Methadone Clinics)
3. Voluntary In-patient Treatment Programme
4. Residential Drug Rehabilitation Programme
5. Counselling and Guidance Service
6. Employment Service
7. Hostel and Half-way House Service
8. Hotline Service
9. Integrated Rehabilitation Programmes
10. Self-help and Mutual Support Network
11. Social and Recreational Activities
12. Volunteer Service

From the list above, there seems to be enough services for addicts/ex-addicts in terms of kinds. However, the adequacy of quantity and quality of available services for addicts/ex-addicts needed to be further investigated.

3. Adequacy of Support Services for Ex-addicts

From the different kinds of support services for the addicts/ex-addicts presented above, it seems that in terms of the diversity of service, the present services for addicts/ex-addicts are adequate. However, the service quantity and quality are in question. Based on the EWs' opinions, some related findings of the present investigation and the observation of the researchers, this section will comment on the adequacy of the current available support services.

Ensuring of Service Quality

1. Some EWs commented that there is not enough office space in their agencies to conduct different service programmes (e.g. group programmes) for the clients. This, to a certain extent, has affected the provision of quality services to the ex-addicts.

2. Many NGOs have not employed professionally trained staff to carry out their services. This has affected the quality of their service provision to the clients.

3. In fact, the above two points are related to the issue of inadequate (or no) financial subvention provided to the agencies by the government. Many NGOs rely much on private donation for running their services. Without adequate financial assistance, not only the physical premises of their offices will be substandard but also qualified professionals cannot be employed to deliver the services. All these will further affect the provision of quality services to the ex-addicts.

Inadequacy of Present Services

1. Heavy caseload was mentioned by all workers who need to provide casework service to the ex-addicts. 'Normally', they have to take care of 80-100 cases at the same time. They admitted that it is unrealistic for them to provide adequate guidance and aftercare to their clients with this caseload, not to mention other forms of services (e.g. groups).

2. One EW suggested that methadone clinics (MCs) are places that should be better utilized since they are locations where 'ex-addicts' can be gathered. A multiple service approaches (e.g. casework service, group programmes, educational programmes, etc.) should be adopted in the MCs so that the needs of the ex-addicts can be better served. Of course, adequate premises in the MCs for the services have to be provided.

3. A majority of EWs has commented the inadequate provision of half-way house and accommodation services to the ex-addicts. As some half-way houses are located in remote areas, they are unattractive to ex-addicts who have to work in the urban districts. Also due to the shortage of half-way houses, there is a long waiting list. This has discouraged those at the end of the list to wait for allocation. Furthermore, the length of stay in the half-way houses should be made more flexible as some ex-addicts might need a longer time to settle their accommodation after their leaving of the treatment programmes. Forcing ex-addicts to go back to and settle down in the their own homes in a short period of time is not too realistic.

It may create tremendous stress on the ex-addicts. The professional input in the half-way houses is rather weak. They lack trained workers to provide adequate services for the residents.

4. Some NGOs have provided hotline service to addicts/ex-addicts. However, the service is not subvented and the output is not recognized in the service standard. This has impeded the NGOs to energetically pursue the hotline service that might have popular demand due to its convenience and concealed identity of the callers.

5. Existing service programmes have focused much on detoxification. Equal emphasis should be put on relapse prevention and aftercare services.

6. Working with the families of the ex-addicts is also an area that needed to be strengthened. As revealed from the findings of the present study, although ex-addicts generally have a positive perception of their families, practically they found it difficult to gain support from their family members. Most EWs also commented that family acceptance and support are crucial for successful rehabilitation of the ex-addicts. So family work should be improved for assisting the reintegration of ex-addicts.

7. The lack of mutual understanding, communication, cooperation and coordination, and hence trust, among different concerned agencies (both governmental and non-governmental organizations) has been critically commented by the EWs interviewed. It is understood that the diverse orientations of different service agencies have made cooperation and coordination difficult. To promote commonly shared missions of the services for ex-addicts is important.

4. Additional Services for Ex-addicts

As mentioned in a previous section, existing services to help both addicts and ex-addicts seem to be quite comprehensive and could widely cover the various needs of the ex-addicts. However, the quantity of services as well as the administration of the services may have much room for improvement. In this section, some services that may further facilitate the reintegration of the ex-addicts will be suggested.

1. Multi-modality Clinics

Our findings indicate that ex-addicts often encounter a variety of health problems. About one-third of the respondents have expressed that they are in need of clinic services. Health concerns and physical pains may sometimes trigger out the reuse of illicit drugs among the ex-addicts. A clinic service which is set up to address the unique health problems of the ex-addicts may channel their health complaints to proper and controlled means. Prompt medical attention to deal with their physical problems may reduce the misuse of drugs or undesirable treatment.

Also, as mentioned by some EWs, drug abusers have very limited knowledge on health issues and practise poorly in personal hygiene. Health education and physical check-up could be very useful for the prevention of diseases and sometimes could serve as channels for the early detection of relapse.

Dental treatment is another service in need as mentioned by some EWs and expressed by the ex-addicts. Poorly managed teeth, unhealthy outlook, and indecent smell not only affect their job seeking and employment, but also further add difficulties to their reintegration into the general population.

Therefore, clinics with a combination of health services such as treatment of diseases, health check-up, mental health service, health and diet education, personal hygiene and dental care seem to be very useful to increase personal strengths of the ex-addicts. The image of medical clinics may reduce the criminal connotation of rehabilitating persons.

However, it is quite questionable whether Methadone maintenance programme should be included as one of the services in the suggested multi-clinic for the ex-addicts. Although one EW suggested expanding the service scope of MCs to include other treatment modalities such as individual counseling and group therapy, it is still controversial if MCs take up the role of a multi-clinic for the ex-addicts. The mix between users of Methadone maintenance service and ex-addicts seems to reduce the clear image of the multi-clinic. Therefore, it is recommended that, if implemented, Methadone service should be excluded in the setup of multi-clinics for ex-addicts. Rather, the multi-clinics could be open to the public so that integration with the normal population could be done.

2. Expanding Service Scope of Methadone Clinics

Currently, MCs have been providing two types of services: a maintenance programme for harm reduction and an out-patient treatment programme. As a place where users of different treatment conditions come together, intervention primarily in the form of casework model may offer a limited scope of services to the users. Therefore, a multiple approach which combines individual counselling, job placement, group training, drugs and health education, and personal growth activities should be considered.

3. Reintegration Training Programme

Although many drug treatment programmes have included a variety of training and rehabilitation elements within the course of treatment and they have also adopted the concept that aftercare service should begin right after the detoxification period, the effort to reintegrate ex-addicts after their discharge are often handled by caseworkers or peer counsellors A casework approach to assist ex-addicts in their unique reintegration process is necessary and essential. However, some EWs mentioned that a systematic group training is valuable to educate life skills and to build up mutual support among ex-addicts.

There are many mutual help networks organized by treatment agencies in order to assist the reintegration of ex-addicts. However, complete abstinence seems to be overemphasized in these networks and it results in blocking out those who relapse from having positive peer support. Therefore, a systematic reintegration programme should be organized by professional social workers. This programme offers both to ex-addicts who relapse and who do not. Contents should include social skills training, stress management, independent livings and relapse prevention. The teaching of

cognitive-behavioural skills to handle cues and risks for relapse is an important element in relapse prevention as often mentioned in the literature. Based on the present findings, relapse status has been associated with a variety of personal problems and negative mental health outcomes, therefore, the psychological preparation of relapse forms a major theme in helping the ex-addicts. Also, as relapse is a common phenomenon among ex-addicts, social workers should educate the ex-addicts that the serving agencies can still provide help in case of their relapse.

4. Supported Employment

Vocational rehabilitation has been emphasized by some treatment agencies so that patients could be integrated into the work life after discharging from the treatment. However, most of the agencies do not provide systematic vocational training, guidance and placement services. Two EWs mentioned that the work contents of the vocational rehabilitation were often outdated. The vocational support of other public agencies to ex-addict population is very limited. Sometimes, ex-addicts are rejected when seeking these services. Therefore, employment service and vocational rehabilitation tailored for ex-addicts are necessary.

The vocational rehabilitation for ex-addicts should target on three areas: the education of positive job attitudes, the development of interpersonal skills, and the placement service. Based on the present findings, low job satisfaction, frequent job change, and being rejected in job hunting are common among the ex-addicts. Therefore, the provision of vocational rehabilitation is very important during the reintegration process.

Many EWs mentioned that job placement is tough especially when low skilled jobs are limited. On the one hand, it implies that employment training and retraining are important to equip ex-addicts to tune in the job life. Employment training on newer job types such as computer word processing may increase their competitiveness in job hunting. On the other hand, supported employment of different models may also provide job opportunities for ex-addicts who cannot find jobs in the open market. With reference to other rehabilitation services, drug treatment agencies may organize supported employment in different forms, namely, supported jobs, mobile crew, and quasi-self-employed units. Sheltered workshop has been suggested by two EWs to help ex-addicts. However, it seems that the service may be contradictory with the idea of social reintegration.

5. Services for Family of Ex-addicts

It is stressful to the whole family having a drug using member. However, there is another story that living in a unhappy family may trigger out the relapse of a rehabilitating person. Therefore, it is always an emphasis for aftercare workers to assist ex-addicts in tuning in their families. Based on the present findings, most of the respondents reported that their family support is quite adequate. However, they revealed that family members were unable to address their emotional needs especially when they felt down.

It has been commented by some EWs that services for the families of ex-addicts are crucial but inadequate. Some parents of ex-addicts do not know how to show concern

to the needs of their rehabilitating members. Family support is an important factor in the process of reintegration and a dysfunctional family situation has been mentioned by the literature as a trigger for relapse. However, some EWs revealed that some family members did not have the patience and skills to deal with their ex-addict members. Sometimes, parents of ex-addicts are critical and confrontative towards their children and do not know how to show concern to the needs of their rehabilitating members. According to some EWs, family members should need the training on how to handle the ex-addicts' feelings and how to deal with the pain and sensitivity during the rehabilitating process. At the same time, family members also need the support from others as living with ex-addicts can sometimes creates frustration. Therefore, family support services including individual counselling and group support should be promoted among the treatment agencies.

6. Hotline Service

As mentioned by one EW, hotline service has been provided by some NGOs. It is proved to be quite helpful for ex-addicts to access to counselling without caring the release of personal identity and the trouble of travelling to the office. Also, it is relatively useful in addressing the emotional crisis of the ex-addicts so that they can have an alternative way of getting help in case of stress. However currently, the hotline service is not recognized as service output for subvention. It is recommended that the hotline service with adequate financial support should be seriously considered as a service approach to assist the reintegration of ex-addicts.

7. Long-term Hostel

There are a number of ex-addicts who have no way to meet their housing needs after discharging from the treatment programmes. The provision of long-term hostels especially for those ex-addicts who need longer time to find proper places to stay is mentioned by some EWs.

5. Assisting Ex-addicts' Reintegration

In the original research design of the present investigation, the researchers intended to identify differences in the needs of 'New Ex-addicts' and '1-year Ex-addicts' in order to construct a stage model for assisting the reintegration of 'Ex-addicts'. However with the performance of Discriminant Analysis among the data, no strong indication of a significant difference between different needs of 'New Ex-addicts' and '1-year Ex-addicts' could be found. Rather, 'Relapse Status' has been identified to be significantly associated with different needs of 'Ex-addicts'.

Biological Needs

In comparison with the non-relapsed cases, relapsees reported more physical health problems, having lower satisfaction with the overall health condition and smoke more.

Psychological Needs

Compared with non-relapsed cases, the relapsed ones are having significantly lower self-esteem, lower self-mastery abilities and lower satisfaction with life. These

observations could be explained by the acquiring of a failure identity caused by the incident of relapse.

Social Needs

Although there is no significant difference among relapsed cases and non-relapsed cases in terms of their perceived family support, relapsees had scored significantly lower in terms of perceived support from friends, overall satisfaction with friends and general social competence than the non-relapsed.

6. A Stage Model of Service Provision to Ex-addicts

As there are no statistically significant difference found between different needs of 'New Ex-addicts' and '1-year Ex-addicts', a stage model of service provision to ex-addicts, as originally proposed to be developed, cannot be recommended.

It is recognized that in the process of rehabilitation and reintegration of the ex-addicts, relapse could easily occur. The appropriate handling of such incidents has significant impact on the success of assisting the reintegration of the ex-addicts into the society. So, this has significant implications for aftercare services of the service agencies. The above observations have strong implication for conducting relapse prevention and relapse education programmes for addicts and ex-addicts.

Basically, relapse prevention connotes the teaching of ways to identify triggers and conditions that may lead to re-addiction. It also implies the teaching of ways for strengthening coping skills with different life stress and assertive skills for resisting drug temptations. The enlargement of supporting social network, the acquiring of appropriate inter-personal skills and development of healthy hobbies should all be included in the programmes of relapse prevention.

Relapse education implies a genuine acceptance of relapses during the rehabilitation process of ex-addicts. Ex-addicts should be made aware that complete abstinence is a difficult but achievable process which requires a strong determination with a restructuring of a healthy life style. Ex-addicts should also be educated to look for help in case of relapse, while aftercare workers should make themselves available to those ex-addicts who approach them for assistance.

VIII. Conclusion

The present study had employed the bio-psycho-social approach to explore the service needs of ex-addicts. Totally 145 ex-addicts, with 55 'New Ex-addicts' and 90 '1-year Ex-addicts' from various treatment programmes were interviewed. Also, 16 'Experienced Workers' who had provided counselling service to the ex-addicts had been interviewed individually.

Based on the data collected, different service needs of the ex-addicts from the biological, psychological and social perspectives are identified. With reference to the current services for addicts/ex-addicts, their adequacy, in terms of quantity and quality, is commented. Also, additional services for the ex-addicts, which are believed to be able to assist their rehabilitation and reintegration processes, have been recommended.

As those addicted to drug might easily relapse into multiple addiction even after detoxification, a clear definition of 'Ex-addict' does not exist in the literature. As an operational definition for facilitating the present study, the current definition of 'Ex-addict' has to be adopted.

Also, due to the skepticism of the ex-addicts and the difficulty of directly getting their consent, although this research had been working for more than 12 months' time, the samples obtained is still relatively limited. A vigorous statistical analysis of the data could not be pursued. However, from the responses of the interviewees, the data obtained are quite informative for the researchers to gain more understanding of the different needs of ex-addicts. In addition, the in-depth interviews with the 'Experienced Workers' had offered a wide range of opinions that have extensive service implications.

In order to fully comprehend the needs of the ex-addicts, the researchers would recommend a longitudinal study on the same topic for tracing the path of reintegration of the ex-addicts after their discharge.

Two last remarks are made here. Firstly, energetic effort on community education to promote public acceptance of the ex-addicts is needed so that their reintegration process can be facilitated. Secondly, some EWs saw the importance of the participation of frontline practitioners in the committee work of the Action Committee Against Narcotics. Promotion in this aspect should be considered.

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Appendices

Appendix 1

Questionnaire for Ex-addicts

香港中文大學
社會工作系

香港城市大學
社會科學部

戒毒康復者的服務需要調查

問 卷

問卷編號 ： __________ 訪問日期：_____ 月 ______日

訪問員編號：__________ 訪問員簽名：_______________

被訪者所屬機構 : ____________________________________

☐ (A) New CTP / VTP ☐ (B) 1 - Yr CTP / VTP
☐ (C) New MHN / MC ☐ (D) 1 - Yr MHN / MC

__________________ 先生 / 女仕,

我係中大 / 城大的學生，

首先多謝你答應接受這次調查訪問。這次調查主要希望了解一下戒毒康復者的各種服務需要，用以協助有關當局策劃適合的服務。

全份問卷約需40分鐘完成。 問卷有些題目可能會令你覺得尷尬，但請不用介意。這只是意見的搜集，沒有對或錯的答案，請坦白回答你的個人看法。

你所提供的個人資料及意見會絕對保密，資料亦不會向你所屬的福利官或輔導社工透露，我們會將資料綜合分析作研究之用。

作爲行政紀錄，請你簽署以下的被訪同意書。

謝謝!

被訪者同意書

本人明白這調查的目的及有關資料的處理方式，並同意接受訪問。 本人已收取港幣六十元之車馬費。

____
被訪者簽署

I. 個人資料

Q1. 性別 ：　1. ☐ 男
　　　　　　2. ☐ 女

Q2. 你上次生日之歲數：_______ 歲

Q3. 你的教育程度是：

☐ 1. 無讀過書
☐ 2. 小學程度
☐ 3. 初中程度（中一至中三）
☐ 4. 高中程度（中四至中五）
☐ 5. 預科程度（中六至中七）
☐ 6. 大專 / 大學
☐ 7. 其他 (請註明 : ________)

Q4. 你的宗教信仰：

☐ 1. 天主教
☐ 2. 基督教
☐ 3. 佛教
☐ 4. 道教
☐ 5. 沒有宗教信仰
☐ 6. 其他（請註明 _____________）

Q5. 你的出生地點：

☐ 1. 香港
☐ 2. 廣東省---那一年來港_____
☐ 3. 外省 ---那一年來港______ (請註明省份 ________)
☐ 4. 外國 ---那一年來港______ (請註明國家 ________)

Q6. 你而家婚姻狀況係點樣呀？

☐ 1. 未婚（轉至問題Q8）
☐ 2. 已婚
☐ 3. 鰥／寡（轉至問題Q8）
☐ 4. 分居（轉至問題Q8）
☐ 5. 離婚（轉至問題Q8）

Q7. 你而家係唔係同你（丈夫/妻子）一齊住？

☐ 1. 是
　　Q7a. 與你同住的伴侶現時有沒有吸食毒品的習慣？
　　1. ☐ 有（轉至問題Q9）
　　5. ☐ 沒有（轉至問題Q9）
☐ 5. 不是

Q8. 你而家係唔係同人好似夫妻咁一齊住？

☐ 1. 是

Q8a. 與你同住的伴侶現時有沒有吸食毒品的習慣？

1.☐ 有　5.☐ 沒有

☐ 5. 不是

Q9. 請問你現在是否與家人同住？

☐ 1. 是
☐ 5. 不是
☐ 6. 沒有家人

Q10. 你有幾多個仔女？（但係唔計你收養　同埋出世就死）。

子女數目 __________

Q11. 請在下列各問題，指出你同意或不同意的程度。請記著，答案是沒有對或不對的，只是按照你所想的去表示。

（**Satisfaction with family life** ）	非常同意	同意	不同意	非常不同意	不適用(無家人)
1. 我的家人可以給我所需的支持。	1	2	3	4	5
2. 我可以從家人中得到關於處理事物的意見。	1	2	3	4	5
3. 其他人的家庭關係，總是比我家的好。	1	2	3	4	5
4. 我的家人樂意聽我所想的。	1	2	3	4	5
5. 我的家人與我分享我所感興趣的事物。	1	2	3	4	5
6. 我依靠家人在感情上的支持。	1	2	3	4	5
7. 當我失落時，能與家人傾訴。	1	2	3	4	5
8. 對我個人的需要， 我的家人都能顧及到。	1	2	3	4	5
9. 整體上，我滿意我的家庭生活。	1	2	3	4	5
10. 我能夠照顧家人。	1	2	3	4	5
11. 我能夠處理家中的事務。	1	2	3	4	

Q12. 以下問題，想了解你過往吸食毒品的資料：

Q12a. 你吸食毒品大概合共有幾多年？ ____ 年

Q12b. 你曾吸食的毒品主要是包括那幾類？（可選多項）

類別	吸用時間
1. ________________________________	___（年）
2. ________________________________	___（年）
3. ________________________________	___（年）
4. ________________________________	___（年）

Q12c. 在吸食毒品後有沒有經歷過離婚或分居？

☐ 1. 有離婚 ____ 次
☐ 2. 有分居 ____ 次
☐ 3. 沒有
☐ 4. 不適用，未婚或未試過同居

II 身體健康情況

Q13. 請問你在最近一個月的身體狀況一般如何 ：

	1. 從不	2.1-2次	3.3-4次	4.5次或以上
1. 很難入睡 / 失眠	☐	☐	☐	☐ _____ 次數
2. 做事不能集中精神	☐	☐	☐	☐ _____ 次數
3. 容易疲倦	☐	☐	☐	☐ _____ 次數
4. 因患病而需要看醫生	☐	☐	☐	☐ _____ 次數
5. 因欠缺體力而沒上班	☐	☐	☐	☐ _____ 次數
6. 沒有胃口進食 / 腸胃不良	☐	☐	☐	☐ _____ 次數
7. 覺得血氣不足 / 想暈	☐	☐	☐	☐ _____ 次數
8. 覺得無原無故心跳加速	☐	☐	☐	☐ _____ 次數
9. 覺得腰酸背痛	☐	☐	☐	☐ _____ 次數

Q14. 整體而言，你對你的身體狀況是：

☐ 1. 十分滿意
☐ 2. 滿 意
☐ 3. 不滿意
☐ 4. 十分不滿意

Q15. 請問你現在有無吸煙的習慣？

☐ 1. 有

Q15a. 請問你吸了煙多久？ ______ 年
Q15b. 請問你大概每日食 ☐ 1. 超過3包
☐ 2. 2-3 包
☐ 3. 每日一包
☐ 4. 1包以下

☐ 5. 沒有

Q16. 請問你現時有沒有飲酒（包括威士忌、拔蘭地、雙蒸、米酒及啤酒等）的習慣？

☐ 1. 有 - 你通常飲那些酒類？（可選多項）

類別	飲用時間（年期）	平均一星期飲用數量 (可用分數)	單 位
1. 威士忌	______ （年）	______	☐ 樽 ☐ 罐 ☐ 大杯 ☐ 細杯
2. 拔蘭地	______ （年）	______	☐ 樽 ☐ 罐 ☐ 大杯 ☐ 細杯
3. 紅酒 / 白酒	______ （年）	______	☐ 樽 ☐ 罐 ☐ 大杯 ☐ 細杯
4. 雙蒸	______ （年）	______	☐ 樽 ☐ 罐 ☐ 大杯 ☐ 細杯
5. 茅台	______ （年）	______	☐ 樽 ☐ 罐 ☐ 大杯 ☐ 細杯
6. 米酒	______ （年）	______	☐ 樽 ☐ 罐 ☐ 大杯 ☐ 細杯
7. 補酒	______ （年）	______	☐ 樽 ☐ 罐 ☐ 大杯 ☐ 細杯
8. 啤酒	______ （年）	______	☐ 樽 ☐ 罐 ☐ 大杯 ☐ 細杯
9 其他（請註明：______）	______ （年）	______	☐ 樽 ☐ 罐 ☐ 大杯 ☐ 細杯

☐ 5. 沒有

Q17. 你有沒有試過戒酒？

- ☐ 1. 有
- ☐ 2. 沒有
- ☐ 3. 不適用，沒有飲酒習慣

Q18. (A)離開（戒毒機構）/ (B)前一年離開（戒毒機構）/ (C)參加美沙酮計劃或互助會 / (D)一年前你參加美沙酮計劃或互助會 後有沒有尋求過以下服務

服務類別：		1. 有	5. 否
a.住屋	1. 宿舍	☐	☐
b.健 康：	2. 診所	☐	☐
	3. 牙醫	☐	☐
	4. 性病治療	☐	☐
c.輔導服務：	5. 照顧子女	☐	☐
	6. 家庭關係	☐	☐
	7. 夫婦問題	☐	☐
	8. 個人情緒問題	☐	☐
d.就業服務：	9. 尋找工作	☐	☐
	10. 再培訓	☐	☐
e.經濟	11. 領取綜合援助	☐	☐
	12. 其他經濟資助	☐	☐
f.其他	13. 自助小組/互助組織(例如康聯會、培康會等)	☐	☐
	14. 法律援助	☐	☐
	15. 義工服務	☐	☐
	16. 與戒毒或斷癮有關的服務	☐	☐
	17. 其他（請註明：____________）	☐	☐

《 A 組 New - CTP / VTP 只須回答 Q19(A) 再轉至 Q20 》

Q19(A). 請問你完成今次康復過程之後有否再吸食毒品?

- ☐ 1. 有
  19a. 請問你再吸食那種毒品 ______________________________
  ____
  ____
- ☐ 5. 沒有

《 B 組 1Yr - CTP / VTP 只須回答 Q19(B) 再轉至 Q20 》

Q19(B). 請問你一年前離開（戒毒機構）後，你有否再吸食毒品？

- ☐ 1. 有
  19a. 請問你再吸食那種毒品 ______________________________
  ____
  ____
- ☐ 5. 沒有 (請跳答 Q20)

Q19(B)a. 你有否再尋找戒毒康復服務？

- ☐ 1. 有
  19b. 機構名稱 ______________________________
  ____
  ____
- ☐ 5. 沒有

《 C 組 New - MHN / MC 只須回答 Q19(C) 再轉至 Q20 》

Q19(C). 請問你參加美沙酮計劃/互助會後有否再吸食毒品？

☐ 1. 有
19a. 請問你再吸食那種毒品 ______________________________
____
____

☐ 5. 沒有

《 D 組 1Yr - MHN / MC 只須回答 Q19(D) 再轉至 Q20 》

Q19(D). 請問你一年前參加美沙酮計劃/互助會後，你有否再吸食毒品？

☐ 1. 有
19a. 請問你再吸食那種毒品 ______________________________
____
____

☐ 5. 沒有 (請跳答 Q20)

Q19(D)a. 你有否再尋找戒毒康復服務？

☐ 1. 有
19b. 機構名稱 ______________________________
____
____

☐ 5. 沒有

II . 精神健康情況

Q20. 請在下列各問題，指出你同意或不同意的程度，答案可以有非常同意、同意、不同意或非常不同意。請記著，答案是沒有對或不對的，只是按照你所想的去表示。

	非常同意	同意	不同意	非常不同意	不適用 (無家人)
(Self-esteem)					
1. 我是個有價值的人，至少與其他人一樣。	1	2	3	4	
2. 我傾向覺得自己是失敗的。	1	2	3	4	
3. 我能夠把事情做好，正如其他人一樣。	1	2	3	4	
4. 我沒有什麼可值得驕傲。	1	2	3	4	
5. 大致上，我滿意自己。	1	2	3	4	
6. 我希望得到更多的尊重。	1	2	3	4	
7. 我有時覺得自己幾無用。	1	2	3	4	
(Self-mastery)					
8. 我經常有些無法解決的問題。	1	2	3	4	
9. 我感到沒法控制發生在自己身上的事情。	1	2	3	4	
10. 我決心要做的事都能做到。	1	2	3	4	
11. 在處理生活上的問題，我經常感到無能爲力。	1	2	3	4	
12. 我可以操縱自己的將來。	1	2	3	4	
13. 我不能改變生命中的許多事情。	1	2	3	4	
14. 我做事可以和別人一樣好。	1	2	3	4	
15. 我不能克服自己的困難。	1	2	3	4	
(Satisfaction with employment)					
16. 找尋工作不是太困難。	1	2	3	4	
17. 我對現在的工作甚感興趣。	1	2	3	4	5

18. 我的工作能給我機會發揮。	1	2	3	4	5
19. 我對我現在的工作情況是滿意的。	1	2	3	4	5
（ **Satisfaction with financial situation** ）					
20. 我能適當地控制及管理金錢的運用。	1	2	3	4	
21. 除日常開支外，我能有積蓄。	1	2	3	4	
22. 我能應付日常金錢上的開支。	1	2	3	4	
23. 我滿意我現在的財政狀況。	1	2	3	4	
（**Satisfaction with life**）					
24. 我覺得生活很開心。.	1	2	3	4	
25. 我覺得生活有很大壓力	1	2	3	4	
26. 我的生活是充實的。	1	2	3	4	
27. 我對將來充滿希望。	1	2	3	4	
28 我覺得生活無乜意義。	1	2	3	4	

IV. 社會 / 人際關係情況

Q21. 在社會 / 人際關係上，你對以下的說法的同意程度如何？

	非常同意	同意	不同意	非常不同意
1. 我能鬆容地與陌生人相處。	1	2	3	4
2. 我和朋友的相處融洽。	1	2	3	4
3. 我有很多普通朋友。	1	2	3	4
4. 我要好的朋友不多	1	2	3	4
5. 我和要好的朋友經常來往。	1	2	3	4
6. 我不太習慣與異性朋友交談。	1	2	3	4
7. 平時我有正常的消遣娛樂	1	2	3	4

Q20a. 請問你平時有什麼消遣？

1. ____________________
2. ____________________
3. ____________________

	非常同意	同意	不同意	非常不同意
（ **Satisfaction with friendship** ）				
8. 我有一些深交的朋友	1	2	3	4
9. 我的朋友給我所需要的支持。	1	2	3	4
10. 別人有的友誼，總是比我的好。	1	2	3	4
11. 我的朋友樂於傾聽我所想的。	1	2	3	4
12. 我的朋友擅於幫我解決問題。	1	2	3	4
13. 我周圍的朋友不重視我。	1	2	3	4
14. 情緒低落時，我有朋友可以傾訴。	1	2	3	4
15. 我的朋友了解我的需要。	1	2	3	4
16. 整體上，我滿意我的朋友關係。	1	2	3	4

	非常同意 1	同意 2	不同意 3	非常不同意 4
17. 我滿意現在的居住情況				

Q21a. 請問你現在居住的地方是：

☐ 1. 中途宿舍
☐ 2. 自置樓宇
☐ 3. 租住樓宇（全間）（私人）
☐ 4. 租住房間（私人）
☐ 5. 租住　位（私人）.
☐ 6. 公屋
☐ 7. 臨屋
☐ 8. 其他（請註明：__________）

V. 工作情況

Q22. 請問你現在有無做工？

☐ 1. 有　　☐ 5. 沒有（請轉Q26）

Q23. 請問你現在的工作是甚麼？（請列出工種和職位）____________________

Q24. 請問你現在每月的薪金大約有多少？

☐ 1. $ 5,000 以下
☐ 2. $ 5,001 - $ 7,000
☐ 3. $ 7,001 - $ 9,000
☐ 4. $ 9,001 - $11,000
☐ 5. $11,001 - $13,000
☐ 6. $13,001 - $15,000
☐ 7. $15,001 - $17,000
☐ 8. $17,001 - $19,000
☐ 9. $19,001 - $21,000
☐ 10. $21,000 以上

Q25. 你在過去一個月內曾工作多少天？ ______ 天

Q26. 在 (A)離開（戒毒機構）/ (B)前一年離開（戒毒機構）/ (C)參加美沙酮計劃或互助會 / (D)一年前你參加美沙酮計劃或互助會 後，你有沒有以下經歷或行爲？

	1.有	5.沒有
1. 找工作遭到拒絕。	☐	☐
2. 被僱主辭退。	☐（幾多次：___）	☐
3. 自己轉換僱主。	☐（幾多次：___）	☐
4. 無法找到工作。	☐	☐

VI. 支援服務的運用

Q27. 在完成 (A)這次戒毒康復過程後 / (B)在前一年完成戒毒康復過程後 / (C)在參加美沙酮計劃或互助會康復過程後 / (D)在一年前參加美沙酮計劃或互助會康復過程後，對於以下一些事情，你覺得有沒有需要他人協助？

	1.有需要	2.沒有需要
1. 居住方面	☐	☐
2. 工作	☐	☐
3. 閒暇活動	☐	☐
4. 金錢資助	☐	☐
5. 身體健康	☐	☐
6. 情緒問題	☐	☐
7. 人際關係	☐	☐
8. 家庭生活（如子女、夫妻、父母或姻親等相處）	☐	☐
9. 其他（請註明：__________）	☐	☐

（若表示完全沒有需要，請跳答 Q32）

Q29. 你有否尋求協助？

☐ 1. 有　　☐ 5. 沒有（轉至問題Q29a）

Q29a. 爲什麼？（可選多項）→（轉至問題Q32）

☐ 1. 不知可向那裏求助
☐ 2. 過去求助的經歷不愉快
☐ 3. 自己的事自己解決
☐ 4. 其他（請註明：________________）

Q30. 你有尋找那些人或機構協助？

	1.經常	2.間中	3.甚少	4.絕無
1. 家人	☐	☐	☐	☐
2. 親戚	☐	☐	☐	☐
3. 朋友	☐	☐	☐	☐
4. 戒毒機構 / 有關社工	☐	☐	☐	☐
5. 其他社會福利機構（請註明：______）	☐	☐	☐	☐
6. 其他（請註明：______）	☐	☐	☐	☐

Q31. 你尋求協助的結果是：

☐ 1. 全部問題獲得解決
☐ 2. 部份問題獲得解決
☐ 3. 問題不能解決

對社會服務的感覺

Q32. 以下各樣的資源，你認爲能有效地幫助你嗎 ？

援助來源	有效程度 1.十分	2.頗	3.一般	4.沒有效	5.不知道
1. 家人	☐	☐	☐	☐	☐
2. 親戚	☐	☐	☐	☐	☐
3. 朋友	☐	☐	☐	☐	☐
4. 戒毒機構 / 有關社工	☐	☐	☐	☐	☐
5. 其他社會福利機構（請註明 ：_______________）	☐	☐	☐	☐	☐
6. 其他（請註明 ：___________）	☐	☐	☐	☐	☐

Q33. 你對以下有關社會服務的描述的同意程度如何？

		非常同意.	同意	不同意	非常不同意
1.	我覺得我自己可以解決自己的問題，所以毋須社會服務。	1	2	3	4
2.	我認爲社會服務未必能幫到我。	1	2	3	4
3.	接受服務時使我感到有慚愧。	1	2	3	4
4.	面對社工或輔導員時，我感到有壓力，因我怕不能達到他們的期望和要求。	1	2	3	4
5.	要接受服務時，我會被人睇低。	1	2	3	4
6.	我害怕給人知道我正接受康復服務。	1	2	3	4
7.	我覺得接受社會服務的手續太麻煩。	1	2	3	4
8.	我的工作令我無時間接觸到服務。	1	2	3	4
9.	我的朋友會取笑我去接受社會服務。	1	2	3	4
10.	接受服務會影響我的工作。	1	2	3	4

VII. 其他

Q34. 最近三個月，有無在你身上發生以下一些事情？

	1.有	5.沒有
1. 向人借錢	☐	☐
2. 惹上官非，上差館	☐	☐
3. 與人有事爭執打架	☐	☐
4. 偷竊他人財物	☐	☐
5. 用性行爲賺取金錢	☐	☐
6. 與吸毒者來往	☐	☐
7. 其他違法的事情 (請註明 ：_________________)	☐	☐

（**Ending Remarks**）：

現在訪問已完畢。
再次多謝你抽時間接受這次的訪問。
祝你生活愉快！

Appendix 2

Interviewing Schedule for Counselling Workers

1. Working experience with drug addicts/ex-addicts

    1.1 Types of and duration in related services served
    1.2 Reasons for changing of services (if applicable)

2. Opinions on problems in assisting ex-addicts to reintegrate into society

    2.1 Problems encountered by ex-addicts at different stages in the reintegration process

        2.1.1 Social
        2.1.2 Psychological
        2.1.3 Physical
        2.1.4 Others
        2.1.5 Individual limitations vs Societal issues
        2.1.6 Other opinions

    2.2 Problems encountered by workers in helping reintegration of ex-addicts

        2.2.1 Adequacy of resources
        (e.g. employment opportunity, housing, services, etc.)
        2.2.2 Support from agencies
        (e.g. manpower, supervision, staff development, etc.)
        2.2.3 Personal factors
        (e.g. relevant knowledge & skills, time & work management, etc.)
        2.2.4 Other opinions

3. Opinions on existing support services for ex-addicts

    3.1 Adequacy of different services
    3.2 Strengths and limitations of different services
    3.3 Possible ways to further utilize the strengths and improve the limitations of different services
    3.4 Other opinions

4. Recommendations of development of new services for ex-addicts

    4.1 Existence of service gap
    4.2 Need of developing new and appropriate services
    4.3 Types and formats of services to be developed
    4.3 Other opinions

5. Other opinions

6. Personal particulars

6.1 Sex
6.2 Age
6.3 Education level
6.4 Post/rank

Content Analysis of Opinions from 'Experienced Counselling Workers'

1. Profile of the experienced workers being interviewed

1.1. Opinions from 16 experienced workers (EWs) were collected through semi-structured interviews conducted by the two investigators. Ten EWs were employed by NGOs while 6 EWs were staff of the Correctional Service Department.
1.2. Among the EWs, 10 (62.5%) were male and 6 (37.5%) were female.
1.3. A majority of EWs (13, 81%) was professionally trained while 3 EWs (19%) had personal experience of abusing drugs.
1.4. On the average, EWs had 7.8 years of experience of providing counselling services to ex-addicts. Their range of relevant experience is from 2 years to 17 years.

2. Opinions on the needs of ex-addicts

2.1. Biological Needs

2.1.1. Having dental problems (K01, K05)
2.1.2. Having poor appearance and poor knowledge on personal hygiene: body smell, skin problems, unpleasant odor of sweat (K01, K04, K05, K09)
2.1.3. Having lung or throat problems (e.g. Asthma) (K02, K03, K06)
2.1.4. Physically, it takes a shorter time for ex-addicts to become re-addicted (K02)
2.1.5. It seems to take a longer time to quit dependency among ex-addicts using methadone substitute (K02)
2.1.6. Having strong sexual desire, sometimes want to use drug to keep up sexual ability or to demonstrate their sexual power and thought that it would work (K02)
2.1.7. Having body pains and aches (K03, K06)
2.1.8. Sometimes pains are generated by psychological reactions so as to find excuses to take drugs again (K07)
2.1.9. Physical health conditions are usually recovered well during the residential treatment period. Therefore, specific needs on health do not always appear among the ex-addicts. (K04, K08, K10, K13, K14, K15, K16)
2.1.10. Having Hepatitis or liver problems (K05)
2.1.11. Having insomnia and trouble sleeping (K06)
2.1.12. Having short concentration span(K07)
2.1.13. The longer the drug taking history, the more likely they have problems on liver or heart. (K01, K02, K06, K10, K11)

2.2. Psychological Needs

2.2.1. Feeling depressed, unhappy and lonely (K01, K03, K09, K13) due to negative past experience (K03)
2.2.2. Being oversensitive, unable to trust others (K02, K04, K09, K15)
2.2.3. Lacking confidence and having low self-esteem (K02, K04, K05, K06, K07, K08, K09, K11, K12, K15)
2.2.4. Being impulsive, easy to get frustrated, having low level of tolerance, poor will power, inability to delay gratification (K03, K04, K07, K10, K16)

2.2.5. Having unstable emotions and unable to control emotions (K08, K10)
2.2.6. Having a strong sense of guilt and failure (K10, K11)
2.2.7. Knowing limited ways of coping with daily stress (K05)
2.2.8. Lacking a sense of future and having limited ability to make long-term planning (K10)

2.3. Social and Interpersonal Needs

2.3.1. Having poor relationship and communication with family members (K01, K03, K11, K16)
2.3.2. Having difficulty to build up family relationship if the rehabilitating person has no job and is in need of financial assistance (K09)
2.3.3. Associating with undesirable peers and unable to handle peer pressure are influential factors for their rehabilitation. (K01, K09, K12, K15)
2.3.4. Lacking social skills to build new friendship or network (K02, K06, K09, K10, K13)
2.3.5. Family members being suspicious on the rehabilitating person (K02, K09, K16)
2.3.6. Lacking knowledge on the social environment (K02)
2.3.7. Having experience of separated from or being deserted by spouse and children due to incarceration (K03)
2.3.8. Having re-integration problems due to poor support and misunderstandings from family members, family members feel frustrated and hopeless on the rehabilitating person (K04, K05, K06, K07, K09, K10, K12, K14, K15)
2.3.9. Facing difficulties to find employment (K04, K05, K08, K12, K16) due to poor appearance (K09, K11) and having no working skills and experience (K09)
2.3.10. Having difficulties to find accommodation or to locate an alternative environment for rehabilitation (K05, K07, K10, K11)
2.3.11. Living in community surrounded by drug addicts (K05)
2.3.12. Being unable to build up life routine (K06)
2.3.13. Having financial difficulties (K08)
2.3.14. Feeling ambivalence when staying in a relationship with a drug-abusing spouse (K08)
2.3.15. Having difficulties to find peers to offer support in resisting drugs (K08)
2.3.16. Having low job satisfaction due to limited choices of job (K10)
2.3.17. Having unrealistic expectations on jobs (K02, K07, K13, K14)

3. Opinions on limitations of existing services

3.1. Having limited resources (e.g. office space, subvention, professionally trained staff) (K01, K02, K13)
3.2. Having low level of recognition, and hence subvention, of hotline services from funding bodies, hence problems of existing hotline services include lack direct human conversation, using non-professional operator, not considered as a kind of service output (K01)
3.3. Having loose coordination and cooperation among drug rehabilitation agencies due to the lack of mutual understanding, having difficulties in making referrals to other NGOs for services (e.g. school placement) (K01, K02, K05, K06, K07, K08, K10, K11, K12). HKCSS serves very limited roles in coordination and promoting cooperation of services. ACAN seems to function only as an advisory body for generating policies. (K10)
3.4. In the government side, drug rehabilitation services are mainly monitored by three departments (CSD, Health Department, & SWD). These departments have different emphases regarding the treatment of drug abusers. Hence, it is quite difficult to agree

on the service objectives as well as service outcomes. A coherent policy on rehabilitation service standard is difficult to achieve. (K01)

3.5. Participation of frontline practitioners in ACAN should be promoted so that their views on the needs of drug abusers and ex-addicts could be incorporated in the planning of rehabilitation services. (K01, K02, K06, K10, K11)

3.6. Lacking subvention to hire professional workers (K02)

3.7. Ex-addicts feel bad when faced with complicated red tapes and bureaucratic attitudes of some government departments, hence, their utilization of necessary public services tends to be low. (K02, K03)

3.8. Biases and prejudice towards ex-addicts are common among schools, Police and employers. Ex-addicts may find it difficult to reintegrate into normal life. (K02)

3.9. To assess the effectiveness of treatment programs, the subvention bodies should look into both quantity and quality of the service outputs. (K02)

3.10. With the growing number of female ex-addicts, existing services are inadequate to meet the increasing demand. (K03, K08)

3.11. Clients-to-worker ratio in aftercare service is too large and workers are not able to give adequate attention to the wide range of needs of ex-addicts. (K03, K04, K05)

3.12. Unethical employer has been found to use drugs as wage substitute for ex-addicts. (K10)

3.13. Inadequate halfway house service: agencies with the service only serve ex-addicts coming out from their own treatment programmes. (K10, K11)

3.14. Some present vocational training programmes are outdated and need to be revised. (K10, K12)

3.15. Inadequate accommodation services to support reintegration among ex-addicts (K05, K07, K10, K11)

4. Suggested services for ex-addicts

4.1. Employment

4.1.1. Employment assistance is greatly needed since it is essential to assist ex-addicts to acquire a normal lifestyle. (K01, K04)

4.1.2. Employment training or re-training is necessary for many ex-addicts. To make ex-addicts employable can help them to build up their self-confidence and self-worthiness. Hence, existing training programmes for ex-addicts should frequently up-date their training contents. (K10, K12)

4.1.3. Sheltered workshops can help reconstructing a healthy and productive life pattern, they can also provide places where support could be built among ex-addicts. This type of service is especially helpful for female ex-addicts. (K01, K04)

4.1.4. For some capable clients, assisted employment that helps ex-addicts to establish their own business should be considered. (K10)

4.2. Accommodation

4.2.1. Service programmes that can help ex-addicts find accommodation appears to be in great need. (K01, K08, K09, K12, K15) Homelessness and living together with their old friends often put many ex-addicts at risk for relapse. (K08)

4.2.2. Usually halfway houses would expect ex-addict residents to find their own accommodation after a period of 12 months. It is necessary to adopt a more flexible approach to consider an extension of the stay period. Pro-longed hostel service may

be considered as an alternative. (K09, K12, K15) Also, intensive reintegration counselling should be provided to the residents of these halfway houses. (K09, K10)

4.3. Direct services for ex-addicts

4.3.1. Group training for ex-addicts may emphasize on training up their skills for independent living, developing a healthy lifestyle, (K01) and building up a mutual support network (K01, K06, K08)

4.3.2. Methadone Clinics (MCs) should be better utilized with various service programmes. (K01)

4.3.3. Ex-addicts also need to develop their proper knowledge on drugs. Also, they need to learn how to face relapses, how to find help in case of relapses and how to reduce harm once they relapse. (K05, K06)

4.3.4. Training and staff development programmes for aftercare workers are very important to keep up their morale and up-to-date skills.

4.4. Services for family members of ex-addicts

4.4.1. Aftercare workers need to provide supports and education for family members of ex-addicts. These family members often encounter continuous stress and have mistrust attitude on the ex-addicts when they live with the rehabilitating persons. (K04, K06, K14, K16)

4.4.2. Resource centres for family members of ex-addicts are recommended. (K14, K16)

4.5. Education to the Public

4.5.1. There are programmes to teach the public about the negative consequences of illicit drug uses in the media. It is suggested to let the public know how to treat ex-addicts as rehabilitating/rehabilitated persons. Acceptance from the public could foster the rebuilding of positive self-image among ex-addicts. Also, allowance and opportunities should be given to ex-addicts so that they could develop their potentials and strengths. (K01, K07)

4.5.2. Education on proper knowledge and attitude on ex-addicts should also be extended to school administrators, employers, and other service providers. (K01)

4.6. Suggestions for policy makers

4.6.1. The Government should consider giving subvention to support programmes which employ peer counsellors. The government should accept service pluralism in the rehabilitation for ex-addicts. (K02)

4.6.2. In view of the long-term segregation and isolation from the society among drug abusers who may not be familiar with the formal bureaucracy, services provided for these clienteles should, as far as possible, simplify their bureaucratic procedures and reduce the blockages and red-tapes for utilization (K02, K03).

Notes to the Revised Report on A Study on the Needs of Ex-addicts

The revised report has addressed to the points raised by members of the Research Sub-committee of ACAN. They are summarized as follows:

1. Reliability analysis of the data collected has been performed for all composite scales. Corrected item-total correlation and coefficient alpha were reported in relevant frequency tables. Summary statements concluding the reliabilities of these scales were produced.

2. It is not feasible to further classify respondents into those who are receiving aftercare services and those who are not. First, the classification of new- and one-year ex-addicts has been deliberately addressed in our study. Second, due to the way of obtaining our sample, all of our respondents have, to a certain extent, contacted or been receiving services from the drug treatment agencies. Practically all of them were service recipients or at least were still under the attention of these service agencies. Although the aftercare services for one-year ex-addicts under the CTP were officially terminated, these respondents constituted a very small proportion of the whole sample.

3. The operational definition of ex-addicts has been further clarified in the section on "Definition of Concepts". The limitation of applying this operational definition was mentioned in the concluding section.

4. An executive summary has been added.

5. Responses to Mr. Lai's comments:

   a) We have classified respondents according to their age into (1) The adolescents, aged 15-19; (2) The young adults, aged 20-29; (3) The adults, aged 30-49; (4) The older adults, aged 50 or older. Analysing the needs of ex-addicts according to this classification may be useful for service providers in shaping their target segment.

   b) We agreed that "borrowing money from others" should not be highlighted as a problem behavior. This item should be viewed in association with other variables reflecting the life style of ex-addicts.

c) Concerning the indicators on Health condition, we have selected items that are commonly used to reflect a general pattern of health. We cannot use these items individually to judge whether a person is sick or not. However, we may draw a conclusion that the more health problems a respondent has the more likely this person has problems physically. Again, only aggregate data should be used to make inference.

d) We have combined some cells in tables where the number of cases in each cell is extremely small so that the chi-square statistics could be used confidently in making inference.

e) We have clearly mentioned in the text when making comparison of data without significant difference statistically.

f) Evidently, perceived support from family is an interesting topic to explore among ex-addicts. However, we did not identify clearly about where support source in the family was received. Nor could we differentiate the type of families from our data in the discussion of family support.

g) Data on the two items (5 & 6) in Table 4.1.1 reflected two aspects of family support among the respondents. Over half of the respondents could not identify one member in their family when they were feeling down.

h) A report on the content analysis of interviews with experienced workers has been produced in Appendix 3.