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Drug users' experiences of a residential rehabilitation program in Western Australia: A thematic analysis of drug users lived experiences

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Drug users' experiences of a residential rehabilitation program in Western Australia:
A thematic analysis of drug users lived experiences

This thesis is presented for the degree of
Master of Criminal Justice by Research

Michelle Fullam

Edith Cowan University
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Michelle Fullam

Abstract

In the last decade, there has been a marked increase in the awareness of drug use and drug-related crime in Australia. As a result, the demand for drug treatment services has increased and 14 recognised government-funded services are now available in Western Australia (WA). The goal of these services is to reduce drug use through full-time intensive programs that are usually residential. This type of drug treatment has been shown to be effective in reducing drug use and promoting pro-social lives post-treatment. However, little is known of the experiences of participants in this type of treatment in WA. As such, this study examined the lived experiences of individuals engaged in a Christian residential rehabilitation program in WA.

Semi-structured interviews were utilised to examine 14 participants' perceptions of their behaviours, links between drug use and criminal behaviour, motivations for treatment and life after rehabilitation. A thematic analysis of the data revealed that drug users have extensive insight into their lived experiences, including an awareness of normalised behaviours that catalysed their subsequent drug use and criminal behaviours. Themes that emerged from the findings include: the lived experience of dysfunction; embodying dysfunction and escaping dysfunction. Additionally, the participants demonstrated strong support for treatment provided by residential rehabilitation, commenting that that recovery from extensive drug use is a lengthy process involving more than simple abstinence from drugs. This research provides support for residential treatment of drug users who previously committed crime, supporting assertions that drug use must be treated to address criminality.

Acknowledgements

Three years ago, I would never have believed that I would be sitting here having completed a master's research degree. Yet here I am having completed what sometimes felt like an impossible mountain to climb. For that there are many people I would like to thank for the role they played in in helping me achieve this dream.

First, I would like to thank my supervisors, Dr Natalie Gately and Suzanne Ellis, for their guidance, patience, knowledge and understanding during this long journey. Most of all, thank you for believing in me and for providing reassurance that I could do this over the years. Without you both, this would not have been possible. Capstone Editing provided copyediting and proofreading services, according to the guidelines laid out in the university-endorsed national 'Guidelines for Editing Research Thesis.

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To the many friends—you know who you are—who listened to endless hours of venting, frustration and anger: thank you for constantly reminding me that I could do this. Finally, to my family who supported yet another of my crazy ideas: thank you for providing an environment that made it easier for me to complete such a journey and for the endless hours of babysitting! To my daughter: your success is only limited by your own imagination and determination. Never stop believing you can achieve everything and anything.

Contents

List of Abbreviations

AAC   American Addiction Centers

ABS   Australian Bureau of Statistics

AIC   Australian Institute of Criminology

AIHW   Australian Institute of Health and Welfare

AOD   alcohol or drugs

APA   American Psychiatric Association

CBT   cognitive behavioural therapy

CJS   criminal justice system

DMP   Department of Mining and Petroleum

DOH   Department of Health

DOJ   Department of Justice

NGO   non-government organisation

NIDA   National Institute on Drug Abuse

NSW   New South Wales

SOC   stages of change

WA   Western Australia

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Chapter 1: Introduction

Drug use is a diverse and complex social issue. The complexity stems from the normalisation and acceptance of certain licit drugs within Australian society, such as nicotine and alcohol. Illicit drugs are generally less accepted and viewed negatively within society due to the well-publicised negative effects they can have on the individual, their family and the wider community (Brorson, Arnevik, Rand-Hendriksen & Duckert, 2013; Chassin, Presson, Rose & Sherman, 2007; Grant, Potenza, Weinstein & Gorelick, 2010; Sussman & Sussman, 2011). Assisting individuals to overcome problematic drug use continues to be an issue that governments seek to address. As a result, the Australian Government's 'war on drugs' has become a priority area, including legislative and treatment-focused approaches (Department of Health [DOH], 2017). Treatment methods are continually evolving to reduce the pressure placed on the medical and judicial system as a result of drug use (Brorson et al., 2013). Australia offers a range of treatment services for drug users, including: cognitive behavioural therapy (CBT), the 12-steps program, therapeutic communities, outpatient services, detoxification centres and medication (Mental Health Commission [MHC], n.d.). Each service provides a different approach to treating drug use and usually varies in treatment content, delivery method and treatment length (American Psychiatric Association [APA], 2007; Brorson et al., 2013; Simpson, Joe & Brown, 1997).

In the past decade, the demand for drug treatment services has increased in Australia due to a growth in public awareness of the issue of drug use, and crime and the resultant societal impact (White, 2007). Previous researchers have confirmed the nexus between drug use and criminal behaviour, which highlights the ongoing importance of treating problematic drug use and dependency (Bennett & Holloway, 2009; Goldstein, 1985; Menard & Mihalic, 2001). In 2016, Australia's population was 24.28 million (Australian Bureau of Statistics [ABS], 2017)

and during that same year, approximately 15.6% of the Australian population were reported to have used an illicit drug (Australian Institute of Health and Welfare [AIHW], 2017b). No figures have been released since to provide an updated estimate of this number. Between 2017 and 2018, the number of publicly funded alcohol or drug (AOD) treatment agencies across Australia was 952, which was an increase of 14% on the previous year and 46% across a 10-year period from 2007 to 2018 (AIHW, 2019). During that same decade, it was also reported that treatment episodes for amphetamines rose by over 300%, whereas other episodes involving alcohol or cocaine decreased (AIHW, 2019). During 2018–2019, recorded crime rates in Australia decreased by 3% from previous years (ABS, 2020c) However, illicit drug offences remained the second-highest recorded offence, accounting for 20% of the 394,466 offenders in the same year (ABS, 2020c). In Western Australia (WA), illicit drug offences comprised 22% of the recorded offences during 2018–2019 and one in five male offenders had a principal offence pertaining to illicit drugs (ABS, 2020c). The Drug Use Monitoring in Australia program highlights that drug and alcohol use is a significant factor associated with criminal acts, even when drug offences are not the principal charge (Australian Institute of Criminology [AIC], 2019). These combined percentages indicate that the rate of criminal behaviour that is influenced by drugs could be higher than the 20% reported above. Additionally, these statistics highlight the negative consequences of illicit drug use in Australia and the importance of research about drug use and compulsive behaviours that lead to criminal behaviour.

Drug use within the context of this thesis refers to the consumption of drugs, illicit substances or narcotics (Chassin et al., 2007). While alcohol is technically a drug, it is not included within this research. The concept and definition of addiction is contested; however, scholars agree that addiction has a core feature of compulsive behaviour with negative consequences (Chassin et al., 2007; Grant et al., 2010; Sussman & Sussman, 2011). Within the current project, addiction refers to problematic drug use, as it encapsulates the compulsive

behaviour with negative consequences often described by scholars (Chassin et al., 2007; Grant et al., 2010; Sussman & Sussman, 2011).

The purpose of treatment is to address problematic drug use and to assist the individual to remedy their drug use and antisocial behaviour (Best, Day, Campbell, Flynn & Simpson, 2009; Best et al., 2013; Holloway, Bennett & Farrington, 2006; McKetin et al., 2018; Thurgood, Crosby, Raistrick & Tober, 2014). However, the definition of recovery is also contested (Iveson-Brown & Raistrick, 2016; Laudet, 2007; Neale et al., 2014, Neale et al., 2016; White, 2007), including how to measure successful recovery. Researchers suggest that recovery can be understood as a journey to become and remain abstinent from illicit drug use, with a concurrent positive change in social identity (Dingle, Cruwys & Frings, 2015; Formiatti, Moore & Fraser, 2017; Iveson-Brown & Raistrick, 2016; Neale et al., 2016; Neale et al., 2015, Timpson, Eckley, Sumnall, Pendlebury & Hay, 2016).

Further, while Australian research on recovery and drug use is increasing, there is still limited research understanding the perspectives of drug users and what the individual requires to successfully recover from problematic drug use and cease potential criminal behaviour (Dingle, Stark, Cruwys & Best, 2015; Formiatti et al., 2017; Gannoni & Goldsmid, 2017; Lancaster, Duke & Ritter, 2015; Neale et al., 2015; Thurgood et al., 2014). Previous research, mainly conducted internationally, identified that drug users are best equipped to provide insight into issues for recovery and how to prevent future drug use and criminal behaviours (Best, Gow, Taylor, Knox & White, 2011; Formiatti et al., 2017; Herbeck, Brecht, Christou & Lovinger, 2014; Martin, MacKinnon, Johnson & Rohsenow, 2011; Neale et al., 2015; Thurgood et al., 2014). It is for this reason that this study was conducted.

The link between drug use and criminal behaviour has also been highlighted in the research, which emphasises the ongoing importance of treating problematic drug use and addiction (Bennett & Holloway, 2009; Goldstein, 1985; Menard & Mihalic, 2001). The WA

criminal justice system (CJS) employs a variety of responses to criminal behaviour. Increasingly, the CJS has favoured alternatives to imprisonment, with 90% of offenders receiving a fine and only 10% sentenced to imprisonment in the 2018/19 reporting period (ABS, 2020a). These statistics were reflected nationally (ABS, 2020a). It has been identified that economic benefits can be generated from treatment that prevents criminal behaviour due to the reduced cost of crime for the CJS, victims and communities (McCollister, French & Fang, 2010). Therefore, the need to improve means of preventing or reducing drug-related criminal behaviour to decrease imprisonment rates and the cost of crime on society highlights the importance of the current study.

While WA has a variety of treatment services for individuals with drug addiction issues, this research focused on one residential rehabilitation centre in WA, Shalom House. Shalom House is a Christian-based non-government organisation (NGO) that provides a residential rehabilitation program for men. This residential rehabilitation is a long-term living environment that offers 24-hour supervision for individuals seeking treatment for addictions and other life-controlling issues. Their program advocates a long-term, holistic approach to rehabilitation for those with drug use addictions. As an employee at the time, the researcher was granted access by management to interview participants about their experiences before and during the program.

This research utilised an exploratory, qualitative methodology to explore drug users' perceptions of rehabilitation while within a residential treatment facility. Semi-structured in-depth interviews were conducted with 14 residents from Shalom House Residential Rehabilitation. The data underwent thematic analysis, which identified patterns and themes (Attride-Stirling, 2001; Guest, MacQueen & Namey, 2012, Liamputtong, 2020), and a question-ordered matrix was used to organise the data and code participant responses.

Although the area of drug use and crime has been researched extensively in the past, there is minimal literature on a drug users' perception of their drug use and criminal behaviour, and their experience of residential rehabilitation. Following this first chapter's introduction of the study, Chapter 2 introduces frequently used terminology and reviews the literature guiding this project. The literature review explores the association between drug use, crime and individuals changing antisocial behaviours. Chapter 3 explains the methodology used to conduct the study. The findings and interpretations of the study are discussed in Chapter 4. Recommendations that emerged from the study are described in Chapter 5 and the study's limitations are explained in Chapter 6. The final chapter discusses the study's conclusion.

Chapter 2: Literature Review

2.1 Background

Drug use is a social phenomenon with highly complex consequences that cannot be understood through simple explanations because it involves etiological factors that are unique to each user (Best el., 2013; Fuller-Thomson, Roane & Brennenstuhl, 2016; Goldstein, 1985; Neale et al., 2014; Nordfjaern, Rundmo & Hole, 2010; Sussman, Lisha & Griffiths, 2011; Timpson et al., 2016). It has become a major health, social and economic problem throughout the world (DOH, 2017; Seffrin & Domahidi, 2014; Whetton et al., 2016; White, 2007). The negative effects of drug use on a nation have been widely examined by research that demonstrated a strong link between drug use and crime (Bennett & Holloway, 2009; Bennett, Holloway & Farrington, 2008; Boles & Miotto, 2003; De Li, Priu & MacKenzie, 2000; Fader, 2016; Goldstein, 1985; Menard & Mihalic, 2001; Riordan, 2017; Seffrin & Domahidi, 2014). In recent years, amphetamine, or more specifically methamphetamine, has become a frequently used drug of choice and the most readily available within Western Australia (Doherty & Sullivan, 2020; Voce & Sullivan, 2019). With this has also come an increased association with drug related violent crime and cost to the government (AIHW, 2019a; Doherty & Sullivan, 2020; Whetton et al., 2016). Further, the expense that drug use places on the government demonstrates the importance of addressing problematic drug use. In 2013–2014, the estimated social cost of methamphetamine use in Australia was over $5 billion, which was spent on a range of factors, including prevention, awareness, crime, health care and treatment (AIHW, 2019a; Whetton et al., 2016).

Statistics show a continued rise in drug-related criminal behaviour, highlighting the need to increase our understanding of the link between drug use and how to effectively treat problematic drug use (Bennett & Holloway, 2009; Bennett et al., 2008; Goldstein, 1985;

Menard & Mihalic, 2001). Drug-related crime has become an ongoing issue within Australia's CJS, with illicit drug acts and offences having the second-highest number of convicted offences in 2018–2019 (ABS, 2020c). In 2019, the most common offence for prisoners in WA was illicit drug offences, which accounted for 20% of the prison population (ABS, 2019). Notably, WA was the only state or territory to report illicit drug offences as its most common offence amongst prisoners during that year (ABS, 2019). While the causal connection between drug use and crime is complicated, the link suggests that as a person becomes more involved with drug, use their behaviour and actions lead to criminal behaviour (Bennett & Holloway, 2009; Bennett et al., 2008; Caudy et al., 2015; Coles, Hochstetler & Sandberg, 2015; Ford & Wright, 2017; Goldstein, 1985; Håkansson & Jesionowska, 2018).

WA has constructed clear criminal legislation surrounding drug use and determined that the following are all criminal offences: using illegal drugs; asking someone to administer an illegal drug to you; administering an illegal drug to another person, whether consensual or not; obtaining an illegal drug; supplying an illegal drug; possessing an illegal drug or drug paraphernalia; trafficking an illegal drug or manufacturing an illegal drug (*Medicines and Poisons Act 2014* (WA); *Misuse of Drugs Act 1981* (WA)). Thus, it is not only drug-related criminal activity that constitutes a crime in WA; the act of using illicit drugs is also considered criminal behaviour (*Misuse of Drugs Act 1981* (WA), s6(2)).

2.2 Terminology

Four key terms have been used to guide this project. The term 'addiction' was used to describe a range of compulsive and socially unacceptable behaviours (Chassin et al., 2007). Different definitions of addiction have been used and vary depending on the context, the period, and the user (Riordan, 2017; Sussman & Sussman, 2011). For this thesis, addiction is defined as a behaviour, activity, consumption or action that a person struggles to cease despite the negative consequences. It is demonstrated by the diminished capability of drug users to stop

using, regardless of the effects or outcomes (Chassin et al., 2007; Grant et al., 2010; Hyman, 2007; Orford, 2001; Riordan, 2017 Sussman & Sussman, 2011). This behaviour can also be referred to as 'problematic drug use', as it encapsulates the compulsive behaviour with negative consequences often described by scholars (Chassin et al., 2007; Grant et al., 2010; Sussman & Sussman, 2011).

A second term used throughout this study is 'recovery'. While the concept of recovery is commonly understood as overcoming addiction, the definition of what 'overcoming addiction' entails lacks consensus. This creates difficulties when measuring the success of drug use treatment services (Dahl, 2015; Laudet, 2007; Neale et al., 2014; Neale et al., 2015; White, 2007). Laudet (2007) refers to recovery as comprising complete abstinence from all drugs, including alcohol and nicotine, while others consider it abstinence from illicit drugs only (Best, Ghufran, Day, Ray & Loaring, 2008; Buchanan & Latkin, 2008; Flynn, Joe, Broome, Simpson & Brown 2003; Formiatti et al., 2017). This study applied the definition used by Shalom House of recovery as complete abstinence from all drugs. This research focused on illicit drug use only and excluded nicotine, alcohol or pharmaceutical medications; therefore, the term 'drug use' refers to illicit drug use only.

A final term frequently used throughout the study is 'residential rehabilitation'. It is commonly agreed that residential rehabilitation for addiction refers to the situation where the recovering drug user lives in a non-hospital environment with 24-hour supervision long-term (National Institute of Drug Abuse [NIDA], 2018; New South Wales [NSW] Health, 2007; McKetin et al., 2018). Residential treatment centres usually address more than abstinence from drugs. Therapeutic communities have highly structured routines to address the individual's psychological and social issues and are the most common model of residential rehabilitation services (NIDA, 2018; NSW Health 2007). In contrast, holistic services aim to understand the underlying reasons for an individual's drug use and work to address those issues, such as

unemployment and poor familial relationships, rather than only treating the physical addiction (NIDA, 2018; NSW Health 2007; Porter, 2013). For the purpose of this research, the term residential rehabilitation will refer to a long-term living environment where individuals receive 24-hour supervision to address their behavioural, psychological and social issues.

2.3 Tripartite Conceptual Framework

To explore the consequences of drug use and its association with criminal behaviour and violence, Goldstein (1985) designed the tripartite conceptual framework for the drugs-violence nexus (see Figure 1) (Boles & Miotto, 2003; Foster, 2012; Goldstein, 1985; Kopak & Hoffmann, 2014). Goldstein (1985) used three models to explain his framework, which can be applied individually or collectively. The three models are psychopharmacological, economical compulsive and systemic (Goldstein, 1985).
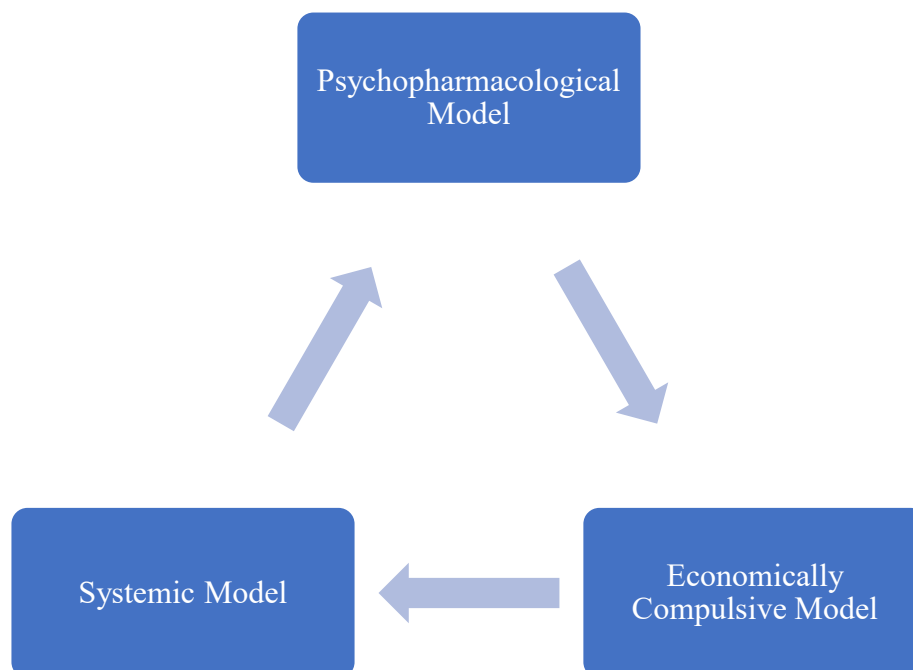

Figure 1. Goldstein's Tripartite Conceptual Framework.

In the psychopharmacological model, drug use is suggested to cause crime and violence as a result of an impairment or change to cognitive brain function due to drug use (Bennett & Holloway, 2009; Boles & Miotto, 2003; Goldstein, 1985). Goldstein (1985) explains that as a

result of the consumption of certain substances, either short- or long-term, some individuals may display violent, irrational or excitable behaviour. The substances Goldstein (1985) refers to specifically include: stimulants, barbiturates, alcohol and phencyclidine (i.e., PCP).

The economic compulsive model describes how a person may engage in criminal behaviour to financially support their drug use (Bennett & Holloway, 2009; Boles & Miotto, 2003; Goldstein, 1985). This type of behaviour is different from the previous model, as it infers that the drug user is conscious of their actions (Boles & Miotto, 2003). The motivation for these acts is often financial gain as opposed to an impulse to act violently. Boles and Miotto (2003) and Goldstein (1985) have suggested that, as cocaine and heroin have a higher street value, they are often associated with acquisitive crimes.

The final model in Goldstein's conceptual framework is systemic, which refers to crime and violence stemming from the culture of and involvement in the drug market and thus, presumes that crime and violence are intrinsically linked (Bennett & Holloway, 2009; Goldstein, 1985). The more prolonged an individual's drug use, the higher their likelihood of being involved in systemic violence or drug culture as they associate with antisocial peers. For example, methamphetamine, like amphetamine, is a stimulant drug known to cause intense violent behaviour, agitation and psychotic behaviour (Boles & Miotto, 2003; Degenhardt et al., 2017; McKetin et al., 2014). Research has demonstrated an association between methamphetamine and systemic violence, such as drug territory feuds and gang-related violence (Boles & Miotto, 2003; Degenhardt et al., 2017; Goldstein, 1985; McKetin et al., 2014; Seffrin & Domahidi, 2014).

In recent years, Seffrin and Domahidi (2014) and Bennett and Holloway (2009) used Goldstein's (1985) conceptual framework to further explore the link between drug use and crime. Seffrin and Domahidi (2014) suggested that drug dealers may increase their risky and violent behaviour as a result of their association with criminally inclined individuals. Similarly,

Bennett and Holloway (2008) concluded that individuals who used drugs were more likely to engage in criminal behaviour. Goldstein's (1985) exploration into the link between drugs and crime remains relevant in modern society and signifies the complex nature of this link and the continued need to understand it. In addition to Goldstein's (1985) conceptual framework, research also considers other etiological factors, such as alcoholism and gambling, which can lead to violence and criminal behaviour (Goldstein, 1985; Menard & Mihalic, 2001; Muelleman, DenOtter, Wadman, Tran & Anderson, 2002). In addition, the framework has also been used to explain how the pharmacological effects of other substances and addictions can instigate not only violent behaviours, but also other criminal and antisocial behaviours (Goldstein, 1985; Kopak & Hoffmann, 2014; Menard & Mihalic, 2001; Muelleman et al., 2002).

Several studies have found drug use to be at the forefront of many violent acts and criminal behaviours (Bennett et al., 2008; Boles & Miotto, 2003; Goldstein, 1985; Kopak & Hoffmann, 2014; Menard & Mihalic, 2001; Muelleman et al., 2002). Kopak and Hoffmann (2014) explored the effects of drugs and alcohol on the types and severity of criminal offences. The study used data from 3,013 face-to-face interviews previously collected by the Arrestee Drug Abuse Monitoring II program in the United States. The findings suggested that drug dependence may predict criminal behaviour, as the study found that motivation to acquire substances is higher in dependent than in nondependent users (Kopak & Hoffmann, 2014). Individuals who use drugs are more likely to be in possession of an illicit drug or under the influence of an illicit drug should they be stopped and/or searched by police, which increases their chances of being charged with a criminal offence (Kopak & Hoffmann, 2014). This highlights that drugs can contribute to more than just violent crime, as initially suggested by Goldstein's (1985) conceptual framework. Bennett et al. (2008) conducted a meta-analysis of 30 studies to explore the association between drug use and criminal behaviour and produced

similar results to those of Kopak and Hoffmann (2014). Their findings supported Goldstein's (1985) link between crime and drug use and noted that the likelihood of offending among drug users varied depending on the type of drug the individual used. However, both studies reused previously collected data and therefore, may not accurately reflect the current association between drug use and criminal behaviour.

Two studies applied Goldstein's (1985) tripartite conceptual framework. Menard and Mihalic (2001) aimed to further the framework by reviewing data collected from 2,360 participants over nine waves of a National Youth Survey from 1976 to 1992. They discussed the concept of an individual being introduced to crime prior to substances, implying that drug use is a result of pre-existing criminal tendencies (Menard & Mihalic, 2001). Similar to the previous research conducted by Kopak and Hoffman (2014) and Bennett et al. (2008), Menard and Mihalic's findings also concluded that a link exists between drug use and criminal behaviour, specifically surrounding adolescence and young adults. A further study by Bennett and Holloway (2009) using the framework included face-to-face interviews with 41 prisoners in three English prisons. It explored the drug users' perceptions of the association between their drug use and criminal behaviour (Bennett & Holloway, 2009). While the research was successful in demonstrating support for Goldstein's drug–crime nexus from the perspective of the drug user, their findings also identified limitations of the framework. One such limitation surrounded the systemic model and its limited ability to account for mass contextual connections. A second limitation highlighted the need for testable propositions, as the mechanisms linking drug use and crime can be extensive.

Despite the extensive use of Goldstein's (1985) model in explaining the link between drugs and crime, it is not without limitations (Bennett & Holloway, 2009; Brownstein & Crossland, 2002; MacCoun, Kilmer & Reuter, 2003). One commonly highlighted criticism is the need to revise and develop the model, as it does not consider the relationship variations

between drugs and crimes other than violent crimes (Bennett & Holloway, 2009; Boles & Miotto, 2003; Brownstein & Crossland, 2002). Researchers have suggested that the framework does not completely explain the connection between drugs and crime and that the relationship needs to be more broadly examined (Bennett & Holloway, 2009; Brownstein & Crossland, 2002). Boles and Miotto (2003) identified biological and psychosocial factors that can affect a person and result in them displaying violent tendencies, which can be amplified due to drug use as opposed to because of drug use. Despite these criticisms, a substantial amount of research supports the existence of a link between drug use and criminal behaviour (Bennett et al., 2008; Bennett & Holloway, 2009; Boles & Miotto, 2003; Degenhardt et al., 2017; Foster, 2012; Kopak & Hoffmann, 2014; McKetin et al., 2014; Menard & Mihalic, 2001; Seffrin & Domahidi, 2014). Therefore, the importance and need for treatment services, such as rehabilitation, to reduce the problematic issues created by the drugs–crime nexus is reinforced. Rehabilitation is only one part of addressing the link between drug use and crime; understanding how individuals can change this problematic behaviour is another integral aspect. Several stages and repeated attempts may be required for individuals to change their drug use and criminal behaviours.

2.4 Change

The Transtheoretical Model or the Stages of Change Model (SOC) created by Prochaska and DiClemente (1982) is widely used to understand and explain how individuals can change their antisocial behaviour and cease their drug use (Callaghan et al., 2005; DiClemente & Hughes, 1990; Evers et al., 2012; Serafini, Shipley & Stewart, 2016; Suk Lee, Lee, Kyung Kim & Lee, 2019). The SOC was designed after the comparison of 18 psychotherapy systems and presented change as a series of staged processes that an individual works through, guided by distinct behaviours, intentions and thoughts (Prochaska & DiClemente, 1982; Prochaska, DiClemente & Norcross, 1992; Walker, 2009). Prochaska and

DiClemente (1982) constructed the model of change around five psychological processes that an individual can experience: pre-contemplation, contemplation, preparation, action and maintenance (Prochaska & DiClemente, 1982; Prochaska et al., 1992).

In the first stage of pre-contemplation, the individual is content with their behaviour and unable to view their addictive behaviour as problematic (Prochaska et al., 1992). During this stage, the individual has not considered changing their drug-using behaviour, as the motivation to continue using drugs is greater than the consequences of the behaviour (Hiller, Knight, Leukefeld & Simpson, 2002; Marko, 1999; Prochaska et al., 1992). The individual continues to view the benefits of using substances as outweighing the consequences (Marko, 1999). In the second contemplation stage, individuals might begin to examine their behaviour and perceive the consequences or problems of their drug use (Prochaska et al., 1992). Here, although motivation to change has begun emerging, the individual has not yet committed to changing their behaviour (Marko, 1999; Prochaska et al., 1992).

A person enters the third preparation stage when they commit to change and can identify their problematic behaviour and drug-related problems (Marko, 1999). However, for the individual to commit to this change, they must be able to clearly see the consequences and problems associated with their drug use (McConnaughy, DiClemente, Prochaska & Velicer, 1989). During the fourth action stage of the SOC model, the person actively works to change their environment and strategies are implemented to change the behaviour and level of drug use (Marko, 1999; Prochaska et al., 1992). In this stage, it is vital that the individual changes their environment to actively modify behaviours associated with drug use (Prochaska et al., 1992).

The fifth and final stage in the model is maintenance; it focuses on maintaining the new drug-free behaviour and preventing a relapse (Prochaska et al., 1992). When in the maintenance stage, the individual is most at risk of regressing back to any of the previous stages or entering

the cycle again and thus, relapsing to the previous problematic behaviour (Marko, 1999). Most individuals are unable to maintain the changes on the first attempt and may relapse at any stage of the model, which requires them to restart and make another attempt (Marko, 1999; Prochaska et al., 1992). This process is viewed as normative and highlights that emphasis needs to be placed on the importance of stage-specific processes during an individual's treatment (Marko, 1999; Prochaska & DiClemente, 1982).

Together, these stages conceptualise how an individual might begin to view their drug use as problematic and progress towards changing their behaviour (DiClemente & Hughes, 1990; Hiller et al., 2002; Prochaska et al., 1992). The SOC model was originally designed as a linear progression. However, Prochaska and DiClemente (1982) and Marko (1999) identified that the process of changing addictive behaviours is not linear; therefore, the model is dynamic to account for variables that could affect progression through the stages. As previously mentioned, individuals may require repeated attempts of the SOC to be successful in changing their behaviour and thus, the model becomes cyclic (see Figure 2; Marko, 1999; Prochaska & DiClemente, 1982). To account for this, Prochaska and DiClemente (1982) discussed a relapse factor after maintenance whereby a person who is unsuccessful in maintaining the stage returns to the previous behaviour before beginning the contemplation stage again. This is called the 'revolving door' (Prochaska & DiClemente, 1892, p. 284). Here, the individual can continue to repeat the cycle of the SOC using the knowledge they previously learned to progress through the stages again (Prochaska & DiClemente, 1982; Prochaska et al., 1992).
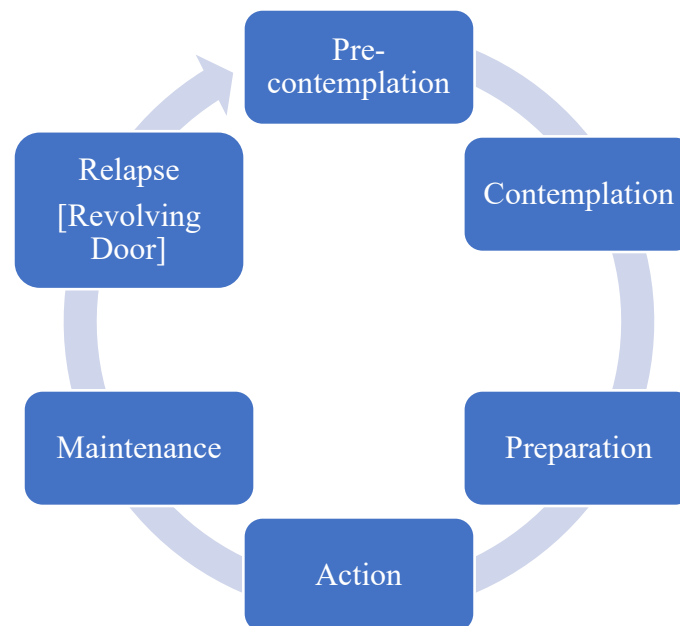
Figure 1. Stages of Change.

The SOC model continues to be used in current literature. In 2016, Serafini et al. applied

the model to examine 264 adolescents in a school-based motivational enhancement

intervention for substance use. Their findings support the existence of significant differences

across the SOC in patterns of substance use. However, in contrast to the original model,

Serafini et al. (2016) adjusted the SOC model to replace pre-contemplation with a coerced

action stage. This additional stage refers to participants whose motivation to change is similar

to the pre-contemplation stage, but they eventually cooperated and continued to make positive

changes to their behaviour. This stage found that the adolescents studied in the intervention

demonstrated reduced substance use, despite not having the motivation to do so (Serafini et al.,

2016). Similarly, Evers et al. (2012) explored the use of a Transtheoretical Model-based school

intervention on 1,590 American students who had previously used, or were currently using, a

substance. Their study produced similar findings to those of Serafini et al. (2016) and showed

that an intervention for adolescents based on the SOC could reduce substance use. While both

studies utilised the SOC, they both explore adolescents in high schools rather than adults. The

two studies also focus on substance use on a broader scale that includes alcohol, tobacco and other drugs, not only illicit drug use.

As identified by Serafini et al. (2016), the SOC model is not without its limitations and it may be necessary to adjust the model to account for modern factors, such as coerced action. Other arguments for abandoning the SOC model identified flaws with the arbitrary lines drawn between the stages, which suggest that a person's decisions and motivations can be clearly defined (Sutton, 2001; West, 2005). Despite this acknowledgement of flaws within the SOC model, its positive applications outweigh its criticisms. The model continues to be widely used to explain how an individual can break the cycle of addiction and drug use.

Prochaska and DiClemente (1982) argue that breaking the cycle of drug use can prove difficult and that a key factor to successfully changing a behaviour is an individual's readiness or motivation to do so. A large and growing body of literature has highlighted the importance of a supportive pro-social network in relation to an individual's readiness to seek treatment for their behaviour or the motivation for abstinence for those already in treatment or post-treatment (Best et al., 2011; Dingle, Stark, et al., 2015; Gannoni & Goldsmid, 2017; McPherson, Boyne & Willis, 2017; Muller, Skurtveit & Clausen, 2017; Timpson et al., 2016).

2.5 Change-Encouraging Factors

The SOC provides an overarching guiding model for how an individual might begin changing their problematic behaviours. However, research has begun to explore factors that can encourage and assist the change process once an individual has committed to change. Dingle, Stark, et al. (2015) examined the experiences of 132 adults in a therapeutic community to explore participants' concept of identity as 'drug users'. They concluded that those who moved away from their drug-using social groups and towards a new drug-free identity had positive recovery outcomes (Dingle, Stark, et al., 2015). In contrast to Dingle, et al. (2015), Moos (2007) examined four social theories alongside a review of literature on protective

resources and social processes that influence successful recovery and remission from drug use. Their findings demonstrate that a correlation can exist between positive treatment outcome and participation by family members in the treatment. This correlation can also be observed when examining the effect of peer groups and friends on an individual's remission outcome (Moos, 2007).

However, while Moos's (2007) findings were positive, the study reviewed specific literature instead of collecting data for a new study. While effective and informative, this method does not capture current data but rather, demonstrates support for the findings of previous studies. This contrasted with Dingle, Cruwy and Frings (2015) who collected data from a sample of drug users in a therapeutic community. However, the research conducted by Dingle, Cruwy et al. (2015) utilised a sample of participants who had recently entered a treatment facility and conducted regular follow-up interviews. The dataset from this study is likely more generalisable and relevant within current society. Overall, extensive research demonstrated that positive social networks can encourage conventional and healthy social activities, which lowers the risk of relapse, in contrast to those who isolate themselves (Best et al., 2011; Dingle, Stark, et al., 2015; Herbeck et al., 2014; Moos, 2007; Muller et al., 2017; Thurgood et al., 2014; Timpson et al., 2016).

In addition to social networks, motivation has been identified as a dynamic and complex factor for an individual to begin addressing their problematic behaviour or to continue with treatment (George, Joe, Simpson & Broome, 1998; Prochaska & DiClemente, 1982). Hiller et al. (2002) conducted a study of 419 probationers, who were remanded by court to engage in a six-month therapeutic rehabilitation and examined the effects of motivation on engagement in a residential setting. They found that individuals with higher motivation levels, displayed through treatment readiness and a desire for help, exhibited higher personal commitment levels to treatment. Brunelle et al. (2015) interviewed 127 drug-dependent adults from several legal,

justice and health services in Canada with an aim to explore participants' perspectives of sources that influenced their motivation to change. The findings show that drug users' motivation to change can vary with time and treatment experience, and can be influenced by external sources, such as improved family and social networks, health and quality of life (Brunelle et al., 2015). Both studies demonstrated the importance of a drug user's motivation to engage in treatment and change their behaviour; however, Hiller et al. (2002) used a sample of prisoners who were coerced into treatment, which differed from the volunteer participants used by Brunelle et al. (2015).

2.6 Treatment Definitions

A wide range of treatment and rehabilitation programs are available for individuals looking to change their drug-using behaviour and each program utilises different methods to assist individuals to recover from drug use (Brorson et al., 2013). Recovery through treatment remains an important factor in society, as treating drug use can reduce drug-related crime and economic costs (McCollister, French & Fang, 2010; Nordfjaern, Rundmo & Hole, 2010). Treatment programs can be separated into inpatient and outpatient programs, with inpatient programs commonly being referred to as residential programs (Porter, 2013). Options for outpatient services include counselling, support groups, medical detoxification, withdrawal management or case management (AIHW, 2019; Mental Health Commission [MHC], n.d.). The delivery of these different drug use treatment programs varies considerably in the model, duration, intensity, objectives and level of abstinence (APA, 2007; Brorson et al., 2013; Nordfjaern, Rundmo & Hole, 2010; Porter, 2013; Simpson et al., 1997).

Further, despite growing popularity, residential treatment programs funded by the Australian Government can be more expensive to operate than outpatient programs and have long waiting lists (Porter, 2013). The limited beds currently available in government-funded residential rehabilitation has seen the formation of NGOs, such as Shalom House, to meet

demand (MHC, 2018). The limited number of available government-funded places is reflected in Australian statistics of treatment service demand. In 2017–2018, it was reported that approximately 130,000 people received treatment for problematic AOD use through publicly funded AOD agencies within Australia (AIHW, 2019). A variety of treatment options were utilised by health care or treatment services to address the reported problematic alcohol or drug episodes.

Counselling was the most common treatment service sought in reported problematic alcohol and/or drug treatment episodes throughout Australia (AIHW, 2019). Case management services provide outpatient emotional support in a similar manner to a social worker for individuals with drug use or alcohol issues, which accounted for 12% of the treatment options selected by the individuals in the reported episodes (AIHW, 2019). Withdrawal management or detoxification through medicated or non-medicated means accounted for 13% of treatment services provided for the reported episodes (AIHW, 2019). Rehabilitation was the least-selected treatment option in 2017–2018 and comprised only 6% of reported treatment services (AIHW, 2019). This might be explained by a lack of availability, high demand for the service or commitment to full-time treatment.

Programs and treatment services are created to help drug users recover from addiction and decrease the likelihood of relapses; however, they do so without a universally agreed definition of what constitutes a 'successful' recovery (Laudet, 2007). The absence of a clear definition is due to the complexities of what it means to be recovered and how this can be measured. This is determined by each treatment program and service and may include milestones such as: program completion, no relapses, being a positive member of society, abstinence from illicit drugs and consideration of whether smoking tobacco or drinking alcohol are acceptable (Formiatti et al., 2017; Iveson-Brown & Raistrick, 2016; Lancaster et al., 2015; Laudet & White, 2008; McPherson et al., 2017; Neale et al., 2016; Neale et al., 2015; Timpson

et al., 2016). Without a clear definition of a successful recovery, policymakers, practitioners and researchers are limited in their understanding of drug use treatment and the effectiveness of the current services (Iveson-Brown & Raistrick, 2016; Laudet, 2007; Neale et al., 2014; White, 2007). Shalom House is an example of a residential treatment service in Australia that measures recovery through program completion, full-time employment, restored family relationships and complete abstinence from drugs, alcohol and nicotine (Shalom House, n.d.).

Treatment programs often incorporate several methods and modalities to create a unique program designed around their definition of recovery (APA, 2007; Brorson et al., 2013; Simpson et al., 1997). Differences between programs may include the length of treatment, level of abstinence from substances, interpersonal interaction and familial inclusion in the treatment process (APA, 2007; Brorson et al., 2013; Nordfjaern, Rundmo & Hole., 2010; Simpson et al., 1997). The treatment duration can often be used by government reports and researchers to establish whether a treatment was successful in rehabilitating a person (Porter, 2013; Simpson, Joe & Brown, 1997). With researchers divided on what constitutes a successful drug use treatment program or outcome for drug users following treatment the importance of exploring the perceptions of drug users engaged in treatment is reinforced. Therefore, this research focuses on the experiences of Shalom House residents who have ascertained what they believe worked for them to change their behaviour.

2.7 Residential Rehabilitation

Residential rehabilitations are one such treatment option available for drug users looking to recover from their addiction and change their behaviour. When a program is residential, it usually involves the individual remaining at the facility for a period of full-time care and counselling until they complete the program (NSW Health, 2007; SA Health, n.d.). The length of time spent in a residential rehabilitation can range from a few weeks to 12 months or longer (APA, 2013; NIDA, 2012; NSW Health, 2007; Porter, 2013; SA Health, n.d.). These

facilities specialise in providing a safe environment free from alcohol, nicotine and non-prescribed medication for individuals to stop using drugs. Further, residential rehabilitations aim to understand and address the issues that may have motivated a resident's drug use and to provide the individual with the necessary skills to be a contributing member of society (APA, 2013; NSW Health, 2007; SA Health, n.d.). Globally, residential rehabilitations are a commonly used service that was demonstrated to be more effective than other treatment services by an increased remission rate (McLellan et al., 1993; Mulder, Frampton, Peka, Hampton & Marsters, 2009; Holloway et al., 2006). They are also associated with reduced criminality, greater involvement in education, training and work, and improved psychological functioning and health for those who complete treatment (Gowing, Cooke, Biven & Watts, 2002; Holloway et al., 2006; Porter, 2013).

Treatment completion has frequently been demonstrated to be linked with a successful recovery and is associated with higher levels of employment, lower crime rates, fewer relapses and maintained abstinence (Brorson et al., 2013; Holloway et al., 2006; McKetin et al., 2018; Mulder et al., 2009). McKetin et al. (2018) conducted a study with 176 participants who entered rehabilitation for methamphetamine addiction. They found that the individual counselling provided by the treatment facility and the resulting rapport with individuals could significantly increase the rates of abstinence post-treatment (McKetin et al, 2018). Muller et al. (2017) investigated the outcomes for 338 adults who entered 21 treatment facilities in Norway. They discovered that positive quality-of-life outcomes were significantly higher for those who completed treatment and had developed an abstinent network. Other studies have examined the outcomes of individuals who participated in residential treatment and found positive improvements in health, employment, crime and levels of drug use (Best et al., 2013; Hubbard, Craddock & Anderson, 2003; Laudet, 2007; Teesson et al., 2008). Mulder et al., (2009) used a mixed method study with 200 individuals engaged in a therapeutic rehabilitation program in

New Zealand to examine their retention rates after three months. The study demonstrated that residential rehabilitation was likely to be effective due to the intensity and length of time spent in treatment. This is also supported by the literature (Hubbard et al., 2003; McKetin et al., 2018; Laudet, Stanick & Sands, 2009). Although research has recognised treatment completion as a strong factor in determining successful recovery post-treatment for many drug users (Brorson et al., 2013; Holloway et al., 2006; McKetin et al., 2018; McPherson et al., 2017; Mulder et al., 2009; Muller et al., 2017), additional factors have been identified as having a positive influence on treatment outcomes.

Family involvement or support during and after treatment is one factor that has been found to have a significant positive effect on residential rehabilitation treatment outcomes (Best et al., 2011; Brunelle et al., 2015; McPherson et al., 2017; McKetin et al., 2018; Thurgood et al., 2014; Timpson et al., 2016). Additionally, programs that encourage pro-social networks have been suggested to improve the long-term effects of treatment, as, conversely, it has been widely demonstrated that contact with antisocial peers increases the risk of re-engaging in criminal behaviours and drug use (Herbeck et al., 2014; Iveson-Brown & Raistrick., 2016; Litt, Kadden, Kabela-Cormier & Petry, 2009; Muller et al., 2017; Thurgood et al., 2014; Timpson et al., 2016). In contrast, those who are unable to complete their residential rehabilitation treatment program face an increased risk of relapse, return to criminal behaviours, poor health, financial and legal issues, unemployment and potential readmission to treatment (Brorson et al., 2013; Hser, Evans, Huang & Anglin, 2004; Neale et al., 2015). The anticipated outcomes for drug users not completing treatment provide further support for Prochaska and DiClemente's (1982) SOC model, demonstrating the continuous cycle that a drug user follows until they seek and complete treatment. The positive outcomes from participating in and completing treatment highlight the importance of increased support for residential rehabilitation as a treatment option for drug use.

Through a multi-site observational study, Muller et al. (2017) examined 338 adults across 21 treatment facilities in Norway. The aim of the research was to explore changes in substance users' quality of life and social networks throughout their treatment. The research found that those who developed a network of abstinent and pro-social peers reported larger improvements in quality of life and recovery. Muller et al. (2017) positively identified that, for a selection of substance-using participants, engaging with pro-social peers can have a positive outcome on recovery. However, the research was conducted with participants in Norway and did not directly explore the relationship between an abstinent network and reduced drug use and antisocial behaviour. In contrast, McPherson et al. (2017) explored data collected from 274 patients in a Canadian residential rehabilitation. They sought to understand the significance of family involvement in the completion rate of those engaged in the residential rehabilitation. Their findings identify a positive correlation with family involvement in supporting the patient and the recovery process. As the studies of both Muller et al. (2017) and McPherson et al. (2017) were conducted outside Australia, their findings may not be generalisable to Australian residential rehabilitation outcomes. However, both studies do demonstrate support for additional factors, other than abstinence from drugs, in potentially predicting positive outcomes from rehabilitation.

Another factor that can often be involved in the rehabilitative process, particularly with residential rehabilitations, is religion or spirituality (Best et al., 2008; Flynn et al., 2003; Laudet, Morgan & White, 2006; Laudet & White, 2008; Maffina et al., 2013). The 12-step program, which is a widely used treatment option utilised by both support groups, Alcoholics/Narcotics Anonymous, and rehabilitation facilities around the world (American Addiction Centers [AAC], 2020; Drug Rehab, n.d). The 12-step program is often interpreted as having spiritual or religious affiliations (AAC, 2020; Best et al., 2008; Flynn et al., 2003; Narcotics Anonymous Australia, n.d). The concept that spirituality or religion can assist in, not

only the recovery from substance use (Best et al., 2008; Flynn et al., 2003; Laudet et al., 2006; Laudet & White, 2008; Maffina et al., 2013), but the desistance of criminal behaviour has been explored (Bakken, Gunter & Visher, 2014).

Bakken et al. (2014) utilised data from a longitudinal study to explore 920 offenders returning to the community after imprisonment. They aimed to examine substance use and measure the influence of spirituality and the cessation of use. Findings from their study revealed that spirituality can play a significant role in preventing continued substance use for offenders re-entering the community (Bakken et al., 2014). Laudet and White (2008) conducted an in-depth exploration of 312 recovering addicts in New York City during 2003 and 2005. Their research aimed to examine recovery capital and whether it can produce greater outcomes one year later. Findings from the research identified the importance of spirituality and 12-step programs in producing positive recovery outcomes (Laudet & White, 2008). Further, their findings suggested that the inclusion of spirituality plays a significant role in recovery as it enabled addicts with means to cope with stresses, and provide meaning in life, hope and strength (Laudet & White, 2008). Although factors that contribute to a drug user completing treatment and remaining drug-free have been researched extensively in the literature, there is no single list of factors that can be utilised by rehabilitative services to increase the likelihood of successful rehabilitation (Iveson-Brown & Raistrick, 2016; Laudet, Becker & White, 2009; Neale et al., 2016; Neale et al., 2015; Neale et al., 2014; Thurgood et al., 2014; Timpson et al., 2016). As this literature review described earlier, factors such as program completion, family involvement and pro-social peers can improve treatment outcomes (Best et al., 2011; Brorson et al., 2013; Brunelle et al., 2015; Herbeck et al., 2014; Iveson-Brown & Raistrick., 2016; Litt et al., 2009; McKetin et al., 2018; Muller et al., 2017; Mulder et al., 2009; Timpson et al., 2016; Thurgood et al., 2014). However, these are not the only factors that contributed to successful rehabilitation outcomes; personal motivation is a significant factor in a drug user's decision to

engage in and complete treatment (Ball, Carroll, Canning-Bull & Rounsaville, 2006; Best et al., 2011; Davey-Rothwell, Frydl & Latkin, 2009; Gannoni & Goldsmid, 2017; McPherson et al., 2017; Muller et al., 2017; Prochaska & DiClemente, 1982; Timpson et al., 2016). The difficulty in identifying a specific set of recovery factors for any one drug user is a result of recovery being an individual process; no two people require the same factors to increase treatment success (Dingle, Cruwy & Frings., 2015; Herbeck et al., 2014; Laudet, Stanick, et al., 2009; Laudet & White, 2010; Neale et al., 2015; Neale et al., 2014; Timpson et al., 2016). Thus, some residential rehabilitations, like Shalom House, apply an individual holistic approach to each new resident (Shalom House, n.d.). This allows them to design specific programs to address each factor preventing that individual from recovering, whether that involves restoring their family relationships or securing employment, new career path, housing or financial stability.

2.8 Successful Factors

In recent years, there has been an increased volume of literature demonstrating that successful recovery from substance abuse requires multiple factors. Thurgood et al. (2014) used focus groups to interview 36 participants who had experience with drug and alcohol treatment services (as service users, friends or family) to determine their perceptions of successful treatment outcomes. The research findings demonstrated that participants valued seven main treatment outcomes that were categorised as: abstinence, employment, accommodation, improved family relationships, new pro-social friends, a crime-free lifestyle and improved health (Thurgood et al., 2014). Of these seven overarching factors, considerable importance was placed on abstinence and its maintenance. The findings of Thurgood et al. demonstrate that no one factor guarantees a successful recovery from drug use and cessation of criminal behaviour; rather, a holistic approach is required. Significantly, their research aimed

to obtain the perceptions of users engaged in a treatment facility and to understand what factors they believed would guarantee a successful treatment outcome for them.

The current research aims to explore similar perceptions from individuals engaged in a residential treatment facility. Best et al. (2013) reviewed data collected by two English drug treatment teams from 11,253 individuals who engaged in drug treatment services in England between 2009 and 2011 to explore factors that might improve a drug user's quality of life. Like Thurgood et al. (2014), Best et al.'s (2013) findings also show that multiple factors are required for a successful recovery from substance use. Best et al. (2013) identified education, volunteering and employment as encouraging an individual to maintain pro-social choices, and environments as important factors for treatment outcomes because they encouraged the continuation of positive choices. Further, while both Thurgood et al. (2014) and Best et al. (2013) demonstrated the significance of multiple factors required for successful drug use treatment, neither work took place in Australian and therefore, the applicability of the findings to the Australian context is unknown. Additionally, Thurgood et al. (2014) used focus groups, which may not have produced in-depth responses, while Best et al. (2013) utilised older data, which may no longer be applicable.

As demonstrated, there are a variety of factors and issues that, if not addressed, might result in a person being unsuccessful in ceasing their drug use and antisocial behaviours (Best et al., 2013; Thurgood et al., 2014). These findings highlight the importance of addressing a drug user's rehabilitation from a holistic approach to see them obtain social normality through employment, education, family and pro-social peers (Best et al., 2013; Iveson-Brown & Raistrick, 2016; Laudet et al., 2009; Mulder et al., 2009). These factors increase the likelihood of the individual removing themselves from pro-drug individuals and negative environments, which may result in continued drug use and criminal behaviours (Iveson-Brown & Raistrick,

2016). Previous research findings explain the importance of the drug user's perception in identifying the factors required for successful recovery.

The importance of acknowledging and understanding the drug user's perception of their rehabilitation and recovery needs, cannot be underestimated because their involvement can improve future treatment engagement and outcomes (Best et al., 2009; Neale et al., 2015). Roberts and Indermaur (2008) discussed a similar concept, in regard to prisoners, they recognised that prisoners could provide invaluable insight on their experiences; but cautioned good ethical practises are required to minimise harm to participants and maximise outcomes. Numerous studies have found that individuals are more likely to respond positively to treatment if they are included in creating their own programs, as they can provide useful input in identifying key aspects of the program that may not be beneficial to their recovery (APA, 2006; Best et al., 2009; Finney & Moos, 1984; Iveson-Brown & Raistrick, 2016; Neale et al., 2015; Nordfjaern, Rundmo & Hole, 2010; White, 2007). Shalom House applies this concept when designing an individual treatment plan for each new resident that is tailored to each of their specific needs at the time. The treatment plan is often amended as the resident progresses through their journey and displays or encounters different issues. This research study at Shalom House aimed to capture the experiences of residents before and during their treatment. Such insight allows for programs and policies to be designed to address the needs of the drug user and therefore, increase the likelihood of recovery and deter further criminal behaviours. This study explores the perceptions of a sample of Shalom House residents all of whom would have likely provided input into their specific treatment needs.

2.9 Shalom House

In 2017–2018, there were a total of 439 beds in Australian Government-funded residential rehabilitations to address drug use and other addictions, with an increase to 598 beds proposed for development by 2020 (MHC, 2018). At the time of this research, no further

government updates had been released to establish whether this target had been met. WA currently has 10 government-recognised and funded rehabilitations (MHC, 2018), alongside a growing number of self-funded centres and community-based programs throughout Australia, which were reported to total 952 during 2017–2018 (AIHW, 2019). Shalom House is an example of a self-funded residential rehabilitation in WA and was the data collection site for this research. As a former Shalom House employee and volunteer, I drew on my personal knowledge of the functionality of the organisation, alongside information present on the public website.

Shalom House is a holistic therapeutic community offering treatment programs to men with alcohol and drug issues (Shalom House, n.d.). The program requires a minimum of 12 months and is strongly shaped by Christian ideals (Shalom House, n.d.), such as compulsory attendance at church services several times a week, mandatory devotionals (bible study in the morning), refraining from swearing, drinking, ill-speaking, judgement and striving to embody the ideals described in the bible. The program aims to holistically restore the men's lives by ensuring they have several issues addressed by the time they complete the program. This includes gaining full-time employment and ownership of a car, are debt-free, have all court matters resolved, are free from alcohol and nicotine, and are reconnected with their family (Shalom House, n.d.). Additional mandatory activities include church services during the week, a weekly peer-support mentoring night (Men's Shed), a family night church service and regular weekend activities. Residents are also required to pass random drug and alcohol tests throughout their program. These tests are conducted in-house and dispatched to external pathology labs for analysis. Test results are then provided to the medical centre aligned with Shalom House. At the time of composing this thesis, there was no known evaluation of the program or treatment outcomes. Therefore, the information regarding the efficacy of the program and treatment outcomes are anecdotal. This limits any reports of success rates as

identified by Bright and Lee (2017) and Henriksen and Moritz (2018) as problematic as it is unable to provide realistic expectations from the treatment.

Residents begin in Stage One (see Table 1) in which they have no access to their personal phone or internet. They are not allowed visitations and can only make phone calls to approved numbers from a centre phone. Shalom House is a working rehabilitation: those in Stage One engage in acts of community service arranged by Shalom House. During Stage Two, participants are eligible for part-time paid employment, arranged through the Shalom House, to assist with their financial needs. They are also given more leadership responsibilities, such as ensuring chores are completed and supervising meetings. By Stage Three, the resident has been in the program for a least six months and is granted access to their phone for texts and calls only. They may be employed three days a week, be working towards obtaining their chosen career or study pathway, have a car and be allowed to leave the property regularly with set curfews.

In Stage Four, the residents have been in the program for a minimum of 10 months and are allowed access to the internet and may have a social media presence. They are working four days a week, have their own bank account, spend most weekends away from the program and are subject to later curfews during the week. In this fourth stage, residents are no longer required to attend church services or family night church; however, they must still attend Men's Shed on a weekly basis and a weekend activity once a fortnight. Stage Five is the final stage in the Shalom House program. Here, the resident is living within the community away from the program and has no obligations to attend any program activities or church services. During this stage, the resident is expected to provide infrequent support and mentorship to residents in stages below them and is still required to provide clean drug and alcohol tests when requested. Like the SOC model (Prochaska & DiClemente, 1982), the stages within the Shalom House

program are dynamic and residents can be moved back to an earlier stage should they fail a

urine test or breach any of the rules of their current stage.

Table 1.

Shalom House Stages (Summary)

Stage	Description	Duration
One	Substance detox. No work. Mandatory daily community service. No access to mobile phone or internet. Phone calls to approved numbers only.	0–3 months approximately
Two	Two days paid work. Mandatory community service on all other days. No access to mobile phone or internet. Phone calls to approved numbers only. Allowed to begin deciding their future career/education direction.	3–6 months approximately
Three	Three days paid work. Mandatory community service on all other days. Allowed a mobile phone for calls and text messages to approved numbers only. No internet access. Continue pursuing future career/education direction. Permitted more responsibility and freedom with an 8:30 pm curfew.	6–10 months approximately
Four	Four days paid work. Mandatory community service on remaining day. Allowed a mobile phone with unrestricted numbers. Restricted access to internet on mobile phone. No social media accounts. 10:30pm curfew if living on a Shalom House property. Can request to move out of Shalom House properties.	10–12 months approximately

Stage	Description	Duration
Five	Permitted full control to all aspects of their life. Expected to be building a life outside of Shalom House and finding positive social groups.	12+ months minimum

2.10 Summary

This literature review has explored the issue of problematic illicit drug use within the community, which has been demonstrated to be a complex social phenomenon. Government and community concern for drug use-related issues has increased, as problematic drug use continues to grow in WA. The link between drugs and crime has been researched extensively because solutions to reduce the drug-related criminal behaviour are in demand. Through this, the SOC model has evolved to explain how individuals might change their addictive behaviours. An individual's motivation has been identified as one aspect that can influence whether they are ready to change their negative behaviours. Treatment services are available for individuals wishing to cease their drug use. These include residential rehabilitation (such as Shalom House), which requires the person to reside at the facility full-time for an extended period of intensive treatment. Previous research has indicated that, to maximise the likelihood of the individual being successful in rehabilitation, it is important to utilise their perceptions of their treatment of the recovery process. These factors vary and change for each individual drug user and thus, creating tailored treatment services that can maximise the likelihood of recovery should result in a reduction in drug use and crime issues within society.

2.11 Research Aim

The literature review has established that further research is required into the perceptions of drug users in residential rehabilitations to increase understanding of drug use and crime issues within society (Formiatti et al., 2017; Menard & Mihalic, 2001; Neale et al., 2015; Seffrin & Domahidi, 2014; Timpson et al., 2016). This current research sought to address

the gap in the literature by exploring the lived experiences of a sample of drug users in a residential rehabilitation in WA—a topic that has predominantly been explored by research in Europe or the United States but not widely in Australia. The current research is valuable to governments, legal and justice departments, policymakers, rehabilitations and future researchers to further their understanding of drug users' experiences of a residential rehabilitation. More specifically, this research is invaluable to Australian stakeholders in furthering their understanding to create effective programs and policies that can address the holistic needs of an individual to cease their drug use and criminal behaviour.

This insight will contribute to the body of knowledge regarding drug use and criminal behaviour, both nationally and internationally. It will support governments to make informed decisions when creating solutions for the consequences of drug use and assist legal and justice departments to provide better support for those individuals. Additionally, the findings of this research might assist other treatment facilities in considering alternative methods to achieve positive outcomes for their clients.

The research explored drug users' experiences of a residential rehabilitation and their perception of its effect on their recovery. The research questions that guided this project are:

1. What are the lived experiences of recovering drug users at Shalom House?

2. How do drug users at Shalom House perceive the link between their drug use and criminal behaviours?

3. What insights do residents at Shalom House have into their rehabilitation?

This chapter has outlined the literature and rationale for this study. The next chapter outlines the methodology used to address the research questions.

Chapter 3: Methodology

3.1 Design

The study utilised a qualitative research design to explore the lived experiences of drug users seeking treatment in a residential rehabilitation in WA. The research required an in-depth understanding of the participants' lived experiences, drug use, experience with criminal behaviour, associated links between drug use and crime and their eventual insights to their rehabilitation. Therefore, a phenomenological framework was adopted. Collingridge and Gantt (2008) explained that a phenomenological framework is used to understand an extraordinary circumstance from those who experience it and to capture the meaning in the same way as the person (Liamputtong, 2013). A qualitative perspective allows for the meaning of the phenomenon to be uncovered through interpretation to understand why it happens through the analysis of data collected directly from individuals' experiences and statements (Creswell, Hanson, Clark, Plano & Morales, 2007; Thorne, 2000).

In-depth interviews were used to allow participant experiences to be explained from each individual perspective; they could also be flexible, dynamic and conducted in a natural setting (Hennink, Hutter & Bailey, 2011; Lee, Mitchell & Sablynski, 1999). In-depth semi-structured interviews with open-ended questions were selected as they explored the complex topic, while gaining meaningful personal opinions from the participants (Hennink et al., 2011; Jamshed, 2014; Liamputtong, 2013). Further, interviews are suggested as the primary means to capture an individual's phenomenological experiences, as they allow each person to describe then elaborate, attribute meaning to and clarify their perspectives on the events they experienced (Collingridge & Gantt, 2008). The study is also considered exploratory, as it investigated drug users' lived experiences in WA, a topic that has received limited academic attention (Neuman, 2011; Stebbins, 2001; Withrow, 2014).

3.2 Sample

A purposeful sampling method was used in this study. Participants were from Shalom House Residential Rehabilitation in WA. Shalom House was selected due to convenience and the rehabilitation's Chief Executive Officer's (CEO's) willingness to work with academics to gain information on their users' experiences. Inclusive of drug addiction, Shalom House also treats other addictions and behavioural issues, such as alcohol, anger, sex and pornography. However, given the focus of this study, only people with drug use addictions were selected to participate.

As discussed earlier, Shalom House operates under a stage-based program (see Table A.1 in Appendix 1). Although Shalom House was willing to cooperate with the researcher in terms of participant access, for ethical purposes, the researcher determined that residents in Stages One and Two were considered vulnerable and unlikely to have spent significant time within Shalom to communicate their experiences effectively. Residents in Stages One and Two were likely still detoxing from their substance use and were too early into their recovery journey to be clear-minded and provide significant insight or reflection on their experiences. Therefore, only residents in Stages Three, Four and Five were eligible to participate in the research. Participants in these stages had been in active treatment for a minimum of six months, had greater responsibilities and had begun to make their own decisions regarding their lives again.

The sample consisted of 14 adult male individuals engaged with Shalom House Residential Rehabilitation in WA during 2018. All individuals voluntarily entered rehabilitation and had spent an average 16.5 months in active treatment at the time of data collection (range 8–30 months). Data were collected until thematic saturation occurred and no new information or patterns emerged from further sampling (Bowen, 2008; Guest et al., 2006; Hennink et al., 2011; Liamputtong, 2013; O'Reilly & Parker, 2013). At the time of data

collection, only a small number of residents at Shalom House identified as Aboriginal and/or Torres Strait Islander. However, those residents were ineligible to participate, as they fell within the exclusion criteria of being in Stages One and Two of the Shalom House program. All participants volunteered and no incentive was offered.

The age range was 23–57 years (m = 33.2 years; median = 31 years). Participants' occupations varied, with each identifying a different career path, including plumber, sheet metal worker, carpenter and plant operator. Education levels varied among participants; the majority had completed Year 10 (n = 6) and Year 12 (n = 4). Participants were from all eligible stages: Stage Three (n=4); Stage 4 (n=5) and Stage 5 (n=5). The demographics questionnaire allowed participants to select more than one drug that they felt brought them to Shalom House. The most used drug type was methamphetamine (n = 13), with prescription medication (n = 7) and cannabis (n = 7) presenting equally as the secondary drug of choice. Poly drug use was common.

3.2 Paradigms and Assumptions

This research employed an inductive approach, as it drew the concepts, conclusions and theoretical properties from data collected through in-depth interviews (Bowen, 2008; Neuman, 2011). A study is usually considered qualitative if it uses inductive reasoning processes that will structure and interpret meaning from the data (Thorne, 2000). These concepts are derived by the researcher from the raw data through detailed readings and interpretations (Elo & Kyngäs, 2008; Thomas, 2006). In the absence of any structured methodologies, inductive reasoning was used to allow findings to emerge from the data without constraint (Thomas, 2006).

Additionally, Goldstein's (1985) tripartite conceptual framework and Prochaska and DiClemente's (1982) SOC model were used through the research and formed the theoretical framework of the study. As discussed, Goldstein's (1985) framework describes the proposed

link between drugs and violence/crime through three concepts: a psychopharmacological model, an economic compulsive model and systemic violence (Goldstein, 1985). This framework was used to explore the link associated with the participants' drug use and potential criminal behaviours. Prochaska and DiClemente's (1982) SOC model provides a five stages through which an individual might progress to change their addictive behaviour: pre-contemplation, contemplation, preparation, action, maintenance and relapse (Prochaska & DiClemente, 1982). The SOC model was used to align participants' reports of their behaviour as they progressed through Shalom House and their recovery journey.

3.3 Materials

Participants were provided with an information letter to inform interested participants on the study's aim, purpose, data use, anticipated risks and access to information (see Appendix 2). All participants were requested to read the information letter prior to agreeing to participate in the study. A consent letter was also designed for agreeable participants to read and sign before the interviews commenced (see Appendix 3). Participants were asked to use their real names when signing; however, a pseudonym was assigned on the transcript to ensure confidentiality. To preserve the participants' confidentiality, the use of pseudonyms was continued in the interview transcripts. The consent forms required participants to agree to the interview audio being recorded and also asked whether they understood and accepted other details pertaining to data storage and participation. A recording device was used to ensure all responses were captured verbatim (Liamputtong, 2013).

A brief demographics questionnaire and semi-structured interview schedule were also created for the study (see Appendices 4 and 5 respectively). Example questions included 'How did drugs become a part of your life?'; 'Tell me about the person I would have met during that time in your life'; 'Had you ever wanted to change before?' and 'Tell me about the person you've become while in Shalom House'. This style of open-ended questioning allowed

participants to respond to each question in a greater level of detail. As participants progressed through the interview schedule, prompts or probes were used to encourage them to expand on the topic where necessary (see Appendix 5). These probes and prompts were used to increase the richness of the data and ensure that a phenomenological understanding of the topic and the study's aim were achieved (Collingridge & Gantt, 2008; Hennink et al., 2011; Jamshed, 2014; Ryan, Coughlan & Cronin, 2009). This line of questioning was best suited to support the research outcomes of exploring and understanding the experiences of drug users (Collingridge & Gantt, 2008; Creswell et al., 2007; Hennink et al., 2011; Liamputtong, 2013; Ryan et al., 2009).

3.3 Ethics

To ensure the project met ethical requirements and that participant risk was limited, in addition to university ethics approval, all materials were reviewed by the research supervisors, Shalom's CEO and Shalom's Head of Counselling (Appendix 7) prior to receiving ethics approval from the Human Research Ethics Committee at Edith Cowan University (ECU). As the researcher was volunteering full-time in an administrative role at Shalom House, which involved contact with the residents, a member from the Shalom House management team explained to participants that the two roles were separate. It was made clear to participants that they should not feel pressured to participate due to the researcher's identity as a volunteer and that any participation or non-participation would not affect their treatment service in any way. Further, as participants were in residential rehabilitation at the time of the study, consideration was given to ensure that any potential harm or risks were minimised. At the time of each interview, it was arranged that Shalom House mentors would be available should the interview content cause the participants distress. Participants were also informed at the end of each interview that mentors were available to talk should they wish to discuss anything that emerged in the interview.

3.4 Procedure

The study was conducted with the approval and support of Shalom House Residential Rehabilitation (see Appendix 6). The study was presented to Shalom House residents by the program's management team during a meeting that all residents, staff and volunteers regularly attended. It was explained that a master's researcher from ECU was seeking residents in Stages Three and above who entered Shalom House, specifically for drug use, to participate in a study. When the meeting had ended, interested residents remained and the researcher verbally explained that the interviews were guaranteed to be confidential, would take approximately one hour and would be audio recorded. The researcher also explained that they could refuse to answer questions or withdraw their consent, without penalty at any time during the interview. Interested residents were then provided with an information letter, which outlined the study in greater detail.

The interviews were scheduled at a local community hall, a location frequently used by Shalom House that was both familiar to participants and convenient. It was arranged for interviews to occur on a Monday, after the weekly meeting, as this was a day and time that would cause minimal disruption to Shalom House's daily routine. As the Monday meetings often finished at lunch time and an hour was required per interview, the collection period took place each Monday across multiple weeks. Prior to the commencement of each individual interview, it was again confirmed that participants still wished to be involved in the study and they were then asked to sign the consent form. The digital voice recorder was then placed between the interviewer and participant for the length of the interview and the researcher informed participants when recording began. The participants were reminded that they could terminate or pause the interview should they need to take a break or no longer wish to continue. To build rapport with participants, each individual interview started with several demographic questions, including some pertaining to their time in Shalom House, which were audio recorded

and later transcribed. The semi-structured questionnaire guided participants through their experiences prior to rehabilitation, since coming to rehabilitation and their goals for future. At the conclusion of the interviews, each participant was thanked for their time and reminded that their mentor was available if they needed to debrief or discuss any contents of the interview.

3.5 Data Analysis

To ensure accuracy, all interviews were audio recorded and transcribed verbatim (Liamputtong, 2013). All interviews were de-identified and assigned pseudonyms so that participants remained confidential (Hennink et al., 2011). Thematic analysis was used to analyse interviews to identify patterns and themes in the transcripts (Attride-Stirling, 2001; Guest, MacQueen & Namey, 2012; Liamputtong, 2020). This form of analysis was selected over a phenomenological method of analysis as the intention of this research was to uncover the themes and patterns amongst participants, this was better achieved through thematic analysis (Attride-Stirling, 2001; Braun & Clarke, 2006; Guest, MacQueen & Namey, 2012; Liamputtong, 2020), rather than interpretive phenomenological or hermeneutic analysis. Participants' responses were organised using a question-ordered matrix with columns listing the questions and rows containing each answer. This process allowed the data to be reduced into a concise and easily accessible form throughout the analysis period. The research was interpretive, as the interview questions had no correct answers, which allowed the researcher to employ inductive methods to interpret and extract the intrinsic and meaningful themes and conclusions (Hayes, 1985; Thorne, 2000).

The data were then coded to allow for meaning, themes and links within the data to be identified and recorded (Liamputtong, 2013; Neuman, 2011). This was performed by reading and re-reading each transcript, examining each line of text and noting observations to generate themes. Themes were then defined and examined in relating to earlier coding to ensure rigor

(Liamputtong, 2020). As themes were defined, overlaps between them arose and were reworked to ensure clear and distinct themes were presented.

The researcher's personal bias was acknowledged as an employee of Shalom House. After the interviews were interpreted and coded into a question-ordered matrix, both research supervisors analysed the data to ensure inter-rater reliability and minimise any personal bias of the researcher. The purpose of inter-rater reliability is to act as a verification tool to validate how the researcher has interpreted and coded the data. The analysis in this study was validated during inter-rater reliability as similar interpretations were found (Campbell, Quincy, Osserman & Pederson, 2013; Marques & McCall, 2005; Roberts, Priest & Traynor, 2006). Emerging trends were categorised into themes, such as Family and Peers, and sub-categorises were used within these themes such as Instability and Drug Use (Attride-Stirling, 2001). This was completed to determine each participant's understanding of their drug use and criminal behaviour and their thoughts on residential rehabilitation.

Chapter 4: Findings and Interpretations

This study explored the lived experiences of recovering drug users at Shalom House. It examined how they perceived the link between their drug use and criminal behaviours and their insights into rehabilitation. The 14 drug users who were interviewed explained their lived experiences and perceptions of the time spent in treatment. Responses from the semi-structured interview questions revealed the overarching theme of dysfunction, which is described throughout the findings, and presented in three sections to explore the linear timeline in-depth. The sub-themes demonstrate participants' explanations of how they broke their dysfunctional perception of drug-taking behaviours. The titles of the three sections are: Lived Experience of Dysfunction, Embodying Dysfunction and Escaping Dysfunction, as presented diagrammatically in Figure 3.

------------ passage of time --------→

Lived Experience of Dysfunction	Embodying Dysfunction	Escaping Dysfunction
Family • Violence and abuse • Drug use & criminal behaviours • Instability	Escalating drug use	Self-hatred
Peers • Drug use	The workplace	Recovery: 'One step from disaster'
Escapism • Drug use • Suicidal thoughts	Crime	Spirituality Purpose in life

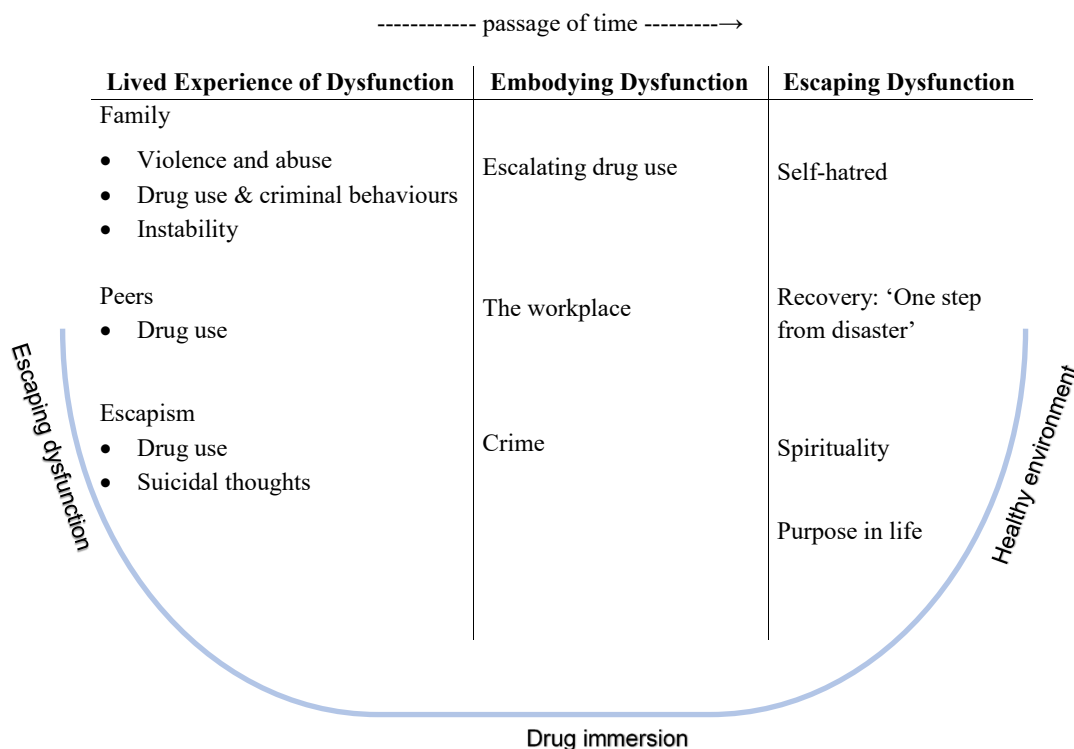Escaping dysfunction

Healthy environment

Drug immersion

Figure 3. Findings and Interpretations.

The first section describes participants' lived experience of dysfunctional events and behaviours, which became normative, and addresses the first research question of *the lived experiences of recovering drug users at Shalom House*. The second section explores how participants described embodying dysfunctional behaviours they experienced with their family during childhood and answers the research question of *how drug users at Shalom House perceive the link between their drug use and criminal behaviours*. The final section addresses how participants worked through the dysfunctional cycle of behaviours and answers the last research question of the *insights of residents at Shalom House into their rehabilitation*. These findings are presented alongside literature and explained using the SOC Model and Goldstein's tripartite conceptual framework. Participant quotes used within this section underwent minimal editing to ensure that it did not alter the participants' meaning.

4.1 The Lived Experiences of Recovering Drug Users at Shalom House

4.1.1 Lived Experiences of Dysfunction

The initial section of lived experiences of dysfunction arose from responses to questions prompting participants to describe their backgrounds. As participants described their childhood, history and experiences, a pattern of dysfunction was evident. Three sub-themes were revealed: Family, Peers and Escapism (see Figure 4). Further, throughout these sections, participants described how this dysfunction had become a normative part of their lifestyle.
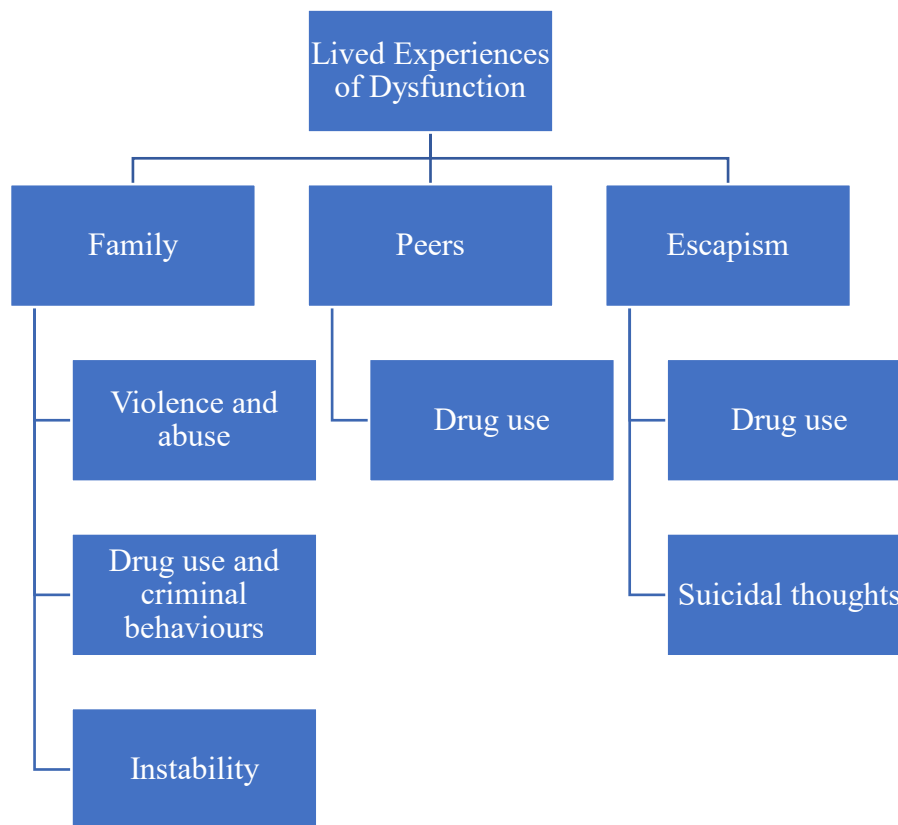
Figure 4. Themes, sub-themes and sub-sub-themes of the Lived Experiences of Dysfunction.

Each of the sub-themes and sub-sub-themes represent dysfunctional aspects of the participants' life and demonstrates how each element combined to reinforce dysfunctional behaviours as normative. Participants were able to identify these experiences as significantly influencing their future drug use. One participant encapsulated the common story:

My older brothers. *Chuckles* Yeah. Drinking and smoking weed at 12.I remember when I was 12, we…got pretty buckled and I was throwing up all over the grass. I think that was one of the first times I smoked weed and drank so much. And…they all…encouraged me to do it. But yeah that sorta…sparked me for smoking pot…most days. I used to hate drugs, until about then but my older brother he was…a speed addict. And I just wanted to hang out with him, so I'd wait in the car out the front [for the brother to purchase drugs]. I'd drive with my L's up, blind drunk *laughs* To wherever we'd go. Yeah we'd go to pubs and stuff, nightclubs when I was 16. (Participant 4)

Family involvement in early drug use was common and highlights the dysfunction experienced from a young age by participants. The overarching theme of dysfunction is present through the abnormal and unhealthy interactions that participants experienced during childhood. Further, the normalisation of dysfunction is evident through participants' recollections of violent and abusive childhoods. This section will demonstrate how these events increased the participants' risk of engaging in drug use and criminal behaviours. Throughout, it was evident that the participants lack control. The sub-themes will be explored individually, with relevant participant quotes and literature utilised to demonstrate the importance of each sub-theme.

4.2 Family

The first sub-theme to emerge within the section of Lived Experiences of Dysfunction was within their early family life. Early in the interview, participants were asked to describe their childhood and family environment. The theme of dysfunction was evident within the early family environment through regular accounts of conflict, drug use, violence, criminal activities and lack of discipline. This is consistent with Segura-García et al.'s (2016) finding that dysfunction within the family is a present aspect within the childhood experiences of some drug users. As they discussed these experiences, three sub-sub-themes emerged: Violence and Abuse, Drug Use and Criminal Behaviour, and Instability.

4.2.1 Violence and Abuse

One-third of participants described abusive or violent relationships within their family environment during childhood. The regular physical abuse and violent behaviours witnessed and described by participants highlights their early and ongoing exposure to dysfunctional environments. One participant reflected on an incident that he recalled vividly from his childhood:

One memory I've of my old man was chasing me down the street cause I'd hit my brother and…ripped me up […] on the side of the street in front of me friends and whipped me, whipped me and whipped me and whipped me… That always sticks with me for, I don't know, some reason. And the rest of time is mum running in and belting us as kids. (Participant 1)

Another participant also indicated that he had experienced physical, mental and verbal abuse from his father during childhood:

The early teenage years for me was…was absolutely traumatic. Dad uhm…assaulted us physically and uhm mentally and verbally throughout…our teenage years. (Participant 13)

This participant described growing up in a single-father family, after the death of his mother. In addition to experiencing physical, mental and verbal abuse, which are all known to be high-risk factors for future drug use and criminal behaviour (Banducci, Hoffman, Lejuez & Koenen, 2014; Fagan, 2005; Holl et al., 2017), the participant was also from a single-parent family. Several studies have revealed that growing up in a single-parent family increases the risk of individuals engaging in future drug use (Barrett & Turner, 2006; Hemovich & Crano, 2009; Hemovich, Lac & Crano, 2011). Barrett and Turner (2006) and Hemovich et al. (2011) explained that the absence of the protective factor of an additional parent to supervise and monitor children often causes the child to form associations with deviant peers. Another participant described in-detail the extensive psychological abuse he experienced by his stepfather.

He [stepfather] was in the army…So, he was pretty messed up, pretty twisted in the head, saw some stuff. The weekend would come, you know, and all the heavy metal, once the heavy metal music came, I knew he was…already drunk. And I just had to wear…whatever came. Uhm, it was never overly physical…it was more tormenting than

anything. I'd find myself in a corner of a room in a situation that…him just doing things

that you shouldn't do to kids…just tormenting sick kinda stuff…depraved kinda

behaviour. (Participant 6)

This participant recognised the psychological abuse he endured and his powerlessness

in the situation. The participant's expression of having to 'wear whatever came', highlights a

perception that this behaviour was unavoidable, but a normal part of life. Psychological or

mental abuse, like physical abuse, has also been highlighted as a high-risk factor for future

drug use and criminal behaviour (Cuomo, Sarchiapone, Giannantonio, Mancini & Roy, 2008;

Hyman, Garcia & Sinha, 2006; Mandavia, Robinson, Bradley, Ressler & Powers, 2016;

Medrano, Hatch, Zule & Desmond, 2002; Tucci, Kerr-Corrêa & Souza-Formigoni, 2010).

Shalom House residents reported they are encouraged to reflect on their childhood experiences,

which allowed them to express their belief that these childhood factors they identified may

have affected their future drug use. Therefore, it is presumed that the participant's

understanding—that his stepfather's behaviour was not a situation a child should experience—

arose because of those reflections. These findings are consistent with those of other studies that

have identified individuals who experience violence or abuse as a child, within the home, are

at a higher risk for drug use during their lives (Banducci et al., 2014; Farrell & Zimmerman,

2017; Fuller-Thomson et al., 2016; Holl et al., 2017; Mandavia et al., 2016; Min, Farkas,

Minnes & Singer, 2007; Taplin, Saddichha, Li & Krausz, 2014).

The quotations represent the trauma associated with the abuse and violence experienced

by participants during their childhood. Farrell and Zimmerman (2017) and Fagan (2005), also

identified a causal link between childhood abuse victimisation and subsequent drug use. In

total, five of the 14 participants described experiencing abuse in the home towards them or

their mother by the father (or father figure). One participant described witnessing his father's

arrest after a violent incident in the home against his mother when he was six years of age:

Ahh Mum and Dad got in a really bad fight…Dad knocked Mum out and I thought she was dead 'cause she didn't open the door quick enough. And then Mum got Dad…arrested and taken away. (Participant 2)

Another participant also described the violent acts towards his mother:

Her [mum] boyfriend had tried to stab her with a blunt kitchen knife. I…went next door and got them to get the cops…We went and stayed at a women's refuge for a couple weeks, I think? Uhm that happened a couple of times. (Participant 4)

Numerous studies have suggested that witnessing acts of violence is significant risk factor for adolescents developing a range of behavioural issues, including drug use and criminal behaviour (Farrell & Zimmerman, 2017; Ford, Elhai, Connor & Frueh, 2010; Fuller-Thomson et al., 2016; Howard, Kimonis, Muñoz & Frick, 2012; Kliewer et al., 2006; Nofziger & Kurtz, 2005). Further, Farrell and Zimmerman (2017) and Howard et al. (2012) suggest that children who witness violent acts are increasingly more likely to be involved in violent crimes or display aggressive violent behaviours during adolescence and adulthood. This link was demonstrated by participants:

I came in, saw some stuff that shouldn't of [sic] been happening. Uhm yeah and since then I…I uhm after that night I found myself hanging out with uhm just more kind of violent people. Just…Not really nice people. (Participant 6)

So, they beat the crap out of me… all I remembered was having the crap beaten out of me most of the time in my childhood. And then I decided it wasn't gonna happen anymore. So, I went and I learnt how to fight. I learnt how to take care of myself and I systematically hunted everyone down who hurt me. And I did to them what they did to me except worse. (Participant 1)

The exposure to violence and abuse within the family environment saw some participants believing they had modelled that behaviour. This was evidenced by two

participants who both identified as being angry or displaying violent behaviours due to behaviours witnessed from their fathers. The first participant described:

> *I wasn't scared to have a fight and things like that when I was a little kid. But uhm I mean my dad was pretty staunch and I think…yeah, I just learned it passed on to me a little bit. (Participant 9)*

While the second participant who had previously recounted witnessing incidents of domestic violent as a child, towards his mother as a child, and from as such he continued to associate his anger and violence as traits he had learned from his father.

> *I think my tempers always been there and again I... I didn't know; there was fix for it. I thought I was literally just angry. I thought I was angry by nature because of my dad and…the way that he was I thought that this is just what I am, you know what I mean? (Participant 2)*

The lived experiences of violence and abuse in the home increased their risk of engaging in violent and criminal behaviours as illustrated. Further, participants often recounted experiencing these events on multiple occasions. Exposure to multiple violent events, both experiencing and witnessing, has been shown to increase the individual's risk for engaging in future drug use (Fagan, Wright & Pinchevsky, 2014; Farrell, Mehari, Kramer-Kuhn & Goncy, 2014; Farrell & Zimmerman, 2017; Fuller-Thomson et al., 2016; Kliewer et al., 2006; Nofziger & Kurtz, 2005; Wright, Fagan & Pinchevsky, 2013). Additionally, experiencing or witnessing dysfunctional situations during childhood, such as abuse or violent acts, have been associated with mental health issues that affect an individual's ability to be happy and satisfied (Farrell & Zimmerman, 2017; Ford et al., 2010; Fuller-Thomson et al., 2016). This can then lead to self-medication through drug use. Therefore, for these participants, the frequent exposure to violent situations was positively associated with their future drug use and involvement in criminal behaviours.

4.2.2 Drug Use and Criminal Behaviours

Within the sub-theme of Family, participants openly discussed drug use and criminal behaviour within their home environment. Most participants described drug use as a regular and acceptable occurrence among their family members and thus emerged as a sub-sub-theme within the Family sub-theme. Over half of the sample described a home environment that also normalised criminal behaviours in addition to drug use. Upon reflection, they believed that this influenced their future drug use and criminal behaviour. The following quotation provides an example of this participant's family involvement with criminal activities and his admiration of their activities:

> *I used to always look up to my older cousins uhm…who retired at 25 as a multimillionaire in the Agency… He got there through…drugs and manipulation…he's a targeted member of society in Casterly Rock now. He's been shot at several times. (Participant 13)*

Although not directly specified, the participant has inferred his older cousins are involved in a criminal/gang organisation; with his successes in life being the result of criminal proceeds either drug and/or crime related. These findings are consistent with other research that has highlighted the significant influential role of family in drug use and criminal behaviour (Kostelecky, 2005; Ledoux, Miller Choquet & Plant., 2002; Low, Shortt & Snyder, 2012). Throughout the remainder of this section, the participants recollections of regular and consistent drug use within the family will be explored followed by their experiences of familial involvement in criminal activities. Four participants within this sample highlighted the influence of siblings on their drug use: Two explained how their older brother influenced or encouraged drug use:

> *And he [brother]…used to shout me weed and whatever. So, I used to grab some every morning before school and smoke most mornings. (Participant 4)*

> *He [brother] also used, probably not as much as I was using at the time. We were*
>
> *basically two peas in a pod…He'd get, I'd get. (Participant 7)*

Often siblings initiated, condoned, and prolonged drug use. Siblings can influence an individual's future drug use and criminal behaviour or association through their own behaviours and negative peer influences (Low et al., 2012). Four participants described how growing up in a family environment in which drugs were readily available enabled them to develop an acceptance of drug use. Another participant explained how his older brother and sister's drug use flamed his desire to imitate their behaviours:

> *Uhm because my sister—she's 6 years older. She was into the drugs and stuff and my*
>
> *brother he was into the heavy stuff. And so, I wanted to be like them. (Participant 3)*

These participants believed in hindsight that they were less likely to make pro-social choices because they were surrounded by siblings who regularly engaged in drug use. This finding supports research on sibling influence, suggesting that pro-drug and criminal siblings are a risk factor for future drug use and criminal behaviours in pro-social siblings (Kothari, Sorenson, Bank & Snyder, 2014; Low et al., 2012; Samek, Rueter, Keyes, McGue & Iacono, 2015; Snyder, Bank & Burraston; 2005). This was summarised by one participant, who explained that he experimented with drugs with few reservations because of the acceptable nature of drug use within his family environment:

> *And uhm whilst dabbling in recreational drug use uhm because of the environment my*
>
> *family brought us up in. I thought it was okay…Uhm and the environment I got brought*
>
> *[up] in was a fairly toxic environment. (Participant 13)*

Although only four participants explicitly identified as having regular contact with drugs during childhood, four stated that their parents were regularly intoxicated or alcoholics. However, alcohol was beyond the scope of this research, which focused on illicit drug use. Half of the remaining 10 participants did not have contact with their siblings; the remaining

five did not discuss their siblings in this context. Therefore, it is not possible to ascertain whether drug use was present in the siblings' activities. However, it is plausible that the regular and acceptable drug-using behaviours within families meant that the participants did not view drug use as criminal. Furthermore, the regular exposure to and participation in drug use within the family prevented the family from functioning as a protective factor between children and future drug use and criminal behaviours (Barrett & Turner, 2006; Kliewer et al., 2006; Ledoux et al., 2002; Trudeau, Mason, Randall, Spoth & Ralston., 2012). The findings demonstrate the pivotal influential role of drug-using siblings in instigating or fuelling drug use among their siblings.

One participant, who had previously cited his parents' lifestyle as the reason for his subsequent drug use and criminal behaviours explained intergenerational drug use and exposure to criminal activity in his family. He described leaving Shalom House for a period and trying to encourage his family to cease their own drug use:

> *Dad was on the gear and…hanging around with Shae [sister] and doing stuff. And then you know, I felt…a little bit uhm…ganged up on if you like…through the family. Even my daughter ganged up on me and I was like 'woah…what's going on here?' you know. So, uhm…it was all these forces against my one force, and it was…'ahh if you can't beat 'em join 'em'. And so, I had a bender again. (Participant 13)*

The participant directly attributes his relapse or 'bender', to pressure from his father, sister and daughter, who were all using drugs, suggesting an intergenerational pattern of use within the family. Another participant stated:

> *Mum was taken away when I was six; went to rehab. She was a speed addict. (Participant 6)*

These two quotations build on familial context from the previous participants who described sibling influence on drug use, which highlights the potential intergenerational effects

of parental and sibling drug use in normalising these behaviours for other family members. This effect has been frequently shown to encourage continued negative behaviours, such as drug use (Besemer & Farrington, 2012; DeLisi, Drury & Elbert, 2019; Farrington, Coid & Murray, 2009; Hjalmarsson & Lindquist, 2012). Within this section many participants reported multiple dysfunctional behaviours during their childhood which included consistent and regular experiences of sibling and parental drug use.

One participant described how his father's choices led to him meeting 'a lot of colourful people' and how he grew up around his father's criminal associates. Within this instance, the participant placed emphasis on the words 'colourful people', which, based on the participant's comments throughout the interview, was taken to mean individuals involved in criminal or illegal activates:

My dad was a…professional gambler. So…I grew up around uhm gambling clubs and racetracks. (Participant 9)

Dad would take me. Had a thing on called 'settling' where they'd go collect the money things like that uhm with all the big uhm professional gamblers would meet and all the bookies. (Participant 9)

The participant had previously explained that his father was a bookkeeper but lost his licence because of these dealings. While the participant may not have understood the legalities of his father's actions at the time, the significance is in the participant's perception that his father was engaged in regular criminal behaviours. Based on the participant's account, his father was likely in breach of the *Gaming and Wagering Commission Act 1987* (s 64), which defines what constitutes social gambling.

Although both participants (9 and 13) could describe specific criminal behaviours by family members, many experienced a broader exposure to family regularly engaging in illegal activities, such as obtaining and selling drugs. Beaver (2013) and Besemer and Farrington

(2012) found that being surrounded by illegal activities during childhood can increase an individual's likelihood of being involved in similar activities. This early-life exposure of drug activities facilitated a normalised view of these criminal behaviours. All participants reported engaging in both drug-related offences and more serious criminal offences in later years:

And uhm…after many…many uhm encounters with the WA police at various levels I ended up getting a jail sentence uhm of 24 months in prison. (Participant 13)

I got done by the federal police for…for the growth hormone [involvement]. (Participant 14)

Uhm and yeah just transporting drugs from A to B. And getting pulled over. And having that…on me…and me being that one…that even though it's uh not my stuff but…I'm the one driving so. (Participant 12)

And I think I went back to jail when I was 27…for sell and supply. I got done with uhm methamphetamines and got 20 months. Uhm and that just started all these small charges. I got done with gaining in the proceeds of crime, uhm and then just things like that…fraud stuff like that. (Participant 9)

Extensive research shows that experiencing complex dysfunction within the family, such as using and selling drugs, can result in those individuals replicating the same behaviours throughout their lives (Beaver, 2013; Besemer & Farrington, 2012; DeLisi et al., 2019; Farrington et al., 2009; Kothari et al., 2014; Low et al., 2012; Snyder et al., 2005). These issues were identified through participants' accounts of regular parental and sibling drug use and acceptance of those behaviours, along with general family structure dysfunction, which will be considered further in the next section.

4.2.3 Instability

The final sub-sub-theme to emerge within the sub-theme of Family was childhood Instability. Drug use is known to cause erratic and disjointed behaviours (Bennett & Holloway,

2009; Bennett et al., 2008; Boles & Miotto, 2003; Fader, 2016; Goldstein, 1985; Menard & Mihalic, 2001; Seffrin & Domahidi, 2014). These factors can explain why participants frequently described a dysfunctional family structure. In addition to parental and sibling drug use, four participants also described a turbulent family life: specifically, a lack of stability and parental involvement in childhood. Two participants described learning to look after themselves at a young age. One participant described his mother being largely emotionally absent and 'not there much' as a child and he stated that he learned to look after himself from an early age:

> *I grew up quite quick. Doing all my own washing and a lot of cooking 'cause Mum was shocking. I got sick of going to school with…smelly, smelly clothes from the nigh-…been in the washing machine for three days. Started doing my…all my own stuff quite early. (Participant 4)*

The second participant, whose mother had died in his childhood, described his father leaving for work and being left to look after himself and his younger sister:

> *Dad uhm got a job in the mines and he started uhm working away. So, it just took us straight back to…That same place as when I was growing up. You look after…you take the reins and look after your sister and here's all this responsibility…And uhm 'I'm outta here' sorta thing. And I was like 'oh cool…What about me?' (Participant 13)*

Several studies have revealed the protective factor of parental presence and monitoring in relation to a child's likelihood of engaging in future drug use and criminal behaviours (Barrett & Turner, 2006; Kliewer et al., 2006; Ledoux et al., 2002; Trudeau, Mason, Randall, Spoth & Ralston, 2012). Dysfunctional parenting and a lack of positive parental monitoring increases a child or young adult's risk of drug use and association with antisocial peers (Barrett & Turner, 2006; DeLisi et al., 2019; Fagan, Lee Van Horn, Antaramian & Hawkins., 2011; Hemovich, Lac & Crano., 2011; Ledoux et al., 2002; Segura-García et al., 2016; Trudeau et

al., 2012). One participant recounted his mother's struggle with alcohol after his father's death, and his sister's admission to mental health facilities from drug use:

> *Watching my mum through the younger years and then my sister…she's been in and out of mental institutions as well. She's, she got hit pretty hard with what happened with dad, and with mum going off the rails so, she didn't turn out too good. (Participant 3)*

Another participant described living with his stepfather while his mother battled her drug addiction. He also explained the shock of returning to his mother once she had 'cleaned up', only to discover she that had a new husband and daughter:

> *I had to stay with my [half] sister's father for a few years, which was horrible. Uhm and then I went back to mum when I was nine and [she] cleaned up, moved up to Dorne. Uh and she'd already remarried and had another daughter. (Participant 6)*

While a single-parent family, consisting of a maternal parent only, does not signify a drug use or criminal behaviour trajectory for a child, these participants recounted the parent–child relationship as negative and largely unsupportive. The combination of a sole-parent household with various factors resulting in an unstable household can increase a child's risk of future drug use and criminal behaviour. Kofler-Westergren, Klopf & Mitterauer (2010) found that the presence of father figures is a combative factor for future drug use and involvement in criminal activities. Eight of the participants described having only a mother present during childhood. Their fathers were absent for several reasons, including separation, divorce, death or complete absence (never having been present). One participant explained that he had never met his father:

> *Uhm never met my father. Got two younger sisters. We're all four years apart; all different fathers. (Participant 6)*

Another described having limited contact with his father following his parents' separation:

Uhm only ever saw my dad…maybe once a year or so on school holidays. So, he wasn't

really around much when I was growing up. (Participant 4)

However, one participant described his response to his parents' divorce when he was

not permitted to reside with his father. He explained that he spent the next few years causing

'trouble' for his mother through his fighting and drug use after his father left and he was unable

to go with him:

I wanted to go and so [when] my dad moved out, I wanted to go with him…I really

wanted to go with my dad. Uhm but my mum wanted all three of us kids to stay together,

my brother and my sister. Uhm and…I was furious about that. And I really, I really

tired hard to go with my dad…until I think uhm…four years later, after… I was

definitely drinking and using drugs every…every week. (Participant 14)

Extensive research on the link between paternal absence in relation to a child's subsequent drug

use and criminal behaviour (Jablonska & Lindberg, 2007; Hemovich & Crano, 2009;

Hemovich et al., 2011; Kofler-Westergren et al., 2010; Pfiffner, McBurnett & Rathouz, 2001)

supports the findings among the current participants. The living environment experienced by

most of these participants was turbulent and filled with heightened negative emotions.

Collectively most participants described chaotic childhoods, absence of parental

monitoring (some with a lack of a maternal emotional presence, and lack of father), violence,

death, grief, and loss likely explained the instability in the family environment. These factors

increase the likelihood of participants using drugs and associating with antisocial peers to

escape the unhappiness at home (Holl et al., 2017; Kofler-Westergren et al., 2010). Family

dysfunction and instability has been linked to subsequent drug use, as individuals attempt to

self-medicate to escape poor caregiving and abuse (Holl et al., 2017; Segura-García et al.,

2016). One participant encapsulated the effect of change on the family structure and how the

instability and lack of parental monitoring increased his risk for drug use and engagement in criminal behaviours:

> *So, when my stepdad left, I sorta didn't have that accountability and sorta do whatever*
>
> *I want to do you know. (Participant 10)*

The majority of participants described experiencing instability within the family through inconsistent and continually changing structures that originated from family separation and paternal absence. Loss of a parent was also described by two participants as a trigger for their instigation or return to drug use. The first participant spoke of having a 'peaceful' childhood and attributed his future criminal activities and drug use to his father's death:

> *And that peace was shattered when I was 13. I was in the top classes, but I just gave*
>
> *up right then and there. As soon as that [father's death] happened, I was broken.*
>
> *(Participant 11)*

The sudden death of his father and the subsequent change to his family structure caused emotional instability for the participant, who described an acute inability to cope with the loss. Similar to other participants' stories, this participant described using drugs to self-medicate to cope with his grief and loss (Maschi, MacMillan, Morgen, Gibson & Stimmel et al., 2010; Masferrer, Garre-Olmo & Caparrós 2017; Schnider, Elhai & Gray, 2007). The second participant also described escaping his grief by returning to drug use after his father's death:

> *My dad got sick with cancer…then I started using drugs again cause obviously that's*
>
> *not normal you need to…process that and I just band-aided it with drugs 'cause I didn't*
>
> *want to deal with that sorta stuff. (Participant 9)*

Maschi et al. (2010) and Masferrer et al. (2017) examined the impact of loss during childhood and found it to be a strong risk factor for future drug use. This participant's experience is consistent with extensive research (Fuller-Thomson et al., 2016; Maschi et al., 2010; Masferrer et al., 2017; Nordjærn, Hole & Rundmo, 2010; Schnider et al., 2007).

The sub-theme of family and sub-sub-themes discussed here have identified that the majority of the sample experienced a variety of family structural issues, which affected their stability during early childhood and adolescence and was evidently a contributing factor to their drug use (Cook et al., 2017; Hemovich et al., 2011; Kostelecky, 2005; Ledoux et al., 2002; Low et al., 2012; Samek et al., 2015). While some of the participants experienced drug use within the family environment and reported previous dysfunctional family situations, others recounted significantly traumatising events that created instability within the family that they believed triggered their drug use. Regardless of how the instability was experienced, it served to reinforce participants' perceived lack of control over their lives and increased their risk of drug use to regain that control and escape a dysfunctional family environment.

4.3 Peers

4.3.1 Drug Use

To further compound the effects of parental and sibling drug-using behaviours, many participants described regular drug use as an acceptable behaviour within their friendship and peer networks. Thus, peer drug use was the second sub-theme to emerge within the theme of Lived Experiences of Dysfunction. Through this sub-theme, it was evident that participants' drug use and peer drug use were intrinsically linked. Therefore the sub-sub-theme of Drug Use emerged to discuss, in depth, the relationship between participants accounts of their drug use in relation to their peers . Half of the sample described associating with peer networks that they reported as initiating or encouraging drug use and criminal behaviours. One participant explained being introduced to drugs at a friend's house that lacked parental supervision:

> *There were no rules and I liked that. So, I spent a lot of time there. And it was in that environment that I got introduced to meth[amphetamine], but I was around it a lot before I started to smoke it. (Participant 5)*

This participant explained growing up in a 'normal' family in what appeared to be a dysfunction-free environment. However, he attended a private catholic school and had strict parents and explained why he liked the friend who did not have to abide by rigid parental and religious rules. For this participant, his involvement with antisocial peers stemmed from his desire to have more freedom and escape his controlled lifestyle. Similarly, another participant described growing up in a 'normal' childhood environment with supportive parents. However, he explained moving schools and struggling to fit in and thus, associated with pro-drug individuals:

> *Uhm that's when things sorta got…bad for me 'cause the group of friends I had at the first school were through primary school and I uhm felt safe there and stuff. And then making new friends was hard for me. So uhm this is when I sorta hung around the guys that were smoking weed. And stuff like this and uhm that's when I sorta stopped surfing 'cause I was smoking heaps of weed and I found it hard to get up early in the morning. (Participant 8)*

While having a protective family environment with involved parents is generally known to reduce an individual's risk for drug use, Segura-García et al. (2016) and Trudeau et al. (2012) have suggested that a controlling family environment can sometimes see individuals associating with antisocial peers and experimenting with drugs to escape parental control. Another participant also reported experiencing a normal childhood with attentive parents. However, his experimentation with drugs evolved from boredom and curiosity after he had a serious accident and was unable to attend school for a period:

> *I found myself hanging around some older fellas. Just to keep the day busy. And within [a] little time I was…experimenting with them, smoking cones and seeing a lot of stuff go down. I started selling a bit of weed myself. (Participant 7)*

Another participant recounted how his drug use initiated through a peer who encouraged him to try methamphetamine.

Ah, actually the first time I did…I did meth was at one of my friends from school's houses. We used to hang out all the time and he wanted me to. (Participant 10)

In total, five participants reported choosing to experiment with drug use specifically because of peer influence.

I met up with one of my…childhood mates and he was hanging out with a bunch of fellas that really liked doing a lot of dodgy, violent stuff; drinking and stuff like that. So, then that became my life for the next two years. (Participant 6)

This participant described that although witnessing drug use in the home, he did not use until engaging with drug-using peers. As the participant had previously described regular exposure to drug use in the home, through his own heroin-addicted mother, he began to emulate similar behaviours that he was unlikely to view as problematic. Another participant who experienced similar dysfunction also described associating with peers who engaged in criminal activities and enabled his drug use:

He [friend] was...started dealing and just whenever he got…some I…he'd ring me and let me know it was there. And I hadn't even finished the last lot, but I'd go get it and just kept using more and more and more. Just 'cause it was there. (Participant 4)

While this participant reported that his family introduced him to drugs, his association with this peer promoted a continuation of his use. Each of the above participant quotations demonstrates the pivotal role of peers in the choice to use drugs, continue using drugs or become involved in criminal behaviours (Hser, 2007; Mason, Mennis, Linker, Bares & Zaharakis, 2014). Further, this finding highlights the dysfunctional nature of the peer networks of the participants and identifies a friendship, which appeared to revolve around drug use and criminal behaviours. Research on the influence of peers has established that a relationship does

exist between an individual's social network and resulting drug use and criminal behaviours (Herbeck et al., 2014; Hser, 2007; Mason et al., 2014).

Additionally, four participants described choosing to surround themselves with drug-using peers while attempting to maintain sobriety. All reported repeated relapses when continuing to engage or re-engage with pro-drug peers while attempting to change their behaviour. While the remaining 10 participants did not directly associate peers with any relapse, the in-depth nature of the interviews likely saw participants only report the relapses they considered significant to their journey. One participant recalled his choice to reconnect with a pro-drug friend and begin using drugs again, despite being drug-free for almost a year:

> *Brienne smoked smack all the time. So, then I just…as soon as I saw her, it was just…took me about three days before I was back into it. I'd been clean about…11 months. (Participant 1)*

A second participant explained that he relapsed several times—sometimes due to his continued association with pro-drug peers. Further, the quotation highlights his choice to allow drug-using peers into his home while he attempted to maintain a drug-free life:

> *Well a couple of times it was friends…come over I was clean for a week or so. And a friend would come over and he had… 'here have some of this'. Argh nah. Nah, can't do it. Ah okay. (Participant 4)*

The participant also reflected on his internal struggle to remain firm in his decision to not use drugs when they were offered to him by the pro-drug peers. Extensive research supports the finding that peer influence can present as a high-risk factor for individuals trying to maintain their new drug-free behaviour (Gonzales, Anglin, Beattie, Ong & Glik, 2012; Islam, Hashizume, Yamamoto, Alam & Rabbani, 2012; Herbeck et al., 2014; Hser, 2007; Ramo, Prince, Roesch & Brown, 2012). One participant who also described choosing to return to drug-

using behaviour by continuing to associate with pro-drug peers, provided insight into why he continued this behaviour:

There weren't too many people who were going to uni and trying to be successful who liked going out and smashing people and having a bad reputation. So, just the people I used to…know and associate with I suppose the drugs just came second nature. (Participant 2)

The participant perceived that drugs and drug use were linked to his choice of peer networks, fuelling a belief of segregation between himself and pro-social individuals. The separation felt by the participant was likely emulated by most of the other participants, particularly those who reported extensive dysfunctional experiences throughout childhood. It is unlikely that they witnessed any pro-social behaviours and would continue to seek out relatable behaviours. Previous research has indicated that drug users often find identity in associating with individuals who have comparable behaviours and similar experiences (Beaver, 2013; Haynie, 2002; Haynie, Giordano, Manning & Longmore, 2005). This finding was also evident here in the participants' reflections on their choice of romantic partners, which reflected similar behavioural patterns as reported within their dysfunctional families and pro-drug peers. This is illustrated by one participant's description of a romantic relationship that quickly increased his drug use to daily usage:

Within six weeks of being together that...you know that…weekly drinking and smoking…weekend pills turned to an everyday needle habit…Every day. Uh two or three times a day. (Participant 14)

As previously established, many participants were exposed to regular dysfunctional behaviours, including drug use, within the family structure. As a result, it is possible that the participants emulated similar dysfunctional behaviours within their own romantic relationships. Several studies described the influential role of romantic partnerships in drug use

and criminal behaviours (Aikins, Simon & Prinstein, 2010; Cui, Ueno, Fincham, Donnellan & Wickrama, 2012; Gudonis-Miller, Lewis, Tong, Tu & Aalsma, 2012). The participants likely met their partners through the pro-drug peers, suggesting that they would reflect similar behaviours to those of their family and peers and this, therefore, would enable participants to continue choosing to use drugs. This finding is reinforced by the admissions of eight participants who provided detailed accounts of their drug use and romantic involvement with other like-minded individuals. One participant described his decision to use drugs with his partner to escape:

> *You know, like I would have a bad day and then it would be an excuse to go get on and she'd have a bad day and it'd be an excuse for her to go get on. And so, we were just…fuelling each other. (Participant 3)*

Further, the participant's admission of his and his partner facilitating each other's drug use supports that participants choose to remain in a dysfunctional situation to continue their drug-using behaviours. Research shows that drug-using romantic relationships are a risk factor for continued drug use and/or criminal behaviours (Fleming, White, Oesterie, Haggerty & Catalano, 2010; Haynie et al., 2005; Nordfjærn, Hole & Rundmo, 2010; Schroeder, Giordano & Cernkovich, 2007). This finding was reaffirmed by the remaining seven participants, who all discussed their choice to be romantically involved with a pro-drug individual. As a result of their previous dysfunctional experiences in their home and peer networks, many participants saw themselves in relationships that reflected their lived experiences. One participant illustrated the consequences of choosing a romantic partner who was also trying to escape their own lived experiences:

> *You know what I mean and then we just went into this spiral of using together and…just, yeah, that's all we did. (Participant 2)*

Another participant described his conscious choice to return to drug use, which he had ceased, to seek out a romantic relationship.

I remember meeting this girl uhm…and seeing her a couple times and knowing she was on drugs, but I was clean… the only way I can really get close to this girl or…or to hang out with her…Is to bring the drugs into the picture and…And that's what happened. (Participant 14)

The participant's behaviour reinforces DiClemente's (2017) argument that if an individual is not be ready to let go of their drug user identity, they remain at risk of continually returning to the behaviour. This participant reported that his parents divorced when he was young and that he felt unwanted by both parents; therefore, his need for an emotional or physical connection saw him choose to return to his previous behaviours. While the remaining participants in this sub-sub-theme who discussed drug-using romantic relationships may not have experienced parental divorce, the dysfunctional experiences in their own family environments likely saw them also seek an emotional or physical connection with an individual regardless of the consequences.

Throughout this sub-sub-theme of Drug Use in relation to the sub-theme of participants recollection Peers, almost all the participants mentioned associating with pro-drug peers, who had also experienced dysfunctional childhoods. As explained by one participant, the choice to associate with like-minded individuals resulted from a perceived disassociation with pro-social individuals stemming from the participants' history and personality. This finding supports research that explores the connection between an individual's drug use and their choice of peers (Gonzales et al., 2012; Islam et al., 2012; Herbeck et al., 2014; Hser, 2007; Mason et al., 2014; Ramo et al., 2012). It is evident through this sub-sub-theme that participants' experiences within the family environment can have a significant influence on their choice of peers and, in turn, romantic partners (Aikins et al., 2010; Hemovich et al., 2011; Herbeck et al., 2014; Hser,

2007; Low et al., 2012). Displaying an overlap in the themes, the men in this project described three main explanations for the initiation and maintenance of drug use: a dysfunctional family, a traumatic event and an opportunity through peers and later romantic partners. Thus far in the theme of lived experiences, the sub-themes and sub-sub-themes have identified the effect of dysfunctional environments and an acceptance for particular behaviours on participants' continued drug use and criminal behaviours. Participants reported that drug use enabled them to escape those experiences.

4.4 Escapism

Escapism was the final sub-theme to emerge within the lived experiences of dysfunction. As each participant began to reflect on their rationale for using drugs and explain their life while on drugs, they described how drug use was used to escape from their lived experiences. During the semi-structured interviews, all 14 participants discussed escapism, illustrating significant weighting on their lived experiences. Initially, most participants engaged in drug use to escape these lived experiences. This saw them enter a cycle of continued drug use, as the drugs created psychological problems that the participants avoided by using more drugs. As a result, the sub-theme of Escapism is explored across two sub-sub-themes: Drug Use and Suicidal Thoughts.

4.4.1 Drug Use

Within the sub-theme of Escapism, the majority of participants frequently discussed their drug use as a coping mechanism which emerged as the initial sub-sub-theme. This was often preceded by reports of traumatic or emotionally charged situations that they were unable to otherwise process and they then used this to justify their drug use. One participant explained:

> *The main reason I used drugs was to block out my life. Block out my feelings. Block out…What's happening in my life and kind of just getting it out of my mind, so I didn't have to deal with it. (Participant 12)*

The participant describes seeking drugs to provide him with a psychological and emotional escape. Research into drug use has regularly identified that individuals who have traumatic or dysfunctional past experiences often display an inability to cope with the events in a psychologically healthy way, and thus, often turn to drug use (Estévez, Jáuregui, Sánchez-Marcos, López-González & Griffiths, 2017; Fagan et al., 2014; Holl et al., 2017; Logan-Greene, Tennyson, Nurius & Borja, 2017; Mandavia et al., 2016; Maschi et al., 2010; Medrano et al., 2002; Min et al., 2007; Narvaez et al., 2012; Nordjærn et al., 2010). For the minority of participants whose drug use was not instigated by childhood dysfunction or trauma, continued drug use was fuelled by a need to escape the negative emotions created by the drugs. A pattern of expressions emerged among all participants as they explained their justification for using drugs, such as to 'numb', improve or forget emotions.

> *And then that [drugs] helped me be depressed because it [drugs] just numbed everything. (Participant 10)*
>
> *Uhm…To feel better. I think…Just for that feeling really…to feel better. (Participant 7)*
>
> *Yeah to forget about life. Forget about mistakes I've made. (Participant 12)*

Nordjærn et al. (2010), suggested that males are more likely to utilise behavioural coping mechanisms, including drug use to manage the effects of negative events and subsequent emotions. It was apparent that participants used drugs to cope and to forget their lived experiences or their life choices. Significantly, in both areas, all participants used drugs to escape negative emotions (Holl et al., 2017). A focus of this factor may guide future efforts to address the issue of drug use. One participant described his conscious choice to return to drug use to cope with a break-up:

> *So, like…at that point I was like 'that's it, I'm just gonna go really hard and I'm gonna like I'm…Screw this I'm gonna do it'. You know what I mean. (Participant 5)*

Another used drugs to cope with the accumulative loss of employment and his intimate relationship.

>*When I lost me [sic] job it was like a second trigger. Me [sic] missus had already gone. (Participant 11)*

A further three participants described the death of a loved one and an inability to cope with the negative emotions in a psychologically healthy manner:

>*Yep, I didn't want to face the world. I just wanted to smash myself. (Participant 1)*

>*A lot of me died when he did, and I never dealt with it. (Participant 2)*

>*I remember at the funeral my friend goes 'ah I can't believe you didn't cry even at your dad's funeral'. I just learnt to shut off all my emotions. (Participant 9)*

Although the participants may have initially began using drugs to escape the negative emotions, it was evident that they depended on the drugs to escape all future negative events. One participant explained the breakdown of his relationship and choice to start using drugs again:

>*Ahh [that] led to me being asked to leave the house…within a week I was using again. Uh chasing that, that shot I wanted to have. (Participant 7)*

Many individuals in society could likely experience the events reported in this sub-sub-theme without resorting to drug use. However, the participants in this sample have extensive histories of dysfunction and trauma that initiated their drug use. During their experiences, they continued to engage with pro-drug and antisocial family and peers, which reinforced reliance on drug use as an acceptable response to future negative events (DeLisi et al., 2019; Low et al., 2012). In the absence of pro-social and positive support networks, either familial or peers, these participants did not learn to cope with negative emotions or situations without drugs (Barrett & Turner, 2006; Davey et al., 2007; Holl et al., 2017; Padykula & Conklin, 2010). One participant who had previously described dysfunction and drug use within his family

environment explained his understanding of using drugs for 'fun' to using drugs 'to numb the pain':

> *Instead of going out partying and doing drugs for fun, I'd do drugs to numb the pain…That was all it was. Was to numb the pain. To get me at a level I could actually operate at. Cause I was…that deep in it. Drugs weren't for fun…well sorta, I still had fun on 'em but it was more…a numbing agent. That's what I used to call it. So, I took meth to…smoked meth to numb myself. (Participant 4)*

During his lived experiences, this participant explained being introduced to drugs at a young age by his siblings. The pain he referenced is related to experiences of violence and drug abuse within his family environment, which is mirrored by many participants. Further, the participant explains his progression from using drugs for fun to a form of self-medication to cope with the events he experienced. This dependence on drug use to control emotions was reinforced by other participants who gave similar reports in the interviews. Another participant provided a similar explanation for his drug-taking behaviour:

> *Because you're so high you feel good. But as soon as you're not high, you got to take drugs to feel normal. (Participant 1)*

Throughout this sub-sub-theme, it is evident that the participants' continued drug use was an attempt to escape their lived experiences and negative emotions (Estévez et al., 2017; Fagan et al., 2014; Holl et al., 2017; Logan-Greene et al., 2017; Mandavia et al., 2016; Maschi et al., 2010; Min et al., 2007; Narvaez et al., 2012). One participant expressed an understanding of the different chemical reactions of each drug and explained his use of different drugs to elicit certain emotional responses:

> *I viewed drugs as feelings in a bag. So, it's like 'how do you want to feel today? Do you want to feel happy? Do you want to feel sad? Do you want to go to sleep? Do you wanna mix them together?'. (Participant 5)*

Within the quotation, the participant makes direct reference to the widely known effects of certain drugs, such as: taking marijuana to sleep, cocaine or heroin to feel happy or benzodiazepines when down. The same participant reported an acute understanding that drugs could control emotions, as he described selling people emotions as opposed to selling them drugs:

Yeah, but you could, you could control the way…people felt as well. The way I viewed it was like 'you wanna feel happy? I can sell you some happiness; you look real unhappy. (Participant 5)

The participant spoke of his intentions in his own drug use (and selling drugs to others) to provide an escape from negative emotions. It is likely that the insight into drug use and the reasons for ongoing drug use was enhanced by the reflective activities they had attended as part of the Shalom House rehabilitation programs. They also understood that their drug use had become a way to deal with future negative emotions due to minimal exposure to healthy coping mechanisms. They then described how while they used the drugs to escape, they then reached a point where they could not escape the drug, and that lead to feeling of depression and hopelessness.

4.4.2 Suicidal Thoughts

Suicidal thoughts emerged as a final sub-sub-theme within the sub-theme of Escapism, from the continued repetition of dysfunctional behaviours and for majority of participants, drug use became a means to escape negative events and emotions. However, most participants described experiencing depression and suicidal thoughts as consequences of continued drug use. The participants again reported managing these feelings in the same way discussed in previous sub-theme and sub-sub-theme: by continuing their drug use to escape to the reality of the situation.

So, I just isolated, just lots of drinking, lots of marijuana, lots of acid. Uhm, I'd only go

out to get that stuff. Just knocking back everyone who wants to hang out. Just not

interested. (Participant 6)

This participant reported a life marred by extreme dysfunction and abuse. Like many

participants, he described a pattern of increasing drug use to escape a dysfunctional life.

Depression and poor mental health are widely acknowledged consequences of regular drug use

(Garlow, Pursell & D'Orio, 2003; Hakansson, Bradvik, Schlyter & Berglund, 2010; Maloney,

Degenhardt, Darke, Mattick & Nelson, 2007; Timpson et al., 2016). Another participant

reflected on the way his personality changed by long-term drug use:

Still helped everyone out that I could. Still did whatever I could. I'd move people's

houses for 'em, hired the truck and everything. Well before that, but…in the end all that

stopped. I just stopped rocking up to peoples. And stopped helping people. Just…stayed

at home and hid from the world. (Participant 4)

Although the participants' peer networks consisted of pro-drug individuals, their

decision to isolate from all peers affected their mentality and fuelled negative thoughts, a lack

of self-worth and depression. This perpetuated the cycle of continuing their drug use to escape

the negative feelings of loneliness, low self-worth and suicidal thoughts. One participant

reflected on a time when he used drugs with his partner to escape:

I'll never forget the look in her eyes and I uh I'd loaded up another needle…and I gave

it to her and she…she just looked at me and she just said 'we're in…we're in a whole

heap of trouble here hey'. And I said 'yeah'…and then we had the shot, you know. Just

to forget. (Participant 14)

The participant's use of the word 'trouble' referenced a previous description of his

mental health as a result of their dysfunctional and violent lifestyle. This finding demonstrates

a transition from using to forget dysfunctional lived experiences, to escaping the situation

created by ongoing drug use. Subsequently, the combination of these behaviours and actions led to five participants reporting suicidal thoughts. The finding of deteriorating mental health causing suicidal thoughts was described by one participant as:

> *I can't live like this. I can't wake up here one more time. I can't do what I'm doing anymore. I can't live like this. I can't exist like this and I don't have the courage to kill myself and I just…I can't do it. (Participant 2)*

The quotation shows the mental torment of wanting the situation to end but the hopelessness of how that could be achieved. Research into the effects of drug use identified that mental health, depression, and suicidal thoughts and behaviours are high-risk factors for those with an addiction to drug use (Cottler, Campbell, Krishna, Cunningham-Williams & Abdallah, 2005; Garlow et al., 2003; Hakansson et al., 2010; Maloney et al., 2007). This is supported by reports from the majority of participants, who at some stages experienced depression and/or suicidal thoughts as a result of their drug use. Two participants stated:

> *I just wanted to end it all that day. I psyched myself up to…to end it. To do it. And I had a plan to do it. (Participant 10)*

> *And I hated myself and wanted to die along… I had a plan in my head; 'the moment she kicks me out I'm going to walk out on Westeros Highway'. (Participant 6)*

Participants shifted from using drugs to escape their lived experiences to wanting to escape the drug use. While all participants reported depression and hopelessness, they were not directly asked about suicidal thoughts. However, five participants explicitly discussed experiencing suicidal thoughts and two described a desire to end their life. This findings supports research of a link between extensive drug use and suicidal behaviour (Cottler et al., 2005; Garlow et al., 2003; Hakansson et al., 2010; López-Goñi, Fernández-Montalvo, Arteaga & Haro, 2019; Maloney et al., 2007; Timpson et al., 2016; Rossow and Lauritzen, 1999). One of the two participants described the event and anger he felt after surviving his attempt:

> *I tried to overdose. I took so many…so many drugs uhm…I woke up about 72 hours later…I remember waking up and…I remember sitting there and just thinking 'aww crap'. Ahh I was really pissed off that…that that didn't work…And just thinking…what are my options now, you know. (Participant 14)*

The second participant described the event in a similar manner; however, his response to the outcome was the opposite and he expressed anger towards himself for committing to the act:

> *Yeah, I was mess…I was mad at myself for trying to take my life. (Participant 7)*

Although both participants described contrasting emotional reactions to their suicide attempts, both reported the event as a catalyst for them to change their dysfunctional drug-using and criminal behaviour. Research by McIntosh and McKeganey (2001) and Best et al. (2011) explains that individuals are more likely to commit to change after realising the 'life or death' consequences of their drug use. This was illustrated by the participant who described his anger over surviving his suicide attempt. Following his report of the event, the participant provided an in-depth recollection of his thoughts afterwards and how he concluded to seek help:

> *I remember this thought come into my head: 'You got a real choice right now, right here…You got a choice'. And uhm…it was either dive headfirst into what I knew so well. I was really good at being a drug addict…Really, really good at it, you know. Uhm and end up dead…Cause that's where your gonna end up. Or ask for help, which is something I'd…I'd…I'd gone and got help myself, but I'd never reached out and said 'hey…Can you please…this is where I'm at, I can't do it'. (Participant 14)*

Other participants described seeking help for their mental health after 'coming to the end' of themselves which is consistent with the findings by McIntosh and McKeganey (2001) and Best et al. (2011). Further, Breda and Heflinger (2004) suggest that drug-using individuals who also

experience mental health issues—and would, therefore, have a greater need for treatment to change their behaviours—are the least likely to recognise the need for formal treatment.

Until now, those two participants were content to continue using their drug use to escape their negative emotions; however, once they experienced the 'life or death' consequences, they began to want to change. This shift in their mentality towards their drug use is reflective of the preparation stage within Prochaska and DiClemente's (1982) SOC model. The shift in mentality generally occurs following the individual understanding or experiencing the consequences of their behaviour—which is supported by the reports from most participants in this current study (Best et al., 2011; McIntosh & McKeganey, 2001; Prochaska & DiClemente, 1982).

In summary, the participants reported increasing their drug use to avoid negative emotions, such as depression. Subsequently, some participants reported having suicidal thoughts and taking action to end their lives. This finding adds to the body of literature demonstrating the increased risk that drug use and dysfunctional lived experiences have for depression and suicidal thoughts (Cottler et al., 2005; Garlow et al., 2003; Hakansson et al., 2010; López-Goñi et al., 2019; Maloney et al., 2007; Timpson et al., 2016; Rossow and Lauritzen, 1999).

This theme on the lived experiences of dysfunction explored participants' backgrounds and significant events during their childhoods and thus, answered the first research question to understand participants' lived experiences. The sub-themes of Family, Peers and Escapism explored different areas of dysfunction in the participants' lived experiences. Within each sub-theme, the overarching theme of dysfunction was evident in the participants' repeated exposure to abnormal and unhealthy interactions. The initial sub-theme of Family saw the majority of participants describing their experiences with dysfunctional behaviours during childhood through frequent reports of violence and abuse and in some cases drug use, in the home

environment. In addition, the sub-theme of Family highlighted participants' exposure to criminal behaviours from family members during childhood; allowing participants to develop a perception of normalisation or acceptability towards these behaviours. In the second sub-theme of Peers, participants explained how early experiences with dysfunction led them to associate with friends and romantic partners who reflected similar upbringings and attitudes to drug taking behaviours. It was evident that many participants' choice of pro-drug peers stemmed from their perceived separation from pro-social groups. As a result of their lived experiences, the participants felt comfortable associating with violent, drug-using individuals. The sub-theme of Escapism emerged as participants described taking drugs to forget their lived experiences and negative emotions. Subsequently, all participants described increasing their drug use to avoid the consequences of drug use, including suicidal thoughts. The combination of dysfunctional lived experiences reported by participants through the three sub-themes increased their likelihood of being involved in future drug use and criminal behaviours.

Chapter 5: Drug Users' Perceptions of the Link Between Drug Use and Criminal Behaviours

5.1 Embodying Dysfunction

Embodying dysfunction emerged as a second theme as participants discussed their drug use during adulthood. As the participants spoke of their ongoing and increasing drug use into adulthood. Participants also reported more reckless and dysfunctional behaviours, including involvement in criminal activities as opposed to experiencing criminal behaviours as described the previous theme. This theme of Embodying Dysfunction answers the second research question, as participants provided in-depth reports of the associations between their drug use and subsequent criminal behaviours. Three sub-themes arose: Escalating Drug Use, the Workplace and Crime, as presented in Figure 5.
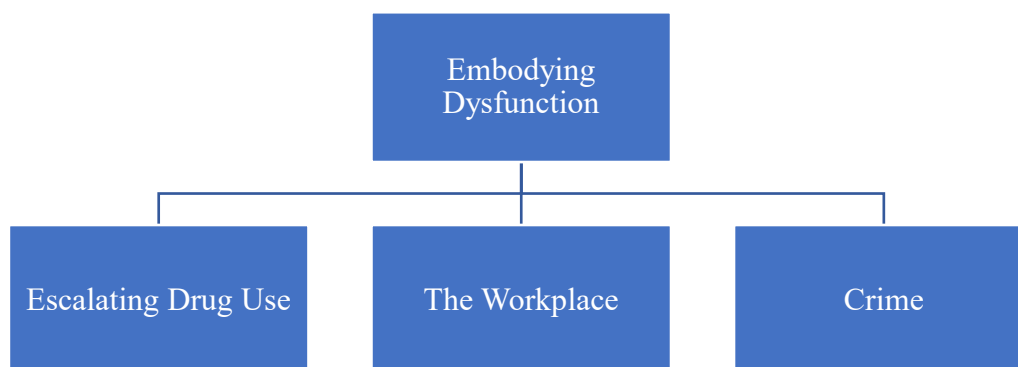
Figure 5. Theme and Sub-themes of Embodying Dysfunction.

The reckless behaviour described by participants is reflective of them embodying the dysfunction with which they were familiar. This is illustrated by a participant, who describes the reckless and offending behaviour he engaged in because of the drug use:

I was doing dumb stuff like when I was on Xanax and stuff 'cause you have no thought

process or anything so I'd…walk across the freeway and…hop people's fences. Me and

my mate would just raid people's backyards…Like, we'd go through people's bar

fridges, through their sheds and because you're on Xanax you got all this confidence

and no thought process, so you just do whatever. (Participant 10)

Throughout the theme of embodying dysfunction, participants' experiences, as discussed in chapter 4, impacted their behaviours later in life whereby drug use and crime were a common theme. Each of the sub-themes will be explored separately and relevant literature and participant responses will be used to highlight important sub-themes.

5.1.1 Escalating Drug Use

The first sub-theme to emerge was Escalating Drug Use. During the semi-structured interviews, participants were asked what sort of person they perceived themselves to be at the height of their drug use and criminal behaviours. In response to this question, all participants described a person who had no concern for the consequences of their behaviour and an over-confidence in breaking the law. This was highlighted by participants who reported a lack of concern towards their reckless behaviour to ensure they could continue their drug use:

No two ways about it. I was doing everything against the law. Didn't matter; I wanted

my drugs and I didn't give a crap about anyone else. (Participant 1)

I literally could not have cared if I'd have got in a head on, if I'd of…died, if I'd of gone

to jail. I did not…there was nothing…That was gonna stop me from getting my next hit.

(Participant 2)

The participant reported knowing that his behaviours were criminal, but he prioritised drugs over the potential consequences of his actions. This dysfunctional attitude towards the consequences of drug use and obtaining more drugs was reflected by all participants. All reported similar behaviours and an awareness that their actions were illegal.

The participants reckless behaviours, can partly be attributed to the side-effects of the illicit drugs they consumed but can also be explained by their previous experiences. The

majority of participants reported 'having to grow up early' and believed they did not have 'carefree childhoods' due to their dysfunctional lived experiences. As previously discussed they then attributed their drug use as a way to escape the negative emotions and experiences (Estévez et al., 2017; Fagan et al., 2014; Holl et al., 2017; Kofler-Westergren et al., 2010; Mandavia et al., 2016; Nordfjaern et al., 2010; Segura-García et al., 2016; Snyder et al., 2005). Not only did drug use provide participants with an escape from their reality, but for a short time, it also enabled them to live that carefree lifestyle during adulthood. However, as drug use escalated so too did risky and offending behaviours.

> *I started to rob uhm a lot of people. I guess I probably shouldn't of robbed. I guess, well you shouldn't really rob anyone but uhm…I sorta started getting a rush and a high off robbing people that…Had a bad reputation so…Yeah, there was a real thrill in it. (Participant 8)*

> *I swapped one of my cars for a…stolen motorcycle just so I could ride it round try get in police chases. And I ended up crashing it and like almost dying, which was really intense. (Participant 5)*

The offending behaviour described by the participants is consistent with research which has found a link between reckless behaviours and drug use (Bennett et al., 2008; Boles & Miotto, 2003; Rossow & Lauritzen, 1999; Seffrin & Domahidi, 2014). Despite the participants' awareness of the illegality of their behaviours, their dysfunctional mentality extended to their disregard of the potential consequences, including imprisonment. Two participants reported being arrested and attending court for drug-related offences. One participant described being arrested for possession of an illegal substance and the minimal consequences imposed by the judge for his actions:

Uh I ahh I got caught…uhm once…ah years ago in Braavos. Had a half-weight on me

and caught me, did me for possession and nothing. So, I wasn't really phased. It was

just a fine. (Participant 4)

The second participant reported going to court for the first time when he entered rehabilitation,

and the shame he felt at being charged with what he considered to be a 'small' amount of drugs:

I've never been charged for heroin before in my life. I always got away with everything.

And the tiniest little bit, it was so embarrassing to go to court over it. But Shalom made

me go, I couldn't do it… It was so embarrassing, the amount of drugs I've…and to be

caught with tha-…it was like a match head. And they charged me for it! (Participant 1)

The participant expressed disbelief as he had never been apprehended for any of his

prior drug possession or criminal offences. This illustrates his awareness that his behaviours

were criminal and supports the finding of participants embodying dysfunction by displaying

reckless behaviour with no concern for the consequences. Brezina and Topalli (2012) and Fader

(2016) also suggested that individuals who display criminal behaviours rarely express a desire

to stop their criminal behaviours when facing arrest or charges. Previous studies reported that

drug use can result in the user feeling over-confident, which can evolve into reckless, life-

threatening and criminal behaviours (Boles & Miotto, 2003; Brezina & Topalli, 2012; Fader,

2016; Rossow & Lauritzen, 1999). One participant provided an in-depth explanation for his

mentality towards his reckless behaviour and the consequences:

It's gonna end in you're either going to jail so…that was my justification to sell and

have…mass amounts of drugs on me 'cause I was like if I'm going to get caught I'm

gonna get caught for…doing something good like if…my mentality was if you're gonna

catch me I wanna be…uhm I'm taking you with me, like. If I'm going to jail, I'm not go

sit in jail and say 'aww I got caught for having a bit of gear'. I wanna be in jail for

doing something decent, like. (Participant 2)

The participant reported a disregard for the law and consequences of his drug use and instead, stated that he wanted his behaviours to warrant a serious criminal offence or 'something decent'. He explained in the interview that this was at the height of his drug use escalation.

Goldstein's (1985) drug–crime nexus can explain these repeated participant expressions of increased reckless and acceptance of criminal behaviour. The participants reported an acceptance of doing 'whatever it took' to get their drugs; criminal consequences provided no deterrent, which supports Goldstein's economic compulsive and psychopharmacological models (Bennett & Holloway, 2009; Boles & Miotto, 2003; Degenhardt et al., 2017; Goldstein, 1985; McKetin et al., 2014). Significantly, the above participant acknowledged that his mentality towards the situation was 'not healthy'.

> *If I'm gonna be in jail I…it needs to be worthwhile and…that mentality is not healthy,*
> *you know what I mean? (Participant 2)*

The continued long-term drug use reported by participants affected their perceptions of the consequences of their actions, particularly those regarding the police and other criminal justice agencies. Despite many participants describing an eclectic range of reckless and illegal behaviours as a result of their drug use, they had minimal contact with the justice system. As a result, participants explained a lack of respect for the police and justice system and that escalating drug use promoted their reckless behaviour and disregard for the consequences (Brezina & Topalli, 2012; Fader, 2016; Rossow & Lauritzen, 1999). This was illustrated by one participant who explained his pride in what he perceived to be his ability to outsmart the police.

> *But coppers aren't that smart. They eventually work it out. But they're always behind*
> *the criminal 'cos the criminal's gotta work out ways to get past them. So, the coppers*
> *are always playing catch-up to the new ideas that criminals are doing. (Participant 1)*

As the participants continued to embody dysfunction through their reckless mentality, continued drug use and disregard for the consequences, they justified and accepted their criminal behaviours. Ongoing drug use has been identified to not only increase but also fuel high-risk behaviours such as engaging in criminal acts (Bennett & Holloway, 2009; Bennett et al., 2008; Goldstein, 1985; Kopak & Hoffmann, 2014). Many participants who reported a dysfunctional lived experience (which involved exposure to violence and criminal behaviours) were already predisposed to accepting and participating in criminal behaviours (Besemer & Farrington, 2012; Farrell & Zimmerman, 2017; Farrington et al., 2009; Ford et al., 2010; Fuller-Thomson et al., 2016; Howard et al., 2012; Kliewer et al., 2006; Nofziger & Kurtz, 2005). The remaining participants were likely influenced by what Goldstein (1985) describes as the systemic model, as their drug use continued and increased. The findings in this sub-theme of Escalating Drug Use, guide the remaining section. The participants also reported the same reckless and dysfunctional mentality present in other areas of their lives, including the workplace.

5.1.2 The Workplace

During the semi-structured interviews, it became apparent that the participants' reckless behaviour was also evident in their workplace. Nine participants reported still maintaining employment despite their drug use. Each described how their ability to work minimised their acknowledgement of the extent of their drug use problem.

I was working but I was still using drugs and stuff. I was just managing it. (Participant 9)

Doing drugs but able to make work every week. (Participant 14)

Yeah so then I continued doing that…always working. Always a weekend warrior, sorta thing. (Participant 12)

The participants' firm belief in their drug use being acceptable if they maintained employment illustrates the level of their dysfunctional thinking. While describing their drug use and work, they acknowledged that at that time, they did not consider the consequences of their behaviour, such as: workplace accidents, commuting under the influence of an illicit substance or loss of employment. The participants were unlikely to consider these consequences while they maintained their drug use, as the drugs continued to increase their confidence (Hiller et al., 2002; Marko, 1999; McConnaughy et al., 1989; Prochaska & DiClemente, 1982; Prochaska et al., 1992). One participant was a self-employed business owner and described using the business to fund his increasing drug use:

> *Started smoking to try and stop doing so many…so much drugs. But I just did more and more of both. Uhm...I was paying myself three and half grand a week just so I could support my habit. (Participant 4)*

According to this participant, he was introduced to drugs at a young age by his siblings and was consistently exposed to regular drug use. He believed this led to him syphon money from his business account directly to fund his drug use. Nine participants reported prioritising their drug use over the consequences of being under the influence of drugs at work, which illustrates their dysfunctional thought patterns. Additionally, by stealing from the business to fund his drug use, this participant supports the theory of Goldstein's (1985) economic compulsive model of the drugs/crime nexus.

Previous research into employment suggested that it is a strong protective factor for individuals to cease their drug use (Best et al., 2013; McKeganey & McIntosh, 2000). Employment is widely known to provide routine and stability for those trying to recover from drug-using behaviours (Best et al., 2013; Iveson-Brown & Raistrick 2016; McKeganey & McIntosh, 2000; Thurgood et al., 2014). However, the participants in this sample reported that while employment had not initiated their drug use, it enabled them to continue funding use. Six

participants described being employed within the mining industry and stated that it served as a catalyst to increase their drug use. WA is largely a mining focused state and continues to be "one of the world's top contributors to the global commodity market" (Department of Mines and Petroleum [DMP], 2019 p.4). Mining is a major source of income for WA and employment in the industry has increased from 75,000 in 2009, to an average of 128,352 during 2018-2019 (DMP, 2019): equating to almost 5% of the states, then, population (ABS, 2020). Employees within the mining industry have consistently received the highest average weekly earnings since 2012 (ABS, 2013). With mining employees in 2019 again earning the highest average weekly earnings of $2,616.90, in comparison to the minimum average weekly earnings of $1,179.20 (ABS, 2020b). One participant described his drug use while on an average wage and subsequent employment offshore with almost triple the wage:

> *I managed to get a job working offshore and so I'd gone from maybe 40–50 grand at the most…Here in [mine site] with a serious habit. To…straight up 130 grand…a year. (Participant 14)*

At this stage the participants had not discussed seeking help for their drug use and therefore, employment in the mining sector facilitated their drug use. However, these nine participants did not attribute their drug use to the mining industry. Rather, the increased income allowed them to use larger amounts more often. Some indicated drug use on site, while others only while on leave. One participant explained:

> *I ended up in the mines working uh…fly in fly out…Uhm that was good for the fact that I'd…when I was working for the two weeks on say I wouldn't use…drugs in that time. But...then when I got back…I was home for six…six and a half days…I wouldn't even blink six times…Let alone sleep. (Participant 12)*

The increased finances prevented stealing or other financially motivated criminal behaviours to fund their drug use, as suggested by research (Bennett & Holloway, 2009; Boles

& Miotto, 2003; Goldstein, 1985). The mining sector, amongst other work places, has an obligation to provide a safe working environment and ensure that employees are not working under the influence (Commission for Occupational Safety and Health, 2008), as a result many companies conduct regular drug and alcohol testing (BHP, n.d; Fortescue Metals Group Limited, n.d; Woodside Petroleum Limited, n.d). Although this recent preventative measure acts as a deterrent for drug users, two participants reported working in the mining industry when regulations were less stringent. One participant described less strict procedures and his ability to manipulate the drug tests, which allowed him to work with drugs still in his system.

You could always buy urine or get somebody to fake it. Back in the, back when I first started, it wasn't…the testing wasn't as strict and…By the time strict testing did come in I was high enough up in the level that I could dodge it or I knew there was urine testing coming. (Participant 11)

The second participant explained being able to completely skip the drug tests, as the management team were also drug users.

I didn't get em [urine drug tests] when I used to go up…Because I had the…the supervisors and everyone was in my pocket doing the same thing. (Participant 12)

Both participants expressed their ability to manipulate measures to continue their drug use. Two participants reflected that they were aware that their employers (the mining company) would have supported them to seek treatment for their drug use, including funding the treatment or allowing them to retain their jobs until they completed the treatment. One of the participants, who had previously discussed manipulating the urine tests, reported that his employer became suspicious of his behaviour and he was unaware of a random drug test. The participant described failing the test for a second time and maintaining to his employer that he did not have a drug use problem:

They got me the second time and the second time round they offered me as much time off work as I needed. Eh…honestly, the second time round if I'd of known about Shalom the second time round they would have paid for me to come here. They would have given me the whole-time off work; they would have…taken me back in [a] heartbeat. But the second time round, I still flat out refused to them that I had a problem. (Participant 11)

Following this admission, the participant described failing a third drug test, which subsequently saw him lose his employment. A similar progression of events was reported by the second participant, and his description included a similar response from the mining company. Despite the participants' reports of the understanding and willingness of their employers to support them through their drug addiction, neither could admit that they had a problem. The participants' denial of their drug-use issues extends beyond ceasing a recreational drug used for fun. Again it was consistent throughout the findings, that the participants viewed drug use as acceptable with all participants reporting dependence on drugs to cope with their dysfunctional lived experiences or negative emotions (Estévez et al., 2017; Fagan et al., 2014; Holl et al., 2017; Logan-Greene et al., 2017; Mandavia et al., 2016; Maschi et al., 2010; Medrano et al., 2002; Min et al., 2007; Narvaez et al., 2012; Nordjærn et al., 2010). While the participants were not concerned about the consequences of their behaviours, they were also still trying to escape the emotions and events that led many of them to begin using drugs. This mentality of a drug user is explained by Prochaska and DiClemente's (1982) pre-contemplation stage of the SOC model, which outlines an individual's inability to change or cease their behaviours if they cannot see the consequences. As the participants continued to embody a dysfunctional mentality towards their actions and their drug use, and reckless behaviour continued to escalate, the progression of events saw many participants reporting involvement in criminal activity.

5.1.3 Crime

As the participants continued to report their escalating drug use and reckless behaviour and how it emerged in different areas of their life, they began to discuss crime and criminal behaviours. This saw a final sub-theme of Crime emerge within the theme of Embodying Dysfunction. Several authors acknowledged that involvement in crime is an expected consequence for drug users (Bennett & Holloway, 2009; Bennett et al., 2008; Boles & Miotto, 2003; De Li et al., 2000; Fader, 2016; Goldstein, 1985; Menard & Mihalic, 2001; Riordan, 2017; Seffrin & Domahidi, 2014). These criminal behaviours can range from purchasing an illegal drug, a criminal offence within Australia (*Misuse of Drugs Act 1981* (WA)), to more violent and serious offences (*Criminal Code Compilation Act 1913* (WA)). The participants' experiences with crime and criminal behaviours stemmed from a combination of their continued drug use, lack of concern for consequences for themselves and others, and association with antisocial peers. One participant described that his criminal behaviours only began once he started to associate with antisocial individuals:

> *So, this is when I started hanging around, like, a shady bunch of people, started doing crimes. (Participant 8)*

Significantly, the participants did not identify behaviours such as the purchasing of drugs or driving under the influence as criminal offences. Therefore, the participants identified their involvement with criminal offences as beginning when they met specific peers or at a later stage of their drug use. Throughout the interviews, the majority of participants discussed their 'lifestyle' when speaking about criminal behaviours prompted by the drug use. Two quotations illustrate the broad nature of the term when used by participants. The first quote is from an older participant whose use of the term 'lifestyle' embodies a range of negative connotations to describe how he lived and behaved:

That whole lifestyle just started again. Clubs. Pubs. Drugs. Lies. Manipulation. Fear.

Violence. (Participant 13)

The second quote is from a younger participant, who applied a positive connotation to his use of the term:

And with the drugs came money and came girls and…I'd say it was a relatively fun

lifestyle. (Participant 5)

Despite being significantly different uses of the term 'lifestyle', both reflect examples of how the participants embodied dysfunction. The participants' described their former lives as turbulent, unhealthy and abnormal—and that hindsight and their time at Shalom House had allowed them to recognise that. Significantly, the older participants consistently reflected on these experiences with a negative perception and while their younger counterparts described it as 'fun', they knew it was not sustainable. The contrast between the younger and older participants is explained by the different length of time spent in the systemic drug world, described by Goldstein (1985). The systemic model theorises that criminal behaviours and violence occur as a result of exposure to drug markets and culture (Goldstein, 1985). The older participants experienced greater exposure to the negative consequences of extended drug use over their lives and may have found it more difficult to break the cycle of drug use and criminal behaviour than the younger participants, who had a shorter exposure time (Hser, 2007; Nordfjærn, 2011). As the interviews progressed, the participants viewed their lifestyle, drug use and criminal behaviours as a repetitive cycle in which they lived. This is illustrated by the following participant, who explained how his escalating drug use and criminal behaviours became his entire life:

You know, it got to the point alright you're doing meth every day at work. Your smoking

it…in the…at lunch times so you can get through lunch time and then you're going out

all night and your selling to people. (Participant 5)

It was reasonable to expect that participants would report involvement with criminal behaviours during their drug use (e.g., driving under the influence or selling drugs) (ABS, 2019a; Bennett & Holloway, 2009; Bennett et al., 2008; Goldstein,1985; Kopak & Hoffmann, 2014). However, participants clearly articulated their perception of a link between their drug use and subsequent criminal behaviours

> *It was amphetamines and…that just from that I was 14…a year later I was in jail for…armed robbery. (Participant 9)*

This quotation highlights how this participant's lived experiences as a child directly affected his future behaviour. The link between drug use and crime has also been extensively explored, consistently finding criminal behaviour among drug users (Bennett & Holloway, 2009; Bennett & Holloway, 2005; De Li et al., 2000; Phillips, 2010; Seffrin & Domahidi, 2014). Two participants described their decision to increase their involvement in the systemic drug culture. The first participant described enjoying the financial benefits from selling drugs and his determination to continue pursuing that direction:

> *And I was making a fair amount of money and I had my own space and I could do what I wanted…I started to do what I wanted. And what I wanted to do was sell drugs. So…I perused that relentlessly. (Participant 5)*

The second participant made a similar admission and explained that his decision to increase his involvement in the criminal world was to obtain better quality drugs:

> *Aww because of the drugs, because I wanted the better drugs. I was hanging out with people…To be deeper…And deeper. (Participant 1)*

Another participant explained that he enjoyed the drug use and the lifestyle:

> *I enjoyed taking the drugs, I enjoyed the notoriety, I enjoyed the cash, the bum bags, the beamers, the gold chains, the women it…it was all attractive to me. (Participant 13)*

This participant previously described that he was introduced to this criminal lifestyle as a child. The introduction of these criminal behaviours to the participant at an early age increased the likelihood that he would perceive them as acceptable and emulate them in the future (Barrett & Turner, 2006; DeLisi et al., 2019; Fagan et al., 2011; Hemovich et al., 2011; Ledoux et al., 2002; Menard & Mihalic, 2001; Segura-García et al., 2016; Trudeau et al., 2012). This finding highlights the significant influential role of participants' lived experiences in their behaviours in adulthood. Further, during this part of the interview, one of the younger participants in the sample justified his involvement in the Perth criminal drug culture:

> *I had gotten into [dealing] the hundreds of the stuff [pills] before but not like…not at this cheap price [bulk price]. You know, you'd broken through and you're now getting [into drug trafficking level]. You can actually really make money off this. (Participant 5)*

Previously, this participant described his lack of identity during his adolescence years and spoke of his desire to create an identity which he found in the drug culture, a finding supported by research (Beaver, 2013; Haynie, 2002; Haynie et al., 2005). The criminal drug world provided participants with an additional means to escape their experiences with dysfunction and continued to escalate their drug use. Subsequently, as participants remained in contact with antisocial individuals and their drug use continued, the combination resulted in an increase in reckless and criminal behaviours. One participant discussed the escalation of his criminal behaviour to more serious offences:

> *I got uhm charged with…weapons, possession of drugs and three times over the limit, twice in one night…got locked up…then came back, got even more high, had another drink, took another car…And got done…the same time and that made the news. (Participant 14)*

The participant reported committing a series of criminal offences and, due to circumstances he was hesitant to discuss, being released from lock-up to then repeat the same behaviour later that night. Seffrin and Domahidi (2014) previously suggested that due to social networks and activities, drug-using and drug-dealing individuals are at an increased risk of escalating into violent and illegal behaviours, supporting Goldstein's (1985) tripartite conceptual framework. One participant reported that no action or offence was too extreme for him to commit if it came between him and the drugs.

> *I'm gonna run girls. I'm gonna run guns. I'm gonna run drugs. I'm gonna…walk through 20 cops with…couple of ounces of smack on me to get to the other side to sell it so I can get my share. No, I'll just get through that 20 police some, one way or another…I'll get through them to get the end result. (Participant 1)*

While the participants expressed a determined mentality to continue pursuing their drug use, slowly they began to express an awareness of the consequences. However, initially this awareness did not evolve into action to change their behaviour, as illustrated by two participants.

> *I knew what I was doing wasn't right and I was screwing myself over. But I continued it cause by like this point I had like six cars. I had…another girl…and we're having fun selling drugs. (Participant 5)*

Although the participant recognised that his behaviour held consequences, he maintained that the positives of his drug use still outweighed the negative consequences.

Extensive research into the intergenerational impact of family members' drug use or involvement in criminal behaviour suggests a strong likelihood of children replicating these behaviours (Beaver, 2013; Besemer & Farrington, 2012; DeLisi et al., 2019; Farrington et al., 2009; Hjalmarsson & Lindquist, 2012). Evidently, for many participants, the dysfunctional family environments they experienced had affected their future involvement in criminal

behaviours. However, Cuomo et al. (2008) and Kopak and Hoffmann (2014) identified that drug users have an increased risk of having a criminal history and often have multiple convictions and incarcerations. Within the sub-section of crime some participants revealed an in-depth understanding of the link between their drug use and their criminal activities. However, others did not acknowledge drug taking, dealing or driving as criminal activities in this stage. Given the participants' repeated accounts of having no concern for the consequences of their reckless behaviours at the time, their reflective responses may stem from content taught to them at Shalom House.

The initial sub-theme of Escalating Drug Use saw participants describe how they increased or continued their drug use and their dysfunctional mentality towards ensuring they could continue this behaviour. The participants in this sub-theme reported a primary goal of consistently obtaining more drugs and having no concern for the consequences of their actions. For many participants, their behaviours were reflective of their violent and dysfunctional lived experiences. Furthermore, they were able to deny drug use issues by citing their ability to maintain employment. Participants reported that even when their continued drug use resulted in the termination of employment, at that time, they would still not admit that their drug use was problematic. In the final sub-theme of Crime, participants explained how their drug use resulted in a variety of criminal behaviours. Within this sub-theme, participants referred to a range of factors, including their involvement with the systemic drug culture and the intergenerational effect of criminal activity. After discussing the chaotic and turbulent lives lived as a result of their escalating drug use and subsequent criminal behaviours, the participants began to describe a desire to escape the dysfunctional cycle.

Chapter 6: Insights of Residents at Shalom House

6.1 Escaping Dysfunction

The final theme within the findings and interpretations considers the participants'
descriptions of wanting to cease drug use. Participants reflected on their recovery journey and
future. This section answers the third and final research question as participants' insights into
their rehabilitation are explored. As the participants reflected upon their time at Shalom House
and their futures, four sub-themes emerged: Self-hatred, Recovery, Spirituality and Purpose in
Life (see Figure 6).
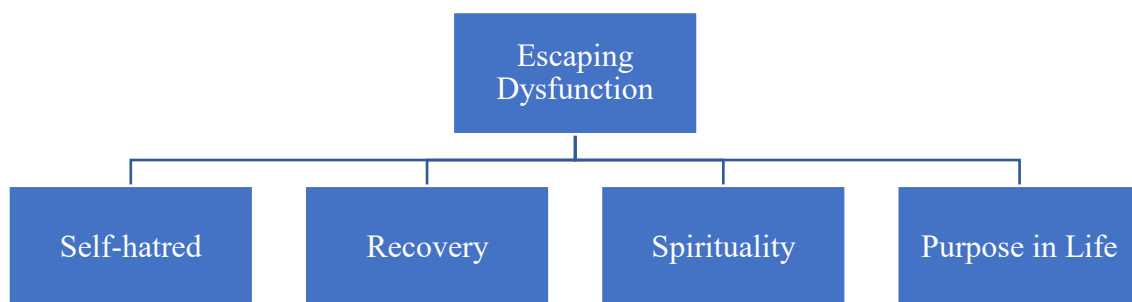
Figure 6. Theme and Sub-themes of Escaping Dysfunction.

Each of the sub-themes explores participants' different perspectives of their journey to
recovery and their new direction for the future. For most the journey had been turbulent, but
all participants reported a determination to escape the cycle of dysfunction and not return:

> *Yeah it's just hopeful like I've got a hope now. Like I know that wherever I end up, no*
>
> *matter where it is, it's not gonna be a bad place anymore. (Participant 5)*

The evidence of participants having learned from their actions and experiences was
apparent throughout this theme. At times, participants described an ingrained fear of returning
to old behaviours. They had through their time in rehabilitation been on a journey of self-

reflection and acknowledging behaviours they had displayed during their drug use. This led to confronting their past lifestyles and the resulting shame and disgust they felt.

6.1.1 Self-hatred

The first sub-theme to emerge within the theme of escaping dysfunction was Self-hatred. Participants regularly used negative terminology to describe their previous personality traits and behaviours. There was unanimous agreement among participants that they despised the person they were before attending Shalom House, and they referred to themselves in these terms:

> *I was really bad. I used to stand over people I pretty…I was a really horrible person. (Participant 9)*

Research suggest that drug-using individuals utilise hindsight to identify socially unacceptable behaviours (Best et al., 2011; Mackintosh & Knight, 2012; McIntosh & McKeganey, 2001). As the majority of participants grew up in dysfunctional environments, they often learned that violence and drug use were acceptable and normal behaviours. Therefore, by applying hindsight to their past behaviours, the participants could examine and understand what was unacceptable with their actions. The reflective comments were possibly gained at Shalom House from participation in the recovery programs. The participants acknowledged that their previous behaviours were negative and unacceptable.

> *I didn't want to stop at all [drug use]. I just wanted to do what I wanted to do 'cause I was a selfish pig. I gave a crap about myself and nobody else. (Participant 1)*

The perception of being selfish or displaying selfish behaviours was a recurring pattern that arose frequently in most participants' recollections of their previous self. Best et al. (2011) and McIntosh and McKeganey (2001) found similar results and identified that recovered or recovering drug users often report displaying selfish behaviours during their drug-using period.

The drugs take you to a place where you got nothing, no morals, nothing. No integrity,

you don't care. All you care about's the drug. Your next hit. (Participant 1)

The concept of drug use altering an individual's behaviour is well established; it is widely accepted that different drugs can have a variety of psychological side-effects. Goldstein's (1985) tripartite conceptual framework includes a psychopharmacological model, suggesting that individuals can display irrational, excitable and sometimes violent behaviours due to drug use. Another participant explained how his methamphetamine use amplified his selfish behaviours:

I was selfish uhm at times: mean, awful…uhm no concerns other than my own concerns.

I was just a selfish guy at the time. Especially when I was on the meth. And as soon as

I would have it I would just…it'd be me, my path, what I'm doing. (Participant 7)

The participants' ability to reflect on past behaviour and identify the specific traits they demonstrated while under the influence of a drug was likely facilitated during their recovery program at Shalom House. Notably, during the initial sections of the findings and interpretations, the participants frequently reported that they used drugs to forget or escape their lived experiences or negative emotions. As in their previous accounts of wanting to escape the dysfunctional life they had created, most participants stated that they no longer liked who they were and the drugs were not fixing this. One participant described the person he became while using large doses of prescription medication and alcohol to sleep:

And then just black out, that's how I could sleep. I couldn't sleep. I couldn't live with

myself anymore. (Participant 6)

This revelation of participants' feelings of disgust and revulsion towards their past actions and drug-oriented lifestyles is supported by findings from McIntosh and McKeganey (2001). Additionally, the participants' dislike of themselves and their behaviours reflects how they first began to perceive the consequences of their drug use. Indeed, recognising the

consequences of drug use is part of the first preparation stage in Prochaska and DiClemente's (1982) SOC; this suggests that the participants were becoming receptive to changing their behaviours. Another participant explained that his addictions were a means to cope with his behaviours and the hurt he had caused through violent offending:

> *It's not normal to hurt [assault and break and enter] people. So, the more I hurt people and did wrong by people, which that whole lifestyle is. I need to take more of these addictions uhm shopping addiction, drug addiction, alcohol, women, partying uhm. Just the whole lifestyle…That criminal lifestyle. (Participant 9)*

In this quotation, the participant demonstrates his perception that his 'criminal lifestyle' consisted only of violent behaviours—and his drug use and other addictions allowed him to cope with the consequences of remaining in that lifestyle. This participant's perception, in addition the previous ones above, demonstrates that while drug use may have initially encouraged their violent behaviour. the drugs became a mechanism to cope with their negative past and the person they had become. Participants' accounts of the relationship between their drug use and violent behaviour identifies an additional characteristic in Goldstein's (1985) drugs–crime nexus. The three-part model currently ceases at systemic violence; whereby individuals become more involved in crime due to the drug culture. However, this study revealed that the participants committed violent crimes, then used drugs to cope with their actions. Further, this study has identified a gap in current research in that the relationship between drugs and crime post Goldstein's (1985) systemic violence model has not yet been explored.

Throughout this section, the participants' reflections on their dysfunctional behaviours have held an undertone of self-hatred. That same tone was evident as many participants discussed recognising the unhealthy behavioural 'cycle' that saw them continuing to repeat the same pattern.

[I] Had a really good job but I would just kept getting back on the gear. Caught back up with my ex-girlfriend and…just made a mess of it again…Kept on sleeping, the same cycle, the same crap. (Participant 4)

… there were three main cycles. So, meth goes away, meth comes back, meth goes away, meth comes back…And every time it comes back, it comes back worse. (Participant 5)

The participants described their struggles with this 'cycle' of behaviours or drug use in a similar manner to Prochaska and DiClemente's (1982) maintenance and relapse stages from the SOC model. Further, studies have suggested that it may be difficult for individuals attempting to cease their drug use and remove themselves from the systemic drug culture because they often create an identity and attachment within that world (Campbell & Hansen, 2012; Mackintosh & Knight, 2012; McKeganey & McIntosh, 2000). One participant highlighted his awareness of the consequences of drug use on families within society and his hatred towards himself for funding the drug industry:

'Cos drugs in society is just…it's disgusting. Really. And it's really…it's tearing up families; it's killing people…it's crap and even handing over money for something like that…To kind of…help that kind of industry yeah…it wasn't it wasn't a real good feeling at all. (Participant 12)

Prior to this theme, the participants made minimal acknowledgement of a need to change their behaviour; they were reportedly content to remain in their dysfunctional lifestyle. This identifies the significance of an individual's lived experiences in their future behaviour, particularly if that individual is exposed to violence and drug use (Banducci et al., 2014; Farrell & Zimmerman, 2017; Fuller-Thomson et al., 2016; Holl et al., 2017; Mandavia et al., 2016; Min et al., 2007; Taplin et al., 2014). The participants' motivation to change their behaviour began to emerge as they recognised the consequences of their behaviour and hatred towards the person they had become. Notably, regardless of whether their awareness of the repetitive

cycle of drug use may have emerged from therapy at Shalom House; this hindsight of their actions further motivated participants to escape the dysfunction they had embodied. As the participants entered Shalom House and began escaping the dysfunctional cycle of behaviour, they acknowledged the fragility of their journeys.

6.1.2 Recovery: 'One Step from Destruction'

Within the overarching theme of escaping dysfunction, a second sub-theme emerged concerning Recovery. This sub-theme arose organically towards the end of the interviews, as participants reflected on their journey and time at Shalom House. Many participants described being conscious of their changed behaviour and the risk of relapsing in their recovery journey. One participant explained how fragile his new drug-free lifestyle continued to be:

I know that I am always one step away from total destruction again. (Participant 5)

Research shows that drug users in recovery must be aware of the risk of relapse and know that they must remain conscious of certain behaviours (Brunelle et al., 2015; Flynn et al., 2003). At the time of the interviews, 10 of the participants were in the final two stages of the Shalom House program (see Table 1, pg.28) and had been drug-free for a minimum of 12 months. Despite this, the potential for relapsing or regressing to previous behaviours remained a prominent concern for the participants.

And being aware that I need to not go there [triggering behaviours], and I need to go here [responses] just gives me some clarity. (Participant 5)

I could go back to being…old Tyrion in two seconds flat. He's just there under the surface, I know he is. Yeah, that's something I gotta work on. Right there. Just…it's…it's a long journey. (Participant 11)

All participants acknowledged that recovery was a journey, requiring ongoing work and commitment to sobriety and behavioural change. Laudet (2007) and Laudet and White (2010) support participants' statements that recovery from drug use goes beyond attaining sobriety,

that it is not a quick resolution and requires ongoing work from the individual (Laudet, 2007; Laudet & White, 2010; Neale et al., 2015). The participants' insight that their rehabilitation and recovery from drug use requires more than abstinence likely emerged as they progressed in their own recovery and possibly began to understand emotional and situational triggers to relapse and their coping mechanisms. Another participant supported the notion of recovery as a long process and provided greater insight into why he believes a full recovery will take time:

> *The thoughts and the memories and…and that deep, that deep engrained pain uhm…is something I think I'll be working on…on for a…for a long time to come…A long time. (Participant 14)*

This finding demonstrates the lasting effects of experiencing dysfunction during childhood and developing poor coping mechanisms for negative emotions. These participants noted that recovery from drug use requires them to work on their coping mechanisms, the trauma from their experiences and their negative self-perceptions and to learn new strategies to manage future issues. The same participant recognised that rehabilitation is only another part of the journey and noted that the pathway to recovery will continue long after he leaves Shalom House:

> *This program will [be]…just be a steppingstone to the rest of my life. I…I now see that it's a full lifetime…it's a lifelong journey. And the struggle will be…will be every day. (Participant 14)*

Research into the process of recovery supports this participant's expression, highlighting that rehabilitation is only part of the process and more is required to maintain newly reformed behaviour (Best et al., 2011; Best et al., 2014; Iveson-Brown & Raistrick, 2016; Laudet et al., 2009; Mulder et al., 2009; Thurgood et al., 2014). However, the individual's true test begins once they leave the safe environment of rehabilitation and apply the coping mechanisms long after they have left treatment (Best et al., 2011; Flynn et al., 2003;

Laudet, 2007; Laudet et al., 2006; Laudet & White, 2010; Neale et al., 2015). Laudet et al. (2006) support the concept of recovery as dynamic, lifelong process that individuals will continue to maintain a stable recovery. Notably, of the 14 participants, who had spent an average of 16 months in Shalom House, none expressed a confidence or readiness to leave rehabilitation. Rather, the participants expressed a fear of returning to their old lives and relapsing:

> *I don't know maybe I'm a little bit scared *chuckles* I'm scared of uh maybe leaving too soon. I wanna make sure that I'm not gonna go back to it and…Maybe I'm not as confident…not too confident yet…Not 100% confident. (Participant 12)*

The length of time spent in treatment for recovery from drug use has been extensively researched and most findings suggest that it can be a determining factor in successful recovery (Brorson et al., 2013; Hubbard et al., 2003; Laudet, Stanick et al., 2009; Mulder et al., 2009; Porter, 2013; Simpson et al., 1997). An average of three to 12 months is regularly considered the most appropriate length of time to spend in residential treatment for drug use (APA, 2013; Hubbard et al., 2003; Laudet et al., 2009; McKetin et al., 2018; Mulder et al., 2009; National Institute on Drug Abuse, 2012; NSW Health, 2007; Porter, 2013; SA Health, n.d.). These long-term residents of Shalom House a residential rehabilitation in WA suggest that a term longer than 12 months is required to successfully recover from a lifetime of drug use. This finding from participants supports the continued argument that they require time and work to overcome their dysfunctional lived experiences and coping mechanisms for negative emotions. Recovery is an individual journey and three participants, who had spent an average of 19 months at Shalom House, reported they were not ready to leave Shalom House yet with one stating:

> *Once it got to a year and it was like 'wow. I'm nowhere near…where I thought I'd be in a year'. I thought I'd be further along. (Participant 12)*

Another participant was also agreed that, after 18 months within the residential program, he was not yet ready to return to society:

> *I know what'll happen if I go, walk…out of here. I know what'll happen. I'm not strong enough yet. I've been here for 18 months and I'm still not strong enough. To go and live and go back into society. I'm honestly not. (Participant 1)*

Many participants' are hesitant to leave Shalom House after an extended period. This could be inferred to be a result of institutionalisation where a particular mode of values and conduct have been instilled within the organisation. However, the participants making these statements were in Stage Four or Five of the Shalom House program which would suggest they would have independence living away from Shalom House. Although these residents often voluntarily attend Shalom House programs such as Men's Shed, Family Church, or weekend activities as a way of staying connected and supported during their recovery, similar to support groups like Narcotics Anonymous. Further, the same participant explained that his reluctance to leave rehabilitation prematurely was due to his newfound in-depth understanding of the consequences of his drug use:

> *Once you get in that addictive cycle, unless you learn to retool yourself, you can't just think you've done a bit of this and a bit of that and half get this and half get that and go back out and do it. It's not gonna work. They're not strong enough. Drugs are too strong. (Participant 1)*

This perception reported by long-term participants is likely due to their extended period of residential treatment and sobriety, and their ability to reflect on the new life they have created. They are, therefore, able to understand the potential consequences should they return to previous behaviours. Debaere, Vanheule and Inslegers (2014) suggested individuals remain in drug use treatment because they want to ensure they will be successful in their recovery once they leave. Further, they suggested participants choose to remain in treatment for the drug-free,

safe and caring environment providing them time to learn the tools to be independent adults (Debaere et al., 2014). One participant commented on the thoughts and temptations he still had about using drugs but also being conscious that each choice has a consequence:

> *You know, I'm anxious to do something…That I can't do. Cause you're not allowed to do it; it makes it even more enticing. Yeah. But I know the consequences would…yeah. Cause consequences suck. You know it's…yeah. It's against what you want to do but. I guess…I guess it teaches you to have that choice. To do the right thing. (Participant 10)*

This quotation highlights the transition that had occurred from earlier narratives. Where participants had previously described not ceasing drug use and having no concern for the consequences of their actions, having escaped this dysfunctional lifestyle, participants could now identify the negative consequences of returning to that life. Their determination to continue reinforcing their new drug-free behaviours reflects Prochaska et al.'s (1992) maintenance stage of the SOC. While participants reflected that remaining drug-free would require ongoing work and conscious choices, some identified dynamic risk factors that they acknowledged could trigger a relapse in behaviours. These included peer influences and old environments.

> *I'm not hanging around bad people anymore. (Participant 5)*

A second participant described his understanding of why certain peer influences needed to be avoided for the benefit of his recovery:

> *If you go hang around these people, I'm gonna use. If I were too, I'm gonna use. If I hang around bad people, I'm going to use; you're gonna do bad. It goes for any of us…Uhm so yeah, I won't be making that mistake again. (Participant 9)*

As previously discussed, numerous studies acknowledge that peer groups can have strong associations with the initiation of drug use, continuing drug use or returning to drug use (Gonzales et al., 2012; Islam et al., 2012; Herbeck et al., 2014; Hser, 2007; Mason et al., 2014;

Ramo et al., 2012). Further, maintaining pro-social peer groups can provide positive support and increase a recovering drug user's chances of a successful recovery (Herbeck et al., 2014; Iveson-Brown & Raistrick., 2016; Litt et al., 2009; Muller et al., 2017; Thurgood et al., 2014; Timpson et al., 2016). The participants in this study recognised this and aimed to avoid any negative peer association upon leaving Shalom House.

The final area in which participants identified the consequences of relapsing from their newfound recovery was in relation to family. One participant recalled a conversation with the CEO of Shalom House:

> *It's one thing that Renly said he goes…you only get one shot. At your reconciliation…You only get one shot. Cause you can't…you know do it and then stuff up and then go back…And then…it's like it's already been done. You know. (Participant 12)*

Reconciliation is a process within Shalom House to restore the relationship between the resident and their family [through counselling and forgiveness techniques] and pro-social friends. This is a significant part of the residents' recovery journey. Prior to the reconciliation process, participants are made aware that they should only proceed if they are committed to changing their behaviour, as Shalom House posit that one cannot genuinely apologise twice. Participant 12 illustrated his understanding that should he restore the relationships with his family and not change his behaviour; he will not be able to return and apologise again. Laudet and Stanick (2010) and McIntosh and McKeganey (2001) identified that in the recovery stage, drug users use fear of hurting family or friends again as motivation for remaining drug-free. Additionally, studies have suggested that support from family and pro-social friends has a positive effect on drug use treatment and increases the person's likelihood of a successfully maintained recovery (Hser, 2007; Laudet et al., 2006; Timpson et al., 2016).

Throughout this, the participants repeatedly acknowledged the fragility of their recovery. They describe the process of ceasing their drug use and creating new, healthy patterns as lifelong. Maintaining abstinence is a goal for the participants and aligns with the final stage of Prochaska and DiClemente's (1982) SOC model: maintenance. Sustaining behavioural change requires ongoing work by the participant (Laudet, 2007; McPherson, Boyne & Willis, 2017) once they have graduated Shalom House. The insight they gained during residential rehabilitation motivated them to continue their pro-social and drug-free lives. While many participants cited their family and an awareness of the consequences as a catalyst for ceasing their behaviour, some mentioned the spirituality aspect of the Shalom House program that assisted them in becoming drug-free.

6.1.3 Spirituality

Following participants' reflections of their recovery journey within Shalom House, eight participants described their newfound spirituality as a key attribute to them escaping the dysfunctional cycle. The sub-theme of Spirituality arose as participants described their current experience of rehabilitation and their new behaviours. This topic was not broached in questions within the semi-structured interview. The finding of spirituality can be explained through the structure of Shalom House as a Christian rehabilitation that employs strict Christian values and features. Within this sub-theme, the participants solely credited God or their spirituality for their change in behaviour and ability to cease their drug use, as illustrated by one participant:

> *I don't think there's anything else but God anymore…If he's not involved…I couldn't have done this to me. I tried for years to sort myself out even though I didn't wanna…I wanted to underneath, but the drugs would drag me back. (Participant 1)*

This perception of being unable to change his drug-using behaviour alone (without God) was reflected by the majority of the sample. Piedmont (2004) suggested that the therapeutic effect of spirituality conveys a sense of community and rejects selfish concepts. The participants may

be reflecting their Christian learning by attributing their recovery to God, as opposed to themselves, which could appear narcissistic—a trait that spirituality often rejects (Piedmont, 2004.) Research into spirituality and behaviour changes, for drug users and offenders, often reports an identify shift as a result of finding spirituality which acts as a catalyst for desistance (Bakken, Gunter & Visher, 2014; Mason et al., 2009; Pardini, Plante, Sherman & Stump, 2000; Piedmont, 2004). A second participant described not wanting to change his behaviour and credits God for his ability to overcome his drug use:

> *I don't know. I believe God had his hand on me. I really do; I think that…I don't even*
>
> *know why I wanted to stop to be dead honest with you. (Participant 2)*

Although Shalom House is a Christian rehabilitation centre, the participants' ability to embrace spiritual coping mechanisms is possibly due to their dysfunctional and traumatic experiences as children. Maschi et al. (2010) suggests that individuals who experience greater levels of trauma during their youth display significantly higher levels of spiritual coping. Further, Bakken et al. (2014) explain that spirituality acts as a form of comfort and strength during difficult times for those in recovery from drug use. Certainly, the participants in this study described a dependency on God as the cause for their recovery, and that belief in God had provided a new coping mechanism. Initially, the participants reported a series of dysfunctional experiences and an inability to manage negative emotions and how drug use provided a way to escape. In this section, the men described how developing positive coping techniques through spirituality had given them a renewed optimism towards their life orientation—a finding consistent with previous research (Bakken et al., 2014; Flynn et al., 2003; Laudet et al., 2006; Laudet & White, 2008; Pardini et al.,, 2000). However, as they communicated their positive outlook and confidence in their recovery, it was evident that they attributed this solely to their spirituality and not themselves:

I think God has always been in my life and just really needed to direct me to…he needed

to really direct me and break me and get me at my lowest for me sort of…Come to that

understanding that I need to change. (Participant 7)

Bakken et al. (2014) explains that spiritual transformations can assist individuals experiencing

a change in identity and increase their likelihood of remaining free from drug use and criminal

behaviours. A second participant reflected on his involvement and associations within the

criminal world prior to entering Shalom House. He cites God as the reason that none of the

consequences from his previous behaviours eventuated:

I know how I'm still here; I know it's only God that's brought me here but uhm I don't

know how I'm still alive, you know. I don't know how people…haven't chased me up in

here. And cut my head off. I don't know how I haven't been kidnapped. I don't. That's

the reason I'm here…I know God's got his hand on my life and it's obvious now he

does. (Participant 6)

Literature about substance use recovery identify a positive correlation between the role

of spirituality and recovery outcomes (Bakken et al., 2014; Laudet et al., 2006; Mason, Deane,

Kelly & Crowe, 2009). One participant was asked to explain his thoughts on the changes in his

behaviour and reported that God was the source:

God. It has to be. I haven't done…I said to my mum I don't do anything different. I

don't do anything different than when I was a drug addict. I'm the same person, I've

the same core values. I wake up. I read my bible. I learnt to be humble. I learnt to

realise that there was something…bigger and better than me. (Participant 2)

In this example, the participant described his perception that as a person (his values and

traits), he remains the same and God is the only new addition; therefore, this reinforces his

belief that God caused the change in his behaviour and drug use. One participant explained that

without his relationship with God, he would not have been able to cease his drug use, having

been unsuccessful in his previous attempts:

> *Yeah, it's really the relationship with, with the Lord there is a…there is a way out…I*
>
> *can't do it in my own power. Tried and failed. (Participant 14)*

Further, to determining their drug-free status was due to God, they described God as

determining their future:

> *Uh only God knows what's in store for me. (Participant 7)*
>
> *So uhm I'm not gonna let that determine what…what the career path is. I'm just gonna*
>
> *leave that to God too. (Participant 13)*

The participants recounted dysfunctional behaviours and poor decision-making

throughout their lived experiences; their spirituality provided them with a secure means to

allow a greater power to make their decisions. The views expressed by participants in this study

support the findings of Mason et al. (2009) and Laudet et al. (2006) who identified that drug

users in recovery can draw strength from spirituality. This reliance on God is further supported

by one participant, who illustrates the weight he has placed on God to determine his life:

> *I'm not gonna make my future. I'm not gonna choose my path. I'm not gonna make*
>
> *these choices. I don't get to. I've learnt as I make choices and make my own path and*
>
> *direction. If I'm in God's will and I make own path I end up on my ass back where I*
>
> *was. So, I'm just gonna chill out, a day at a time and I'll go wherever I'm sent.*
>
> *(Participant 6)*

Studies have indicated the positive effects that spirituality can have on drug users in

rehabilitation, including increasing confidence in completing treatment, maintaining recovery

and preventing relapse (Bakken et al., 2014; Laudet et al., 2006; Mason et al., 2009). While the

relationship between recovery and spirituality offers clear benefits, Sremac and Ganzevoort

(2013) suggest that recovering drug users may become dependent on their spirituality and

depend on it as a coping strategy to the exclusion of others. While these participants' relationship with spirituality may have increased their confidence towards their recovery, they have evidently become dependent on God and spirituality as a coping strategy. Many organisations such as the 12-steps program widely used for addiction support groups, including Alcoholic Anonymous and Narcotics Anonymous, are considered to have a spiritual element (AAC, 2020; Best et al., 2008; Flynn et al., 2003; Narcotics Anonymous Australia, n.d). This highlights a potential issue for treatment providers and policy makers in determining when spirituality is an acceptable tool within the recovery process versus becoming a coping strategy. The participants previously described escaping their dysfunctional experiences by forming an identity within the criminal drug world; this identity has now shifted to God and their spiritual journey. Nevertheless, it is noted that the participants' belief and dependence on a spiritual entity reflects a significant shift towards pro-social influences and environments—in contrast to the negative environments of their previous pro-drug criminal networks. A quotation from one participant supports this finding:

> *I was drowning, and I just grabbed the only thing I could see [God], the only thing. And it's…it's taken me to the clouds. (Participant 6)*

Not all participants discussed God or spirituality as an integral part of their recover process. One participant described not being spiritual or believing in God:

> *Look, I've got a really open heart and I love for what it stands for…I've got a really soft heart now because of it. It's good. The morals are good. Even just the softening just…I love the thought of love, peace, patience, gentleness…Kindness, you know uh it's the person I wanna be. (Participant 11)*

Despite not believing in God, the participant articulated a desire to reflect the values and features of Christianity. Laudet et al. (2006) explain that while not all drug users in recovery will accept spirituality, they may report a connection or appreciation for the values it

represents. This explains why a minority of the participants may not have discussed God or spirituality with the same fervour as most other participants. However, this does not mean that they did not reflect similar beliefs and perceptions of Christianity. As the interview schedule did not directly query participants' spirituality during recovery, it is likely that the minority may not have felt it necessary to discuss this topic. Additionally, the minority who did not discuss God in more detail, had spent less time in Shalom House and less frequently describe the role of God in their recovery. Laudet et al. (2006) suggest that spirituality and religious beliefs in recovering individuals increase significantly as they progress in their rehabilitation. Here, the participants frequently highlighted that the addition of God within their lives provided them with a coping mechanism to deal with their dysfunctional past. However, such dependence on spirituality or religion can become threatening to individuals, as the process switches dependence on drugs to religion (Shamsalinia, Norouzi, Fallahi Khoshknab & Farhoudiyan, 2014). As they continued to reinforce their new positive behaviours, free of dysfunction and drug use, the participants began to express having a purpose in life.

6.1.4 Purpose in Life

As each participant described their future after Shalom House, an underlying pattern emerged, to become the final sub-theme with the over-arching theme of Escaping Dysfunction, whereby they now believed they had a Purpose in Life that was free from dysfunction, drugs and criminal behaviours. All participants displayed an ability to reflect on their journey and identify the differences between their past and future direction. While participants did not always know what their future held, they consistently described life with increased positivity and meaning. This is illustrated by one participant, who stated that he had found that happiness in his drug-free life:

> Like, I'm trying to find my happiness…And I've found my happiness. And
> like…it's…just being content with who I am. Not even, I don't know really who I am,

but I know who I'm not. And knowing who I'm not rules out a lot of things.

(Participant 5)

This insight was also reflected by other participants, who believe they were meant to be more in life than a drug user engaging in illegal activities; in contrast to the beginning of the interviews, when participants used negative terms to describe their lives. The perspective was expressed by all participants, regardless of their age, stage in the program or time spent in Shalom House. One participant explained:

I don't believe I was a drug addict; you know what I mean? In like as in I don't believe I…that wasn't my calling in life an…I really fell into it. I did and uhm it consumed me for a long time but…I knew there was something better. There…had to be something better. That couldn't be what life was, all that hurt and pain and…it couldn't be. (Participant 2)

The participant refers to the 'hurt and pain' of his dysfunctional childhood experiences. This reinforces the significance of an individual's risk of using drugs to cope with the negative emotions attached to these events. A second participant directly attributed rehabilitation with assisting him to become the person he believes he should have become:

But I think it's [Shalom House] just enabled me to step into who I was always meant to be, and I was never meant to be a drug dealer and I was never meant to be a person who hung around people like that. (Participant 5)

This participant's expression of gratitude for the treatment he has received at Shalom House is significant. Research has previously identified that individuals with positive treatment experiences are more likely to not only remain in treatment but also maintain sobriety post treatment (Hser et al., 2004; Laudet, Stanick & Sands, 2009; McKetin et al., 2018; Nordfjaern, Rundmo & Hole, 2010). As the participants remained drug-free and removed themselves from their previous dysfunctional lifestyles, they gained clarity and greater insight into their

behaviours. Subsequently, many participants identified that their experiences and past choices did not necessarily determine their future, and they communicated the belief that they could still change the outcome. Following these admissions, the participants often expressed a desire to use that dysfunctional lived experience towards a greater purpose. One participant explained how he could use his past to promote change in other drug-using individuals:

> *I don't wish to uhm ruin lives. I wish to save lives. It's a bit of a cliché. But I don't wanna be part of the problem. I wanna be part of the solution. And I think just through my own experiences and my bad choices and my traumatic upbringing. I can…I can be a big part of that solution. (Participant 13)*

Similarly, another participant also explained a desire to use his lived experiences and all the 'pain, and all this hurt' to help the community and others like him:

> *I wanna turn it into my strength and so I'm really grateful for Shalom [House] to be…to enable me to be able to flip the script on it…And uh use it for good. (Participant 14)*

A positive outlook in life—which participants used to give meaning and purpose to their lived experiences—has been shown to increase positive treatment outcomes (Laudet & Stanick, 2010; Martin et al., 2011). This common theme of using dysfunctional experiences for a purpose mostly pertained to participants using their recovery journey to help the wider community or other drug users.

> *And I want to help others…break it. And turn everything into positive. (Participant 6)*
>
> *That's why I actually work for Shalom [House] now so…I wanna give back what I can, which I don't see as being a lot but it's what I can, you know. (Participant 8)*

Additionally, two participants specifically identified areas within society where they wanted to promote drug awareness and advertise that recovery was possible. One of the younger participants had attended the army and spent time in military prison. He mentioned a

desire to visit these places and speak about his lived experiences and how he escaped that cycle of behaviour.

> *Uhm to give back to the prisons and the schools and maybe even one day, the army.*
>
> *Uhm and take a bit of God and a bit of love. (Participant 2)*

The second participant was older and reported spending a significant length of time revolving in and out of prison. Subsequently, he identified with individuals who are currently incarcerated and wished to share his testimony of escaping his dysfunctional life to encourage and demonstrate change is possible:

> *I still got a lot of friends in jail sorta stuff…I'd like to share there's a way without going*
>
> *biblical. That there is a way out if they wanna and…And they can; it's for their family,*
>
> *children if they wanna. But I would just sternly warn them that it's the hardest thing*
>
> *they've ever done in their life. (Participant 9)*

Research supports this finding: drug users often place importance on utilising their personal experiences to provide hope for others with drug-related issues (Dingle, Cruwy & Frings., 2015; Herback et al., 2014; McKeganey & McIntosh, 2000; Sremac & Ganzevoort, 2013). Significantly, one participant discussed preventative action as an intervention for assisting youth with drug-related issues, as he associated his drug use and criminal behaviour with his own childhood experiences:

> *But yeah, I'd like to go back as far as…kids and uh…try and prevent I think prevention*
>
> *can be the best…the best form of…the best form of stopping a problem. (Participant 14)*

Overall, children became an important topic for many participants, as they described wanting to have children and the significance of family in their future. One participant commented:

> *I can't wait to have kids, I can't wait to have a family, I can't wait to have a home*
>
> *to…have 'em in…I'm really excited about that. (Participant 14)*

A second participant described wanting a family, alongside a desire to be an 'average person' with his own business, house and family:

> *A plumbing business with a wife and kids and a house, I guess. Just something simple.*
>
> *Nothing flash. Just a…average person. (Participant 8)*

As a result of the participants' dysfunctional and often abusive family environments, it was not uncommon for them to report a desire for a future reflecting a life they had never experienced. Previous studies suggest that drug users in recovery will crave normality and stability in their future, including everyday activities and socially acceptable norms (Nettleton, Neale & Pickering, 2013; McKeganey & McIntosh, 2000). This desire for a 'normal' life with a family was repeated by the participants as they discussed their new purpose in life. One participant described regaining visitation rights with his daughter since being at Shalom House and spoke of the importance of being a father to her:

> *Have as much time as I can to see her [daughter] and spend with her and build that*
>
> *relationship back up with her. That's my goal; that's my end game, right there. To be*
>
> *with her, walking on the beach doing stuff. (Participant 4)*

Evidently, with clarity and sobriety a greater appreciation for family became more significant to them and for their future. Brunelle et al. (2015) and Timpson et al. (2016) highlight the importance of family relationships in recovery, motivation to remain sober and reintegration into society after treatment. Throughout this final theme within the findings and interpretations, the participants maintained a positive mentality towards their purpose or future in life, even though 'the future' seemed a long time off for some. When asked directly about the future, all reported a confident and positive outlook:

> *But I feel…I've definitely got a bright…a brighter future. (Participant 12)*
>
> *So…my future…it's definitely positive. And it's bright. (Participant 5)*

Laudet et al. (2006) suggested the hope for a brighter or better future can motivate drug users in recovery to complete treatment. The future described by the participants referred to post Shalom house treatment, once they felt more secure in their sobriety and had graduated. Although participants recognised that their future would be positive, they could identify the need to maintain positive peer networks and environments:

> *I really don't know. I have a really, really promising future. A really promising future. I'm confident that whatever I choose to put my hands to uhm…With the right people around and the right environment. (Participant 14)*

Their admissions for the future and their current lives, which remain drug-free, are consistent with what is expected when individuals enter the maintenance stage of Prochaska and DiClemente's (1982) SOC model. While the participants expressed a confidence in the unknown future, each acknowledged the benefit of having the support of positive family and friends. There is a consensus among social scientists that support from pro-social relationships can have an integral role in a person's recovery and maintaining that recovery in the community (Herback et al., 2014; Hser, 2007; Timpson et al., 2016). Throughout this sub-theme, all participants reported a perception of hope and a strong sense of positivity for their future outside of Shalom House—a stark contrast to their descriptions of their lives at the beginning of the interview. The participants were also able to provide significant insight into their own rehabilitation, by reflecting on their past behaviours in comparison to the person they feel they have become. Having escaped the dysfunctional cycle of drug use and criminal behaviours, the participants reported a desire to use their testimony to educate the community and other drug users that recovery was possible. Further, the participants exuded a confident positivity towards the distant future and a desire to have normal family-focused lives.

6.1.5 Summary

This final theme, of Escaping Dysfunction, within the findings and interpretations examined participants' insights into their rehabilitation. As the participants continued their rehabilitation, reinforcing drug and criminal-free behaviours, it was evident that they had escaped the dysfunctional drug taking lifestyles they previously embodied. The sub-themes of—Self-hatred, Recovery, Spirituality and Purpose in Life—utilised participants' insights into their rehabilitation to explore how they escaped this dysfunction. Throughout these sub-themes, it was clear that the participants' mentality towards their previous reckless behaviour had shifted to a more positive mindset and that they wanted to escape their lived dysfunction.

In the initial sub-theme of Self-hatred, the participants explained their understanding of their drug use and criminal behaviours through perceptions of themselves. The participants began to acknowledge the consequences of their drug use and criminal behaviours; frequently reported hatred for the person they became due to their continued dysfunctional lifestyle; and expressed a desire to escape the cycle. Within the Recovery sub-theme, the participants identified the fragility of their recovery and explained that rehabilitation was only part of the process. Throughout this sub-theme it was evident that the participants were in the maintenance stage of Prochaska and DiClemente's (1982) SOC model. They displayed an acute awareness of the consequences of their drug use and a determination to not return to their previous dysfunctional behaviours.

Spirituality emerged as a sub-theme organically, as participants reported a strong religious influence in their recovery. While this thesis acknowledges that Shalom House is a Christian rehabilitation and that religion has a strong role in the program's content, it was not anticipated that participants would attribute their recovery to God and religion, as opposed to themselves. In the final sub-theme, Purpose in Life, the participants expressed positivity towards the future, having ceased their previous dysfunctional behaviours. The participants

communicated a desire to use their lived experiences to help other drug users escape the cycle

of dysfunction and to provide hope that recovery is possible. Having escaped the dysfunction

of their lived experiences, the majority of participants described their future as 'bright' and

desired a family orientated, drug-free life.

Chapter 7: Limitations

The present study includes both sample and methodological limitations. As the qualitative research was exploratory and due to the sample paucity, it cannot be assumed that the findings are transferable to a wider population of WA or at a national level. Additionally, the sample comprised of males interviewed during a specific period during the Shalom House program. Therefore, this sample may not be an accurate reflection of the lived experiences of drug users in the broader, general community, as it does not consider the experiences of female drug users and was limited to participants from a specific residential treatment program. This would require further investigation and replication on a more diverse sample of drug-using individuals, including the general community, or comparisons between treatment programs.

Specifically, this project focussed on Shalom House which has several unique operational aspects. These included reintegration to external paid employment while still engaged in Shalom House and strict Christian values, which involved attending three different church services per week. It was also unique in that it utilised five distinct rehabilitative stages, as opposed to an inclusion of the 12-step philosophy. All participants were in Stage Three or higher and had sustained sobriety prior to the interview. This was necessary to address the research questions that focussed on reflections from those in a certain stage of recovery. However, it is acknowledged these participants may have a different perspective of their experiences as a result of their extended recovery period: interviews with participants earlier on in their recovery might present different findings.

This study relied on self-reports and did not collect collateral information. This is required in a phenomenological approach which seeks evidence of lived experiences. However, they are based on the honest and transparent nature of the residential program that the participants engaged in and it is unlikely that they understated their substance use or

criminal behaviours. During their recovery journey, the participants are encouraged to discuss their past substance use and behaviours with complete honesty. As they progress through their program, talking openly about their history and experiences becomes an acceptable and normal part of their routine. Future research might explore whether residential rehabilitation programs altering or tailoring the program to the resident's specific addiction, social, family, employment or education needs affects recovery outcomes.

Irrespective of the limitations in the possible transferability of the findings and the methodological aspects, this study has made a significant contribution to the understanding of drug users' lived experiences and the impact of rehabilitation on their criminal behaviour and drug use.

7.1 Recommendations

The current research has several methodological aspects that future research might investigate to further develop and confirm these initial findings. These aspects include utilising a larger and varied sample, as the current sample consisted of 14 male participants. Future research might collect a larger sample and include females, which could provide more transferable results and benefit the literature. The inclusion of females in the sample could reveal different findings, as women have different criminogenic and lifestyle needs; this warrants further investigation.

The findings of this thesis will prove useful for future researchers, policymakers and other drug use treatment services to understand the factors and issues that may need to be addressed for drug users to recover and cease future drug use and criminal behaviours. Additionally, this research can help policymakers to identify when prevention and intervention strategies are needed to combat the childhood experiences that result in subsequent drug use and criminal behaviour. The findings and interpretations revealed that many participants experienced abuse and dysfunctional parenting, which became entrenched features of their

childhood: a finding consistently supported by research into drug users and criminal offenders (Banducci et al., 2014; DeLisi et al., 2019; Farrell & Zimmerman, 2017; Farrington et al., 2009; Fuller-Thomson et al., 2016; Holl et al., 2017; Mandavia et al., 2016; Min et al., 2007; Taplin et al., 2014). The education provided during their treatment at Shalom House allowed them to reflect on the links between their childhood experiences and subsequent drug use and criminal behaviours. Participants described a myriad of dysfunctional experiences that influenced their choice to initiate and continue their drug use and criminal behaviours. These findings have highlighted the importance of considering the past experiences of drug users for all the stakeholders involved in designing or implementing policies and practises. An understanding of the participants' family backgrounds has clear criminological importance, as it not only influenced their previous behaviours but also their present actions (DeLisi et al., 2019). To target these behaviours, any potential treatment or policy should aim to address these experiences (Banducci et al., 2014). In respect of these findings, early intervention programs in both primary and high school to assist in identifying and supporting students from dysfunctional and/or abusive families, could minimise the risk of future drug use and criminal behaviours. The findings highlighted the link between drug use and escaping negative emotions stemming from dysfunctional, abusive or traumatic experiences. Focus must be placed on assisting drug users to overcome negative experiences to support their rehabilitation (Holl et al., 2017).

Current research into the perceptions of drug users in Australia is limited; many studies focus on the treatment services, government organisations or the public surveys on drug use (Formiatti et al., 2017; Jordan, 2015; Lancaster et al., 2015; Neale et al., 2014). While this focus is important to further current understanding of drug treatment services and reduce drug-related crime, the effectiveness of those prevention strategies depends on the individual receiving the services. The current research fills a gap in the research within Australia;

however, additional studies may seek to repeat the study using multiple residential rehabilitations or in different locations to examine whether the findings are replicated.

Within the research community, there has been frequent discussion of the link between drug use and criminal behaviours. Here, the participants lived experiences support a connection between drug use and criminal behaviours. The initiation into drug use stemmed from a variety of childhood experiences and for many participants, this was a gateway to more serious criminal activities. At a basic level, the link is evident in the act of possessing and consuming illegal drugs, as outlined in the *Misuse of Drugs Act 1981* (WA). Prolonged drug use increases the individual's involvement in the criminal world and as described by over half of the participants in this study, can result in recurring contact with the CJS. The majority of the participants in this study reported early and prolonged exposure to dysfunctional lived experiences and drug use, the combination of which increased the severity of the outcomes through problematic drug use, mental health issues and regular criminal activity. Consistent with other research, participants who often reported various dysfunctional family situations (i.e., divorce, absent fathers, drug-using parents and siblings, violence and abuse) used drugs to escape continued dysfunctional family situations (Besemer & Farrington, 2012; Fagan, 2005; Farrell & Zimmerman 2017; Fuller-Thomson et al., 2016; Hemovich et al., 2011; Holl et al., 2017; Kofler-Westergren et al., 2010; Low et al., 2012; Segura-García et al., 2016). It would be remiss for policy makers and rehabilitation services to continue ignoring the myriad of issues an individual may have experienced that led to their initiation and continued drug use. All participants within this research reported a positive impact from the use of a holistic approach to rehabilitation taken by Shalom House, which they suggest allows them to maintain their new behaviours; and not enter the relapse stage described by Prochaska and DiClemente (1982), thus beginning the cycle of change again. These findings demonstrate the positive impact of utilising a holistic approach to rehabilitation on treatment outcomes for problematic

drug users and break 'the cycle' of drug use. However, this may not reflect the experiences of those who prematurely exit the program, particularly as Shalom House, at the time of writing this thesis, had no reported success rate.

Although the study participants were approached at Shalom House, a Christian rehabilitation program, this study did not initially aim to obtain information regarding the spiritual or religious aspects of the participants' recovery. However, the participant-led discussion of spiritual beliefs and their role in most participants' rehabilitation adds a deeper insight to the findings that was not entirely explored here. The expressions made by majority of participants identify a strong reliance and dependence on their new-found spiritual faith. While research recognises the positive role of spiritualty in treatment outcomes as a source of strength, comfort, hope and ability to cope with stress (Best et al., 2008; Flynn et al., 2003; Laudet et al., 2006; Laudet & White, 2008; Maffina et al., 2013); it is noteworthy that the participants expression of spiritual support can appear to be addiction substitution in the form recovery based on spiritual dependence. Future research may wish to explore alternative residential rehabilitation programs and examine whether religious and spiritual factors are influential in other individuals' recovery from substance use. Additionally, further research could explore the experiences of recovering drug addicts within a non-religious or spiritual based rehabilitation; to determine their views on what has assisted in their recovery journey.

Evidently, the holistic nature and extensive length of Shalom House has increased the likelihood of the participants successfully ceasing and changing their drug use and criminal behaviours by providing meaningful activities throughout their recovery, such as: employment, family restoration, financial stability, volunteering and regular community outings. Engagement in such activities provided participants with stability and a sense of familiarity and offered opportunities to connect with pro-social individuals. This supports research showing that abstinence from drug use alone is insufficient for individuals to change their

criminal and drug-using behaviours (Best et al., 2011; Best et al., 2014; Iveson-Brown & Raistrick, 2016; Laudet et al., 2009; Mulder et al., 2009; Thurgood et al., 2014). Further, the establishment of these meaningful activities in the lives of these participants required significant time and a series of stages.

The length of time spent in treatment has also received extensive scrutiny, with research suggesting that twelve months in treatment is satisfactory to establish recovery from drug use (APA, 2013; Hubbard et al., 2003; Laudet et al., 2009; McKetin et al., 2018; Mulder et al., 2009; National Institute on Drug Abuse, 2012; NSW Health, 2007; Porter, 2013; SA Health, n.d). The collective responses from these findings disagree with this claim. Here, it is evident that the recovery process requires a range of personalised considerations applied on an individual basis over a sustained period to maintain abstinence. The protective factor afforded to these participants through the long-term nature of Shalom House allowed them to: recreate their lives, remain free from drugs and criminal behaviours and be exposed to the community while still adhering to the program's requirements. As participants in the final stages of the program began to secure their position within the community, living away from the Shalom House environment they would continue to involve themselves in activities such as family night church and Men's Shed. The continuation of these activities aims to provide additional support to residents living in the community, similar to support groups like Narcotics Anonymous. This finding has identified the need to explore more long-term rehabilitations and support systems for individual's post-rehabilitation. Additionally, when exploring new means to address drug use and related behaviours, governments and other rehabilitation organisations should consider factors beyond simple abstinence from drugs.

7.2 Conclusion

This study was designed to examine the lived experiences of drug users in a residential rehabilitation in WA. Specifically, it sought to understand the insights of participants into their

rehabilitation and whether they identified links between their drug use and criminal behaviour. An exploratory, qualitative methodology was used with a phenomenological approach to explore the participants' backgrounds, drug use, criminal behaviour and experiences in rehabilitation in-depth. The findings suggest that drug users in stages 3-5 of Shalom House's residential rehabilitation have extensive insight into the factors leading to their drug use and the subsequent association with their criminal behaviour. The findings revealed that the participants could also identify the positive influence of residential rehabilitation on their recovery and describe a pro-social drug-free life in the future. At the time of interview, the participants described an uncertainty in completely separating themselves from Shalom House and being without the additional support network they can provide. This applies even for Stage 5 participants living away from the premises although they are still connected to Shalom House. It appears participants can understand the fragility of sobriety and reflect a determination to maintain the behaviours they have established, further supporting Prochaska and DiClemente's (1982) SOC model, whereby the participants are currently in the maintenance stage and endeavouring to avoid entering the relapse stage. As a result of their self-reflections participants acknowledged the link between their drug use and criminal behaviour, often describing subsequent criminal behaviour as a result of economic (stealing, selling drugs), psychopharmacological (violent behaviours, selfish actions, no morals or integrity) or systemic (dealing drugs, gang-related associations, crime and violence) models. These findings further support Goldstein's (1985) argument of a link between drugs and crime.

The findings supported research showing that recovery encompasses more than remaining abstinent from drugs and most participants acknowledged that recovery is a lifelong process that will continue after they leave Shalom House. Additionally, this finding supports that a holistic approach is required for individuals to recover from drug use and the associated lifestyle. While this study did not aim to evaluate the Shalom House program, it is noted that

at the time of submission, eight participants had graduated from the program, four had prematurely terminated treatment and not returned, and two were still completing the program. The holistic approach to drug use treatment, adopted by Shalom House, appears to compliment Prochaska and DiClemente's (1982) SOC model whereby residents move through stages in a similar fashion to the stages described in their model. For the majority of participants, they have appeared to successfully entered the maintenance stage and graduated the Shalom House program to continue applying and reinforcing their new drug-free behaviours.

This study appears to be the first to examine the perceptions of a drug user in the maintenance stage, from a holistic approach to understand their drug use, association with criminal behaviour and treatment experiences. Moreover, the positive outcomes for the participants at the time of submission demonstrate the importance of understanding a drug user's experiences if society is to successfully address the issue of drugs and drug-related crime. Overall, these findings contribute to the growing knowledge that drug users have and can provide insight of problematic drug use, its link to criminal behaviour and the support needed to cease drug use.

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Appendix 1

Table A1.

Shalom House Stages (Extended)

Stage	Description	Duration
One	Substance Detox from all drugs, alcohol and/or medications. Mandatory daily community service. No access to mobile phone or internet. Phone calls to approved numbers only. Not allowed off property. Must attend all Shalom House activities; men's shed, church services, Shalom House family night church service, and weekend activities.	0–3 months approximately
Two	Two days paid work. Mandatory community service on all other days. No access to mobile phone or internet. Phone calls to approved numbers only. Allowed to begin deciding their future career/education direction. Start addressing debts and getting any suspended licences back. More leadership responsibilities. Not allowed off property. Must attend all Shalom House activities; men's shed, church services, Shalom House family night church service, and weekend activities.	3–6 months approximately
Three	Three days paid work. Mandatory community service on all other days. Allowed a mobile phone, for calls and texts. No internet access. Continue pursuing future career/education direction. Permitted more responsibility and freedom with an 8:30 pm curfew. May look at purchasing a car or bringing	6–10 months approximately

Stage	Description	Duration
	own car to property. Must attend all Shalom House activities; men's shed, church services, Shalom House family night church service, and weekend activities.	
Four	Four days paid work. Mandatory community service on remaining day. Allowed a mobile phone with unrestricted numbers. Restricted access to internet on mobile phone. No social media accounts. 10:30pm curfew if living on a Shalom House property. Open personal bank account. Can request to move out of Shalom House properties. Only required to attend men's shed, Shalom House family night church service, and one weekend activity each fortnight. Additional time spent participating in Shalom House activities is voluntary but encouraged as part of the therapeutic community process.	10–12 months approximately
Five	Permitted full control to all aspects of their life. Expected to be building a life outside of Shalom House and finding positive social groups. Participating in Shalom House activities is voluntary but encouraged as part of the therapeutic community process.	12+ months minimum

Appendix 2

SCHOOL OF ARTS AND HUMANITIES

JOONDALUP CAMPUS

270 Joondalup Drive, Joondalup
Western Australia 6027
☎ 134 328

www.ecu.edu.au

ABN 54 361 485 361 CRICOS IPC 00279B

INFORMATION LETTER TO PARTICIPANTS

A substance users' experiences of a residential rehabilitation program in Western Australia

My name is Michelle Fullam and I am a Criminal Justice Masters student at Edith Cowan University (ECU), Perth WA. You are invited to participate in this research project, which is being conducted as part of the requirements of a Master research degree. This research project has ethics approval from the ECU Human Research Ethics Committee.

This project aims to investigate the experiences of substance users in a residential rehabilitation in Western Australia. If you choose to take part in the project you will be asked to participate in an interview which will take approximately one hour. The interviews will be audio recorded using a voice recording device. All information collected during the research project will be confidential and coded so that your responses remain anonymous. This information will be stored securely on an audio recording device and laptop, held by the researcher while completing the project. No Shalom House staff or resident will be able to access the data collected or be told what was spoken about in the interview. However, it cannot be guaranteed that other residents will not know who chooses to participate in the study. All de-identified data collected will be stored securely on ECU premises after the project has concluded. After 7 years the data will be destroyed.

The information will be presented in a written report in which your identity will not be revealed. You may be sent a summary of the final report on request. The written report will be submitted to reviewers for marking and after which it will be prepared for publication. No results within the paper will include information that could identify participants.

I anticipate that there may be minor risks associated with participating in this research project, as the issues raised are sensitive and may cause some distress. Your counsellor will be briefed on what the study will require and will have to approve any request to participate.

This study has the full support of Shalom House's CEO, however, whether you participate or not will have no reflection on your program or relationship the Shalom House staff. Although I currently volunteer for Shalom House, residents should know that there is no pressure or expectations for you to participate or complete the study. Participation in this study is voluntary and you are free to withdraw at any time and there will be no penalty for doing so. Should you withdraw from the interview or the study, all information you provided will destroyed.

This study also involves the collection of information on any experience you have had with illegal or criminal activity, including the purchasing, using, and possession of drugs. You will be asked some questions regarding any past criminal behaviour during the interview. However, it is important that specific details or any planned crimes are not disclosed as the researcher may be obliged to pass this information on.

If you have any questions about the research project or require further information, I will be available to talk after the recalibration meeting. You can also contact me at ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮ or via one of the counsellors. Alternatively, if you have any questions about the research project or require further information you may contact my supervisor, **Dr Natalie Gately (08 6304 5930, n.gately@ecu.edu.au).**

If you have any concerns or complaints about the research project and wish to talk to an independent person, you may contact:

Research Ethics Officer
Edith Cowan University
270 Joondalup Drive
JOONDALUP WA 6027
Phone: (08) 6304 2170
Email: research.ethics@ecu.edu.au

Thank you for your time,

Yours sincerely,

Michelle Fullam
Master of Criminal Justice by Research
Edith Cowan University

Appendix 3

SCHOOL OF ARTS AND HUMANITIES

ECU
AUSTRALIA
EDITH COWAN UNIVERSITY

JOONDALUP CAMPUS
270 Joondalup Drive, Joondalup
Western Australia 6027
☎ 134 328

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ABN 54 361 485 361 CRICOS IPC 00279B

CONSENT FORM

A substance users' experiences of a residential rehabilitation program in Western Australia

- I have been provided with a copy of the Information Letter, explaining the project.

- I have been given the opportunity to ask questions and any questions have been answered to my satisfaction.

- I am aware that I can contact Dr Natalie Gately or a Research Ethics Officer if I have any further queries, concerns, or complaints.

- I have been given their contact details in the information letter.

- I understand that participating in this project will involve an interview lasting approximately one hour.

- I understand that my participation is completely voluntary and will not influence my program in any way.

- I consent to having my voice recorded during the interview.

- I understand that the researcher will be able to identify me but all the information I give will be coded and kept confidential.

- I understand that I will be asked questions about any illegal or criminal activity I may have been involved in, and should not disclose specific, identifying details about the events.

- I understand that if I do disclose such information the researcher may be obliged to pass it on.

- I am aware that information collected during this interview will be stored on an audio recording device and laptop used by the interviewer <u>before</u> the project is completed.

- I am aware that the information collected during this research will be stored in a locked cabinet at ECU <u>after</u> the completion of the project.

- I understand that Shalom House staff or residents will not have access to any data collected or be made aware of what was disclosed.

- I understand that I will not be identified in any report, thesis, or presentation of the result of this research.

- I understand that I can withdraw from the research at any time without penalty and any material collected from me will be destroyed.

- I agree to further contact should the researcher require clarification of any aspects I raise.

I freely agree to participate in the project

……………………………………………………………………………

Signature

……………………………………………………………………………

Date

Appendix 4

SCHOOL OF ARTS AND HUMANITIES

<u>Demographic questions</u>

1. How old are you?

2. What is your profession? (Student, Boiler Maker, Construction, Hospitality etc)

3. What is your level of formal education?

   Primary school ☐   Year 10 ☐   Year 12 ☐   TAFE course ☐

   University degree ☐   Other: _____

4. How long have you been at Shalom House? _____

5. What Stage are you at in the program?

   Stage 3 ☐   Stage 4 ☐   Stage 5 ☐

6. What has brought you to Shalom House?

   Alcohol ☐   Cannabis ☐   Methamphetamines ☐   Heroin ☐   Sex ☐

   Cocaine ☐   Cigarettes ☐   Prescription pills ☐   Gambling ☐   Anger ☐

   Social difficulties ☐

   Other: _____

7. How long have you experienced these issues?

Appendix 5

SCHOOL OF ARTS AND HUMANITIES

Interview Schedule

1. Tell me a little about yourself and your background?

- What did your childhood look like?

- What about your teenage years?

2. How did drugs become a part of your life?

- Tell me more about that.

- When did you start using drugs?

3. Tell me about your 'big bang' moment when it all came crashing down?

4. Tell me about the person I would have met during that time in your life?

- What were you like?

- What were you doing?

- How did you behave?

5. Had you wanted to change before?

- If no, tell me some of the reasons you didn't want to change.

- If yes, did you act on that desire to change?

- If yes, what did you do to try and change?

6. Do you have any experience with offending behaviours, whether you've been caught or not?

- Did your offending change over time?

- Do you think buying/using/having drugs is a crime?

7. Tell me what led you to Shalom House?

- What were your life circumstances at the time?

- Was it a decision you made on your own?

8. Tell me about what you think your life would be like if you never came to Shalom?

9. Tell me about the person you've become while in Shalom House?

- What do you think has contributed to you becoming this person?

- Is there anything that you still need to work on?

10. Is your motivation to change your life different from when you first entered Shalom House?

11. What do you see your future looking like now?

- What are your goals?

- What sort of person do you want to be?

- What do you want to achieve?

Appendix 6

Correspondence from Shalom House confirming permission for the research to take place

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From: Milena Djurasinovic
Sent: Tuesday, 1 August 2017 4:44 PM
Subject: Research for your Masters of Criminal Justice

Dear Michelle,

I can confirm that Peter Lyndon-James, Chief Executive Officer of the West Australian Shalom Group Inc. (Shalom House), has given his approval for your Masters of Criminal Justice research to be conducted at Shalom House.

We will be at hand to help all research and interviews conducted will be done in accordance with ethical guidelines.

Kindest regards,

Milena Djurasinovic

Chief of Staff

PA to the CEO

0451 137 757

milena@shalomhouse.com.au

www.shalomhouse.com.au

Appendix 7

Correspondence from Shalom House approving the demographic questions and interview schedule

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From: milena@shalomhouse.com.au

Sent: Tuesday, 27 March 2018 11:53 AM

To: Michelle FULLAM

Cc: geoff@shalomhouse.com.au

Subject: RE: Masters Thesis

Hi again Michelle,

All good on this end, Peter has just asked that Geoff has a look over the questions and makes sure everything checks out on his end.

Geoff, I've forwarded you Michelle's initial email with the attachment.

Thanks.

Milena

Kindest regards,

Milena Djurasinovic
Chief of Staff
PA to the CEO
0451 137 757

milena@shalomhouse.com.au

www.shalomhouse.com.au

From: Geoff Walker

Sent: Wednesday, 28 March 2018 8:20 PM

To: Michelle FULLAM

Subject: Re: Masters Thesis

Looks good to me!

Geoffrey

Shalom