Dancing with Death:
Young people’s pathways in and out of substance abuse

A thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

Kathryn Rebecca Daley
BSocSc (Psych). BSocSc (Hons)

School of Global Urban and Social Studies
College of Design and Social Context
RMIT University

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Declaration

I declare that:

Except where due acknowledgement has been made, the work is that of the author alone; the work has not been submitted previously, in whole or in part, to qualify for any other academic award; the content of the thesis/project is the result of work which has been carried out since the official commencement date of the approved research program; any editorial work, paid or unpaid, carried out by a third party is acknowledged; and, ethics procedures and guidelines have been followed.

Signed

Kathryn Daley

June, 2014
For my family: my brother Jared and our mother Lorraine.

I wish you were here.
Funding

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Acknowledgments

I hope as researchers you continue to wonder about those unrevealed stories. Not just because they are interesting, but because they are unjust.

At the beginning of this research, a woman who had been raised in state care anonymously left this comment on my blog. Her voice has kept me focused and I thank her.

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List of participants

Alex was 20 years old, pregnant and in detox at the time of the interview.

Ally was 20 years old and waiting for a vacancy in rehab.

Amber was 17 years old, in detox and six months pregnant with her first child.

Amy was 21 years old and had a two and a half year old daughter.

Andreas was 18 and planning to move to the country once out of detox.

Andrew was 21 years old and had been accessing a drop-in centre.

Andy was 19 and was trying to find housing and reduce his substance use.

Anthony was 18 and interviewed at a service where he was getting outreach support.

Ashly was 19 years old and interviewed at a drop-in centre she was accessing.

Asiah was 20 years old and accessing a day program for homeless youth.

Beau was 21 years old and occasionally accessed day programs for youth with AOD issues.

Ben was 19 and referred to detox from the day program he accessed regularly.

Brandon was 19 years old and interviewed while he was in detox.

Cameron was 18 and in detox after learning about it through friends.

Chris was 21 years old and in detox for the first time.

Christina was 19 and in detox. She was on a waitlist for rehab.

Clark was 19 and interviewed while he was in detox.

Crystal was 19 and was two weeks away from her admission to rehab.

Damian was 19 and frequently accessing a drop-in centre for young people.

Ebony was 18 and living in an abstinence-only Christian boarding house.

Gerald was 22 and transitioning out of the day program he was interviewed at.
Habib was 20 and had been involved with alcohol and other drug services for seven years.

Jackson was 18 and interviewed while he was accessing a residential service.

Jahl was 14 and accessing a day program for young people with substance abuse issues.

Jai was 21 and had been accessing youth AOD services since he was 14.

Jake was 21 and had a 15 month old son. He was hoping to get a bed in rehab.

Jakey was 20 and in residential withdrawal for the first time.

James was 20 and had recently completed a stay in detox.

Jazmine was 18 and had recently finished school. She was interviewed in detox.

Jerry was 19 and in detox for the first time.

Jessica was 16 years old and interviewed in detox.

Jess was 22 and interviewed at another participant’s home where she was couch-surfing.

Jessy was 19 and interviewed at a drop-in centre she was accessing.

Josh was 21 and had been abstinent for a year before a recent lapse.

Kate was 22 and transitioning out of alcohol and other drug services.

Kate C was 20 and had been in detox for a week when she was interviewed.

Katte was 17 and in detox after being referred from an outreach service.

Larry was 20 years old and interviewed at a detox.

Liam was 19 and interviewed on his last day in detox.

Lisa was 20 and had been accessing a variety of youth AOD services.

Lizzie was 21 and had been abstinent for more than three months.

Lucinda was 21 and found out about the research when in detox.

Luke was 17 years old and accessing a youth outreach service.

Maddison was 24 and transitioning out of the youth outreach service because of her age.
Maggie was 19 and interviewed at her family home.

Mary was 20 and recruited by her outreach worker.

Matt was 19 and referred to an outreach worker by his school when he was 15.

Matty was 19 years old and occasionally accessing a youth day program.

Michael was 18 and in detox after being referred by his outreach worker.

Mick was 17 and had been referred to drug services from where he had been held on remand.

Pailin was 21 and had recently relapsed after 18 months of abstinence.

Pupps was 20 and at the end of his first stay in detox.

Riley was 21 and was introduced to drugs by her boyfriend.

Roxanne was 21 and interviewed at a drop-in centre for young people with AOD issues.

Sam was 20 and accessing a day program.

Shawn was 19 and found out about the research from his outreach worker.

Simon was 17 and in detox for the first time.

Stacey was 20 and was in detox to withdraw from her pharmacotherapy.

Stevie was 20 and found drug treatment services when she walked past their office.

Voni was 19 and had been bailed to detox.

Will was 16 and in detox to try and get his drug use under control.
Glossary

**Ambos:** Ambulance officers

**AOD:** Alcohol and other drug

**Baked:** Substance affected

**Bludging:** Being slack / lazy / unproductive without reason

**Blues:** Physical fights / Brawling

**Bongs:** Implement used to smoke cannabis

**Bricks:** 2mg Xanax tablets (that look like bricks)

**Bupe:** Buprenorphine (See: Pharmacotherapy)

**Centrelink:** Australian government agency responsible for welfare payments

**Choof:** Marijuana / Cannabis

**Chroming:** Inhaling paint for mind-altering effects

**Couch surfing:** Sleeping on couches of acquaintances when homeless

**DHS:** Department of Human Services

**DoCS:** Department of Community Services

**Eckies:** Ecstasy tablets

**Ecstasy:** MDMA tablets

**GHB:** Gamma Hydroxybuturate. A central nervous system depressant with very high lethality

**Graffers:** Graffiti artists

**Habit:** Dependence on a substance

**Hammered:** Substance affected. E.g.: 'She was really hammered and couldn't recognise me'

**Hooked up:** To have casual sex with someone, though not always penetrative sex
**Ice**: Methamphetamine

**Juvie**: Youth detention, derived from ‘Juvenile Justice’ the previous name of the government department now operating as ‘Youth Justice’

**Missus**: Girlfriend

‘**On the nod**’: Substance affected, usually referring to opiates describing the physical effect of user’s ‘nodding off’

**PDAC**: Premier’s Drug Advisory Council

**Pharmaco therap y**: Opiate substitution therapies such as Methadone, Buprenorphine

**Punch-ons**: Physical fights / Brawling

‘**Sick cunt**’: Someone very cool / popular. Generally because of their ‘toughness’. Always a compliment

**Shard**: Methamphetamine / Ice

**Smack**: Heroin

**Speed**: Amphetamine

**Stoned**: Substance affected

**Stoners**: People who smoke cannabis daily or almost daily and are heavily entrenched in a sub-culture where drug use as a daily practice is the norm

**Suss**: Suspicious

**Sussed out**: To have checked one’s suspicions about another; ensuing they are an ally

**TAFE**: Tertiary and Further Education. It is the primary form of post-secondary vocational education in Australia

**Using**: Regular drug use

**Weed**: Cannabis / Marijuana

**YJ**: Youth Justice (Government department)

**YSAS**: Youth Support and Advocacy Service
Publications arising from this research


Summary

Many young people use alcohol and other drugs (AOD), but few do so to the point that professional intervention is required. This research sought to answer the question of how some young people come to experience problematic substance use.

In lots of AOD research, there is the underpinning normative claim that drug use always causes problems, so these researchers do not often ask how drug use becomes problematic. Another body of literature has sought to identify ‘risk factors’, ‘protective factors’ or ‘structural determinants’ (Hawkins, Catalano & Miller 1992; Mason et al 2011; Loxley et al. 2004). These studies identify key markers that differentiate young people who experience problematic substance use from those young people who do not. However, these studies do not explain why only some people who have these risk factors go on to develop a substance abuse problem. In my view, an adequate explanation of why some people develop problematic substance use must explicate the link between structural factors and human agency. This is the core contention of this thesis.

In order to explain the link between structural factors and human agency, I adopt a biographical approach (Chapter 1). A biographical approach gives particular attention to the relationship between structure and agency, and the role of situated choices in people’s lives. It also draws attention to the fact that young people with substance abuse issues are not a homogeneous group, and it contends that most human action – including substance abuse – is purposeful.

Chapter 2 describes how I undertook 61 life-history interviews with young people aged 14 to 24 who had substance abuse problems. They were recruited through two services that provide assistance to young people with alcohol and other drug issues in the state of Victoria, Australia. The mean age of my participants was 19 and there were 26 women in the sample and 35 men.

In Chapter 3, ‘Dancing with Death’, we meet the young people when they were engaging in extreme risk-taking behaviours. The next four chapters trace their journey from their early childhood, through their school years into unemployment, homelessness and crime.

Chapter 4, shows that many of the young men and women had ‘troubled childhoods’, marked by considerable disadvantage. Nonetheless, I point out that these
were not drug problems and troubled childhoods do not necessarily cause substance abuse.

Chapter 5, ‘In the Mix’, investigates their pathways between early childhood disadvantage and substance abuse, focusing on their teenage years. There was not a single pathway from childhood trauma to substance abuse, but there were key factors – leaving school, separation from family, unemployment and homelessness – that were always ‘in the mix’.

Chapter 6, ‘Cutting out the Pain’, focuses on the experiences of the young women. Twenty (77 per cent) out of the 26 young women disclosed that they had engaged in self-injury (‘cutting’) when they were in primary school or in their early teens. This chapter takes a deeper level of analysis and investigates whether there is any link between self-injury and substance abuse.

Chapter 7 examines the dominant style of masculinity adopted by the young men and explains how this shaped their alcohol and other drug use. Four concepts are used to guide the empirical analysis: working class hegemonic masculinity; working class machismo; and Erving Goffman’s (1959) concepts of ‘front-stage’ and ‘backstage’.

Chapter 8 meets the young men and women as they are trying to re-build their lives. Finally, in Chapter 9, I draw conclusions about the implications of my findings for policy and practice.
Chapter 1

Introduction

This thesis attempts to answer a deceptively simple question: why do some young people come to experience problematic alcohol and other drug (AOD) use? The focus is on the experiences which led to drug use, rather than the use itself. The research will also question two assumptions that are quite widely held in the Australian community. The first assumption is that drug use inevitably leads to substance abuse. The second is that young people are unable to make rational decisions about their drug use.

In order to investigate these issues I undertook 61 life-history interviews with young people aged 14 to 24 who had substance abuse problems. They were recruited through two services that provide assistance to young people with AOD issues across the Australian State of Victoria. I realised quickly that each young person travels their own unique pathway into problematic substance abuse. Understanding the extent of this diversity is of fundamental importance for the analysis that follows. Therefore, let us begin by meeting three of the young people.

Larry, aged 20, came from a working-class family and his parents were still together. He and his two brothers had left school early and the three boys had been involved in crime. Larry had serious mental health issues and he used drugs to manage his mental health symptoms. This was effective in suppressing his anxiety, but it inflamed his psychosis. Larry was part of a social group where masculinity was sharply defined by machismo and aggression and drug use was an expected social practice.

Jerry's background was quite different. Jerry, aged 19, came from a middle class family and his parents had separated when he was eight, causing Jerry a great deal of emotional pain. Jerry went to, and was expelled from, three elite private schools. After enrolling at the local state school he began to thrive academically and was the dux of his graduating class. Accepted into university, he deferred for a year and travelled overseas where his recreational drug use increased. Upon his return to Australia, Jerry abstained from all drugs, but following the death of his best friend Jerry became dependent upon heroin.
Lisa, 20, also had a different pathway into substance abuse. Her parents separated while she was an infant and both had substance abuse issues. Lisa was raised by her mother, although this relationship was volatile. During primary school, Lisa experienced ongoing sexual abuse which she kept secret. She began ‘acting out’ which soured her relationship with her mother. This relationship deteriorated so badly that Lisa’s mother kicked her out when she was 14. Lisa spent the next few years living ‘on the streets’, where she was taken care of by an older woman who introduced Lisa to heroin. During this period of her life, Lisa met a young man who was so violent toward her that Lisa ended up in intensive care.

The brief biographies of Larry, Jerry and Lisa show that these young people come from very different backgrounds: Larry came from a working class family and his parents were still together; Jerry came from a middle class family and his parents were separated; and Lisa’s mother was a single parent. Their pathways into substance abuse were also different; Larry used drugs to manage his mental health symptoms; Jerry had been a recreational drug user before he became dependent on heroin; Lisa was introduced to heroin in her mid-teens by an older woman. This diversity raises some dilemmas for policy makers. First of all, how do we design programs focusing on early intervention if young people’s pathways into substance abuse are so diverse? Moreover, how do we pick which young people should be included in those programs if we have little idea of who is at risk? In order to think about these questions, we need to have a sound understanding of the reasons why some young people experience substance abuse. This is the primary concern of this thesis and I will make some points about these important policy issues in Chapter 9.

This chapter covers four issues. First, I define what I mean by ‘problematic substance use’. Then, I review the Australian evidence on drug use and outline the ‘normalisation’ thesis. After that, I look at the data on young people using AOD services. Following this, I review three explanations for problematic substance use, and then I outline the theoretical framework that will be used in this thesis.

**Defining ‘problematic use’**

It is difficult to define ‘problematic drug use’ because whether or not drug use is ‘problematic’ does not just depend on the quantity imbibed or injected, but it is also mediated by social context. A simple example will illustrate this point. Let us suppose that two 35 year old males use exactly the same amount of alcohol and cannabis every day. However, one has a professional occupation and lives in his own home, whereas the other
is unemployed and lives in emergency accommodation. Our professional man may well view his drug use as non-problematic, whereas our homeless man is far more likely to be involved with drug treatment services. Whether drug use is problematic or not is always mediated by social context, and it does not simply depend on the quantity consumed.

Valentine and Fraser (2008) have argued that the distinction between problematic and recreational drug use is not a particularly useful way of categorising drug use. This is because it creates a binary which does not acknowledge the progressive continuum which drug use behaviours fall within. These authors argue that drug users are typically presented as either hedonistic pleasure seekers (who are usually socially privileged) or as poverty stricken problematic users taking drugs for their pain-killing properties. Valentine and Fraser (2008) argue that these are inaccurate stereotypes that do not capture the diversity of human experience.

While I agree that there is no clear line that demarcates one group from the other, I do think that a distinction is useful to enable some sort of categorisation. Among young people, the distinction between ‘recreational’ and ‘problematic’ use is often stark. While many young people experiment with drugs, problematic use is rare. However, those young people who do experience substance abuse have serious issues. Thus, I am reticent to accept that the term ‘problematic substance use’ is meaningless. The term may be difficult to define, but we should not forget that some young people need intensive supports to assist them when they are in the grip of substance abuse.

Jay (1999) suggests that there are, in fact, two groups of drug users. While not mutually exclusive, he purports that their motivations are different. Firstly, he explains that the large majority of drug users are pleasure seeking and this is made obvious by the fact that only drugs with pleasurable effects are used excessively. The second group of drug users are those whose use is problematic. Jay (1999) argues that this group need to be considered in context. He explains that as problematic users are only a small minority of the drug using population, the question that should be asked is: ‘why do they use drugs in large quantities?’ Jay contends that those who are ‘problematic drug users’ are seeking to escape from intolerable emotional situations, whereas recreational drug users use drugs for pleasure and to increase sensory awareness. As this thesis unfolds, it will become clear that this is an important insight.

Simpson (2005) offers a third category of ‘persistent’ use, which includes regular, often heavy, drug use which may not always be problematic. While ‘problematic’ and ‘non-
problematic’ drug use are not easy to define, I needed an operational definition for research purposes. Given that all of the young people who participated in this study were engaged with drug treatment services, I took this to mean that they found their drug use problematic. Therefore, I did not define problematic use by the amount of drugs that people consumed or the frequency with which they used them, nor did I apply some form of diagnostic-like categorisation. Instead, I worked from the premise that my participants had been engaged in problematic substance use (or ‘substance abuse’) because they were participating in interventions offered by drug treatment services.

Recreational drug use

Before we look at explanations for problematic substance use, we need to look at the data on overall drug use in the community. First I will discuss recreational drug use and then I will discuss the ‘normalisation thesis’.

There are two main sources of data about the drug use patterns of young Australians. First, the National Drug Strategy Household Survey (NDSHS) is undertaken every three years by the Australian Institute of Health and Welfare. People are asked about their drug use and their attitudes towards drugs. The 2010 NDSHS (AIHW 2011) had a sample of 26,648 people aged 12 and over.

There are significant limitations with the household survey on drug use and these need to be noted. Some household members may not be confident that their individual data is confidential and thus not report accurately. Also, those who are not housed are not included in the survey. Finally, the sampling frame used for the study is not stratified by population size, so some States and Territories are either over or under-represented. Notwithstanding these limitations, the NDSHS is an important source of data on the epidemiological patterns of drug use in Australia.

The second source of data is the Australian Secondary Students’ Alcohol and Drug Survey (ASSAD) which provides figures on drug use prevalence amongst young people enrolled in Victorian secondary schools (Department of Health 2013). This study collects data on young people aged 12 to 17 enrolled in public, private and Catholic secondary schools. The most recent study had a sample of 4413 young people. As with the NDSHS study there are some obvious limitations. Some young people may be reticent about disclosing their drug use patterns, and others may exaggerate their ‘worldliness’ out of a sense of bravado. Most importantly, young people who are not at school when the survey
is carried out are excluded, and some of those who are absent may be the more marginalised students who have higher levels of drug use.

Both surveys ask whether young people have ever used particular drugs ('lifetime prevalence') as well as whether young people have used various drugs in the preceding four weeks ('period prevalence'). In this section I examine the lifetime prevalence data and I will come back to the period prevalence data later.

**Table 1.1:** Drugs ever used by people in different age groups

<table>
<thead>
<tr>
<th></th>
<th>NDSHS* 18-19 years</th>
<th>NDSHS* 20-29 years</th>
<th>ASSAD** 17 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>86%</td>
<td>85%</td>
<td>91%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>32%</td>
<td>47%</td>
<td>28%</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>10%</td>
<td>24%</td>
<td>5%</td>
</tr>
<tr>
<td>Meth/amphetamine</td>
<td>6%</td>
<td>15%</td>
<td>5%</td>
</tr>
</tbody>
</table>

*National Drug Strategy Household Survey
**Australian Secondary Students' Alcohol and Drug Survey

Table 1.1 presents the ASSAD data for those aged 17 years (the oldest cohort) and the NDSHS data for those aged 18 to 19 and 20 to 29. First, I will examine the data for the two younger age groups. There is some variation between the findings of the two studies, but the broad pattern is fairly similar. About 90 per cent of the young people in their late teens have tried alcohol (86% in the NDSHS study and 91% in the ASSAD research); and about one-third have tried cannabis (32% in the NDSHS study and 28% in ASSAD). Much smaller numbers have tried the ‘party’ drug ecstasy – five per cent in one survey and 10 per cent in the other; and about five per cent have used meth/amphetamine.

However, if we look at the data for those aged 20 to 29 there is a sharp increase in the number of people who have used all of these drugs, except for alcohol which remains steady at 85 per cent. The number who have tried cannabis rises from about one-third among the younger age group to almost half (4%) among those aged 20 to 29; the number who have tried ecstasy rises from 10 per cent to 24 per cent; and the number who have tried meth/amphetamine increases from five per cent to 15 per cent.
On the available evidence, it appears that a significant minority of young people have tried illicit drugs by their late teens, and the proportion rises quite sharply amongst those in their twenties, with half having used cannabis and a quarter having used ecstasy.

**The ‘normalisation’ thesis**

The high rates of illicit drug use detailed in the last section have led many to the claim that it has become normal for young people to engage in recreational drug use. The ‘normalisation’ thesis was developed by scholars in Britain, but it has also been influential in Australia.

One aim of these researchers was to overturn the prominent discourse that drug use was a pathological form of behaviour. In the early 1990s, the British scholars wrote extensively about the apparent ‘normalisation’ of recreational drug use among young people (see: Measham, Newcombe & Parker 1994; Parker, Measham & Aldridge 1995; Parker, Aldridge & Measham 1998; Parker, Williams & Aldridge 2002). Their work was thought-provoking.

They undertook a longitudinal study with more than 700 participants, tracking them from when they met them as 14 year olds until they were 18. The study began in the early 1990s and explored drug use prevalence among young people. These researchers advanced the thesis that recreational drug use was now normal among young people in Britain. They acknowledged that there are a small minority of young people whose use does become problematic, but that this group were atypical. Parker, Measham and Aldridge (1998) focused on six dimensions of drug use that were said to have become normalised: drug availability; drug trying; drug use; being drugwise; future intentions; and cultural accommodation of the illicit.

The normalisation thesis moved away from the older sociology of drug use that was developed in the early 1960s. Howard Becker (1963) had argued that drug use was a clandestine activity and that cannabis users had to take great risks to obtain marijuana (which was subject to significant social controls). Moreover, cannabis smokers had to engage in their recreational activity in secret, making sure that outsiders did not discover their ‘deviance’. The major claim of the normalisation thesis was that the cultural taboo attached to illicit drug use had all but collapsed among the younger generation. Drug use was now so prevalent that people no longer felt the need to hide their activities or to even deny that they engaged in them.
Research in Australia has also examined the normalisation thesis. In a study of recreational drug use among young people frequenting bars and nightclubs, Duff (2005) found that the acceptability of drug use was increasing. Of the 379 participants, more than half had used illicit drugs and one in three had done so in the previous month. Further, the attitudes of the participants reflected a culture among these young people where recreational drug use was acceptable, and certainly not something for which one would be ostracised. The attitudes of these young night-clubbers were consistent with the main contention of the normalisation thesis. Drug use was no longer behaviour that had to be cloaked in secrecy; rather, drug use was now an accepted recreational activity in youth culture.

In the broader community, drug (although not alcohol) use was still stigmatised, and it was often assumed that drug use inevitably leads to substance abuse. The normalisation researchers were attempting to deconstruct this stigma by pointing out two things: recreational drug use is widespread among the younger generation; and that few of these young people experience drug-related harm (Parker, Aldridge & Measham 1998). The architects of the normalisation thesis did not necessarily condone drug and alcohol use. Nonetheless, they wanted to emphasise an important factual point: drug and alcohol use does not usually lead to dependence.

The normalisation theorists did garner some support from policy makers for their arguments; however, this was not for the reasons that they hoped. The normalisation theorists were trying to de-stigmatise recreational drug use among young people and challenge the common construction of youth leisure as inherently delinquent and often worse – deviant. More than a decade on, the normalisation pioneers reflected that,

... the underlying political thrust of normalisation was an attempt to cast young people in a more positive light, as reasonable, responsible agents making their drug-taking decisions, weighing up the costs and benefits of their actions, carefully deciding which drugs to take or avoid. (Aldridge, Measham & Williams 2011, p.217)

The focus on young people’s agency in their drug use was intended to demonstrate that drug use was not an inherently reckless or ill-considered behaviour. However, it was a nuance overlooked by policy makers who did not take on the recommendation for de-
penalisation of cannabis or to increase harm-reduction policies (Aldridge, Measham & Williams 2011). Policy makers appeared to take the normalisation of recreational drug use as further evidence that young people need greater policing. This is a prime example of the overemphasis of agency and under-emphasis of structure that MacDonald has emphasised as typical in explanations of marginalised youth (MacDonald 2006; MacDonald & Marsh 2001).

Later in this chapter I will outline criticisms of the normalisation thesis, but two of the arguments made by the normalisation theorists were well-founded and their contribution was important. First, there is no doubt that recreational drug use has increased amongst young people. Second, they were right to point out that most people who engage in recreational drug use do not develop a substance abuse problem. However, a minority of young people do develop substance abuse issues and this is the group that I am interested in. Let us have a look at what we know about them.

**Young people in alcohol and other drug treatment**

In 2013, Kutin et al. undertook a survey of all young people accessing treatment for drug and alcohol issues across Victoria (Kutin et al 2014). It is known as the *Statewide Youth Needs Census* (SYNC). This was the first study of its kind in Australia and it asked workers to complete an online survey for each client who had an open episode of care on the 6th of June 2013. All 42 youth AOD services across Victoria were contacted and 41 services (98 per cent) provided information. In total, information was gathered on 1000 young people, or 80 per cent of their current clients. The survey covered key indicators of health, wellbeing and vulnerability.

Table 1.2 compares the drug use over the past four weeks of clients accessing AOD services with the drug use reported by young people in the two general surveys discussed previously. Table 1.2 shows that alcohol was the most commonly used drug by young people in the two general surveys but the findings were somewhat inconsistent: 62 per cent of respondents in the ASSAD survey had used alcohol, compared with 39 per cent in the NDSH survey. Roughly two-thirds (63%) of those accessing AOD services had also used alcohol in the previous four weeks, similar to the ASSAD result for the general population. The similarities between the young people with substance abuse issues and the general population end there.
Table 1.2: Drug use during the past four weeks

<table>
<thead>
<tr>
<th></th>
<th>NDSH* 18-19 years</th>
<th>ASSAD** 17 years</th>
<th>SYNC*** 12-27 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>%</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td>Cannabis</td>
<td>6</td>
<td>8</td>
<td>64</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>1</td>
<td>n/a</td>
<td>4</td>
</tr>
<tr>
<td>Meth/amphetamine ('ice')</td>
<td>4</td>
<td>n/a</td>
<td>35</td>
</tr>
<tr>
<td>Heroin</td>
<td>0</td>
<td>n/a</td>
<td>7</td>
</tr>
</tbody>
</table>

* National Drug Strategy Household Survey  
** Australian Secondary Students' Alcohol and Drug Survey  
*** State-wide Youth Needs Census

Almost two-thirds (64%) of those with substance abuse issues had used cannabis in the preceding four weeks, compared with six to eight per cent of young people in the general population. One-third (35%) of those with substance abuse issues had used meth/amphetamines in the preceding four weeks, compared with four per cent of the youth population; and another four per cent had used ecstasy compared with one per cent of the general youth population. In the general population, no-one reported using heroin in the preceding four weeks, although 0.2 per cent had tried heroin during their lifetime. However, seven per cent of those accessing AOD services had used heroin in the preceding four weeks.

The SYNC survey also found that many clients came from disadvantaged backgrounds and were often disconnected from both the education system and the labour force. Just over half (53%) had experienced high levels of family conflict, and one-third (33%) had been involved with the state care and protection system. Nearly two-thirds (62%) had experienced either abuse and/or neglect at home, and 73 per cent of the young men had been involved with the criminal justice system. Young women were faring worse on other measures of vulnerability with much higher levels of sexual abuse, self-injury and injecting drug use. Finally, it was reported that 43 per cent of the young people 'lacked any meaningful daily activity'. This implies that they were disconnected from both the education system and the labour force (Kutin et al. 2014).
These findings were consistent with the findings from the pilot study that was undertaken for this research (Daley 2008; Daley & Chamberlain 2009), as well as with the findings from a number of overseas studies (Catalano & Hawkins 1996; Kosterman et al. 2000; Kuperman et al. 2001). The pilot study adopted a mixed-methods design. Life-history interviews were undertaken with 12 young people accessing a youth AOD service and structured interviews were completed with 14 youth AOD outreach workers. The outreach workers provided demographic information about the 111 young people who were currently working with that service. That study found that family breakdown, abuse, neglect, parental substance abuse, involvement with child protection as well as homelessness were all common among these young people, and there were no significant differences between males and females.

This study was based in Australia, but its findings are not geographically unique. There is a well-established link between childhood trauma and later adolescent substance abuse. Rosenkranz, Muller and Henderson (2012) undertook a study of 16-24 year olds entering treatment for substance abuse (n=216) and among this sample, 90 per cent of the young women and 72 per cent of the young men had histories of psychological abuse. Similarly, several American studies examining children who were in foster care have shown issues of adolescent substance abuse to be vastly over-represented (Aarons et al. 2001; Keller et al. 2010; Traube et al. 2012). However, the relationship is not causal; many children who experience trauma will no develop a drug problem thus, I was curious as to why some do.

**Three explanations for substance abuse**

This section examines three explanations for problematic drug use, before outlining the approach that is employed in this thesis. In the broader community, substance abuse is often seen as an individual failing brought on by poor choices or weakness of character. An alternate understanding is the biological-determinist view which argues that addiction is a disease of the brain over which an individual has little control. Social scientists offer a different view again, often drawing attention to a range of structural factors that increase the likelihood that a young person will develop a substance abuse problem.

**Individualistic explanations**

In the broader community it is often said that substance abuse is an individual choice; or that it reflects various types of character weakness. This view often seems pervasive, although it is given little attention in the scholarly literature. Alexander (2008) draws attention to this in his historical account of addiction. Alexander argues that only through
an historical perspective are we able to understand the complex development of ‘addiction’ as a cultural phenomenon:

The conventional wisdom depicts addiction, most fundamentally, as an individual problem. Some individuals become addicted and others do not. An individual who becomes addicted must somehow be restored to normalcy. There is an odd dualism built into this individual-centred depiction: addiction is seen either as an illness or as a moral defect or—somehow—both at once. Accordingly, addiction can be overcome by professional treatment or moral reformation of the afflicted individual, or both ... the historical perspective does not deny that differences in vulnerability are built into each individual’s genes, individual experience, and personal character, but it removes individual differences from the foreground of attention, because social determinants are more powerful. (Alexander 2008, p.1-2)

The view that those who suffer the negative effects of substances do so because they choose to use drugs and therefore do not ‘deserve’ help is simplistic. While it is true that substance use is an individual choice; it is hard to believe that individuals choose to experience problematic substance use. Nonetheless, this view has influenced some policy makers. In 1981, the ‘Just Say No’ campaign driven by the United States First Lady, Nancy Reagan, perpetuated the view that drug abuse could be prevented if individuals were to make ‘better’ choices. Of course, people make choices all the time, but we need to understand why some people make choices that lead to substance abuse whereas others do not.

On the other hand, there is another strand in the individualist argument that explains substance abuse as a consequence of ‘bad character’. This populist argument purports that some people have personality traits – fecklessness, laziness, slothfulness and so forth – that explain their excessive alcohol and other drug use. Substance abuse is a consequence of bad character rather than bad choices. In a sense, this argument explains ‘everything’ and ‘nothing’ at the same time. Question: ‘Why do people become drug addicts?’ Answer: ‘Bad character’. Question: ‘How do you know they have bad character?’ Answer: ‘They are drug addicts’.
There are problems with both versions of the individualistic argument that I have reviewed. Nonetheless, one should not dismiss the argument completely. It is important to bear in mind that people are conscious actors who always make choices about their lives, as the normalisation researchers had hoped to emphasise. This ‘obvious fact’ about the human condition – that individuals do make choices – has to be incorporated into an adequate explanation of why some people develop substance dependence. Surprisingly, the next approach says people have no choice at all!

**Biological-determinist explanations**

The biological-determinist view argues that addiction is a disease and that ‘addicts’ have an illness that has a physiological basis. One of the largest AOD research centres is the US National Institute on Drug Abuse (NIDA) which bases its research on the ‘science of addiction’. The head of this centre is a psychiatrist, Nora Volkow, who argues that addiction is a disease of the brain (Volkow & Fowler 2000).

The medical model of addiction is closely aligned with the 12-step model of treatment that is used in Alcoholics Anonymous and Narcotics Anonymous. This approach suggests that there are genetic determinants of addictive behaviour. Magnetic resonance imaging (MRI) has been used to show the effects of drug use on an individual’s brain and also to argue that there is a process of neuro-adaptation where the brain becomes ‘addicted’, thus over-riding the individual’s agency.

The biological-determinist view has difficulty explaining why problematic substance use is over-represented in groups with low socioeconomic status. It also has difficulty explaining why many people report recreational drug use for many years, before the development of an addiction. Addiction theories tend to view drug misusers as ‘helpless addicts’ who continue to consume simply because they cannot do otherwise. This approach precludes the role of agency altogether.

**Social scientific explanations**

Various commentators have observed the lack of research of a sociological bent within the AOD field. Hamilton (1993), for instance, has argued that sociology is the ‘poor relation’ in AOD research, and Zajdow (2005) suggests that this is because sociologists are ‘scared’ of entering debates about drugs. Social scientists have traditionally taken the view that a variety of factors are involved in the development of problematic substance use and that there can be no single causal factor.
In the Australian literature, a number of authors have attempted to identify ‘risk factors’, for substance abuse, as well as ‘protective factors’ (Hawkins, Catalano & Miller 1992; Mason et al. 2011; Loxley, Toumbourou & Stockwell 2004). These authors draw attention to a number of risk factors, but I will use one example to illustrate their approach. The age of substance use initiation is said to be related to the onset of problematic drug use is (Degenhardt et al. 2010; Degenhardt, Lynskey & Hall 2000; Loxley, Tombourou & Stockwell 2004; Mason et al. 2011). There is evidence that shows that statistically, young people who have problematic drug use began drug use earlier in life than their peers without drug issues. Research has also consistently shown that people with more chaotic drug use and those who are poly-drug users also commenced drug use at an earlier age (Degenhardt et al. 2010; Degenhardt, Lynskey & Hall 2000; Hawkins, Catalano & Miller 1992; Loxley, Tombourou & Stockwell 2004; Mason et al. 2011). These statistics are used to conclude that the earlier in life that an individual tries drugs; the more likely they are to develop problematic substance use. Essentially, this approach identifies various structural factors that are correlated with substance abuse (early drug use), but it does not incorporate the role of human agency.

Most importantly, this argument does not explain something very significant: why do some people who try drugs early go on to develop a substance abuse problem, whereas others who try drugs early on do not? Several social scientists have raised this question. Hamilton (2004) points out that while drugs must precipitate problem use, drugs rarely lead to problem use. She, like MacDonald (2006) and Webster et al. (2004), found that risk factors alone do not throw much light on who is likely to go on to develop problematic substance use. These researchers found that in highly impoverished areas, there were people with the same number of risk factors without a substance use issues. Hamilton (2004) argues that to best identify those most ‘at risk’, it is more useful to measure the number of protective factors an individual has with the hypothesis that those with the least are those most ‘at-risk’.

Webster et al. (2004), found in their sub-sample of people with criminal and/or drug-using careers that those who desisted from crime and drug use had similar life troubles to those whose drug use and criminal activity persisted. However, upon reading the biographies of the selected participants presented in their report (Webster et al. 2004) it appears that while the number of risk factors was not a distinguishing variable, on reading the report at face value, those who were doing well at abstaining from drug use and crime were those who had more protective factors in their lives.
In order to understand these differences, we need more biographical information. For example, why do some young people have access to drugs at a very early age? Why do drugs appeal to some of these young people, but not to others? What sort of families were these young people in where early-drug use was acceptable? There is an increasing body of evidence that these young people often come from families where there has been child abuse, neglect, parental substance abuse, or the young person has been involved in the state care and protection system (Best et al. 2012; Keller et al. 2010; Kutin et al. 2014; Rosenkranz, Muller & Henderson 2012; YSAS 2012). In some cases, these factors precede drug use initiation. Explaining problematic drug use is complex: it does not occur in a vacuum free of structural influence yet it is also not biologically determined. There are some established ‘risk factors’, namely childhood trauma, but this alone does not explain substance abuse. This thesis seeks to disentangle the nuance of the relationship between childhood and problematic substance use.

**An alternative framework**

**Critics of the normalisation thesis**

The normalisation thesis drew attention to the point that recreational drug use is now widespread among young people and that few of these young people were experiencing drug-related harm. The normalisation theorists were trying to de-stigmatise recreational drug use among young people, so that policy makers could direct their attention to the smaller number of teenagers who were experiencing drug related harm and to stop over-policing young people.

However, we saw earlier that this did not work and that perhaps it did the opposite by perpetuating the idea that young people’s leisure is always a problem (Aldridge, Measham & Williams 2011). The underlying belief that drug use is always problematic was never questioned. There was an implicit – and sometimes explicit – assumption that ‘adults’ are morally superior and that it is the responsibility of ‘grown ups’ to police young people’s behaviour. In the eyes of some people, if drug use was becoming more widespread then punitive policies should be introduced to curb this dangerous trend. While the evidence suggested that drug use was increasing, but that it was not necessarily a problem; the widespread uptake of the normalisation thesis led to harsher drug policies (Blackman 2004).
From its inception, Shiner and Newburn (1997) were critical of the normalisation thesis. They were concerned that the thesis made exaggerated claims about the number of young people who used drugs and how widely this was accepted. They pointed out that drug use is not a ‘normal’ activity among young people although it is fair to say drug use is more socially acceptable than in previous generations. They also pointed out that some young people use neither alcohol nor illegal drugs and we cannot assume that they necessarily condone drug and alcohol use.

Shiner and Newburn’s (1997) second objection was that the normalisation thesis gave insufficient attention to diversity within the youth population. They pointed out that the normalisation thesis ‘... stresses the uniformity and apparent ubiquitousness of youthful drug use, and underplays the tensions and divisions that continue to exist within youth culture(s)’ (Shiner and Newburn 1997, 513). They argued that there are still major class, gender, ethnic and regional differences among young people in Britain, and this makes it unlikely that young people engage in recreational drug use for the same reasons or in the same way.

One inference that had been drawn from the normalisation thesis was that young people are ‘much the same’ but this over-emphasises the homogeneity of the youth population. Most importantly, it distracted attention away from the different causes, as well as the diverse consequences, of drug use for different groups of young people. Shiner and Newburn (1997) concluded that there were no grounds for assuming that the choices that young people make about drugs are all the same; nor are the contexts in which they use drugs similar; and nor are the outcomes of drug use necessarily the same.

Shiner and Newburn (1997) were particularly concerned that the normalisation thesis had little to say about minority groups in the youth population. For example, did the thesis have the same applicability to homeless youth as it did to middle-class nightclub patrons? It seemed unlikely that these two groups engaged in drug use for similar reasons, and it seemed even more unlikely that drug use had the same consequences for them. Most importantly, the normalisation thesis did not explain why some young people experience substance abuse. These teenagers are both marginalised from mainstream society and very needy. Would government no longer feel the need to assist them? After all, isn’t teenage drug use now ‘normal’?

In the midst of the debate about the normalisation thesis, MacDonald and Marsh (2002) undertook a longitudinal study exploring youth transitions among people
experiencing social exclusion. MacDonald and Marsh (2002) conducted a detailed study in an area with nine council housing estates in Teesside, in Northeast England. Their study was conducted between 1999 and 2001 and the data collection was a three stage design. Firstly, 40 professionals who work with the young people were interviewed. This was followed by a 12 month participant observation. Finally, interviews were conducted with 88 young people aged 15 to 25 years; these participants were re-interviewed about 12 months later. There was a 60 per cent response rate at the second round of interviews.

The research undertaken by MacDonald and Marsh was designed to test the normalisation thesis, and it focused on the ‘socially excluded’ who were the group that Shiner and Newburn were most concerned about. With regard to the normalisation thesis, MacDonald and Marsh stated that: ‘At best, our evidence would support a theory of differentiated normalisation’ (MacDonald and Marsh 2002 p.27). This was supported by a later paper by Measham and Shiner (2009) who reflected that their respective positions on normalisation – Measham was a proponent while Shiner a critic – did not allow for a sufficient understanding of young people’s ‘situated choices’.

MacDonald and Marsh (2002), whose findings had shown diversity even among young people from the same social class, explained their ‘differentiated normalisation’ within a threefold typology. On the basis of their research, they identified three groups in the marginalised youth population in Teesside. First there were young people who abstained from drug use and were critical of those who took drugs. Second, there were a large group of recreational drug users; and, third, there were young people who were engaged in problematic drug and alcohol use.

The young people who were recreational drug users (50% of participants) held views that were broadly consistent with the normalisation thesis. They engaged in recreational drug use with other young people, did not feel stigmatised by their behaviour, and thought that recreational drug use was ‘normal’.

However, those young people who abstained from drug use (35% of the participants) were critical of any drug taking. They acknowledged a high prevalence of drug use in the area, but they refused to agree with the suggestion that drug use was ‘normal’. The acceptance of this suggestion would have positioned them as ‘abnormal’, whereas they felt morally superior for abstaining from drug use.

The final group in MacDonald and Marsh’s typology were those young people who were engaged in problematic drug use (14% of the sample). This group were self-defined,
but they were usually partaking in daily use of various types of drugs and alcohol, and some were very heavily ‘into the scene’. MacDonald and Marsh felt that a biographical approach was essential to disentangle their pathways into problematic substance use from the multiple forms of disadvantage they had experienced as they were growing up. Similarly, Shildrick and MacDonald (2007) also articulate that a biographical conceptualisation of disadvantaged youth is crucial to understanding them. This is what informs the approach of this thesis.

**A biographical approach**

My biographical approach is guided by five propositions that will be used to shape the empirical analysis that follows.

1 **Individuals are conscious decision makers**

It has already been pointed out that people are conscious actors who make choices about their lives. This is an ‘obvious fact’ about the human condition and it has to be incorporated into explanations of substance dependence. We met Larry, Jerry and Lisa briefly, but we saw evidence that they were making decisions about their lives. For example, Larry chose to use drugs to manage his mental health symptoms; Jerry decided to abstain from all drugs upon his return to Australia; Lisa made a conscious decision to not ever go home after she had been evicted by her mother. An adequate explanation of young people’s pathways into substance abuse must take into account how young people make decisions about their lives, sometimes changing their minds, and often reflecting on what has happened.

2 **Structural factors are important**

The term ‘structural factors’ is widely used in sociology to refer to those external factors that influence people’s lives. They come in two main forms which are sometimes referred to as ‘material structures’ and ‘non-material structures’. Material structures relate to institutions, organisations or physical structures that typically have some form of material presence, such as the education system, the criminal justice system, the housing market and so forth. Non-material structures relate to belief systems that are external to the individual. So, for example, hegemonic masculinity is a non-material structure, as is patriarchy, as are other cultural beliefs about how people should act. One of the most important challenges in the analysis that follows is to demonstrate the link between external structures that influence people and how actors make their decisions. This is
sometimes referred to as understanding the 'link between structure and agency'. The key analytical device that I will use to make this link is the notion of 'situated choices'.

3 People make situated choices

The idea of a ‘situated choice’ refers to the range of alternative forms of action (or possible decisions) that are available to an actor in any given situation. Shiner (2009) has suggested that young people make ‘situated choices’ with regard to their drug use. To illustrate, I will give an example relating to youth drug use in Australia. When young people go out night-clubbing, they often want to use recreational drugs that heighten pleasure and increase sensory awareness. Since these drugs are illegal, they have to consider *inter alia*: which drugs are currently available in their area; whether any or all of those drugs are suitable party drugs (heighten pleasure, increase sensory awareness etc.); the relative prices of different drugs; which drugs are the most pleasurable; and whether one drug is safer than another. If we think about drug use in this way, then we start to understand why Ecstasy is the second most commonly used illicit drug in Australia and why it is particularly popular amongst people under 30 (AIHW 2008). Ecstasy has the required effect of heightening pleasure and increasing sensory awareness and for an illegal, and thus unregulated, substance it is relatively safe. Only 0.7 per cent of young people who present at drug treatment services report that ecstasy is their drug of concern (AIHW 2013). Young people probably choose ecstasy rather than more harmful party drugs (such as ketamine or GHB), because ecstasy has the desired effect, is readily available, and rarely leads to involvement with drug treatment services. When young people choose their drugs for a ‘night on the town’, they are making ‘situated choices’.

4 Young substance abusers are not a homogeneous group

A biographical approach has to take into account that young people who engage in problematic drug use are not a homogeneous group, and that there are multiple pathways into substance abuse. We have seen that there is an increasing body of evidence which shows that young people with substance use issues often come from very disadvantaged backgrounds, with about half having been involved in the state care and protection system. Nonetheless, it is wrong to conclude that all young people with a substance abuse problem come from these backgrounds. We saw earlier that Jerry came from a middle class family and he had attended three private schools. As I have pointed out, understanding the extent of diversity is of fundamental importance for the analysis that follows.

5 Action is usually purposeful
I pointed out earlier that this research will also question the assumption that young people are unable to make rational decisions about their drug use. In my view, this claim causes more harm than it seeks to prevent, because it directs us away from recognising that most behaviour is purposeful, even when it involves young people taking extreme risks. At the end of this thesis I hope to be able to answer another simple question: why do young people continue to use drugs problematically when this involves: breaking the law (fines and imprisonment); widespread opprobrium in the community; condemnation in the media; and rejection by one’s peers? What purpose could their drug use possibly be serving? There is an answer – and it is not good news.

**Conclusion**

This chapter began with three cases of young people whose stories are detailed throughout the thesis. Then I defined what I meant by 'problematic substance use'. This was followed by a review of the Australian evidence on drug use and an outline of the 'normalisation' thesis. After that, I looked at the data on young people using drug and alcohol services, before reviewing three explanations for problematic substance use. None of these explanations – individualistic, biological-determinist or social scientific – dealt adequately with the fact that people are conscious actors who make choices about their lives.

Finally, I outlined the theoretical framework that will be used in this thesis. I referred to this as a biographical approach. It gives particular attention to the relationship between structure and agency, and the role of situated choices in people's lives. It also draws attention to the fact that young people with substance abuse issues are not a homogeneous group and it contends that most human action – including substance abuse - is purposeful. I outlined my approach in the form of five propositions. These propositions will be used to guide the empirical analysis that follows.

Chapter 2 outlines my methodological approach and in Chapter 3 we meet my participants 'in the grip' of substance abuse. The following four chapters outline how they undertook this journey into problematic drug use. Chapter 4 focuses on their early childhood, and Chapter 5 traces their journey from recreational drug use to substance abuse. Then in Chapter 6 I examine the women's pathways into substance abuse, and in Chapter 7 I examine the experiences of the young men. In Chapter 8 we see them trying to rebuild their lives. Finally, Chapter 9 makes some tentative policy points. This is not an easy story to tell – and there is some heartache on the way.
Chapter 2

Methodology

To answer the question of how drug use becomes problematic for some young people, I had to think extensively about what research design would be most appropriate. The aim of the project was to explain problematic substance use within the context of individuals’ life experiences and to achieve this I adopted a largely qualitative design. Within sociology, this is not a novel approach. However, much literature on youth drug use comes from psychology and psychiatry, where research is heavily couched in the framework of risk and protective factors and adopts quantitative approaches (Loxley et al 2004; Hawkins, Catalano & Miller 1992; Loxley, Toumbourou & Stockwell 2004). In order to provide a sound, detailed account of the complex interplay between agency and structure in young people’s lives, life-history interviews were selected as the key method. Given that the population whom I was seeking to research were vulnerable in several ways – not all were 18 years of age, most were engaged in illicit activity (drug use), and many were homeless – there were a number of ethical issues to consider prior to undertaking the interviews. This chapter begins by discussing the method that I employed, before outlining the complex ethical considerations which come with researching young people experiencing problematic substance use.

Method

Recruitment

The success of this research was dependent on being able to recruit participants. It was important to engage a wide array of young people participating in services. Gaining access to participants and successfully recruiting them do not always go hand in hand. This section outlines the recruitment strategy. First it introduces the two services that I worked with collaboratively to engage young people in the research and, more importantly, to do so in a way that was most beneficent to the young people. What constituted ‘most beneficent’ involved an ongoing dialogue between my collaborating agencies and the university ethics committee. For instance, where the committee felt that paying participants was an inducement, one of the collaborating agencies had a policy that all researchers must pay clients for their participation in research. This was to ensure that they were remunerated for their time and expertise. The university committee were
happy to follow the best practice of the services. Participants were each paid $30 for the interview, although I did not advertise this. More often than not, it was a pleasant surprise at the end of the interview.

For two reasons, it was essential to collaborate with service providers for this research. The first was logistical: how else does one locate 60 young people with problematic substance use? But more importantly, it was imperative that young people were engaged with services as a mechanism to ensure that participants had some supports and resources in place should the research process be distressing in any way. I collaborated with the Youth Support and Advocacy Service (YSAS), and Barwon Youth Alcohol and Other Drug (AOD) Service

Engaging with YSAS was important as it is the largest youth AOD service provider in Victoria, operating many different programs, and providing services to clients across the state. YSAS was the first specialist youth AOD agency in Australia. It began operation in 1998 and pioneered the model for youth AOD work. They offer a variety of services including: outreach, residential withdrawal, residential rehabilitation, a supported housing service, day programs, a young parents program, forensic services, and primary health services. YSAS see clients aged 12 to 21.

Barwon Youth is a generalist youth service in regional Victoria that offers a variety of programs including education and training, and an AOD service. The AOD service has two programs: outreach and a day program. Barwon Youth sees clients aged between 15 and 25.

Previously, I had been employed in the sector and this meant that developing these collaborations was a smooth and organic process. Often I knew, or knew of, the staff and management at the service sites. Getting ‘access’ was not an obstacle: services were positive about the opportunity for research which they could not otherwise afford. As an ‘insider’ of sorts, I was given an ‘access all areas’ pass. Senior management at both services were comfortable for me to arrange my visits on my own rather than to supervise me or to arrange the first meeting with program managers. There was an implicit understanding that as a former frontline worker, I would adopt the same philosophical approach to the young people as research participants as I did when they were clients. There can sometimes be a chasm between researchers and service providers. It is important to bridge this chasm for collaboration to be successful. This can be both time consuming and resource intensive. Service providers are short of time and resources and they are usually concerned that researchers may negatively disrupt programs. Having a pre-existing
relationship with the sector, I was often referred to as ‘one of us’. It was assumed that we had a shared understanding of problematic youth substance use. Being an insider was integral to the success of the recruitment.

When seeking to recruit participants, it is necessary to seek approval from the senior management of the organisation. However, it is inevitably the frontline staff who promote – or do not promote – the research to clients. Having good relations with these workers, and respecting the nature of the work (i.e. working around their very hectic schedules rather than asking them to work around my own), contributed significantly to their enthusiasm for the research. It was these frontline workers who let clients know about the research, who arranged meetings between the clients and me, and who let me ‘hang out’ in their spaces and immerse myself in the environments in which the clients were spending their time. The workers did not ask me to disclose what was shared between the client and myself, but were able to help the young person should they need debriefing later on. There was no passive resistance; rather, workers were active in enabling the research process.

This positive relationship was built on reciprocity. As the researcher, I too needed to understand the nature of the work. At the beginning of data collection, the staff at the first agency were still recovering following a spate of youth suicides in their region. There was a heavy sense of grief in the town and both clinicians and clients were distressed. It was inappropriate to begin an interviewing program at that time. I suggested that I return to the site as my last service provider, two years later, which the site both agreed to and appreciated. They wanted to be involved, but at a time that was appropriate.

Time was central to the research process. It was necessary to allow a long period of data collection to ensure a large and diverse sample were recruited. While it took time, like MacDonald (2008) reported, the population here were not ‘hard to reach’.

I wanted to interview a cross-section of the young people in the service; not only those who were outspoken or the usual nominee for youth participation activities. These people were certainly welcomed, but I also wanted to engage those who were typically quite shy with strangers. My strategy was to spend a lot of time near them, typically ‘hanging around’. I regularly and consistently spent whole afternoons and evenings in day programs, detoxes and drop-in centres. Here I got to know the regulars, but I also got to know the occasional visitors too. I actively sought to distance myself from the staff by not taking keys or spending any time in ‘Staff Only’ areas. It was important to avoid
exacerbating the already obvious power imbalance between myself and the young people and to assure them that what they told me as research participants would not be relayed to any of the workers. This project did not adopt an ethnographic design to the extent of Venkatesh (2008) or Bourgois (2002) who both immersed themselves in high-rise public housing tenements in areas throughout America for many years. Nonetheless, basic ethnographic principles were applied with the intention of making young people feel comfortable and familiar with me by being in, and understanding, their spaces and the practices which govern them (Hammersley 2007).

Young people sometimes asked who I was, but more often they watched who I was. In our banter and chats around the basketball court or the lounge room of a detox, they would watch my interactions with others and listen to how I spoke. Very often, young people – young men in particular – would look up in shock when I swore. This was an obvious marker that their perception of a researcher was someone who did not swear. Similarly, I seemed to build some credibility by being able to understand the colloquial terms for drugs and various other practices in which they partook. Frequently, I found myself strengthening my connection with them accidentally. On one occasion, a young woman wanted to make a sandwich but could not make because she had just painted her nails. When I offered to do it for her, this small act received far more gratitude than was warranted. Likewise, asking a young man, ‘Have the dreams started yet?’ when he told me he was at day seven of withdrawing from cannabis, was received with a look of connection. He had not realised that this symptom was normal. He found it comforting in hearing that these dreams were common and that it would pass. These interactions which were casual and unplanned, often led to deeper conversations and helped to develop a bond with the young person. Unintentionally, these interactions showed the young people that I cared about them, enabling me to become a welcome visitor. While ‘hanging out’ with the young people, I was never able to become an ‘insider’ in the true sense of the term. Separating myself from the staff was done reasonably well; yet while I developed very close relations with the young people, I was still older than them and not one of them.

As with every researcher undertaking anthropological methods, who I was shaped the nature of my relationship with participants. In my mid-20s, I often found myself being asked the sort of advice one asks an older friend or big sister. Young women asked about make-up, menstrual cycles, relationships, body image and anxiety. They talked about fashion or asked my advice about love and everyday life. The young men often took some time to feel comfortable. Many masked their vulnerability with machismo. They were
assertive in their use of shared space, sometimes punctuating their sentences with the word 'cunt', and then apologising for swearing in front of a 'lady'. They were not trying to use 'standover' tactics on me; rather, this was simply how they interacted with women. The more days I spent with them, the more I saw this fade. Typically, there would be a 'moment' when I would see the bravado fall. These moments were always unplanned.

One young man mentioned in passing that he had had his first psychotic episode and had woken up in hospital, unsure of what had happened. I observed, 'Gosh, that must have been scary'. He paused, 'Yeah, yeah it was', he uttered, seemingly surprised that he had admitted to that. It was these moments, often where I offered the young men a chance to be something other than 'tough', which developed the richness in our relationships; where me being a young woman stopped being a barrier and instead I became an adult who cared. At the beginning of the research many people warned me that one does not get the same quality data from young men as from young women. There seemed to be an accepted belief that young men were inarticulate and inexpressive. At first meeting, this would seem to be the case. However, the more time I spent with the young men, the more opportunity I gave them to present themselves as more than simply full of testosterone and machismo. Slowly, in small interactions, the young men learned that I was interested in them when they were vulnerable as well as when they were tough. I was more impressed when they cried when they told me about violence. These nuances, Komesaroff’s (2008) 'microethics', enabled the young men to express other dimensions of themselves – and they did so as articulately as the young women.

**Interviews**

In order to collect young people’s biographies, I undertook one-on-one life-history interviews. Some young people were interviewed on the day of meeting and others were interviewed after months of seeing me hanging around. Interviews ranged in duration from 45 minutes to two and a half hours. Most were just over an hour in length. Interviews were selected as the primary data-collection method because of their ability to develop an intimate space where an individual feels safe to share their story. Minichello, Aroni and Hays (2008) describe the aim of the sociological life-history interview as being to 'understand the ways in which a particular individual creates, makes sense of and interprets his or her life' (p.125). Obvious limitations to this are that the participant's presentation of their story, and the researcher's interpretation of it, are highly subjective. However, the life-history interview is an instrument which allows the participants to present their life in a way that is meaningful to them, and guided by what shaped them,
rather than by being confined to the predetermined categories of methods deemed to be more objective. Willig (2003) argues that the value of this type of research is that it does not seek to reduce human experience to 'abstract statements about the nature of the world in general' (p.51).

An interview schedule was used to ensure a systematic inquiry among all participants. Despite this, in practice the interviews were very conversational in nature. I drew on my experience as a clinician and reflected on more and less effective methods of engagement to develop the interview schedule. To this end, I intentionally designed the schedule in a way that began with a reasonably ‘safe’ and impersonal aspect of the young person’s life (school) while we built rapport. This then led to areas where ‘heavy’ content was likely to emerge (abuse, homelessness, mental health), before finishing with focus on the young person’s strengths and goals for the future.

In the interviews process, I drew on principles of narrative inquiry, encouraging participants to narrate their own biography and position themselves as an active agent in this narrative. Plummer eloquently describes narratives as ‘a most basic way humans have of apprehending the world’ (2001, p.185) He describes the narrative as the vehicle of communication and outlines two key approaches to narrative which informed my own approach. Telling one’s story through developmental stages (childhood, adolescence, adulthood etc.) is common, although it does limit the narrative to a linear sequence and may fail to afford appropriate weight to particular events. Acknowledging this, I also drew on what Plummer refers to as the ‘obstacle race narrative’ where participants focus their story around specific events irrespective of the order in which they occurred. Tamboukou, Andrews, and Squire (2012) suggest that a strict focus on collecting information chronologically may ‘close off information about unconscious realities’ (p.12) and thus restrict the depth of the data collected.

I approached the interviews through a constructivist-interpretivist paradigm which holds that there is no single reality, but that understanding the world is relativistic and subject to an individual’s experience (Ponterotto 2005). Denzin and Lincoln (2008, p.31) claim that all research is interpretive as the design, approach and analysis are all informed by the researcher’s own beliefs and values about the world. The interpretivist paradigm is closely aligned with phenomenology in that it seeks to construct meaning from how individuals experience their lives (Bryman 2008; Willig 2003). There are two fundamental assumptions to this approach to research. The first is that participants are
able to reliably make sense of their own histories; and the second is that the researcher can accurately interpret and explain another's life (Minichello, Aroni & Hays 2008).

I had a detailed interview schedule but I rarely followed it in a linear fashion. Participants usually canvassed all of the areas in the schedule, though the order in which they did this varied considerably. I suspect that knowing that I had a background as a 'worker' made some young people comfortable that I was not going to judge or be shocked by their stories and engendered a sense of forthrightness in their disclosures. Lemmon (2008) researched a service that worked with young people who were involved in the criminal justice system and who were experiencing substance abuse issues. He discussed how some of the young people in his study limited what they disclosed. While Lemmon (2008) knew anecdotally that some of his participants had engaged in sex-work; none of them told him this themselves. While I did not ask my participants about sex-work many spoke with me about having undertaken it. Likewise, I did not specifically ask any young person if they had ever been abused, yet it was a key theme in their narratives.

For the majority of participants, histories of abuse were at the heart of their stories. Some young people spoke very explicitly about their abuse, what happened, where, who they were with and how they felt. Others, while making it clear that they had been abused, made it equally clear that it was not a conversation which they wanted to elaborate on. Young people wanted their traumas to be acknowledged as significant in their life histories; however, it would be idealistic to expect that acknowledgment and acceptance go hand in hand. Some young people told me about their abuse as they felt it contributed significantly to where they were. They were not always comfortable to talk in detail about such a sensitive topic which points to a limitation of the interview as the primary data collection method. As the interview was a one-off meeting, the relationship between myself and participants had little history. This would have inhibited or constrained some young people's revelations. It is almost certain that the prevalence of issues such as sexual abuse (especially among the young men) were under-reported, given the shame so frequently associated with the topic. Likewise, collecting a life history in a single interview doubtlessly neglects to address many aspects of a young person's history. Perhaps the biggest ask of the interview is what Pilkington (2007), who privileges biographical methods, has noted herself – they task the individual with producing a coherent, reflexive narrative of themselves which is a considerable undertaking.
Participants
In total, 35 men and 26 women were interviewed. The sample was stratified to ensure that the distribution of gender and region were representative of all of the young people accessing those services. I collected demographic information from reports on their respective client databases at the services, though this provided only very basic information as there were gaps in what workers had entered into the electronic system. In order to obtain more detailed demographic information, I had planned to conduct a structured interview with outreach workers across the state to collect aggregated statistical information on young people currently in treatment. However, after beginning this process, it became clear that this would not achieve its aim as workers often did not have comprehensive data on their clients. Thus, this was abandoned.

Fortuitously, during the research process, a statewide census of young people in AOD services was undertaken (Kutin et al 2014) and this provided the quantitative data I was seeking. It was not feasible to stratify my sample for ethnicity or age; however the average age of young people in my study (19) was consistent with the average age of young people in treatment (18.5 years). Interviews were mostly conducted in counselling rooms of service sites with some young people interviewed in public parks or their homes.

I interviewed young people until I was ‘saturated’. Very early on, some clear patterns emerged among the young women; however, the experiences of young men appeared more diverse. It was not until I had completed approximately 20 interviews with the young men that a pattern became apparent. In keeping with phenomenological principles I continued interviewing until I felt certain that I understood the reasons for the diversity in their narratives. Following this, interviews were transcribed verbatim and coded thematically.

Analysis
Original codes were intentionally very broad so as to not exclude any data. Following this, another round of coding was undertaken where sub-themes and nuances were identified. For example, ‘Homelessness’, became: ‘Homelessness entry’; ‘Homelessness - sleeping rough’; ‘Homelessness - couch surfing’; ‘Homelessness - accommodation’; and ‘Homelessness - drug use’. Data from interviews was also quantified. Spreadsheets tallied the occurrence of a multitude of factors including experiences of child abuse, parental substance use, highest level of education achieved, criminal justice involvement, and mental health issues. Using both qualitative and quantitative methods of analysis revealed key themes and the nuances of the patterns which had emerged. The quantitative material
also helped to highlight key phenomena that were common occurrences, but not dominant themes in the qualitative material. This dual approach was a way of cross-checking that the key themes I had sensed in the process of the interviews were actually the key themes for the majority of participants. I was wary that in collecting people's life stories, some would leave more of an impression than others and I did not want to overlook the themes in those stories that had left a quieter impression. This approach comes from the traditions of grounded theory which intentionally begins data collection and analysis without any predetermined hypotheses and instead collects data until patterns, or 'phenomena' emerge on their own (Minichello, Aroni & Hays 2008).

Ethics
The ethical considerations that came with this project involved more than meeting the standard guidelines and obtaining institutional approval. The study did receive formal approval from the RMIT University Human Research Ethics Committee (HREC); however, doing ethical research was more than simply 'getting approved'—it was about being prepared to negotiate the inevitable ethical quandaries which arise when out 'in the field'.

There is no universally accepted way of being a 'good' youth researcher. On the contrary, it is the mixed constellation of methods that various researchers use that creates a solid body of literature in the youth studies field. These methods, and the way they are employed, need to be ethical. Research ethics has become a highly regulated domain, which has subsequently led to queries about whether the heavy focus on ethics guidelines precludes researchers from exploring more complex ethical considerations. There is concern that focus on regulatory frameworks reduces researchers to speak of ethics as a largely bureaucratic process that one must deal with prior to fieldwork (Batsleer 2010; Clark & Sharf 2007; Ensign 2003; Shaw 2008; Kellehear 1989). Halse and Honey (2007) articulate that there needs to be more discourse on ethical issues rather than the current focus which is on ethics committees. Certainly, resolving ethical issues can be complicated and frequently require more time than anticipated; however, Bogolub and Thomas (2005) are correct in stating that 'we have to get the ethics right even when the result is that it messes up our schedules' (p.275). To uphold the integrity of what we do, we need to think about how we embody an ethical research practice.

Understanding how to be ethical is complex: not because it is inherently difficult to 'do good', but because what is 'good' is so rarely absolute. Clark and Sharf (2007) have asked: 'What responsibilities do we, as qualitative researchers, have beyond the fulfilment,
of approved informed consent?’ (p.413). In addition to consent, there are other generally accepted principles, such as beneficence and respect (see Ensign 2003; NHMRC, ARC & AVCC 2007). However, what actually constitutes being beneficent or respectful differs considerably. Hence, the idea of having ethics guidelines that are applied to all research falsely gives the impression that there is a single right way to being an ethical researcher (Shaw 2008). This assumption, that one way is more right than another, overlooks what makes the philosophy of ethics different from the philosophy of science: in science, a single truth is held to be more correct over all others; in ethics it is not only acceptable, but typical, for there to be multiple, equally valid actions (Komesaroff 2008).

In Australia, researchers are bound by the National Statement on Ethical Conduct in Human Research, henceforth referred to as the National Statement (NHRMC, ARC & AVCC 2007). The guidelines in the National Statement were designed to assist researchers to develop ethically sound research projects; they were not designed to instruct those wondering what the ethics committee would think if they knew a participant cried throughout their research interview. Certainly, interviews must be conducted ethically, but how we best do this is not information that the National Statement provides. Fortunately, when researchers are sitting down with participants they are in the privileged position of being able to make assessments on what is good for that person. To do this, the researcher needs to make ongoing decisions and understand how the finest nuances in an interaction between themselves and the participant – what Komesaroff (2008) calls the ‘microethics’ – can alter what the ‘right’ action is. Acknowledging that the purview of the National Statement is not to teach ethical thought, and that most researchers are not philosophers, the following question is raised: what does the researcher then use to inform the ethical practice of her work?

When I began this research, I sought out materials on interviewing vulnerable young people and found little discussion of the complex ethical conundrums I was facing. Burke (2007) suggests that this noticeable absence is partly due to journal editors’ failure to grant credence to discussions of ethics and methods in authors’ papers. Similarly, after conducting an empirical examination of the state of social work research ethics, Peled and Leichtentritt (2002) concluded that a useful way to improve ethical practice would be to require journals to have a discussion or report of ethical dilemmas that researchers encountered. At present, with the exception of articles on ethics, reference to ethics typically does not exceed the customary line, ‘institutional ethics approval was obtained prior to research commencement’. 
While word counts are limited and researchers (rightly) want to discuss their findings, Shaw (2008) suggests that the absence of substantive mention has unanticipated consequences. He points out that the lack of discussion of ethical issues implies that ethical decisions can be made reasonably uniformly and this is not the experience of the practised social researcher. Hardwick and Hardwick (2007) suggest a move to a model of ‘situation ethics’ to guide research ethics. They suggest that the desire to have a regulated framework, which places greater value on one method over another, stems from the oft-held belief that a scientific model legitimises a field. In any case, they astutely point out, the absolute inability for there to be a single correct way of being an ethically sound practitioner undermines the validity of any sought-after regulations. A similar sentiment is held by Noddings (2003), who contends that whether people follow specific philosophical principles is of less concern than whether they have caring relations.

Relational ethics

Care theory is a moral philosophy that argues that ethical actions are those which stem from caring for the other. Noddings (2003), a significant contributor to care theory, posits that the role of the cared-for is equally important as the role of the care-giver: ‘... we cannot justify ourselves as carers by claiming “we care”. If the recipients of our care insist that “nobody cares”, caring relations do not exist’ (p.58). The focus on both roles has led Noddings’ theory to be called relational ethics.

Noddings (2003) articulates that the history of moral philosophy has sought to suggest that there are specific ethical principles that maintain universality: therefore, in a series of similar circumstances, one’s actions ought to be the same. The need for principles and universality is something which Noddings opposes as she asserts that each human interaction is so unique that there is no useful way of applying the test of universality because situations are never similar enough for comparison. Nor, she points out, does one typically defer to ethical principles prior to making decisions about preventing harm (2003).

Noddings’ critics have suggested that her aversion to principles is oxymoronic given that her own theory rests on a principle itself: that people should, and do, care for others (Johnston 2008). Noddings has addressed this critique by discerning between descriptive and prescriptive principles. Prescriptive principles dictate that Y must always do Z when in situation X; whereas descriptive principles observe that when in situation X, Y typically does do Z. Denying that ethics be reduced to total relativism, she maintains that
the principle upon which her theory lies is descriptive in nature: what she describes is naturally occurring.

I do not seek to argue for relational ethics as a superior moral philosophy; nor do I suggest that human research be governed by some sort of total ethical relativism. My key contention is that relational ethics are the best way to negotiate the ethical quandaries that arise when one is actually ‘doing research’. I am concerned with the micro-level interactions too nuanced to be understood by guidelines alone. By adopting a care-theory framework, I was better equipped to make thoughtful decisions on a case-by-case basis. Further to this, negotiating ethical conundrums through a framework of relational ethics married up with the aim of using the interview – which is a relationship between the researcher and participant – as the method of collecting people’s stories.

Having adopted a framework of moral philosophy to guide the research process, it was then necessary to reconcile some of the conflicting concerns which arise when researching the young. These conflicts were weighted by the dilemma of balancing the need to protect participants, while also not abrogating their right to participate. To avoid researchers taking advantage of the vulnerable, research ethics guidelines have various stipulations in place to protect participants from abuses of trust. The risk-mitigation approach adopted in research ethics guidelines has seen the need to protect the young supersede the need to ensure that they are able to participate in discussion that are about them, and which will affect them.

There is a widely held assumption that the need to protect people is more important than the need to enable participation (King and Churchill, 2000). This is valid if the potential risks from participating outweigh the potential benefits. In making the decision to abrogate someone’s right to give voice, it is imperative to think carefully about what constitutes harm and benefit, as well as the likelihood of each prevailing. Further to this, consideration ought to be given to the potential risks and benefits of disallowing participation.

King and Churchill (2000) astutely point out that there is a distinction between harms and wrongs, and Human Research Ethics Committees (HRECs are the Australian equivalent of Institutional Review Boards) tend to focus on the former. Consequently, while there may be no immediate harm that arises from a young person not participating in research, over-riding their self-determination – where competency has been established – is wrong and can lead to harms. This wrong has broader implications for young people’s
well-being. Not including young people in research is likely to lead to misrepresentations and misunderstandings about their lives and their experiences. Billett (2012) observes that because young people under 16 are frequently not invited to participate in research, there is only a ‘constructed’ picture of their lives available. Additionally, she supports De Vaus (2002, in Billett 2012) in arguing that this leads to an invisibility of the group. Grover (2004) emphasises that social research is increasingly being used to inform policy. As a result, a lack of understanding as to how young people experience their lives may see policy and service provision develop in ways which are counter to their needs. With regard to including the voices of those being affected by these policies, Grover states that:

*It should be appreciated further that to have some control over how one is portrayed in the world by others is related to issues of human dignity ... [and that] how one is reported about in the world can profoundly affect one's human rights.* (2004, p.82).

Including young people’s voices in research is not just polite, but one of their rights.

Article 12 of the United Nations Convention on the Rights of the Child (United Nations, 1989) stipulates that where a child (defined as a person under the age of 18 years) is competent to develop their own views, that they be given the right to express these views in all matters which affect them. As Grover notes:

*Unless children are permitted to become active participants in the research process, as discussed, they will continue to be ‘vulnerable to representations that others impose on them’ (see Barron, 2003: 33), just as they are in all other domains of life. To be in such a position is to have one’s own voice silenced and one’s fundamental right to be heard effectively quashed.* (2004, p.92, original emphasis).

Therefore, while it is necessary to give weight to protecting participants, it is equally important to protect them from the wrongs which arise from precluding their participation. This issue is noted in the *National Statement,* which says:
For ethical review bodies, there can be a profound tension between the obligation on the one hand to give maximum scope to participants freedom to accept risk, and on the other hand to see that research is conducted in a way that is beneficent and minimises harm. (NHMRC et al, 2007, p.17)

While the need for formal ethics approval was obvious, dilemmas such as the aforementioned liberalism versus paternalism challenge highlight that what constitutes best ethical practice is far from absolute. Barratt et al. (2006) observe that research ethics guidelines are in place to protect and assist the research participants; nonetheless, they are not without limitation. Te Riele and Brooks suggest that principles should be understood as a ‘provisional resource’ as they ‘are not straightforward recipes leading to perfect solutions’ (2012, p.11). A similar sentiment is expressed by Kellehear (1989) who suggests that guidelines should be interpreted as a ‘minimum standard’ rather than a definitive authority. There are some matters for which the National Statement offer clear guidance: consent and confidentiality, for instance. However, there is an area where this guidance is almost entirely absent: researcher wellbeing. In the next sections I explain the nuances of obtaining consent among the populations I interviewed and follow this with discussion of confidentiality in research on illicit activity. Focus then turns to the researcher, and ethical considerations for researcher safety.

Young people and informed consent
In all research, there is the requirement that participants must provide consent. Informed consent is a slippery notion. On one hand, it can be seen as a specific act (consent is given). On the other, Renold et al. (2008) suggest that informed consent is an ongoing dialogue and that the participant is, as they continue to participate in the research, consenting. These authors see consent as iterative and open to revision throughout the research process. When it pertains to young people, the necessity of consent is complicated by competing definitions and practices regarding a young person’s ability to consent. For research with people under 18, parental consent is an issue. Parental consent either needs to be obtained or, alternately, there needs to be a sound reason for it not being obtained. Where it is not obtained, a young person’s maturity and competency must be established.
Parental consent

The inclusion of young people in research is often avoided because of the assumption that a parent or guardian must provide consent. In many research areas, recruiting participants is time consuming and difficult. In social research with marginalised groups such as the homeless, recruiting participants is often opportunistic and people are interviewed at the time of recruitment. The need to gather parental consent complicates the research in that it places additional demands on participants. For example, a young person might be happy to participate in an interview while they are waiting for something or not have much else to do; but to ask them to first take home a form for their parents to sign is a lot to expect and stymies the research process. Added to this, homeless young people often do not have parents whom they are going home to and, therefore, are unable to obtain parental consent. In my application to my relevant HREC, I sought exemption from the parental consent requisite and was therefore required to demonstrate that participants would be of sufficient maturity and competence to consent independently.

Maturity

Defining the ‘mature’ from the ‘not yet mature’ is complex. The National Statement articulates that ‘it is not possible to attach fixed ages to each level [of maturity]’ (2007, p.55) and this recognises that maturity is developmental. It also allows for people under the age of 18 to be recognised as being of sufficient maturity to consent to research participation independently. Given the ambiguous nature of ‘maturity’, the statement defines four levels which research participants fall within. Rather than attempting to apply fixed definitions, the Statement instead acknowledges that young people may be mature in some aspects, and not in others. The only level of maturity able to consent independently is defined as:

*Young people who are mature enough to understand and consent, and not vulnerable through immaturity in ways that warrant additional consent from a parent or guardian.* (NHMRC et al, 2007, p.55)

I argued that the young people who I would be interviewing had enough maturity to consent independently given that they were old enough to initiate and consent to substance abuse treatment. I also explained that because these young people had often had to navigate the broader service system and negotiate a world where homelessness is ever-present, they have demonstrated a high level of maturity.
However, a committee member was concerned that young people’s disposition to use drugs as a way of coping demonstrated their immature response to life’s challenges. This concern was abated when it was explained that the position of the collaborating youth services was that their clients had great resiliency and were mature enough to consent to an interview provided they had the ‘competence’ to do so.

**Competence**

Informed consent is underpinned by the presumption that the participant is competent to consent. Discussions of a young person’s competency often become paternalistic as they begin from a position of adult hegemony (Christensens and Prout, 2002; Haudrup-Christensen, 2004; Matthews, 2001). Newman describes the current approach to research with young people as a ‘paradigm of vulnerability and dependence’ (2005, p.iv) with the need to protect young people often being the sole focus.

It is important to recognise that although young people may have less competence; this does not imply that they have less capacity. Duncan et al (2009) discuss how, by virtue of their age, young people have less life experience and in practical terms have less life experience at asserting their rights (for example, the right to withdraw; the right to seek clarification). Mishna et al (2004) point out that because young people are also less practised at speaking about themselves, they may be less able to anticipate what a research interview may entail and how it may affect them. This lack of experience can hamper a young person’s competency to provide informed consent, but Bessant (2006) has observed that concerns about competence do not mean that young people should be refused the right to have a say. Rather, where possible, provisions should be put in place to ensure that young people are competent.

Mishna et al (2004) suggest not only telling a young person that they can withdraw from an interview, but also telling them how to withdraw should they wish to do so. Recruiting through a third party is also a useful strategy as young people may be more comfortable to decline to participate to a neutral or familiar adult (i.e. a worker) rather than to the researcher directly. Adopting strategies such as this is consistent with the recommendations by the Inter-Agency Working Group on Children’s Participation (IAWGCP, 2007). The IAWGCP explain that ethical practice is not to exclude young people, but to have safeguards in place to support them. They also remind us that including young people does not negate adults’ responsibility to care for their wellbeing.
Assessments about young people’s competency need to take into account their vulnerabilities while facilitating ways for them to participate. Bessant points out that:

‘Concern about competence does not provide grounds for refusing these basic principles of equality, or refusing young people the right to have a say about matters that they have an interest in. Moreover, a commitment to equality does not call on us to treat each person the same.’ (2006, p.53).

Ways of increasing competency can be simple. In my study, I anticipated that some of my participants may not be sufficiently literate to understand the plain language statement. To ensure that the information was conveyed, I discussed the plain language statement with every participant. This prevented them from having to self-identify as illiterate while ensuring that the information was given to them. On the plain language statement, contact numbers for various free welfare services were also provided should the participant discuss things in the interview that raise issues for them later on. All of the research participants were recruited through welfare services which assured that they were linked in with a welfare service for assistance and advocacy should they require it. A key part of increasing a young person’s competency is for them to know that they have a trusted adult to turn to – a worker or service provider was able to do this. In addition to protecting participants, it was equally as important to honour their right to autonomy in participation. One way of doing this was by giving participants options in the research process.

Participants were offered the option of using their own first-name or to nominate a pseudonym, and surnames were not collected. I chose to offer young people the option of using their own names because I did not want to make the implicit assumption that their story was so shameful that they would not want to be identified. This gave young people options in the research process and all thought carefully about their decision. When participants initially stated that they would like to use their own names, I discussed the implications of this with them (people might recognise their story etc.) before they made their final decision. Information that might identify other people in their narratives was also changed to protect those people’s identities. Three young women chose versions of the name ‘Jessica’ and two young men chose versions of the name ‘Andrew’. In the
narrative that follows, 'Jess', 'Jessica', and 'Jessie' are different people, as are 'Andrew' and 'Andy'.

**Confidentiality in research about illicit activity**

The normal assumption when we carry out research is that participants have a right to confidentiality; but in subject areas where research data is incriminating, it is especially important to de-identify data. In ethnographic studies, where de-identification is not possible, the researcher needs to consider competing ethical demands. As Moore (1993) has noted, an ethnographic study into drug use raises all sorts of precarious issues.

When researching illicit behaviour, the notion of research confidentiality is juxtaposed with laws that prosecute those involved with such activity. Although, researchers seek to protect participants from potential harm, we do not have the legal privilege of confidentiality. In instances where the researcher has been privy to potentially incriminating information, then a court may subpoena the records forcing the researcher to reveal data sources and a desire to protect participants (lie) may conflict with the need to protect oneself (be honest).

Fitzgerald and Hamilton (1996; 1997) have highlighted ‘the consequences of knowing’ in their account of a research project that was suspended for six months. A small study into the behaviours of hallucinogen users was funded by a Victorian state government funding body. Although the project was initially approved by their university ethics committee and classified ‘low risk’, the project was later suspended after the researcher made enquiries about the legal requirements regarding confidentiality of their research data. The impetus for these queries came about when a police officer approached the lead investigator with an offer to assist in recruiting participants in exchange for access to information sourced through the research process (Fitzgerald & Hamilton 1996). The researchers wanted to know how they could assure participants of confidentiality when there was no legislation that protected their research records from being subpoenaed. This led to the university suspending their research until a legal team had examined it. Fitzgerald and Hamilton’s experience illustrates the contentions and complexities with research ‘confidentiality’.

While some instances of ‘confidentiality’ are clear cut – we know it inappropriate to publish a list of participants’ names and addresses – other pledges of confidentiality are less absolute. While I wanted to assure potential participants that information that they share with me would remain confidential, I was not legally able to do so.
To avoid placing participants at risk, I made clear in the consent forms that I can be forced to disclose my records should I be subpoenaed or where I feel there is an imminent risk to someone. In the preamble to my interview, I explained that issues that are potentially legally incriminating should not be discussed and that participants should not refer to themselves or other people by their full name. As I transcribed the interviews, I changed all identifying features. This way of de-identifying information is a way of increasing anonymity and confidentiality to protect participants.

While ethics committees are guided by the *National Statement*, the statement itself has a disclaimer at the beginning:

_It is the responsibility of institutions and researchers to be aware of both general and specific legal requirements, wherever relevant (NHMRC, ARC & AVCC 2007, p.9)._ 

This places the responsibility of being legally compliant with the HREC. Whether or not what is ethical is synonymous with what is legal is the subject for another paper. The focus here is that in defining ‘confidentiality’ for participants, our understanding of what is ‘ethical’ must be consistent with the absolute authority on the matter – the law (Fitzgerald & Hamilton 1996). In addition to ethical issues that arise with participants, a relatively unregulated aspect that arises in the course of social research are concerns about the safety and wellbeing of the researcher while ‘in the field’.

**Protecting the researcher**

While there are guidelines in place to inform HRECs about how to minimise any risk to research participants, there is little that discusses how we can minimise the risks to the researchers. Issues to do with safety and security arise in the course of research, and these are often considered as an extension of workplace safety. However, there are also issues of emotional wellbeing when researching other people’s trauma. Seear and McLean (2008) have observed that the current *National Statement* ‘... does not adequately explore the question of how best to protect or support the emotional or psychological needs of the researchers.’ (p.13).

Although HRECs do take researcher safety into consideration; what informs their ideas of ‘risk’ are subjective and discretionary. Obviously, they are bound by workplace
insurance and compliance matters; however, what both Kellehear (1989) and Seear and McLean (2008) refer to as the 'silent' issues – ones that involve deeming groups of participants as 'high risk'; or measuring the psychological effects of research on the researcher – are left for each committee to manage individually. In my experience, members of my university ethics committees have always expressed concern about the researcher as well as the participants. This addresses two main issues – the personal safety of the researcher, as well as the researcher’s emotional wellbeing.

The issue of personal safety was contentious and there were starkly oppositional views from my collaborating agencies and my university HREC. This issue arose when discussing the potential interview locations. Although I planned on interviewing most participants in the counselling rooms of various services, there were some young people who, for reasons of both convenience and anonymity, would prefer to be interviewed elsewhere. Cafés and parks were likely locations and a small number had accommodation which is visitor friendly (unlike rooming houses). Young women with children are occasionally afforded public housing, and for these women in particular, an interview at their home was most convenient. Yet the argument put forward by my university committee was that my safety would be placed at risk by doing this.

As an outreach worker in these agencies, it is standard practice to visit clients at home (unless there was evidence that this would not be safe). Therefore, I queried whether or not this situation entailed a real risk, or whether the expressed concern reflected the committee’s assumptions about young people who engage with substance abuse services. It is questionable whether my safety would have been of such concern were I male, older, or interviewing young people who did not publicly identify as drug users.

As mentioned, there are also ethical concerns about how well I, as the researcher, would manage emotionally researching this area. Members of the committee expressed concern about how I would be supported in a project that involved such intense emotional labour. Several members have stated that while they felt that the research was ethically sound in terms of minimising risk to participants, they were concerned about how the research would affect me emotionally. Their concern regarded the potential vicarious trauma in researching the lives of people with backgrounds of abuse. The committees had reassurance in the point that I have worked in the field and was therefore aware of, and familiar with, the issues that I was likely to face; but they also wanted assurance that I would be supported by other sources.
Having previously experienced the emotional effects of this type of research, I agreed that there was cause for concern. In the pilot study for this project, I had felt that my experience working in the field meant that I knew what to expect when my role changed to ‘researcher’. However, the distinction between worker and researcher was vast in terms of how I was left feeling when transcribing these stories.

The interviews themselves were a positive experience. It was their transcription which left me saddened and with a deep sense of futility. As a worker, when young people share these stories with you, you are able to take some comfort in knowing that you will be able to see them again; to provide counselling, or support, or a referral, or – most typically – a hug. As a researcher, I was of no practical assistance. Perhaps, hopefully, I could use their stories to give them a voice, but I was not going to see these young people again the next week or the week after and share their successes and their sadness. I had their stories, but I was not there to actually support them. Knowing that this feeling was likely to come helped a lot in managing it. Ensuring rest, recuperation and regular supervision meetings provided a safeguard against experiencing my own emotional distress.

**The ethics of telling other people’s lives**

The young people in this study shared with me the most intimate parts of their lives. Some young people were practised at telling their story and others were telling it for the first time. There were ethical issues in protecting young people as they shared their stories without going so far as to preclude, and thus silence, them. In this thesis, I quote the young people extensively and often with little analysis or comment interspersed. This is partly because I feel that these young people spoke with more eloquence than I could offer them; but most significantly, I wanted their voices to permeate this account of their lives. Christensen and Prout (2002) have rightly articulated that, ‘The task of the social scientist is to work for the right of people to have a voice and be heard’ (p. 483). It is in this spirit that, wherever possible, I aim for the young people’s voices to ‘speak for themselves’. At times, this is very confronting; however, to disassemble these stories to the point to which they are not confronting fails to accurately portray the experiences this research aims to give voice to.

Bourgois (2002) discussed his own dilemma about wanting to soften the sometimes ugly aspects of his field data drawn from the years he spent living in East Harlem undertaking an ethnography on the street-based crack trade. He decided against it for much the same reason as I: as researchers, our job is to report the worlds we are
seeking to understand. Therefore, the darker our subject, the darker our writing. To add light where they may be none is a disservice to participants and research integrity. Attempting to soften our readers’ experiences privileges the reader over the participant. The researcher’s duty is to tell the story, irrespective of how disconcerting it may be.

What follows in the next six chapters are the stories of 61 young men and women aged 15-24 attending AOD services in Victoria. Collectively their narratives shed light on young people’s pathways into problematic substance use.
Chapter 3

Dancing with death

The opening chapter of this thesis outlined the various ways that youth drug use is understood. Problematic substance use is often seen as a sign of adolescent delinquency. Some young people accessing youth drug treatment services fit the common perception of what a ‘drug user’ looks like, but most just resemble ordinary teenagers. As I began spending time with these young people, there seemed to be many explanations for why they had developed substance abuse issues. Many told me that they had fallen in with the ‘wrong crowd’; others explained that they had ‘always been naughty’. Some found drugs a way of managing mental health symptoms. Many of the women and two gay men explained that drug use was something they did with their boyfriends. Some took a long time to see their use as a problem because it was something they had always done with their parents. Each of these explanations made some sense, but there seemed to be a lot of diversity – perhaps the explanation of these things being ‘a bit of bad luck’ had more traction than I had assumed.

There is little research exploring just who comprise the population of young people accessing treatment in Australia. Until 2013, there had been no comprehensive statistical information on the number of young people in treatment collected. Victoria is the only state which has a statewide service system, but there are many separate service providers each with their own unique record keeping processes. There is minimum data required for those in receipt of government funding (AIHW 2013); however, this lacks any detail and to further complicate matters, it reports on number of treatment episodes rather than number of individuals. Thus, individuals receiving intensive supports tally up many episodes compared with a young person on a diversionary order who may have one treatment episode. Therefore, it is not possible to make inferences about the population as the figures over-represent some and under-represent others. The two groups are likely to have different needs.

In the 2013 Statewide Youth Needs Census (SYNC: Kutin et al 2014) of young people accessing drug treatment services in Victoria, it was found that 46 per cent of young people were disconnected from school and half of them (51%) had been suspended or expelled, indicating that many were seriously disadvantaged in the labour market. Disconnection from family was very high, with 41 per cent of young women and 28 per
cent of young men separated from family, suggesting that many had experienced serious family trauma (Kutin et al 2014; Daley & Kutin 2013).

Although these statistics do not illuminate whether these issues precipitated or followed substance abuse, some factors were almost certainly apparent from very early in life, prior to any drug use. These figures show that there are clear trends which mark young people in treatment as ‘different’ from other young people of the same age. This diminishes the veracity of the ‘bad luck’ explanation. Therefore, it was necessary to search more deeply to understand the pattern among the seemingly disparate explanations offered in the cursory discussions I was having with young people in the current study.

This chapter focuses on how young people described their lives prior to entering AOD treatment services. First, it draws attention to the dramatic events and extreme risk taking that characterised these young people’s lives. Second, I note that young people are always conscious actors making decisions about their lives even in the most extreme circumstances. I refer to these decisions as ‘situated choices’ because they were often constrained by external factors over which the young person had little control. Finally, the chapter uncovers why these young people continued using drugs even when they were putting their lives at risk.

**Extreme risk taking**

It took little time to realise that these young people’s lives were characterised by dramatic events. Amber, 17, was six months pregnant when I met her. She had no family support and no savings. Amber had been searching for accommodation, but without a job she had little chance of success. Andreas wanted to look for work or return to school, but he was due for sentencing in a month’s time and faced the prospect of incarceration. Damian was in treatment for post-traumatic stress disorder after being seriously assaulted by a policeman. Each young person seemed to be in the midst of a significant event or episode. Many of these things seemed traumatic enough to explain their heavy drug use; however, some things did not add up. For instance, while these events seemed significant to an outsider, the young people themselves spoke about them very matter-of-factly. The way they spoke about these events was so inane and ordinary that it seemed as though these events were in fact inane and ordinary.

In lay discussions about young people and substance abuse, turns of phrase such as ‘teenage rebellion’ and ‘fallen off the tracks’ litter the conversation. These all focus on
the drug use being an entirely individual decision made in a vacuum free of structural influences. While this explanation is simplistic, there were some cases where it appeared to have credence. For some participants, mostly the men, ‘reckless’ or ‘risky’ behaviours could be seen in their drug use patterns. Jake had been experimenting a little with alcohol and other drugs, but it was his entry into the subcultural world or graffiti artists which saw this escalate:

I dabbled with a few things, but I wasn’t into them. I was hanging out with the older boys, the graffers and that. I did all sorts of stuff with them – speed, heroin … just whatever was going. I did my first pill with them.

Jake’s case shows that the drug use was not always as desirable as the social bonding with which it was tied. For other young people, drug use was desired, though again, there were decision-making processes at play in the choice of drugs being used.

Jahl encountered many high-risk situations. Living on the streets from a very young age, as well as being small in stature, meant that Jahl was particularly vulnerable to falling victim of the predatory behaviour of others. In the early hours of the morning on one of his nights on the street he was approached by a man who offered him a cigarette. After talking a while, the man had persuaded Jahl to steal some items from a shop in exchange for some cash. Jahl went to the supermarket with the man to do this. After leaving the supermarket the man introduced Jahl to another man:

This guy is fresh out of prison – tattoos and stuff – he was a bad cunt. Anyway, we started talking to him, and we ended up going off to Richmond where he scored heroin. I was like, ‘What the fuck?!’, and the next thing I know he’s got me to go and buy his needle and he’s sitting there whacking up and shit. I am 13 years old.

Shortly after, the man then offered Jahl some cannabis in a peace pipe:
The choof had white all the way through it – white bits – and I thought it looked like really good choof. I wouldn’t have taken it if I’d known it was laced. I started smoking it, but then half an hour later I am freaking out on the floor, I am out of my brain. I don’t remember the whole day from then on. The first guy had left so it was just me and the guy out of prison. It was just me and him on our own ... he takes me back to these flats and I just woke up and there was this guy spooning me on this mattress in the lounge room and I was like, ‘What the fuck?!’, but I couldn’t move. I actually couldn’t move. When I woke up, he dropped me off at the corner of his street and I am waking up from the worst feeling in my whole life. Two days later I look at my arm and he’d fucking injected heroin into me. There were two dots on my arm and it was all bruised up and shit. That’s a big thing that I am going to carry with me.

Jahl’s experience shows that despite very limited options, he was actively making decisions. While he welcomed the cannabis, he did not want to use it if it was laced with other substances. He was also scarred by his experience of being given heroin. Jahl made other situated choices. He made the decision to steal as it would provide him with much needed money. This decision was not desirable, but the best of very limited options. However, Jahl was less active in regards to his personal safety. While he felt safe in the company of the first man, it seems as though he was immediately uneasy in the company of the second. Despite this, he remained with him. It is unknown whether he did not trust his instincts; or whether the need to raise money was so high that he was forced to compromise his own safety – possibly a combination of both. When I asked if he had been tested for blood borne viruses as a result of this encounter, Jahl said that he was too scared to know.

The combination of vulnerability and limited choices was something that was very prevalent among the women. When Katte was living on the streets, she was ‘taken care of’ by some of the older people. At 14 she was the passenger in the front seat of a car driven by a man in his twenties who was loosely acquainted with someone in Katte’s group. He indicated that he was going to buy alcohol for them:
We went past so many bottle shops and I was like, ‘Um, what are we doing? There’s a bottle-o just there?’, and he’s like, ‘Yeah, I am going to a really good one’. Then he pulls over to this place and he just smoked some peace pipes. I was really creeped out ... then he was being sleazy and he kept trying to kiss me and shit, and I was like, ‘Fuck off’, and I was pushing him off of me and I just kept trying and trying. He hit me and shit, and was like, ‘You’re a fucking little bitch’, and I was just bawling my eyes out ... Then he started to drive off again, and I jumped out of the car. I didn’t care if I had a huge scar up my arm, I was just like, ‘I am not staying here with him, I’ll get raped’ ... so I jumped out of the car while it was moving.

Here we see Katte quite literally make the decision to place herself in harm’s way to avoid being raped.

Being on the streets was not the only source of danger. Stevie was staying with her girlfriend Tash and Tash’s child in high-rise public housing. One day Stevie was raped by a man who lived in the building. She was too scared to report the incident in case he got angry and returned to their flat when Tash and the child were home. Stevie was deciding between reporting her rape and keeping her family safe. Stevie, like Katte and Jahl, was in circumstances where the options were bleak; nonetheless, we see each of them actively reasoning and rationalising their behaviours. These young people were active agents making decisions but with options that were deeply problematic. Stories like these pervaded participants’ narratives, as did experiences of accidental overdoses – both of which were discussed as accepted parts of the worlds in which participants lived.

Overdosing is something closely associated with heroin, although to some extent that is a mistruth. Almost all fatal overdoses are a combination of combined drug toxicity where benzodiazepines – such as Xanax or Valium – are in the body system and then a short-acting central nervous system depressant – heroin or alcohol – is used as well (Dwyer 2013). The effects of benzodiazepines increase in intensity over time, whereas a drug like heroin works almost immediately. Having the former in the body prior to using heroin or alcohol can see the effects of the two drugs peak simultaneously and the nervous system being depressed to the extent that breathing stops. The ‘on the nod’ effect opiate users seek can walk a close line with fatal overdose. Thus, most fatal overdoses happen when one is using alone and nobody is able to administer the opiate antagonist drug, Naloxone (also referred to as ‘Narcan’). Naloxone, which is administered by ambulance
officers, pauses the effects of opiates on the brains receptors which gives the body time to process the drug and reduce its level in the blood.

Ben had overdosed twice. Both times he was with friends who gave him mouth-to-mouth to keep him breathing until the ambulance arrived and administered the injection of Naloxone. Similarly, Jerry had had several overdoses. The frequency that young people had had more than one near-miss with death suggested, at face-value, that either they were suicidal, or unable to learn from their mistakes. It made little sense that the benefits of the drug could be so great that one near-death was not a sufficient learning curve. I inquired further.

Jerry’s most recent overdose had left the previously athletic young man with permanent injury. The first overdose was at a friend’s house whose mother performed mouth to mouth. His parents were notified, and given they were unaware of Jerry’s heroin use, I queried how they reacted: ‘I think they were just really worried at that point. They weren’t angry, just worried’.

Jerry’s next overdose came when he was travelling overseas with a couple of friends:

*My plan wasn’t to go there and use, I just got so shitfaced ... I don’t remember anything ... Then I got airlifted to Thailand ... I had an 80 per cent chance of dying, my kidneys failed, my lung was punctured.*

Jerry was in hospital for three months before he was able to fly home to Australia. He was transferred straight to a private hospital in Melbourne with the aid of a family member who was a doctor there. He stayed there for six weeks, which meant that after the overdose, he had accumulated more than four months abstinence. Spending weeks laying in a ward, his depression worsened. This combined with the grief of a friend’s death earlier in the year led Jerry to relapse soon after he was released from hospital.

Ebony had had several accidental heroin overdoses, although her explanation that, ‘When I’ve woken up I didn’t give a shit if I died’ suggests a degree of suicidality that may have contributed to her frequently high-risk drug use practices.

Ally and her boyfriend had a daily heroin habit. She overdosed at his house:
His grandma walked in and I was blue. He thought I was joking and then I started fitting and fell out of bed. They called the ambos ... then the cops came because I had died. They were going to charge him with attempted manslaughter ... [his grandmother] went to my parents and told them ... they went crazy.

For Ally, this experience was a wake-up call. Although she ran away from her parents who had tried to ‘ground’ her, she called her worker immediately to get a place in detox. For others, overdosing was part of the drug using life. Andreas’s discussion about it illustrated this well:

Recently we were at this guy’s house, and this girl had 50 bricks in an hour, and she’d drunk a bottle of methadone as well and we woke up and she was dead. Yeah, she died ... [she was] 15 or 16. So that was pretty bad. And another person died about a year ago, one of my mates. Overdosed on Xannies and then choked on his vomit. That’s happened to me a couple of times – where my mates have had to move my tongue around ‘cause I take too many and pass out after a drink.

Andreas’ story can be explained in an individualist explanation as foolish: he had seen first-hand the lethality of drug use yet persisted with using them. But this happened to many participants and it was clear that they were not fools. The question at hand seemed to be not why they were so foolish; but what benefit were they receiving from the drug that outweighed the risk of death? Further, not only was there a risk of overdose, but many participated in activities they did not like in order to procure their drug of choice.

For some, an accepted way of raising money was sex work. Most of the participants who engaged in sex work had been homeless, but were below the minimum eligible age for government financial assistance. Government policy stipulates that children under the age of 17 must be enrolled at school, and children under the age of 18 without a caregiver should receive state intervention. The practice is much different. Policing young people who are not at school is largely the responsibility of the parents. For young people where there is no parent or other caregiver, or whose parent or caregiver does not enforce school attendance, the notion of ‘compulsory’ schooling is foreign. For young people who are
without a caregiver, school is a near impossible task: an absence of secure accommodation makes attending school unfeasible. While these young people should, technically, be able to receive access to Out of Home Care, the under-resourced system has no mechanism in place to sufficiently identify these young people, and when they do come to the attention of the relevant authorities, there are often few, if any, placement options available. The care system prioritises infants due to the risk of death being far greater were they to stay in unsafe environments. A combination of these factors places young people in very vulnerable positions.

Ineligibility for government assistance is premised on the belief that young people are either in the care of a parent or the state; this renders the homeless teenager with few options to raise money. Jai’s first year of homelessness was financed through sex-work while he was unable to access financial assistance from Centrelink. Jai’s entry into sex work was accidental. Seeking to meet other gay teens, he entered the online world:

*I found a gay chat room online and started chatting. Then I got offered money for, yeah, in exchange for that ... I thought, ‘Wow, that’d be great’ ... I didn’t realise at the time what the ramifications would be; what I would have to do. ... [then] I did my first job. It was kind of, interesting. I met really, really disgusting guys.*

Jai moved onto street-based sex work briefly, but he found this both unsafe and degrading and soon moved into the world of escorting. This was not something he enjoyed, but despite this, Jai’s homelessness created desperation for both accommodation and money. Ineligible for government assistance because of his young age, sex work was a way of satiating this desperation:

*I never had to sleep on the streets. I’ve always just, well, it’s the perks of being gay and homeless – it makes life a bit easier. Being able to sleep around and kind of go from one guy’s house to the next, or to be doing jobs escorting, ... well, making the best of a bad thing happening really.*
When I asked Jai if the drugs helped him, Jai explained that they helped him ‘deal with it – yep, totally’. Jai’s sentiment that being a young gay man was a ‘perk’ was similar to the some of the young women who felt that they were taking advantage of their gender when trading sex for money, drugs, safety or accommodation. These participants seemed to accept that as a young female they were not entitled to gender equity. Roxanne expressed remorse about using her gender to get access to drugs:

> I never did sex or anything for drugs, but I made boys think that I would and took their drugs ... It's kind of easy for a girl to get drugs, and especially heroin, because not many girls who do it are single ... and all male users really want is heroin and a girl to use with, so it makes it pretty easy if you are a girl and want to get drugs.

Voni expressed a similar sentiment when explaining how she financed her habit, ‘Anyway I could. You know, just ... I was going out with dealers. Just the usual – what girls can do’. Voni’s case was typical of others who participated in an informal type of sex-work, sometimes referred to as ‘survival sex’. The woman engages in an undesirable sexual relationship with a man in exchange for accommodation, drugs, and/or money.

Ebony’s explanation of her ‘decision’ to enter into sex-work was frequently couched in explanations that it was the only acceptable form of crime and that acquisitive crime was simply not comprehensible to her as she identified strongly as a Christian. Ebony’s ‘choice’ was to sell herself over stealing from another. Certainly, two undesirable choices, but we can see that even in such dire circumstances, Ebony was using agency to negotiate her options.

Jessy has been street sex-working for some time. For Jessy, and for most of the young people who participated in sex-work, her drug use escalated as a result of needing to be stoned to be able to block out the reality of these evenings on the street. Increased use meant an increased tolerance which meant that more drugs were needed to get the same effect. In turn, her nights working went from one or two a week to daily at a rapid rate. At an equally rapid rate, Jessy’s drug problem flourished. Despite the increased income which came with sex-work, it appeared to be accompanied by an even greater increase of life complexity. Despite many engaging in sex work to increase their ability to finance their habit, their habit increased concurrently which rendered the young people
far worse off as the more expensive their drug habit was, the less feasible it was for them to leave the sex-industry.

It is clear that there were significant issues in the lives of the young people. The risks they had taken were not because they were too young to think properly – their ability to enact reflective thought in other areas of their lives made clear that these young people were conscious actors. I sought to understand the structures in which they were so bound that the options from which they were choosing were so dire. Given that illicit sex-work had not reduced young people's drug use, and that drugs were clearly not being used for recreational partying, I reasoned that their use persisted because the thus far unseen positive effects outweighed the very apparent negative effects. So I asked each of the participants what they liked about using drugs.

'Drugs make you feel better'

Young people’s answers to what they liked about using drugs were remarkably similar and there was no difference between women and men. Most could explain the function of their drug use easily and in a single sentence. Ben, for instance, stated clearly: 'It took the thoughts away from my head'. James’s explanation was almost identical: ‘To stop thinking about things’. Similarly, Stacey explained why she liked being stoned: 'I didn't feel anything. I didn't worry about stuff'. There was a common theme that was very clear; but less clear was why so many young people would want to stop feeling. Brandon was more elaborate in just why he liked being able to stop his thoughts:

*I think about the bad things a lot. It doesn't get out of my mind, no matter what I do, so I use drugs to make me feel better about myself, to make me feel differently. That's why I kept smoking a lot – it gave me something to do, put the shit out of my life.*

Several participants, all of whom had a mental health diagnosis of either Attention Deficit Hyperactivity Disorder or Obsessive Compulsive Disorder, both of which present with considerable mania and racing of thoughts, used drugs to slow this down. Maddison explained:
**The main thing I liked was that it helped with my attention – I wasn’t all muddled in my thoughts and mainly it helped me make up my mind. My thoughts were at a normal pace – not racing.**

Maggie, whose anxiety prevented her sleep, also liked the effects of drugs which depressed the central nervous system:

*It relaxes me, it slows me down. It slowed all my thought processes down. It puts things in order in my head and it clarifies a whole lot of things so that I can just see one thing at a time.*

The discovery of a drug which slowed down a permanently racing mind was very welcome for those who had been feeling muddled.

Drugs which depressed, rather than stimulated, the central nervous system were by far the preference for all of the young people in this study. While reference to young people and drug use often focuses on ‘party drugs’ taken in clubs and at parties; ecstasy and amphetamines were not often used among this cohort. This is not to suggest that depressants are more likely to lead to a problem. The pharmacological effects of depressants are more appealing to those seeking to pause their thoughts and feelings. Stimulants do the opposite – increase the body’s senses making one hyper-aware of how one feels. Matt’s short and sharp reply to what he liked about drugs – ‘It numbed me ... I didn’t have to think about shit’ – indicated the difference between the young people in this study and young drug users more generally. Where general youth drug use is central to socialising and increasing sensory responses to create higher states of awareness; the young people in this study wanted the opposite. Mary said poignantly: ‘I always did drugs to avoid reality rather than enhance reality’. Desperate to avoid and escape their realities, there was a natural magnetism between these young people and depressant drugs. Amy elaborated on the function of her drug use:

*It just numbed everything; I just wanted to forget about life. It just made you feel good – like you were actually somebody.*
I asked Amy when the feeling of not being somebody began, and she explained:

*It probably started when I was a kid – from family violence, and no one knew about anything—feeling that no one cared.*

These feelings of abandonment and not being cared for were similar to the sentiments shared by Jai, whose parents had died and whose grandparents abandoned him when he revealed that he was gay. He offered a detailed insight into why feeling numb was so desirable:

*It's the trauma. It's being discarded as just a piece of lint pretty much. Just being belittled and going and doing drugs to become a bigger person and to deal with people in my life ... [drugs were a] confidence builder and helped to deal with people who were really quite scary and that's the only way to get respected in the group – to do drugs.*

Abandonment and a lack of family support gave some insight into why these young people wanted to stop their thoughts and feelings. Homes which lacked care and safety were increasingly becoming a common thread.

Jessica's inner turmoil was inescapable and its source was the family violence she lived with. Using drugs with her mother became a salve: ‘You don't have to feel the way you feel, you can just have a bong and pretend that things are different when they're not. It's an escape’.

Not all the participants used drugs as pain-relief. Jerry, the young man who overdosed in south-east Asia, had tried a variety of drugs with his friends during adolescence. He was typically smoking cannabis and taking ecstasy through the week and then would use ‘harder’ drugs on the weekend. He used ice for a while, mostly smoking it, ‘I injected it a few times, but I never really got into it’. But then heroin came into the scene and this had much greater appeal to Jerry, although it was a very occasional thing. It was after Jerry finished high school that heroin became a real issue for him. When I asked the
appeal of heroin, Jerry was reluctant to suggest it was self-medication and this seemed closely tied to ideas of autonomy:

*I don't like to blame it on things 'cause it's just me, really. ... [but] when my best mate died, I just felt like all I wanted to do was be numb, pretty much.*

Heroin was also a way of managing grief for Shawn:

*It just made you numb to everything – I didn’t feel pain. I remember when my stepmum’s mum died and I’d been clean for eight months, and I used smack, because I knew [it would stop the pain] ... it blocks everything out and you can just forget. For a couple of hours, make it like it didn’t happen.*

Despite there being an emotional need for substance use to sedate psychological turmoil, many of the young people were still making 'situated choices' about their drug use. As outlined in the first chapter, the presentation of young drug users as simply hedonistic pleasure seekers unable to make reasoned decisions and reckless in their behaviours overlooks the options that youth are faced with. Shiner and Newburn (1997) accurately point out that young people are not homogenous and that their reasons for substance use are diverse. Further, young people also make decisions about their drug use; it is not simply that they seek out any drug in any amount and in any combination. The common representation of young people is that they lack adequate cognitive capacity to negotiate decisions. Research into other areas demonstrate that even in serious situations such as war, young people are able to negotiate decisions about safety and risk (Newman 2005). The youngest participant, Jahl, whose primary drug was cannabis, explained his own negotiations with various drugs:
I was getting into shard [methamphetamine]. When I came out of juvie [youth detention] I tried it once and I liked it. Then every time I got the money up, I’d go and get it. It’s really expensive, it’s like a treat. I’d go and have a little bit, and then go and have another little bit, and before I knew it, I was liking it too much. It was getting hectic, so I was like, ‘No more, before it gets too bad’. So I stopped altogether. I realised I can’t do that – it’s 80 bucks for a point of shard and that’s nothing – it doesn’t last. Now I pay 10 bucks for a gram of choof and that lasts heaps longer.

This kind of decision-making process is typical of young drug users. Young people using drugs are generally forced to be opportunistic in what they are using. Limited access to money, as well as dealers less-inclined to sell to unreliable teenagers, leaves little room for preferences. Unlike Jahl, most of these young people may have had a predilection for depressants; but what these depressants were tended to depend on availability. These young people were making situated choices in their drug use, and which drug they used was subject to change. However, the choice was about which drug was most affordable or had the least ill-effects. There was less ‘choice’ in drug use itself.

While participants were making decisions about their drug use – whether it be to use clean needles, use a drug which was less expensive, to not smoke cannabis if one had psychosis – the more problematic drug use became, the less individuals practiced any legitimate decision making. Jazmine showed insight into how this situated choice was practiced as well as the meaning of making the ‘choice’ to be reckless:

I don’t have a lot of friends who do drugs, but my friends who do do drugs, they are pretty responsible about it. They will test pills and stuff like that. But I got to a point where I could just not give a shit. I would take ecstasy, snort a line of speed, do a bunch of alcohol, and I did not care at all. And that is self-harm in itself, obviously.

The point at which Jazmine’s regard for her own wellbeing deteriorated so markedly was also the point at which her depression had flourished. There was a strong relationship between substance abuse and mental health issues and this is detailed in chapter five.
Discussions about drug use being a choice need to be anchored in the reality that for some of the young people in this study, drug use was not a ‘choice’ and it was often a way to ‘stop thinking’ about traumatic experiences in their lives, over which they had had no control. Ebony started using drugs when she was 13, the same age she began living on the street:

Mum knew and didn’t do anything. She always called me a bad kid but she doesn’t [get it]. I tried to tell her why I’ve done what I’ve done is because of, you know, that man [stepdad]. Everything I have done is because of that man … my first heavy drug – I’m talking about heroin and stuff like that – was when I was homeless. One of the girls shot it up my arm for me because I was too scared to do it myself. [I was] 13 and she did it, and I just thought, ‘This is so good’. [It makes you] just forget everything. Shortly after I ended up having an $800 a day habit.

Ebony’s expensive ‘habit’ soon led to street-based sex-work – a means of raising funds that she felt was the most morally viable of her options (each of which were illegal). Ebony’s explanation that she was not particularly unsafe did not seem convincing as this explanation was followed with a story about a girl she was friends with who was stabbed multiple times and left for dead.

Another example where the young person had no ‘real’ choice in their drug use initiation was Stacey. Stacey’s mother had introduced her to cannabis early in her adolescence. It was a normal and accepted practice in their daily lives. Stacey did not question it – drug use was the normal way of coping with emotions. This lesson was one that stuck:

The pot was because of my mum, but the heroin was, um, when I started to get older and I realised that what happened when I was really young [sexual abuse from school priest] was really wrong, I didn’t know how to cope with it, and I just wanted something stronger than pot to block it out … I really liked it. I didn’t have to feel or put up with any of that emotional shit.
Few young people would presume a stronger illicit substance was required to cope with recovery from rape but for Stacey, it was the logical pathway. The dilemma with using drugs as a way of coping with psychological distress was expressed by Roxanne: ‘You forget about your problems, until you become addicted to drugs, and that’s a bigger problem in itself’.

**Conclusion**

This chapter has established that these young people were in pain and the drugs were providing relief from that pain. It has focused on how young people described their lives prior to entering AOD treatment services. First, it drew attention to dramatic events and extreme risk taking that characterised these young people’s lives. Second, the chapter pointed that these adolescents were active agents in their drug choices, albeit making ‘situated choices’ that were often constrained by factors over which they had little control. These drug choices often put them in grave danger and a number had nearly died. Most could explain why they liked drugs in a single sentence. Drugs enabled them to ‘stop thinking about things’. They were ‘dancing with death’ to anaesthetise emotional pain.
Chapter 4

The early years

I met the participants when they were accessing services for problematic substance use. Upon meeting them, it was not long before I could think of reasons for their substance abuse: sex-work, homelessness and involvement in peer groups where drug use was common were all possible reasons. Nonetheless, I wondered if there was more to it than that—a deeper layer of explanation. I wanted to know why these young people had moved on to problematic drug use, when others who had faced similar life adversities had not. I wondered if the concept of resilience was relevant—were those who had ‘recovered’ from their adverse experiences more resilient than those who had not?

There are many cases of young people demonstrating remarkable resilience in the face of extreme adversity. Newman (2005) studied young people living in war which showed that even when placed in circumstances for which one cannot prepare, young people demonstrated an undeniable resilience. Ungar (2011) has undertaken considerable work into children's resiliency and argues that children can cope with immense stress provided that their broader ‘social ecology’ has sufficient protective factors. This is because resiliency is not an innate quality.

Resilience is a widely-used term that has a somewhat rubbery definition. Olsson et al (2003) found that the many different definitions made the study of resilience difficult. Undertaking an analysis of literature on resilience that was relevant to youth and mental health, they found many definitions used. Ultimately, they proposed their own:

*Resilience can be defined as a dynamic process of adaptation to a risk setting that involves interaction between a range of risk and protective factors from the individual to the social.* (p.2)

These authors posit that rather than a fixed concept, resiliency is fluid and multi-factorial. They highlight that increased protective factors can do much to ameliorate the effects of risk factors and that these factors are an interplay of individual and environmental influences. This is similar to Rutter (2012) who describes resilience as an ‘interactive
concept’ where the presence of resilience can be witnessed by a positive outcome despite adverse circumstance. It is generally accepted that resilience is acquired through experiencing adversity (Hunter 2012). It is also accepted that resilience is not a static trait – it can both develop and dissipate in the life course (Luthar 2006; Hunter 2012).

Resilience is a trait which is shaped by both risk and protective factors in an individual’s life and it is thought that these factors are environmentally based. Ungar (2011) theorises resilience within a framework of ‘social ecology’. He contends that the difficulty in operationalising resiliency stems from the inability to understand how resilience can occur in situations where there is seemingly innumerable risk factors present. To redress this, he proposes that more significance be given to the influence of the ecologies a young person is in – both social and physical – in order to understand the factors that shape resilience.

Olsson et al. (2003) suggest that rather than any adverse event itself being a single causal factor to negative outcomes, it is more instructive to look at the preceding contexts and social ecological factors in a young person’s life. The nature of family relations prior to adversity are significant in predicting resilience. Olsson et al. state:

*The importance of positive parent-child attachment is a common theme in the literature. Likewise, parental warmth, encouragement and assistance, cohesion and care within the family, or a close relationship with a caring adult are commonly associated with resilient young people.* (2003, p.7)

The authors explain that family factors appear to be the strongest indicator of resilience, but other factors are also influential. Irrespective of one’s academic achievement at school, school experiences with positive friendships, strong relationships with teachers and opportunities for encouragement and success all foster resilience. In a sample of 205 elementary school students, Masten et al. (1999) also found that those with more resilience had healthier peer networks and more resources than those who had ‘maladaptive’ responses to stress and adversity.

Although there are complexities in defining a measurement of resilience, there is a consensus that both risk and protective factors influence a young person’s capacity for resilience. Further, the strongest protective factor – which has the capacity to counter the
most extreme life adversity – is positive relationships with family. Following this, a strong connection with peers and broader social environments such as school can buffer the likelihood of poor outcomes following traumatic life experiences. Significantly, the social environment one is in both prior to, and following, an adverse life event appear to be more influential in the development of resilience than the specific event itself (Olsson et al. 2003). This understanding of resilience is useful as we begin to unpack the early-childhood experiences of the young people in this study.

In this chapter I demonstrate that these young people’s early childhoods were often filled with risk factors and relatively few protective factors. The chapter tracks participants through primary school and is narrated around their experiences of home.

**Early years**

'So tell me about your experiences of Primary School' was the first question I asked participants in the study. Purposefully broad, and reasonably impersonal, this question was left open for participants to share as much or as little as they felt comfortable. As such, it is not surprising that their responses to this question varied considerably. For some young people, primary school was wonderful and for some it was awful. Jahl's response was typical of many: 'Primary school was terrible. That is a good place for you to start. Everything started there'. There were some exceptions. Jess, for instance, explained that she 'really excelled' in primary school, winning championships for athletics and cross-country running. Similarly, Amy 'loved' her early years of school, 'I never had any troubles ... I had grouse teachers and I had heaps of friends'.

Having friends explained why several people liked school. As Roxanne explained, 'If there's at least one person who's nice to you and is your friend, it's a lot easier to wake up in the morning and go to school'. For many, an absence of friends made school an awful experience. Experiences of being bullied were common and the effects of this permeated many aspects of participants' lives for many years. Sam was bullied through both primary and secondary school. This was often to do with his intellectual disability:
I started getting bullied and they just made me feel really frustrated and angry and I wouldn’t tell anyone ... people with a different intellectual level made me feel worse than I was ... they were a lot smarter than I was, and they could use things against me and that’s when I became really depressed and upset. I’d sort of like, keep it inside ... I ended up feeling like I wanted to suicide.

In Year 7 when it became too much, Sam spoke to teachers and they, along with other workers in his life, helped him to work through this. Despite both the bullying and his intellectual disability, Sam completed school. Completing secondary education was very unusual: More typical is James, who was also bullied because of dyslexia but there was no intervention. Doubly disadvantaged because of dyslexia and discrimination, James found the ‘wrong crowd’ and left school by Year 10.

Eight of the young men and six of the young women had experiences of being bullied as central to their narration of school. More commonly, young people’s absence of friends was explained by frequently moving schools. The majority of the young people in this study went to multiple schools and the main reason for shifting schools was poverty – the young person’s family had to move suburbs because of financial constraints.

Poverty
By the time I met them, most participants were living well below the poverty line, and many had started life this way. Some had been middle-class with university-educated parents, but most were from working class families who struggled financially. A significant minority of participants were raised in abject poverty, although the difficulty in measuring this categorisation makes quantifying just how many participants fell into these class categories unknown.

Some parents were able to get the bills paid each week, but this came at the cost of time with their children. Damian’s father ensured the rent was always paid, but there was no money left over and his low hourly rate of pay meant that he spent very long hours at work, leaving Damian alone for long periods of time.

As well as an absence of time with a parent, poverty also meant that some young people did not have their most basic physical needs met. Ashly, who had oscillated between the care of her mother and father in Gippsland and Melbourne, described some of the daily experiences of waking up poor. When asked to discuss primary school, she
recalled, ‘Going to school with no food. We never had food.’ This extreme poverty led Ashly, along with her dad and other siblings, to live on the streets. Ashly’s case was unusual because she and her siblings were in the care of the father, which excluded them from women’s refuges because he was male. They were also excluded from men’s refuges, because children were not allowed.

Housing was a major issue for many and a significant factor in young people’s transience in schools. Maddison’s family lived well below the poverty line. They were evicted from house after house which meant that Maddison changed schools regularly. Her mother sought to make the best out of their situation – negotiating with the school principal to waive the school fees to get her children into private schools, as well as always seeking to live in ‘good’ areas, even if it meant that the house itself was falling down. Unfortunately, Maddison felt like an outsider: ‘a poor kid in a rich school’. Not having a blazer and her holed shoes marked her as ‘different’ and left her on the outside of peer networks. Maddison left school at Year 10.

Ebony’s family were also unable to make ends meet and evictions were followed by Ebony switching schools. Most did not enjoy changing schools. As Josh noted:

*I would have preferred to stay at one primary school, because I had to make friends every time I moved to a different area and I would have to go to a new school and make new friends and it just made it a bit harder to have long-term friends.*

Having to make new friends is difficult, yet integral to feeling a sense of belonging in a new school. Jessica struggled with this and found making new friends ‘anxiety-provoking’. The effects of all of this instability were obvious – poorer literacy, fewer friends and a permanent feeling of instability. However, it was also the smaller nuances that they spoke of which highlighted the broader effects of moving around. Despite Ashly’s love of sports she could never be involved because the constant moving around made joining a sports team unfeasible. The issue of never being engaged in a long-term school curriculum also took its toll. The inconsistent standard and curriculum across schools in separate states meant that not only were these young people being shifted between schools, but also between grades. Ashly found herself in Grade Two at one school, and then
Grade One at another. None of the young people had positive recollections of moving around.

Some young people who did have positive memories of primary school were those who described school as an ‘escape’ from home. For these young people, primary school was a salvation from volatile home environments. When I asked Jai to tell me about primary school, his reply was clear: 'It was an escape from home life'. It did not follow that the young people who found this respite thrived at school; generally the opposite was true. Andy described primary school as ‘nice and fun for me’, because he escaped being the victim of violence at home and instead, became the perpetrator of it at school. Andy was expelled from several primary schools because he was a bully.

‘Bad kids’

Andy's description of himself as a ‘troubled child’ was a sentiment shared by many others. Explaining that school was problematic and that this was because the young person themself was the problem was a common narrative. Mick also had an ingrained acceptance that he was bad, 'The teachers just knew that I was one of those kids that wasn't going to be the easiest ... I got expelled in primary school; that's just how school was for me'.

The notion of the ‘kid’ being ‘bad’ was common, but as an outsider, it appeared that their 'bad' behaviour always had a logical explanation. For example, Jahl's strong attachment to his mother came about after his stepfather, with whom he was very close, moved out of the family home. Jahl explained that losing his stepfather gave him a fear that he may also lose his mother and his explanation of being a ‘bad kid’ showed how this fear influenced his behaviour:

I was just a bad kid in primary school. I wasn't so much a bad kid, I just always wanted to spend time with my mum, every recess or lunch time I would just walk home. Every time I got to school I was like, 'I don't want to leave my mum' ... then every primary school I went to, I did not want to do anything. I was destructive, I would leave school – the teacher would try and stop me, and I would just push them out of the way.

In retrospect, Jahl's attachment issues seem obvious; yet at the time, the schools – of which there were several – were focused on his behaviour which was unacceptable, and Jahl was
expelled more than once. As an outsider, this seems to represent a failure in how the school addressed the situation, but for Jahl, it simply reinforced his belief that he was disobedient and difficult.

A phenomenon that dominated the ‘bad kid’ explanations was the common prevalence of a learning disability or other developmental disorder. Jahl’s case above was one of many where the student’s behaviour was treated as delinquency, when there was actually an underlying issue. Frequently, this was a learning difficulty. Lisa struggled with school:

*It was harder to teach me what to do and stuff, ‘cause I didn’t really understand it all and then the teachers would go with the other kids who don’t have difficulty learning because they find it easier to teach them, I guess... I felt like I got left out a bit in trying to learn certain things.*

Doubtless, meeting the needs of students with learning difficulties is hard in a classroom of 30 students; but it is therefore not surprising that leaving these students without attention created later issues. Lizzie, for instance, was placed in a ‘special reading class’ but despised it. Most of the children were older than Lizzie but she still felt more advanced than them, yet behind the ‘mainstream’ students. Lizzie explained that being bored in this class led to her acting up which in turn further inhibited her educational development.

Alex had dyslexia but she reported her early school experiences positively, explaining that she had an integration aide which helped her enormously. This support stopped at the end of primary school, after which she ‘started running amok and getting into the wrong crowd’.

These young people were able to identify issues which affected their education such as an absence of peers, bullying, housing instability, and abuse and neglect. Nonetheless, phrases such as ‘bad kid’ or ‘not the academic type’ littered their descriptions of themselves. They believed that their actions were controlled by themselves, implying that they had the potential for a brighter future, should they choose to pursue it. It is often unwise to over-emphasise to young people that their disadvantages are due to structural factors beyond their control, because it can be disempowering and dissuade them from
using their agency to work toward a brighter future. Nonetheless, conceptualising a brighter future was difficult for some of these teenagers as we shall see in the next section.

**Risk factors**

It is acknowledged that the incidence of parental substance abuse is over-represented among young people who experience problematic substance use (Beyer et al. 2004; Loxley et al 2004). There are some explanations from a biological determinist view which suggest a genetic disposition (Bevilacqua & Goldman 2009; Kreek et al. 2005); however, there is a competing literature which argues that it is nurture, not nature, which explains the correlation. Similarly, having been raised in a home with family violence has also been identified as a risk factor for later problematic substance use (Kilpatrick et al. 2000).

Very few of the participants were raised in families with two biological parents. A few were in the primary care of their fathers, most were with their mothers. Some had step-parents that were stable figures but more commonly, their mothers had a 'boyfriend' who rotated in identity. Marital breakdown was common and the high prevalence of it among the participants in this study is, at first glance, not especially noteworthy. However, many of the young people had a parent with either a severe mental health disorder or a drug issue, and violence was common in some families.

**Parental mental illness**

Thirty five of the 61 young people spoke of a parent having a mental illness and this was more common for the women (66%) than the men (48%). Often young people felt responsible for their parents and did not attend school so that they could look after them, particularly if they were concerned a parent might commit suicide.

Jakey’s mum had bipolar disorder, as did his auntie who had attempted suicide on several occasions. Jakey explained that he had gotten used to his mother's extreme mood swings, but that it was hard to cope with and not something his friends could ever understand. His mother’s mental health issues affected his own mental health in a number of ways, contributing significantly to Jakey's own battle with depression. Added to this were daily restrictions – not wanting to bring friends over, not being able to go to friends’ homes because he felt a need to care for her – as well as the emotional impact of being the carer rather than the cared-for.

Damian’s mother also had bipolar disorder and was at times suicidal. When Damian was living with her, he often missed school because he feared she might kill
herself. Damian was unsure of what to do, ‘They don’t teach you this stuff at school’, he lamented. This casual reflection emphasised just how deep the crevasse must have been between Damian’s home life and his experiences of school.

Because of their mothers’ mental health issues, neither Crystal nor Sam were ever in their primary care. Both began to have relationships with their mothers later in adolescence, and almost immediately were burdened with the responsibility of protecting their mothers. Both Sam and Crystal had romanticised ideals of re-uniting with their lost parent, but both were confronted by a reality that was starkly different from their ideal.

Parental substance abuse
Parental substance abuse was also a feature of many young people’s developmental years. Research in Canada from the Ontario Health Supplement (n=8472) found that parental substance use was a critical factor in young people who had experienced childhood physical or sexual abuse (Walsh, MacMillan & Jamieson 2003). Forrester (2000) had similar findings in a smaller sample in the UK.

Parental substance abuse was present for 31 participants (51%) in the current study, and this affected participants in different ways. Jakey, for instance, did not know that his father had a significant cannabis habit until he was 19 when he found a bag of marijuana and stack of pornographic magazines on the inside cabin of a canoe. Jakey’s father’s drug use was always kept out of the house and away from the children; it was only later that his father admitted that it was a daily habit.

More typical were the cases where substance use was visible, even when this was not intended. Sometimes, substance abuse had negative impacts on people’s parenting skills. Jai’s mum was often out at night, leaving her children by themselves. Jai explained that his mother would come home early in the mornings ‘drugged up and binging on alcohol’. He said that going to school ‘guarded’ his siblings from the worst effects of his mother’s alcohol abuse.

Attempts to hide drug use from children seemed futile. Jessica explained that her parents’ separation was because of her mother wanting to get the children away from their father’s drug use, but not only was Jessica aware that her father’s drug use was heavy, she moved in with him in her early teen years after her mother had re-partnered with someone who was violent. Jessica still lives with her father and while she is physically safe, his drug use makes it difficult for her to sustain a drug-free life.
Many young people were in homes of very heavy drug use and when parents attempted to hide this, it demonstrated to young people that drug use was not an acceptable activity. Maddison’s father smoked cannabis daily, while her mother had a history of heavy heroin use. Maddison was aware of this, but drug use was not used as a familial bonding activity the way it was for several others. Like Maddison, Shawn was also aware of his mother’s drug use, but not encouraged to participate in this behaviour. He explained:

My mum always kept me away from her drug use – she always did everything she could [to hide it]. One time, I actually caught her with the needle in her arm and she lied to me and said that she had diabetes.

As Shawn got older, this story’s improbability became clear. But Shawn’s mother did not encourage or provide Shawn with drugs. However, her inability to parent effectively because of her heavy drug use led to Shawn, and his five siblings, being placed in and out of the care of the state. Ashly, who had slept rough with her father and siblings, had earlier been removed from her mother’s care:

We were just waking up to our mother drunk and going to sleep to her drunk. That’s when my sister had to step in and take us on ... She’s still got my baby sister in her care. ... She’s only 24. She’s been doing this since she was 13.

For Ashly and others, the heavy use of drugs within the family created an environment where drug use was an accepted and expected family practice. These young people were often using for lengthy periods before they realised that their drug use might be an issue. For many of them, drug use was not a choice or a leisure activity; drug use was a part of everyday life.

**Physical violence**
As well as substance use and mental health issues, family violence dominated participants’ narratives of their early biographies. For Anthony, alcohol and other drug use inflamed his step-father’s violence. Often the house was smashed up entirely. Brandon was the
youngest child of three brothers and they were raised watching their father beat their mother:

*Dad just used to come home and flip out. Mum’s had broken bones and everything. She’s gone through hell ... I used to run into my room and sit on my door and push it back and just hide because Dad used to beat her hard. But one of my brothers used to stand around and make sure that he didn’t do anything too serious. But they were only 17 when it was happening so they were getting a flogging too.*

Shawn’s mother had many boyfriends, all of whom were violent. Shifting from one violent relationship to the next, there were many periods where the family would have to flee without notice which meant that Shawn’s school attendance was infrequent and interspersed with long period of absence:

*I’d go one day, and then I couldn’t go for a month because my stepdad belted my mum and we’d be staying in a domestic violence place, or we’d have to move house, or some other reason ... my stepdad was very violent ... he was actually charged with the attempted murder of me and my mum.*

Young people spoke about their experiences of violence matter-of-factly. Shawn’s casual follow up that his stepfather tried to murder him was treated as an almost unremarkable part of his story. This attitude was typical, especially so among the young men. Andy explained some of the daily grind of his experience:

*There was a lot of family violence when I was younger. A lot of family issues, break-ups, house moving ... you go to school, but then you don’t want to come home because you know you are going to get belted when you come home.*

Andy described how after being slapped on bare skin by his stepfather, his skin was bruised for a week. He was told to not show anyone at school.
The normalisation of violence in the home was common. For instance, when I asked Cameron how primary school was, he reported that it was good and that he had a stable home and family around him. Then he said, ‘I suppose there was some bad things’. This soon followed by a dispassionate explanation that his dad used to abuse him and ‘shit like that’. Cameron recalled the violence as ‘normal’.

For Alex, violence was also part of ‘normal’ family life. Her stepfather’s violence was discussed as something trivial:

*I remember my stepdad picking me up and chucking me against the wall. Just little things like that. Nothing like full physical.*

Adult men role-modelling violence was not unique. As well as her stepdad, Alex’s biological father was also violent. He beat his pregnant partner so severely that she was hospitalised. Alex described the assault as inconsequential, ‘a few bruises’. The tendency to diminish the severity of violence did not differ across genders. Gerald described his childhood as having both physical and emotional abuse, but qualified this by saying that he had ‘heard worse’ stories than his. It was as though Gerald felt guilty for mentioning such an inane point.

Experiences of extreme physical violence were common. Many of the young men carried with them permanent injuries from childhood abuse. The extent of head trauma Anthony suffered has resulted in the permanent loss of his olfactory senses. Gerald was unable to straighten his legs properly because the physical assaults in the home so early on in his life had damaged his skeletal development. Yet despite the extremity of the violence they experienced, it was perceived as a routine part of growing up by the participants themselves. It seemed as though they had never experienced a world free from violence.

The normalisation of violence in the home led to a normalisation of violence more generally. Andy explained the details of his step-father’s physical assaults and then concluded that:
I knew I was getting bashed because I needed it. If I didn't cop it, I would have been ten times worse than I already am and I know that for a fact because I have matured and stuff.

Andy accepted of violence as a necessary part of life.

**Sexual violence**

Many participants were also victims of sexual violence. This was much more prevalent among the young women; but also to be expected is the under-reporting of sexual abuse among the young men. Jessica was raised in a home where abuse of all forms were inescapable. Her mother’s dependence on her abusive stepfather added more emotional pain to Jessica’s daily experience of violence and rape. After they finally fled the violence and received housing from a women’s service, Jessica’s mother resumed contact with him. She explained to Jessica it was for the sake of her younger half-sister, nonetheless, things downward-spiralled rapidly:

*Then he started giving Mum drugs and money and shouting at her all the time. She started bringing him to the house, and he wasn’t allowed at the house. She only had that house because she was getting away from him and she promised she wouldn’t bring him to the house. Then she starting having sex with him and she was like, ‘Oh, we’re just having a bit of fun’... she kicked me out and told me that us kids stole the best years of her life and she wishes she never had us.*

When Lisa spoke about her physically abusive stepfather, she recalled when it first began: ‘He grabbed me a bit one day and my mum just stood there and watched it and didn’t try to stop it’. A mother’s failure to act was deeply troubling for the young people; though sometimes the mother was unaware of the abuse her children were experiencing.

Amber was sexually abused by her father, as too were her brothers. She was the youngest and only later did her older brothers confide in her that their father also used to have ‘friends’ come over and sexually abuse them when the mother was out drinking. Amber felt a deep injustice that her father had not been punished for what he had done:
I wish my father was six-foot under the ground. Heaps of people know about my life and they wish that too. Fuck it. But my brother, apparently he went psychotic and he went into the cop station and told them everything about my father, and he still hasn’t been locked away for it – he should be in jail for what he has done to me and my brothers. I just reckon it’s so unfair.

Amber recalled that when she was about five, upon hearing that her father had had a heart attack, she replied to her mother, ‘I hope he dies’. Even Amber acknowledged that this was a very extreme thing for a small child to say. She explained that it was an instinctive reaction to all of the abuse, ‘I’d just been belted up that much and touched and that’.

Young people were traumatised by their experiences of abuse and neglect, but also by the absence of protection. The inaction of their non-abusive parent scarred them deeply. Lucinda was sexually abused by her brother, which was something that her mother refused to accept:

*My mum told me it was a dream. When I was five I brought it up with her and she was like, ‘Oh, it was just a dream’.*

Lucinda was eventually placed into the care of the state, but there were also cases where abuse was hidden from the authorities.

Ebony was sexually abused by her stepfather while her brother suffered extreme psychological abuse from both their mother and stepfather. They would serve his dinner in a dog bowl on the driveway and make him eat and sleep outside. Bearing witness to this had effects on Ebony:
[It was] really hard, extremely hard. I was just hard because I was younger, I didn’t know a lot of the services. I didn’t know what I could do, and they are people who, when you put people in front of the household, they’d look like perfect parents. But behind, they were evil. I’ve had DoCS [Department of Community Services] over once, and they just acted like the perfect parents so they left and didn’t do anything.

State care

I felt very lost. Very, very lost. I needed rules. I needed a mum, I needed a dad.

I needed stability and someone to help me. – Jess

Interventions from the State were a vexed issue. There were 32 (53 per cent) young people who had been in state care, but there were many others where one wonders why the state had not been involved. Young people who had been in care, and those who had not, expressed concerns about the child protection system; however, all agreed that there is a need for child protective services. Nonetheless, being removed from the family and placed into the care of the ‘The State’ came with many issues.

In order for the Child Protection Services to become involved in a family there needs to be ‘notifications’ made to them. The number of notifications required to warrant a home visit depends on the nature of the notification as well as the age of the child. Once at the home, the social worker makes an assessment as to whether or not the notifications are substantiated. In Ebony’s case, there were several reports to the Department of Community Services (DoCS) for them to send a social worker out to her home, but given that there were no infants in the home whose lives were at imminent risk this rarely amounted to anything. Despite Ebony’s desperation to be rescued, this led to no further contact and she continued to live in an abusive household. Ebony reflected on what could have been an alternate outcome the day the worker came to her home:
Just believe us – what’s the use of us lying? They should have put us in a refuge overnight and just went from there. You know, at least got some counselling that the family had to abide by. For the whole family – relationship counselling. I wish they had of put something in place rather than just walk away.

Ebony’s suggestion that family counselling and monitoring would have assisted highlights just how reluctant children are to be removed from their families. Ebony was the victim of multiple forms of abuse at home and eventually ran away. During her time on the streets, Ebony came to the attention of an outreach service attached to state care. She was placed in residential care which she often absconded from. At 16 Ebony was exited from care back to her mother’s, where her stepfather again sexually assaulted her. Soon after, Ebony was back sleeping on the streets. Nonetheless, even years later, and now separated from her family entirely, Ebony still suggests that working on remedying the issues within the family, rather than simply removing her from them, would have been the ideal course of action.

There were many pathways into the care of the state, but the defining feature was that the transition was rarely linear. For example, Luke first went into foster care after his mother placed an intervention order against him. His father had refused to accommodate him, but after only one night in care, his father changed his mind. However, after two months with his dad things broke down and Luke was again placed in care before he began couch surfing.

For some, the circumstances surrounding the removal from the family were so traumatic that it seems improbable for state care to have any prospect of being positive. Ashly, for instance, was removed from her mother’s care on many occasions and recalls these uncomfortably:

It was scary. ‘Cause my mum’s always going off her head, Dad was never there. It was always after a big night of drinking or something. Every time my mum got drunk, she’s got a big mouth, so she always got bashed and we’d be getting dragged into the car by DHS and police and mum’s going off her head, pissin’ out blood.
These care placements were always temporary and this exacerbated the feeling of volatility and instability in her life:

They used to come and grab us ... most of the times they used to take us together, but sometimes they’d separate us ... but we were only there for two or three weeks at the most, then mum would go fix herself up and be straight into court and then she’d get us back straight away.

When Ashly was in her first year of high school, she was removed from her mother’s care permanently and placed in the care of her older sister. We see later that this did not mean Ashly was consistently housed: at many times over the years she and her siblings slept rough.

For other young people, well-intended efforts to avoid removal failed and during the period of trying to find a sustainable outcome, the young person’s wellbeing deteriorated. Jess was one such case. After eventually being removed from her mother’s care, she spent two years in different residential units before being placed into kinship care with her grandparents. By this point, Jess had many emotional and behavioural issues:

[By] the time they got me, I was haywire. My heart and head were doing two different things. My head was like, ‘I will do whatever the fuck I want’, because I had been in resi-units for two years; and my heart was telling me that I was still their little princess and that I should be doing housework and helping my grandparents ... we fought.

Jess was then placed into foster care with a woman who she became quite close with. However, Jess’s biological mother was still her legal guardian and she vetoed this arrangement. Jess’s mother was enraged that Jess appeared to be thriving under the maternal instincts of another. She told Jess that if she was not going to be a ‘good girl’ for her at home – where a ‘good girl’ required submitting to the sexual desires of her stepfather – then no one else could have her. Jess was subsequently placed back into residential units. Jess still has the ‘family photo’ with her foster family.
These convoluted pathways through care emphasised the already marked absence of stability of structure in young people's lives. There is a distinct tension between removing children from abuse, but at the same time inflicting so many traumas in the experience of removal that children are irreparably damaged.

**Experiences in state care**

As discussed, 32 of the young people had been in the care and protection system. This was much more prevalent among females with 69 per cent having contact with child protection services compared with 40 per cent of males. Some children were on supervision orders but remained in the monitored care of their family; others were placed into alternate care arrangements, typically residential units with other young people, often after multiple foster placements. This is not typical of young people in the care of the state. Only a small percentage of children in care are in residential care, most are placed in foster families.

The Australian Institute of Health and Welfare (AIHW) provides an annual report on child protection figures in Australia, with information collated from each of the states and territories. The 2011-12 report indicates that at 5.1 per 1000 children, Victoria has the lowest rate of children in care, with the national rate being 7.7 per 1000. Only eight per cent of children in care in Victoria reside in residential care, with 80 per cent living in either foster care or kinship care and 12 per cent in ‘other/unknown’ accommodation (AIHW 2013). While most young people in care reside with foster families, we have seen that young people in this study who had been in state care had all been in residential units. Some of them had been in foster care first. While state-care involvement was a factor which was vastly overrepresented in this sample, it also true that this over-representation was from a small minority within the care system. The children who were subsequently in AOD services had almost always been in residential care – this is the group of young people who are too complex to be placed in foster care.

The common perception of child protection systems is that they are inadequate and often cause more harm than that which they seek to prevent. Child protection services are typically perceived as failing to care for those whose protection they are tasked with; seeing children’s wellbeing deteriorate rather than improve. For some participants, this was the case – especially those who were placed into residential care, which was almost universally described as a breeding ground for drug use and crime. However, there is a concurrent narrative to the negative construction. Some of the young people who had
been in the care of the state provided a description of what it was like. On one hand, they were able to identify problems and shortcomings, but on the other, were equally able to identify the positive aspects.

Habib entered the care system when he was 16 and placed into foster care. He enjoyed this, but repeatedly ran away from his placement. He was then placed into Secure Welfare, where young people are detained involuntarily after being assessed as too high a risk to self or others. Habib also liked this. The experience of enjoying state care was an unexpected narrative. I enquired what he liked about it:

*Everything. You can eat whatever you want; you can go out; you get seven smokes a day – they look after your smokes; you get your own shower; you get your own bed. You can do whatever! You've got the gym, you've got computers, you've got a basketball court – you've got everything.*

This quote tells much more than what Habib liked about state care: it also illuminates what he did not have at home. Few young people are likely to list having their own bed as a reason to appreciate accommodation. Things like this are (rightly) taken-for-granted aspects of home life for young people.

The appeal of state care as a 'home' was also echoed by Lisa:

*I kind of liked the resi-unit – there was heaps of food ... I kind of liked it in there because it felt a bit stable. I felt safe in a stable place, a little bit.*

Lisa and her best friend had come into contact with Streetworks – the child protection street outreach team – when they were 14 and sleeping rough:

*They saw us hanging around people ... seeing these two girls always hanging around older people. I don't know, they think you're at risk. And they're probably right ... I didn't feel at risk at the time; I just thought it was fun.*
Jahl also came into contact with Child Protection during his time on the streets. The police would pick him up on the streets and upon discovering that he was homeless, arranged for DHS to place him into residential care. Jahl was happy to have somewhere to stay and recollected his first placement almost identically to Habib: ‘We could do whatever we wanted – we could eat food. We’d wake up and eat food’.

The common reason young people enjoyed care was because there was food and because they were safe. Lizzie had many negative things to say about her time in care but was adamant that the safety and stability it provided was much needed. My early surprise that participants enjoyed state care was perhaps not so much a reflection on my misunderstanding of the care system, but my misunderstanding as to how dire their home lives had been.

Despite these positive experiences, not all care placements were equal. After his first experience which was positive, Jahl also encountered hostile, unsafe and uncaring placements:

\begin{quote}
It smelled like Juvie and I just did not like it. One of the workers caught me with choof and then hated me since then. We nearly punched on. He was like egging me on, ‘Fucking hit me’, and I was like, ‘What the fuck? Are you serious?’ ... I made seven complaints because all of the workers turned on me and this other kid that was living there. We were shit-stirring them, but they fully turned on us. I got out of care after that – I didn’t like it.
\end{quote}

Jahl ‘got out of care’ by getting into homelessness.

Many young people had negative recollections of being involved in child protective services, and this was always because they did not feel cared for. Stevie loathed foster care, yet conceded that ‘it was still better than living with my mother’. But she reported feeling like a ‘number being pushed around on a piece of paper ... No one was listening to me; no one was helping me ... I just felt like some forgotten kid’. Feeling as a ‘kid in the system’ rather than someone’s child was a sentiment which resonated with many even when there were positive experiences in care. Kate felt that her being placed into care was ‘probably a good thing’, but also added, ‘I don’t think that they prepare you very well for leaving care though’. Poor transitions out of care have been a key theme in literature on
children in care in Australia (Mendes 2009; Mendes, Johnson & Moslehuddin 2011) Australia-wide, the outcomes of young people in care are poor.

Participants’ experiences and views on care and protection differed. What is noteworthy is that they were aware of the dilemmas involved in their situations and in light of that, did not dismiss the role of child protection entirely. Some young people spoke of Child Protection positively while other were contemptuous; however, all were aware that there was a need for the state to be involved in their lives. Removing children from the care of their parents – regardless of how warranted it may be – is a traumatising experience for the child and makes the relevant authorities arbiters of very precarious decisions. Balancing the tension between protecting young people, while not further traumatising them, is inherently difficult.

This section has shown that there were consistent positive responses to state care – safety, stability and food. Notwithstanding, there were also significant problems. Some of these issues could be addressed with programmatic solutions, but the deepest concern that came with being placed in care was not something service providers could escape. As the formal name, ‘Out of Home Care’, suggests, it does not substitute a ‘home’. Lisa captured this sentiment well:

*It’s a stable place, but if you don’t have the affection from a parent and everything like that, you are an outcast in the world.*

**Conclusion**

This chapter began by pointing out that both risk and protective factors influence a young person’s capacity for resilience. Further, the strongest protective factor – which has the capacity to counter the most extreme life adversity – is positive relationships with family. This chapter has tracked participants through their early childhood narrated through their experiences of home.

There were indicators in early childhood that these young people were at risk. Most grew up in homes that were without safe and secure attachments, where abuse and neglect were common. Parents failed to provide these young people with consistent affection and emotional security that encourage pro-social development and foster resiliency. Half (53%) of the young people were in contact with the state care and
protection system and half (47%) were not, although this is not necessarily indicative of their needs. Each pathway had its own issues, with those in care feeling uncared for, and those not in care, often suffering in silence. The research on resiliency (see especially: Ungar 2011, 2013) helps us to understand that many young people are able to overcome extreme adversity, but they need to have at least one positive adult in their life who provides consistent support, and emotional security.

The more I explored young people’s early childhood, the clearer it became that for many it was not a single adversity that characterised their early lives, but a barrage of adversities that they had to face without consistent love and support from parents. These young people did not have a safe home, or even a safe person in their lives. There was no adult to help them develop the resiliency needed to deal with the challenges and disappointments that life throws up. In many ways, these young people had spent much of their early lives not trying to ‘overcome’ adversity, but working out how to live with it.
Chapter 5

In the mix

Macquarie Dictionary (2007 p. 772)

mix: 1. to put together (substances or things) in one mass or assemblage with more or less thorough diffusion of constituent elements among one another. 2. Also, mix up: to put together indiscriminately or confusedly.

Colloquial

To ‘make up a mix’ is to describe the preparation of illicit drugs.

Many of the young men and women in this study had ‘troubled childhoods’, but this does not explain why they developed a substance abuse problem in their teenage years. Troubled childhoods do not necessarily cause substance abuse, so I wanted to investigate the pathway between early childhood disadvantage and adolescent substance abuse. The chapter focuses on how young people became disconnected from three integral structures in their lives: school, family and housing.

I begin with young people’s experiences of secondary education where they had their first initiation with alcohol and other drugs. From here we see how, for the vast majority of the sample, leaving school and separation from family occurred at roughly the same time, leading to unemployment and homelessness. This critical juncture was a catalyst for heavy drug use and poor mental health.

There were six young people who had never been homeless and an account for their pathway into problematic drug use is also provided at the end of the chapter. I conclude that while there was not a single specific pathway from childhood trauma to substance abuse, there were key factors – leaving school, separation from family, unemployment and homelessness – that were usually ‘in the mix’.

High school

Fifty-six of the 61 young people began high school. The five who did not had many similarities: all were male, all had been in state care, all had a mental health issue, all had a
parent with a substance abuse issue, and all but one had a parent with a mental health issue. Thus, despite being legally required to be enrolled in education until they are 16, their non-attendance in secondary education was undetected. School attendance and enrolment is largely the responsibility of the parents. In these cases, the parents had little attention and/or interest in their child’s participation in education. All but one of these young men ended up involved in the criminal justice system.

Among the rest of the sample, there was uneven engagement with secondary education. Sixty-two per cent attended more than one high school. The persistent shifting of schools was typically associated with the issues outlined in the previous chapter. For instance, domestic violence saw families relocate and likewise, those placed in state care were often in temporary placement, and with each shift in care placement came a shift in schools.

In the last chapter we saw that many of the young people had learning difficulties and this issue was central to their memories of primary school. This issue resurfaced in their discussion of secondary education. James did not know he was dyslexic until he was in high school. While late, it did offer an explanation for his extreme difficulty through primary school. Insufficiently literate, he left the mainstream school he was enrolled in for a school catering for young people who had learning disabilities. James’s experience of school improved considerably when he was in an environment where his needs were identified and addressed. Ally also struggled in a mainstream school and found that her emotional and social needs were better met at an alternative school; however, her academic needs were not. She found herself bored and then left school permanently.

Shifting schools was a common experience in both primary and secondary schools. Girls were more likely to have had a consistent school experience in primary school, with 50 per cent having attended just one school, whereas only 31 per cent of boys were at the same school from prep through to year six. In high school, this pattern was reversed with only 31 per cent of girls remaining at the same school, compared with 43 per cent of boys. One-third of the young people had been to three or more high schools. Their unstable home environments combined with the frequent displacement between schools laid a poor foundation for academic success. There is no single explanation for why those who truant and/or leave school early are more likely to have substance abuse issues. Nonetheless, there is certainly a relationship between being disconnected from school and youthful drug use. These are two issues, among others, which contribute to an overall sense of disaffection among young people (Newburn & Shiner 2005).
Jess had been sexually abused by her step-father and this became known to the authorities. One day in Year 7, Jess arrived home from school to find the police and child protection workers at her house. Jess was removed from the care of her parents and placed into the care of the state. Child Protection were unable to find a permanent placement and Jess shifted between temporary foster placements and residential units. This explained why she had attended seven secondary schools. When I asked her how she found shifting around all the time she replied: 'Well my education was fucked up – it was very holey'.

**Drug use initiation**

For most participants, their first experience of substance use came during secondary school. For most, initiation was with friends, but for a significant minority, drugs were first offered by a family member. For young people in the care of the state, drug use was the norm. Ebony's early drug use was reasonably typical of most:

*I started smoking marijuana, hanging around the wrong people, peer pressure ... I didn't have many friends, so I thought, 'This is great having friends!'*

It was not just drug use that connected Ebony to her new friends. Among other young drug users, she found a shared understanding:

*[It was good] having friends and people to hang out with and talk to. People who related to my family environment – [It helped] to get that off my chest.*

Ebony alludes to her inability to disclose her family background to her mainstream peers. However, she was able to disclose it to others who had similar life experiences. The benefits of having friends she could talk to, as well as taking part in shared recreational activities, made drug use appealing.

Josh was having difficulties coping with school. He was asked to leave several schools and struggled to make friends. He left the mainstream education system when he was 13 and tried an alternative school but left by Year 10. Upon leaving school, he started smoking cannabis and through this activity he started to build friendships with other
young men. He explained that he would ‘get baked first thing in the morning and then go
to town and hang out with my mates at the park smoking’.

For some participants, drug use was a normal family practice and this is where first initiation took place. Jessica said:

*My mum and stepdad always smoked bongs and that was just normal, them smoking at the kitchen table, around the house. So I grew up thinking that when I was a teenager, I would smoke bongs and cigarettes, because that’s just what you did ... I first started using at Dad’s.*

Young people who were raised in homes where drug use was a normal family practice often followed in their parents’ footsteps.

Other members of Ashly’s family were heavy drug users, and this made it likely that Ashly would also become a drug user. Nonetheless, we can see Ashly exercising agency and making choices about which drugs she would use:

*I started smoking choof when I was about 10 or 11 ... I was hanging around the city and had all my mates there ... I was always the straight one [not drinking alcohol] and in the end I just thought, ‘Fuck it! If you can't beat ‘em, join ‘em!’ . But I didn’t start off on the smack straight away – I started off on speed and then moved onto heroin. But still, it’s all fucked.*

Growing up on the street amidst a backdrop of heavy injecting heroin use, Ashly initially rejected intravenous drug use. She had watched her father and sister use heroin, and she was determined not to make this ‘choice’. However, she eventually adopted the drug using practices of her peers and heroin became her primary drug of concern.

Some participants could not escape from environments where there was widespread drug use. Matt was resistant to trying drugs, but at 16 he was living in a refuge and he needed allies in this all-male accommodation. He was able to make friends, but a tacit condition of entry to this group was that he participate in drug use with them. While initially reluctant to smoke marijuana, Matt soon found this an effective way to forget
about the pain of his abusive childhood. When asked what he liked about drugs, Matt said, ‘It made me feel good .. I didn't really think about stuff’.

Others who had been in state care found substance use and friendship a welcoming combination. When Jess was put into residential units, ‘chroming’ (inhaling paint), was widespread. Staff in her unit often remarked how impressive it was that Jess continued to attend school. Eventually, their expectations were fulfilled when Jess left school in Year 10 and her drug use became entrenched.

Voni was using heroin while she was still at school:

*I would go into the cubicles and have a hit, then come back in class and go on the nod. I remember once, this specific day, I went and had a hit in the toilet and came back ... I passed her [the teacher] a piece of paper and she clearly saw my arms [with blood from a recent injection], and you know, nothing was ever done about it. That's when I first started using.*

Voni explained that she had a loving family and did okay at school. I wondered if there had been a traumatic event which made the pain-killing properties of opiates desirable. When I asked about traumatic events in her life, she replied: 'Well I started using drugs after I was sexually assaulted'. Voni had been raped by someone she knew in high school. The school was unaware of this, but at least one teacher knew of her drug use. Voni received neither care nor intervention and eventually she left school completely.

**School separation**

We can see that by this point young people were on the margins at school. Shifting from school-to-school, as well as initiation into substance use, only served to widen the gap between them and formal education. Kate went to six high schools and was in the care of the state. She was in temporary foster placements and then residential care, which led to her moving homes and schools every few months. Three years into high school (Year 9) she left school completely.

Cameron had an abusive home life. When asked what he liked about school he said that it was an ‘escape’ from home. However, despite school providing him with a safe-haven, he was ‘acting-up’ and was kicked out of school when he was 14. Immediately after this happened, his father kicked him out of home.
Lizzie had been bullied through primary school and this continued in high school. She was placed into state care when she was in Year 10. Just days after entering care, Lizzie, aged 15, met a man aged 40, who lived nearby. On their first ‘date’ he injected her with heroin. Their relationship continued for many years, as did their heroin use. Lizzie soon developed a ‘habit’ and left school in Year 11.

Simon told how he had been rude to various teachers and had been suspended a number of times. Around this time, he had also become friends with a group of older teenagers and preferred to hang out with them. He emphasised that he had not been expelled from school: ‘I just kinda got out of the habit of going’.

Michael was the sole protagonist in his narrative of school – there was no reference to his parents or other care-givers in his explanation of how he ‘got out of the habit’ of attending. Michael thought he was solely responsible for his exit from school and made no reference to any contextual factors that influenced his decision. Once he left school, his substance use escalated dramatically:

[I was] smoking heaps of pot ... It just took up heaps of time. The whole day would be gone and I wouldn't realise. Weeks would just go by and I wouldn't realise.

The transition from substance use to substance abuse happened swiftly once young people were disconnected from school.

Table 5.1 shows that only nine per cent of the young men and 15 per cent of the young women completed Year 12. The young people who completed Year 12 were atypical for a number of reasons. Jerry was a private school rebel. After being expelled from three elite private schools, he went on to thrive in a public school and did very well in his final year of education despite his drug use. However, he had a safe home and loving relationship with his parents who were financially secure.
Table 5.1: Educational outcomes by gender

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<td>Total</td>
<td>101*</td>
<td>99*</td>
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*Totals do not add up to 100 per cent because of rounding.

Lucinda also completed school and was accepted to do an events management course at TAFE. Lucinda's middle-class, university-educated parents were 'role models' which most participants did not have. While both Lucinda and Jerry had issues in their childhoods, they had been raised in homes where completing school was expected and there were some family supports.

Early school leaving was the norm in this sample despite more than 80 per cent of young people of comparable age completing secondary education (Year 12) (DEECD 2013). School is legally compulsory for everyone in Victoria until they reach 16 years of age (Year 10). However, half (53 per cent) of the girls had left school before Year 10 (Table 5.1), and another one-third (31 per cent) left at the end of Year 10 or early in year 11.

The figures for the boys were even more dramatic: two-thirds (66 per cent) of the boys had left school before Year 10 and another one-fifth (20 per cent) left school at the end of Year 10 or early in Year 11. In fact, Table 5.1 shows that more boys left at the end of primary school (Grade 6), than completed their secondary education (14 per cent compared with nine per cent).
As we have seen, half of the girls and two-thirds of the boys did not complete Year 10. Their pathways out of school usually had the following characteristics: they had a disrupted experience of primary school that prepared them poorly for secondary school; many of them found it difficult to ‘fit in’ or make friends at their new school; they felt like ‘outsiders’ because they came from families where there had been poverty, abuse, neglect and family disruption. To be an ‘outsider’ is a considerable burden at such a young age. In search of friends, they found kindred spirits in the ‘wrong crowd’. They began behaving badly, often failing academically. Some were expelled, others were ‘advised’ to find a ‘more suitable’ school, and some simply stopped attending altogether.

Truanting turning into complete separation from school was common. Amy had been smoking a lot of cannabis at home and stopped getting up each day to go to school. She explained her reason for leaving school in Year 11: ‘I was smoking and just lost my way’.

Jessica was also smoking a lot of cannabis at home:

* I was starting to get depression and anxiety and I didn’t know, or understand, why I was feeling that way. I was arguing with Mum a lot, I was very unhappy, I missed a lot of days – Mum didn’t really make me go. Eventually when I moved out from my mum’s to my dad’s, I just never got back into it.*

Jessica’s case illustrates that drug use was one of a number of factors explaining her pathway out of school.

Participants were quick to acknowledge that they were not the ideal student; nor that they especially enjoyed school. Some regretted not having an education, but most regretted leaving school because of what they ended up doing instead: very little, other than meeting up with ‘mates’, smoking ‘bongs’ and ‘hanging around’. Despite disliking the structure of school, for many of these young people, the school bell ringing at set times each day was the only structure that they had in their lives. Leaving this behind left them with a sense of purposelessness and many hours to fill each day.

The separation from school was a critical disconnection in their lives. For most, substance use had been a part of their lives before leaving school. But it was once they
were out of school and left with hours of time to pass that drugs became a significant issue. This was exacerbated by the reality that most left school directly into unemployment.

**Unemployment**

Unstable living arrangements, and a growing drug problem, explain why so many of the participants left school early. These factors also partly explain why most of them became unemployed upon leaving school, although limited literacy and a poor educational record were contributing factors. For many, employment was not even considered. This was not because they were lazy, but because they suspected they were ‘unemployable’.

For Simon, once the daily structure of school was no longer a part of his life, there was little to do:

> [I was] smoking heaps of pot. I don’t really remember. It just took up heaps of time. The whole day would be gone and I wouldn’t realise. Weeks would go by and I wouldn’t realise ... I was smoking more than my mates because all of my friends still went to school and after Year 9 they kind of stopped doing it – they got over it – but I kept going because I was at home all day and I had nothing to do so I just smoked.

Jakey regretted leaving school, but this was not how he felt at the time:

> I thought back then that I was too slick, that I was too cool for everyone. I was like ‘Fuck this! I am going to get money’. I thought I was too cool for school and now I look back and I was the biggest idiot ever. Looking back, I’d be at uni now, but I didn’t want to ‘waste’ my time at school.

This was a common binary: young people had been desperate to leave school, only to quickly regret doing.

Luke enjoyed his first few months away from school, explaining that it ‘was really good. I didn’t care – no work, no nothing. No teachers telling me what to do. I could live my own life’. Within a short period of time this faded and he began to miss school:
But I did like it [school]. Just the feeling of going there. And I had a lot of friends – people did like me; I was a nice person. I miss them – even now. I still wish that I had stayed – really wish that I had stayed at school. That’s the only reason that I feel that everything is happening and that I’ve gone downhill – ’cause I left school.

These young people were aware that their employment options were bleak. Not having completed secondary education was a barrier to future opportunities given that they belonged to a generation where more than 80 per cent of young people will complete school. The proliferation of undergraduate university degrees leaves those without even a high school certification considerably disadvantaged. This was something which Alex was feeling:

*Just looking at some of the kids, looking at other people’s lives – kids I used to go to school with and the potential they have compared to me. Sometimes I feel like, ‘Fuck, I could be that person’, but I have taken the wrong path.*

Alex takes individual responsibility for taking the ‘wrong path’. However, her decision to leave school was influenced by the fact there was no integration aide at her high school, as well as becoming homeless to escape sexual abuse. To infer that Alex had a free ‘choice’ is simplistic. Nonetheless, Alex adopts complete agency in her narrative. This is consistent with the participants in Bourgois’ (2002) landmark study of ‘crack’ dealers in the United States. They rejected any suggestion that they were ‘victims of circumstance’ and emphasised their own agency in choosing to become street-based crack dealers. Similarly, MacDonald, who has undertaken extensive work with the ‘economically marginal’ in the United Kingdom, points out that individuals in these areas experience public social issues as personal troubles (MacDonald 2008).

There was little reflection from the young people about their experiences of unemployment and I suspected this was because they found it boring – and therefore had little to say about it. There were a small number of young people who gained paid work, but this was often on a casual or part-time basis, and in some cases it did not last long.
Homelessness

The vast majority of participants had experienced homelessness: 96 per cent of the women and 86 per cent of the men. Of the six participants who had not been homeless, only two had genuinely stable housing. These were Maggie and Michael and my questions about stable housing seemed odd to them. For instance, when I asked Michael if he had ever been kicked out of home, he replied, ‘But *where* would I go?!’ The possibility that a parent would evict a son or daughter was unthinkable to him. Michael had been raised in a family where, despite many issues, children were to be cared for. This was also how Maggie felt. Michael’s reply illustrated the sense of security that was missing in the other young people’s lives.

Understanding young people’s pathways into homelessness can help determine the supports they are likely to need. Toro, Lesperance and Braciszewski (2011) undertook a longitudinal study with 250 young people entering homelessness in Detroit. The researchers propose a three-category typology: (1) Transient but connected; (2) High-risk; and (3) Low-risk. The ‘transient but connected’ group had the longest histories of homelessness, but were the most connected to their family and had other social supports and networks. The high-risk group were those most likely to have substance use and mental health issues, along with disconnection from their family. The low-risk group were those who presented with the lowest severity on each indicator. All of the participants in my study who had been homeless fell within the ‘high risk category’, although a minority were still connected with their families.

Becoming homeless

As we saw earlier, 90 per cent of the young people had been homeless. Asiah came to Australia from Sudan as a child refugee without his parents. He lived with his older stepsister, though this arrangement soon became acrimonious and she kicked him out when he was 14. Asiah left school soon after this, passing time by smoking marijuana. He explained: ‘smoking weed makes you forget everything’.

Roxanne had a stable, albeit strict, family life. However, she had been raped and soon after, both her best friend and her grandfather had died. One day she got drunk at school and was suspended. Her father was furious and threatened to kick her out of home. Rather than motivate her to ‘straighten up’, this left Roxanne feeling more alone:
All those people had died. Every time I was at home I was getting yelled at and told that I was a worthless piece of shit. I didn't really have any steady friends.

Roxanne’s drug use increased steadily and true to his word, her father did kick her out of home. Roxanne spent many years feeling abandoned and unloved and she found that drug use softened this.

About three-quarters (72%) of the young people became homeless at around the same time that they left school. It appeared that for the majority, the disconnection from school was the catalyst for the disconnection from home. Becoming homeless ‘locked’ young people into unemployment and made a return to education virtually impossible. Many reported feeling isolated and depressed.

Luke was kicked out of his mother’s home not long after he was expelled from school. He had ‘lost the plot’ and his mother had an intervention order placed against him. Luke explained that his ‘losing the plot’ was closely related to his heavy cannabis use. He said that he ‘couldn’t handle’ the drugs, which only exacerbated his depression. Luke went to live with his father, but this did not work out:

I wasn’t happy living there. I don’t know. I ended up leaving his house – it was just before I turned 15 – I just left and then I wasn’t at my mum’s or my dad’s.

Luke stayed temporarily with various friends and acquaintances. When he turned 16, he became eligible to receive a government welfare payment and was able to rent a room. Luke explained that this ‘wasn’t too bad’. After having been homeless for so long, it took little to impress Luke: ‘I got food, I had a roof over my head, I had a bed—I made it work’. This arrangement ended when Luke was ‘kicked out’.

Sam was raised by a single father, but their relationship deteriorated during Sam’s teenage years:
He kept telling me to get work, and then when I did get work, he was still complaining about stuff, and we just didn’t really get along so I thought I’d leave but I ended up being on the streets.

Sam was on the streets for 18 months before he found a youth refuge.

Katte was another case where fleeing the home was more desirable than being there. As I probed how it was that her apparently caring – but ‘boring’ – parents would let her remain homeless, it became clear that the ordinary, middle-class home life that Katte had portrayed was not entirely accurate. Katte went on to talk about feeling safer on the streets, ‘cause my dad used to hit me a lot’. While Katte’s own narrative about her homelessness had been framed with a sense of agency – she ‘chose’ to run away from her ‘boring’ family – the reality appeared to be that she was, in fact, fleeing ongoing physical abuse; and it was not just Katte’s father who was violent. When Katte’s mother discovered that Katte had a tattoo, she ‘went fucking crazy’, slapping Katte before pushing her head into the bonnet of the car. Katte said that her family had a ‘nice home’, but she would ‘rather be homeless than be with them’.

Many of the young people appeared to have been escaping from their family home. Lisa’s undisclosed abuse at her after-school care program had affected her in many ways. While the sexual abuse had not happened at home, there were other issues of family violence and neglect within the family. When I asked Lisa how she became homeless she answered, ‘I went to the city with my friend and I ended up staying there for three years’. In a literal sense, this was true; but Lisa was also escaping violence.

Some young people were abandoned by their caregivers. For example, Jai’s entry to homelessness came at 14 when he ‘came out’ as gay and his grandfather no longer wanted anything to do with him.

Pathways into homelessness were varied – and, not surprisingly, no-one travelled exactly the same route – but one consequence of becoming homeless was that most young people were now disconnected from family, home and school. Their new life of transience was a critical juncture in their pathway to substance abuse.

**Being homeless: ‘It just made you feel un-homed’**

Each explanation for how a young person became homeless was unique, but there were also common themes in their narratives. Many of the young people felt abandoned by one
or both parents. In some cases this was literal and the young person was evicted. In other cases it was figurative when the parent abandoned the role of care-giver. Others had ‘homes’ with a parent in them, but these homes were characterised by abuse and neglect. Many of the young people, particularly women, made reference to feeling safer on the streets. This tells us little about the streets, but a lot about the severity of their home life.

Every participant had a clear memory of what happened when they became homeless, but their recollections of daily life after they became homeless were often quite hazy. They recalled dramatic events, but not the more mundane aspects of their day-to-day lives. One thing that people did remember was that they often did not know how to get assistance with housing or food when they first became homeless.

Voni was transient for a long period of time. Sometimes she could not find anywhere to stay:

There were times when I got kicked out and had nowhere to go ... I didn’t know where to go. I didn’t know that if you were homeless there were actually places that you could go.

Ebony was also unaware of services for food or accommodation. The lack of services combined with her naivety did not bode well:

I slept at the bottom of a staircase and I had these really weird people looking at me. An old man kept watching me and I had to get changed there, I had to go to the toilet there – at the bottom of the stairs where I was sleeping ... It was really disgusting ... I was only 13 at the time.

Ebony only began to access services when she was 16 – three years after becoming homeless. Ebony nonchalantly explained that after sleeping in the staircase, she decided, ‘I’ll sell myself’. However, she went to the main strip and saw the working girls and quickly realised that was not something she could do. When I asked Ebony what made her think of doing this, she said she had ‘no idea’. I wondered whether the sexual abuse at the hands of her stepfather had taught her that women’s bodies were a commodity that could be traded.
For those who lived on the streets, the experience was a sharp learning curve. According to Jahl:

_Roaming the streets, not doing anything ... I just kicked it with all the younger kids that were in the city ... That was a fucking terrible part of my life. That's why I am mature today. I went there young and naïve, and I went through so much stupid stuff. Perverts, paedophiles, punch-ons—just bad people. I learned how to read people ... it was mostly [minor] dramas, but then there was also stuff that you’re going to carry with you for life._

Participants often recalled the events of homelessness, but their narratives were told as a series of experiences, almost separate from the embodied, emotional aspect. I asked, ‘How did it feel?’ to which Riley replied, ‘It was fucking scary. I’d walk until I couldn’t walk anymore – literally – and I would just fall down on the road ... then I’d wake up later’. Roxanne, who entered homelessness after her father kicked her out for being drunk at school, offered a detailed insight:

_It’s a different feeling when you are homeless. You don’t even really feel like a person anymore. You just feel like a piece of garbage on the side of the street. That’s how people view you and that’s how you feel._

Asiah also described the desolation of homelessness:

_You don’t know where you’re gonna go, what you’re gonna do, where you’re gonna eat, when you’re gonna sleep ... it kind of like freezes your mind ... Sometimes you just do stuff or go places because you don’t have anything to do ... I started getting scared because there’s nothing to do._

The challenges of homelessness were compounded by the reasons people were homeless. Asiah used drugs use to help him deal with his homelessness as well as the desolation he felt about leaving his family as a child. Asiah was trying to find comfort in a world where there was none.
The effects of homelessness on young people's emotional wellbeing were considerable. Christina was succinct: 'It was depressing, extremely depressing. It just makes you feel un-homed – like you don't fit in anywhere.' The feelings of despair that Christina expressed, combined with the ready availability of drugs, made substance use an attractive option for 'killing pain'.

Once on the street, the availability of drugs increased significantly. Ashly, who was sleeping on the streets, lived in a world filled with violence and drug use:

It was everywhere – people robbing. That was when the heroin season started getting really bad. I just used to follow my sister. She was 14 at the time ... and I just used to follow her around everywhere because she was the one with the heroin. I was scared. I hated the stuff, I hated the people, so I just used to follow her everywhere they went and just watch them. I'd go up alleyways and watch them, and help them if they're going off their heads. They tried to tell me to piss off, you know, 'You're just a little girl', but I was like, 'I'm not going around the corner in case you drop dead'.

Despite all of this, Ashly did not start using drugs herself – she was determined not to. As we saw earlier, her drug use came a few years later.

There is no clear pattern as to the relationship between homelessness and substance abuse. In a study of 4291 homeless people, Johnson and Chamberlain (2008) found that 43 per cent had substance abuse issues, but two thirds of them developed their substance abuse issue after becoming homeless. It was certainly the case for the young people in the current study that homelessness made drugs both more available and more appealing.

Voni began using before she was kicked out of home, but homelessness brought a sharp increase in her use:

Even just when it was cold, I’d want to have a hit to numb me out and not think of anything. Yeah, definitely more using.
Voni used heroin for the first time after being raped – heroin worked well for anaesthetising her emotions; however, her heroin use led to her becoming homeless and being homeless was far more bearable if one was stoned, thus her heroin use increased. Emotional and psychological distress were experienced by all of the young people in this study and drug use helped them manage these symptoms – but drug use was not a foolproof solution.

Eleven (44%) of the young women disclosed a suicide attempt as did six (17%) of the young men, an overall rate of 28 per cent. Riley had tried to hang herself in a boarding house which is an unusual method for a woman (Canetto & Sakinofsky 2010; Denning, Conwell, King & Cox 2000). She was found unconscious by a member of cleaning staff and was revived.

Jazmine had attempted suicide three times. She recalls her experience in a hospital emergency department:

_They made me feel so small that I didn’t want to have anything to do with their services at all … I remember that two people came in … and they just said, ‘Are you Jazmine?’ … then they were like, ‘What have you gone and done to yourself now? … So what are we going to do with you? This is the third time now, we can’t let this keep happening’, and they just preached at me like that._

Suicide was a topic that was unearthed later in the interview, after childhood and adolescence had been canvassed. Almost invariably, suicide attempts came in the period after disconnection from family, home and school. When participants spoke about their suicide attempts, their desperation was clear.

**Alternative pathway**

There were six young people in the sample who had never been homeless, though their trajectories into substance abuse were not a case of ‘bad luck’. Three of them used drugs to help mask mental health symptoms and I will examine them in the next section. The other three I will examine now.

One of them was Gerald who came from a background that was typical of many of the participants. He was raised in a home where there was abuse, neglect and very heavy
parental drug use. Gerald’s stepfather would often end up in violent rages after drinking alcohol. As a consequence, Gerald hated alcohol because he associated it with his stepfather’s violence. Nonetheless, his introduction to alcohol came early:

*I was about nine or 10. My stepfather bought me some Wild Turkey [Bourbon] and taught me to be a man. I got really drunk and then he made me bounce on the trampoline. That day really hurt, I felt really, really sick.*

Like the other young people who grew up in families where drug use was normal, Gerald followed in his stepfather’s footsteps.

The other two young men, Michael and Jakey, were both atypical of the broader sample. Both had a father who had had an affair, and both had a younger sister who was ‘devastated’ as a consequence. After their father’s infidelity, Michael and Jakey were left deeply troubled about what it meant to ‘be a man’. The link between their emotional trauma and substance abuse is explored in greater detail in Chapter 7.

**Mental health**

In total, 53 of the 61 (87%) young people had a mental health issue and there was little difference between men and women (men: 86%; women: 88%). The most common diagnoses for both genders were anxiety, depression and psychosis. There were six young people whose primary mental health diagnosis was likely to be organic: these are the psychiatric disorders which are believed to have strong biological and genetic foundations such as schizophrenia and bipolar disorder.

There were 47 young people whose mental health issues were not inherently biological or genetic. Their diagnoses were mostly depression, anxiety and psychosis. It is almost certain that environmental factors were impacting on the mental health of these 47 young people, although separating organic factors from lifestyle factors is almost impossible.

There were three young people in the sample who had not been homeless, but who had developed a problem with substance abuse in the process of self-medicating to manage their mental health symptoms. They were Larry, Andreas and Maggie.
The two men, Larry and Andreas came from stable families, where both parents remained together. Andreas had thoroughly enjoyed primary school and the early years of high school where he won academic awards. However, by Year 9, things had come unstuck:

I got diagnosed with psychosis, schizophrenia, depression – all that sort of stuff.

Soon after this, Andreas started to experiment with drugs which stopped the voices he was hearing. However, this cessation of symptoms was only temporary. Later, he found that drugs sometimes made his symptoms worse:

As soon as I had the bongs I knew it was a psychotic episode. I started hallucinating, seeing things, and it got real bad. There were people screaming in my head, full screaming. Then what happened was, I was trying to walk home but I realised that I was just stepping up and down, I wasn’t walking, and I was like, punching trees, all this shit. I went to the station, and I had a knife, and I thought someone was fighting me, so I stabbed them. And then I just lost my shit, and the next day was the first mental health appointment, and I got there and I told them what was happening and they knew straight away.

While Andreas knew that drugs were ‘bad’ for him, he also knew that they had been able to give him relief from some of the symptoms which his prescribed medication appeared unable to manage. This was very similar to Larry who also had psychosis.

Maggie also came from a stable family environment and had a childhood free from abuse or neglect. However, her mental health issues were significant. Maggie was bright, warm and had a loving family, but her obsessive-compulsive disorder and her depression severely limited her potential. There were days when she could not get out of bed. Her anxiety crippled her and she found that cannabis helped control these symptoms:
It relaxes me, it slows me down. It slowed all my thought processes down. It puts things in order in my head and it clarifies a whole lot of things so that I can just see one thing at a time – the first thing that I need to do, and then the second thing. And I can check boxes and check things off, ‘cause I like checking boxes.

After one stay in a psychiatric hospital she was prescribed a new medication. At first, this appeared to work well:

I just bounced into life. I was so happy. I was like, ‘I’m in recovery!’ I was off dope ... I was doing really well ... and then I just crashed again. I was like, ‘I can’t deal with this anxiety’ ... so I saw my psychiatrist and I basically said to him, ‘I can’t deal with this anxiety, I can’t deal with hour long panic attacks every night’.

Maggie knew that cannabis was able to calm her and, soon enough, she relapsed into substance abuse as a way of stopping the panic attacks.

**Conclusion**

In Chapter 4, we saw that participants had many problems in their childhoods, but these were not drug problems. This chapter has examined what happened in their adolescent years that led to substance abuse problems. For the majority, secondary school was a largely unhappy experience with only seven (12%) completing Year 12, compared with 80 per cent of their age group.

Most had begun to try alcohol and other drugs while they were still at school, although it was not their substance abuse which had led to their departure from education. Housing instability, family breakdown and developmental issues had all created barriers that made staying at school a difficult option. Half (53 per cent) of the young women did not complete Year 10, nor did two-thirds (66 per cent) of the young men, and most of the remainder left school at the end of Year 10 or early in Year 11.

The separation from school was a critical disconnection in their lives. Most had been recreational drug users since their early teens, but once they were out of school
drugs became a significant issue. This was exacerbated by the reality that most left school directly into unemployment. Substance abuse was an effective way of ‘killing time’, especially so for those who were without housing.

The vast majority (90%) of participants had experienced homelessness, and in many cases this occurred roughly around the time they left school. If substance abuse had not been an issue prior to homelessness, it quickly became one once they engaged with other homeless people. This chapter has shown that there was not a single pathway from childhood trauma to substance abuse, but there were key factors – leaving school, separation from family, unemployment and homelessness – that were usually ‘in the mix’.
Chapter 6
Cutting out the pain

Early on in the data collection I began to suspect that there were gender differences in explaining pathways into problematic substance use. Of the first six women interviewed, five had shared similar life experiences and, strikingly, the young women all used the same language to describe these experiences. One of the issues that came up repeatedly was that when these women were younger they had engaged in self-injurious behaviour. All of them had partaken in ‘cutting’. Often people are reluctant to disclose this behaviour, because they are aware that in the wider society, cutting is stigmatised and carries connotations of pathology.

I had not planned to ask any questions about self-injury. However, if young people raised the issue themselves, I offered them a space to talk about their experiences. In asking these questions, I followed the guidelines identified in Noddings’ (2003) theory of relational ethics outlined in Chapter 2. I asked the questions in a non-judgmental fashion, indicating that I understood the issues they were talking about, and trying to convey that I cared about their feelings.

Twenty (77 per cent) out of the 26 young women disclosed that they had engaged in cutting when they were in primary school or in their early teens. We have learned in earlier chapters that unemployment and homelessness have some connection with substance abuse. Now I want to look ‘below the surface’ and ask whether there is any link between self-injury and substance abuse.

First, I define self-injury and I review two broad approaches to explaining this activity. Then the chapter explores the childhood experiences of the 20 young women who had a history of cutting. It points out that all of them had experienced either sexual and/or emotional abuse. Focus then turns to the phenomenon of ‘dissociation’. This is a psychological defence mechanism that helps people cope with abuse by separating the mind from the body. Finally, the chapter shows that self-injury and substance abuse served a similar purpose for these young women: they were different ways of ‘cutting out the pain’.
Self-injury

Definition and social characteristics

Self-injury refers to the purposeful, non-suicidal, injury of oneself. The most common form of self-injury is cutting. Other types of self-injury include: burning, bruising, pinching, or wound interference. The severity of self-injury varies. It is often mild with superficial wounds not requiring medical treatment but self-injury can sometimes be so severe that it is life-threatening (Adler & Adler 2011; Levenkron 1998). Self-injury is sometimes referred to as ‘self-harm’ or ‘self-mutilation’, and both terms imply that self-injury is irrational behaviour that is damaging to a person’s physical wellbeing. In the wider community, self-injury carries connotations of mental illness. It is usually taken for granted that self-injury is a deeply stigmatised form of behaviour and that those who self-injure should not disclose their ‘deviance’ to other people.

Self-injury is usually associated with women. However, little is known about the demographic characteristics of the self-injuring population. It is difficult to assess the representativeness of various research samples. Studies drawn from psychiatrists’ case studies portray the typical ‘cutter’ as a middle-class white schoolgirl (Favazza 1996; Levenkron 1998). Similarly, Strong’s (1998) book on the topic reported that people who self-injure are usually women, although many of those who were interviewed for this research were well past their teens. Chandler (2012b) interviewed 12 people aged 12-37 years and purposively sampled to include both men and women (7 females, 5 males). Adler and Adler (2011) undertook 135 in-depth interviews with people who had self-injured. They reported that 85 per cent of their sample were female.

In Australia, Martin et al. (2010) completed a cross-sectional telephone survey of 12,006 people drawn from a representative sample of the adult population. They found that self-injury was most common in the age group 20-24, and that 24 per cent of young women aged 20-24 had self-injured, compared with 18 per cent of men. In the United States, Tyler et al. (2003) examined the prevalence of self-injury in a sample of 428 homeless teenagers. They found that 69 per cent had at least one episode of self-injury, though there was no significant difference between males and females. Overall, there is considerable uncertainty about the characteristics of people who self-injure. Reliable statistics are almost impossible to obtain because most people who self-injure conceal their activities.
Two explanatory frameworks

Next, I review two broad approaches to explaining self-injury. The first approach views self-injury as evidence of pathology. I refer to this as the ‘common sense explanation’. The second approach views self-injury as a form of ‘coping’ behaviour that must be understood in context. According to this approach, self-injury may be ‘unconventional’, but is not ‘pathological’ (Alexander & Clare 2004; Crouch & Wright 2004; Harris 2000). There are a number of versions of this argument. I refer to them as ‘contextual explanations’.

The common sense explanation rests on the assumption that the intentional injury of oneself is extremely disconcerting. This discomfort is generally exacerbated when the injury involves perforating one's flesh. The sight of blood is confronting as the breaking of the body's boundaries is a powerful symbolic gesture which is deeply embedded within the social imaginary as something deviant and/or pathological. Hodgson (2004) has suggested that attempts to classify self-injury as a form of mental illness is a consequence of society's need to explain that which appears ‘irrational’ or ‘pathological’.

In fact, self-injury is a feature of several formal psychiatric diagnoses. However, in the recently released fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, non-suicidal self-injuries were listed as ‘section three’ disorders. These are disorders which may not be covered by health insurance in the United States and that ‘require further research’ (American Psychiatric Association 2013). Prior to non-suicidal self-injury having its own diagnostic criteria, non-suicidal self-injuries were seen as pathological forms of behaviour and thought to be closely associated with borderline personality disorders (Cameron et al. 2012; NIHM n.d.).

The common sense approach to self-injury assumes there is something inherently wrong with this behaviour and is consistent with the ‘heavy psychiatric lens’ through which self-injury has often been viewed by medical professionals (Adler & Adler 2011; Chandler et al 2011; Hodgson 2004). Psychiatrist Armando Favazza (1996) has written extensively on self-injury. He calls for a different approach from mainstream psychiatry. He refers to his approach as ‘cultural psychiatry’. Cultural psychiatry adopts a more holistic understanding of people’s psychopathologies by assessing the role and place of culture in their lives. Nonetheless, cultural psychiatry still views individuals as ‘patients’ and cutting as a symptom of pathology.

There is a small body of sociological work which questions the assumption that self-injury is indicative of psychopathology. These studies suggest that self-injury may
actually be meaningful behaviour if it is understood in context (Claes and Vandereycken 2007; Chandler 2012a). These ‘contextual explanations’ come in a number of different forms.

Harris (2000) undertook a ‘correspondence study’ where she exchanged letters with women who self-injured to learn about the contexts in which they cut themselves and found that there was a ‘situated logic’ to young women’s cutting. Many of her participants explained that the intention of their self-injury was to ‘cut out the bad’. Rather than focusing on the ‘bad’ being intrinsic to the individual, Harris was curious to understand how the ‘bad’ ever ‘got in’. She began from the viewpoint that the negative emotions which instigated self-injury were not manifestations of an individual’s pathology but a consequence of an individual’s experiences.

Harris (2000) suggests that the oft-held view that self-injury is irrational is a consequence of Western society’s privileging of dispassionate knowledge. When looking at self-injury in isolation from the individual’s experience, the logic of the behaviour is impossible to see. This apparent absence has helped to reinforce the view that self-injury is a psychiatric issue. However, seeking to separate emotions and experiences from understandings of an inherently embodied phenomenon such as self-injury fails to capture a complete understanding of the function it serves for the person who engages in it (Chandler 2012a; Harris 2000; Horne & Csipke 2009).

Strong (1998) suggests three possible explanations for the link between sexual abuse and self-injury. She argues that women who have been sexually abused experience extreme emotional pain and this often leads to separation of the mind from the body. They no longer identify with their own body and feel emotionally disconnected from their physical selves. Strong’s first explanation for self-injury is that it disrupts these feelings of ‘dissociation’ or emotional disconnectedness. Her second explanation is that it allows women to re-assert control over their bodies, which is taken away when they are raped. Her third explanation is women internalise intense emotional pain following rape, and self-injury symbolises ‘cutting out’ the pain.

Other sociologists have focused on self-injury as a strategy for dealing with intense emotional pain and have drawn attention to the possibility that self-injury is a coping strategy. For example, Hodgson (2004) conducted an exploratory study which sought to understand how cutting is learned, as well as how people who cut manage the stigma with which it is associated. Adler and Adler (2011) undertook a major longitudinal study which
drew attention to these issues, and I draw upon their study throughout this chapter. Similarly, Chandler's small empirical studies (2011; 2012a; 2012b) sought to extend the sociological literature, and to give voice to those who self-injure and who are not involved in psychiatric care.

Sociological studies draw attention to the social context in which people undertake self-injury, and raise the possibility that self-injury is primarily a strategy for coping with intense emotional pain. In the next two sections, I investigate the utility of this approach. First, I examine the 'social context' in which these young women grew up and whether they had experienced significant childhood trauma.

**Childhood trauma: the body's boundaries**

There were 20 young women in this study who were had a history of cutting. Of the 20, 16 (80%) disclosed that they had been sexually abused as children and 14 (70%) reported feeling 'abandoned'. This section explores these young women's early lives and their experiences of trauma.

**Sexual abuse**

The topic of sexual abuse presented itself in a variety of ways within the participants' broader narratives. I did not ask the young people about sexual abuse, but if they disclosed abuse I offered them the space to talk about it, provided I could see no obvious risks for the young person.¹ My background as a clinician informed these judgments, as did my understanding of Noddings' (2003) theory of relational ethics which was explained in Chapter 2. This suggests that caring for people, and ensuring they feel cared for, should guide ethical reasoning. With care, I listened as these young women spoke, often tearfully.

Ebony had a biography that was typical among participants. When I asked her if as a teenager she had stayed at home much, she revealed:

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¹ For a detailed discussion of assessing the risks of over-disclosure, see Daley, 2012.
Nup, never. I just ... I’d rather live at my friends’ houses ... [where] I’d never get bashed or hurt in other ways. I’d always try to prevent going to my parents.

KD: Was there abuse at home?

Yeah, yeah. I got, er, ah ... by my so-called stepdad ... I was staying there, in the living room, in the fold-down bed, and he raped me. I was only 15 ... He bashed our family ... Yeah, we’ve bled a lot over him.

Lisa was also sexually abused. She was raised in a home of family violence and neglectful parenting; but, Lisa’s case differs from Ebony’s in that her mother did not know about the sexual abuse and the perpetrator was not a family member. Lisa had spent three years sleeping on the streets in her early teenage years and when asked if her safety had ever been compromised during this time, she explained that it had not been while she was on the streets, but it had earlier:

When I was in primary school, Dad wasn’t there, because Mum had to go ... what it feels for me ... I am just trying to get the words – I am not very good with words, sorry ...

KD: No, take your time ...

... what made me, when I first was young, what started everything, being angry and sort of wanting to, I don’t know, knock off somewhere or just drink, was because ... it was when Mum put me in after-school care and like, I feel that’s what caused me to go off the rails a bit. Because, like, what happened ... it was one of the ladies’ sons or something ... I couldn’t tell my mum what he was doing, because, well [*starts crying*], I felt like I was going to get in trouble or something. Yeah, he just kept ... I had to go there every day. Mum sent me. Mum asked him to babysit me ... he just kept making me do shit with him [*sobbing*] ... I can still remember it.
Riley had also been sexually abused. For her, it was in the place she had sought refuge:

*I was in Year Eight ... it was one of my friends who I was staying with when my mum kicked me out – her dad sexually assaulted me. He always sexually assaulted my other friends when they stayed over too.*

Not long after this, Riley had moved interstate to a boarding school which an estranged – albeit caring – extended family member financed. However, this did not work out and she left. At one point, Riley was able to find accommodation in a share house and she attempted to return a local public school for Year 11. However, with the complexities in her life this was not sustainable. Throughout all of this, there was no contact with her mother. When I asked if she missed her mother, Riley replied, ‘She really hurt me. She really, really hurt me’. The young women often had many unresolved issues and were attempting to ‘move on’ from these while simultaneously trying to build a new future.

**Abandonment**

Sexual abuse was not the only trauma that these young women experienced. Other traumatic events included parental mental illness and/or substance abuse, disconnection from school, housing instability, family violence and involvement in the child protection system. However, the most common trauma after sexual abuse was their sense of being abandoned. This affected 14 (70%) of the young women. For the purposes of this chapter, abandonment refers to a young woman’s ejection from the family home by her mother. I define ‘abandonment’ in this way because most of these young women’s biological fathers were not present in their lives.

Ebony’s mother kicked her out of home when she was 13: ‘Mum sent me up to Melbourne, she just didn’t want me anymore’. When asked how that made her feel, she replied, ‘I cry, I cry every day. Every day I cry’. Ebony’s sadness about being kicked out was compounded by the reasons she was excluded from the family. Ebony’s stepfather had been sexually abusing her and she felt that her mother was envious that her daughter was receiving his sexual attention:
Yeah, she knew about the abuse, but she loved him. I'd ask her, 'If you put us first, why didn't you leave him?', and she'd say, 'I didn't have anywhere else to go', and I'd say, 'Well going anywhere is better than going back there', and she goes, 'Yeah, well I loved him and I didn’t want to break his heart’ ... I asked her again down the track and she said, ‘When you’ve been with someone, you just become attached and you know, the sex just becomes, well you know, you just really love it and you need it’. That just really hurt me.

Lisa was aware that her mother did not know of her years of abuse at the after-school care program, but she still felt a deep sense of hurt and abandonment that her mother had left her in this program to be ‘cared’ for. Later, Lisa’s feeling of betrayal was cemented when she was literally abandoned:

... one night my mum kicked me out basically, and I went down to my best friend’s house, and into the city ... we both went into the city on a train and ended up staying in this squat with these old guys. ... sometimes I would go back home, because they’d put a warrant out or something, and then I would go back and stay a couple of nights and we would have a fight or something and I would just go again. So yeah, I don’t know, she got a bit sick of me being, just, um, just having a daughter, I guess.

In addition to this abandonment, there were other issues in Lisa’s past which made living at home untenable. Lisa’s stepfather was abusive and this was not an issue addressed by her mother. As Lisa shared this, her voice both lowered in volume and began to tremble in tone. The pain associated with this trauma was still raw. It was apparent that her mother’s inaction caused just as much – if not more – distress than the assault itself. The absence of her mother’s protection affected Lisa not only physically but also psychologically as she felt that she had been neglected by the person who should have kept her safe.

A feeling of abandonment was echoed by Riley:
I was always having problems with Mum ever since I was a little kid. Always the little things: I was sporty, but she wanted me to do music. It was always a lot of hate with each other. Even though I was only so small ... it got to the point where she just didn’t want me anymore.

Pining for a mother’s love was a common narrative. Lisa spent some time in the care of the state, an experience which she found mostly positive because it was the one place where she had both food and safety. Nonetheless, she eloquently captured the feeling of being without a parent’s love: 'If you don’t have the affection from a parent and everything like that, you are an outcast in the world'.

For 16 year old Jessica, a volatile and problematic home environment increased the insurmountable pain she experienced after being abandoned:

She kicked me out and told me that us kids stole the best years of her life and she wished she never had us, that we were all spoilt little brats ...

KD: Do you miss Mum?

Yes. I hate her so much that sometimes I think I could actually kill her, but ... [*starts crying*] ... she doesn’t deserve fucking anything. She’s an arsehole and that’s the truth.

Jessica, like all of these young women, experienced a tension between feeling hurt and angry at her mother and a desperate want for her mother’s love. We can see that these young women’s trauma was not confined to their experiences of sexual abuse. The abuse the young women in this study experienced was compounded by the absence of support and safety. Often their mothers ignored or dismissed their cries for help and, not uncommonly, abandoned them entirely.

Of the 20 young women, three had been abandoned, five had experienced sexual abuse and 11 had experienced both sexual abuse and abandonment. Only one young woman had experienced neither. She had a same sex partner and her girlfriend had committed suicide.
This section has explored these women’s early lives and their experiences of trauma, paying particular attention to sexual abuse and abandonment. The young women did not have the supports of their immediate or extended families. Rather than be nurtured, they were often trying to survive. In the next section, we see that the intense emotional pain that these women experienced, combined with a lack of physical safety, contributed to many of them having overwhelming feelings of dissociation.

**Dissociation and self-injury**

*What is dissociation?*

A woman’s relationship with her body after sexual assault can be highly troubled as her sense of embodiment is violated. Adler and Adler (2011) argue that when women are very young they learn that their body is a commodity. After rape, many women are traumatised and some women start to see their body as the ‘enemy’ or the ‘cause’ of their emotional agony.

It is also possible that some victims view their body as ‘seductress’ and they blamed their bodies for attracting unwanted attention (as is so often the case in mainstream conjecture about whether ‘she asked for it’). Strong (1998) explains the relationship between sexual abuse and one’s sense of embodiment:

> Sexual abuse is the most obvious, and perhaps the most devastating, attack on body image. The body is never wholly one’s own again. In fact, the victim’s own body is used as a weapon against her. It is controlled by others and can be made to respond—the ultimate betrayal—against the owner’s will. Its boundaries are violated and intruded upon, creating a lingering confusion between inner and outer ... An abused child may come to feel totally divorced from her physical self. (p. 122)

After rape, the body can be seen as the enemy. Yet the body, the site of the trauma, is physically inescapable.

One strategy that women have for dealing with the trauma caused by rape is to ‘separate their mind from their body’. In everyday language, we might say that that they experience acute emotional numbness. Psychologists refer to this ‘separation of mind and body’ as dissociation:
Dissociation in its more serious forms is a psychological defense mechanism that keeps traumatic memories, sensations, and feelings out of conscious awareness. It is a key defense used by abused children. In the face of overwhelming danger from which there is no physical escape, it is an ingenious bit of mental gymnastics ... Mind and body separate. Pain is anaesthetized. The individual feels depersonalized: numb, unreal, outside oneself, a dispassionate observer rather than an anguished participant ... She can’t remove her body from danger, but she can leave it emotionally. (Strong 1998, p.38, emphasis added)

Dissociation is a strategy for the mind to help cope with stress by internalising emotional pain. When people experience very stressful situations, some individuals externalise the pain whereas others internalise it. Those who externalise emotional pain are likely demonstrate their anger in ways that are immediate, obvious and visible: for example, yelling, screaming, swearing, punching a wall, or vociferously blaming others.

In contrast, people who internalise their stress remain silent: they may bitterly reflect on their disappointment; become intensely angry with themselves; or become moody, withdrawn and resentful; but always remaining silent, internalising their pain, not speaking out. Disassociation is a strategy for dealing with emotional pain that internalises stress. Women who have been sexually abused often internalise their emotional pain because they feel that they cannot talk about what has happened. To reveal that one has been sexually abused is to run the risk that one will be blamed for ‘putting oneself at risk’ or having been ‘complicit in the encounter’. We are all familiar with the cruel assertion that ‘she probably asked for it’.

Women who have been raped typically experience dissociation. They may start to see their body as ‘the enemy’ or to blame their body for attracting unwanted attention, yet their own body is their physical prison. Dissociation involves separating the psychological self from the physical self and it brings with it its own problems. Shutting off the mind from the body led many of the young women in the current study to say that they no longer felt alive. The consequence of dissociation was that they felt numb, no longer ‘alive’.

At the same time, internalising their emotional pain meant that they had not been able to rid themselves of the destructive emotions that accompany rape. For some, this
meant they had internalised a deep sense of self-loathing for their body was perceived as the impetus for their troubles.

**Feeling alive and cutting out the pain**

Now we examine three explanations for the link between sexual abuse and cutting. The first I will call *disrupting dissociation*. Strong (1998) points out that the visibility of the blood disrupts the young woman's dissociated state and provides evidence that despite their emotional numbness, they are in fact alive. Horne and Cispke (2009) also say that cutting can be used to suspend an intolerable emotional state, to disrupt dissociation (see also: Suyemoto 1998).

When asked what she liked about self-injury, Stevie replied: 'It made me feel like I was alive'. In fact, when asked about the function or purpose of self-injury, the descriptive language participants' adopted was profoundly similar. The frequency that 'feeling alive' was used to describe self-injury was what initially alerted me to it being a common phenomenological pattern among participants. Lizzie also explained, 'I just felt like I deserved it ... so that I knew that I was alive', as did Katte, who stated that, 'It was the only thing that made me feel alive'. To need to do something to feel 'alive' implied that they were previously feeling in a way which was not alive; not dead, but numb, which is consistent with the previous discussion of dissociation.

A second explanation for the link between cutting and sexual abuse is that cutting symbolically releases the emotional pain that is internalised within the body when dissociation takes place. I will refer to this as *cutting out the pain*. This implies that the neat conceptual understanding that the woman who has experienced dissociated cuts herself to feel alive is not an adequate account on its own. There is, in fact, a more complex relationship between self-injury and dissociation.

Suyemoto (1998) accepts that one purpose of self-injury's function is to disrupt dissociation, enabling people to feel 'alive'; but she also suggests that for some women, the purpose of self-injury is to cut out emotional pain that has been internalised as a consequence of dissociation. Adler and Adler (2011) also reported that both motivations were present among the participants in their study.

The need to release overwhelming emotions was cited consistently among the young women in this study. The sight of blood itself seemed to be therapeutic in that it
was a symbolic release of these emotions. When asked what she liked about self-injury, Alex replied:

*I don't know. It was like a release. After I'd seen the blood, it was like a release of anger or some sort of release. I can't really explain the feeling, but it was just a release.*

‘Releasing’ pain in a controlled way, where the woman feels as though she is in command of her body, is a theme found by others (Chandler, 2012b; Harris, 2000; Horne & Csipke, 2009). Alex’s feelings were similar to those expressed by Riley, whose deep sense of self-loathing and overflow of heavy emotions was the catalyst for her self-injury:

*I'd hate myself so much, and I'd just feel so much pain, and just feeling ... I don’t know how to put it ... just seeing myself hurting, I don’t know ... It’s because you hate yourself. You hate yourself. I don’t know – seeing the pain when I did it—it helped.*

Riley’s description of ‘seeing the pain’, as opposed to ‘feeling the pain’, illuminates that for these young women, the pain associated with self-injury was emotional, rather than physical. Chandler (2012a, b) has discussed how society’s privileging of physical pain over emotional pain is a consistent theme among people who self-injure. People use self-injury as a way of turning emotional pain into physical pain because physical pain is seen as more valid. Harris (2000), as well as Horne and Csipke (2009), also found this a common pattern among their respective participants.

Emotional anguish was pervasive among participants. Stevie was engulfed with a deep sense of sadness. Self-injury helped her to ‘feel things other than hate and negativity and depression’. The search for emotions other than depression was common. Mary, for instance, pointed out, ‘It’s the only thing that makes you feel some other way than what you are feeling’. For these women, self-injury was, ‘cutting out the pain’. Although this may initially seem a bizarre way of dealing with emotions, Amanda, a participant in Hodgson’s (2004) study into self-injury, points out that it may not be as unusual as it first appears:
Cutting, even at 11, is not REALLY such a foreign idea. We cut the brown part off our apple when we eat it, we cut the dead leaves off house plants, we cut the grass when it no longer looks neat and tidy, heck, we even cut out body parts when they no longer work right. Even small children want you to cut the part they don’t like off [like the crust off bread]. Everybody cuts the bad out. (p. 176, Original emphasis)

Amanda’s quote highlights that it is a learned human characteristic to remove the intolerable. For these young women, cutting serves to remove their pain and gives them some control.

Among the 20 young women who had self-injured, a common theme was that they felt a tension between wanting to feel alive and wanting to cut out the pain. This duality was integral to these young women’s explanations for their self-injury.

**Re-asserting control**

The third explanation for the link between cutting and sexual abuse is that women can use self-injury as a way to regain some control over their bodies. I will refer to this explanation as re-asserting control. Like dissociation, control is a theme which abounds in the literature on self-injury (Adler & Adler, 2011; Favazza, 1998; Tyler et al, 2003). Strong (1998, p. xviii) asserts that cutting may ‘allow the tortured individual to play out the roles of victim, perpetrator, and finally, loving caretaker soothing self-inflicted wounds and watching them heal’. This explanation is supported by the work of Suyemoto (1998) and Chandler (2012b) who found that for some self-injurers, having control of their body’s injury, as well as being able to care tenderly for their wounds, was the purpose of this behaviour.

While injuring oneself as a way of controlling emotional turmoil seems paradoxical and counter to one’s wellbeing, it needs to be understood in conjunction with the fact that these young women are also seeking control of their physical bodies which has been ravaged by others. Suyemoto points out that: ‘Self-mutilation serves to define the boundaries of the self, as the skin is the most basic boundary between self and other’ (1998, p. 546).

Wanting to remove emotional pain, as well as define and enforce the parameters of her own body makes self-injury multi-functional. While none of the young women in this study spoke explicitly of self-injury as a form of self-care, Strong’s explanations
concerning the control of the body and control of emotions were themes that recurred throughout the interviews.

Sixteen-year-old Jessica explained, 'I liked feeling like I could control things—I liked hurting myself'. Similarly, Christina found relief in self-injury as a means to seek justice for her own perceived (and misguided) wrongdoings:

*It just made me feel better. I felt like I was punishing myself – I felt like it was my fault that he was doing it ... I don’t know, it got out pain, if you will.*

It seemed that having control over the pain inflicted upon their bodies was part of the function of self-injury. Given the common experience of childhood abuse where their bodies were assaulted and their control stripped away, it is easy to understand why having this control of the body's boundaries is so desirable. While violating the body further as a way of releasing pain and garnering control seems nonsensical, it is pertinent to remember that many of these women loathed their bodies for ‘attracting’ the sexual abuse.

For these young women, the need to be punished was a part of their everyday experience. Jazmine explained that while her cutting wasn't pleasurable, it was functional: ‘Sometimes I felt like I deserved it’. Self-injury was not a sign of pathology; self-injury was a method of coping.

The high prevalence of self-injury among this sample was an ‘accidental’ discovery. I have explained that the behaviour of these young women engaged in was not pathological. When asked why she self-injured, Ebony replied, ‘I’d just cut myself to kill the pain’. When one understands the context in which she made this decision, and her need both to ‘feel alive’ and to remove emotional pain, then Ebony's behaviour seems quite logical. Rather than being ‘mad’, these young women had engaged in self-injury to disrupt dissociation, to cut out emotional pain, and to reassert control over their own bodies.

**From self-injury to self-medication**

By the time of the interview, the young women were no longer engaged in self-injury. All of them had ‘graduated’ from cutting to substance abuse. Katte was in a residential
withdrawal unit for her substance use when I met her. When reflecting on the period of her life where self-injury was a common strategy, she explained:

*At the time, [cutting] was the only thing that made me feel alive ... it's true. It's kind of like, if you don't have drugs, what the fuck else are you going to do? You feel that shit about life. ... Yeah. Like, I crave it [cutting] all the time. I wouldn't do it now, but I crave it because it was so good at the time – it's unreal.*

Typically, people couldn’t recall the specifics of either their entry into, or exit from, self-injury; rather, self-injury was something that they had moved into, and subsequently out of, without distinct delineation. Only two of the young women had made a conscious decision to stop cutting. Roxanne made a pragmatic explanation for her discontinuation and dryly explained that she ‘... didn’t need scars up my arms to remind me how shit my life is’. Kate stopped because it was becoming an issue within her relationship:

*My partner – who I am with now – his younger brother killed himself and it and, well it wasn’t that he was angry with me when I would do it, but it, well it became too much of a problem. It was easier to not do it; to find another way to cope, because it was too much.*

For Kate, this other way to cope was something which she could do with her partner: use drugs. The graduation from self-injury to substance use was typical, although it was less intentional for others than it was for Kate and Roxanne. When asking young women about their reasons for using drugs, there was a familiar sentiment being expressed. Roxanne explained her transition into problematic substance use:

*I think the reason that I started using heroin was because I was either going to kill myself, or I was going to find something that was going to make me not kill myself; and at that point in time, as bad as it was, it helped. Well, it didn’t help; but it helped.*
Roxanne’s insight shows that there was a distinct similarity in the functions of both self-injury and substance abuse, though the former always preceded the latter.

Mary was the only participant who still had episodes of self-injury, although these were less frequent:

*I guess when I am really angry in myself, it’s a way to vent that anger at yourself, the frustration, the self-pity. It’s something I fall back on because it’s one of the first things I did to cope with feeling really isolated and depressed and stuff ... I did that before I tried drugs or anything. It’s pretty easy to get addicted to, because – I know it’s a cliché that everyone says about it – but it’s the only thing that makes you feel some other way than what you are feeling.*

Mary’s explanation indicates the similarities in the function of self-injury and substance abuse. She shows that self-injury was her coping mechanism before drugs. This was a frequent narrative and young women always moved from self-injury to substance abuse, never vice-versa.

Jazmine also spoke about the gradual shift from self-injury to substance abuse and the purpose drugs served:

*Well if I am on drugs, I wouldn’t cut – if that makes sense? ‘Cause that’s why I did them—so I wouldn’t get sad. Well, you can get sad, but if I am on ecstasy or speed, obviously I am not really in reality at all; I am in another place, not really thinking about that stuff ... I wasn’t managing at all. Not just not managing school, I wasn’t managing. That’s why I was doing drugs – it was an escape.*

*KD: The drugs were the managing?*

*Yeah, they were the managing, because it was like, ‘I don’t want to think about anything right now, so if I take some drugs, I won’t have to’.*

For Jazmine, both cutting and substance abuse had helped her escape from her sadness. Jazmine’s need to escape reality in order to survive was similar to Roxanne who had used
drugs to stop herself from taking her own life. When these women were without support, their coping methods were self-injury and substance use:

To be honest, I can’t imagine myself – the state I was in – dealing with what I was dealing with in any other way. I think that if I didn’t do drugs I would be dead, to be honest. I would have committed suicide by now. There would have been another time in hospital, and I wouldn’t have come out. Or I wouldn’t have gone to hospital, if that makes sense?

Needing to escape reality and dull intolerable emotions were the reason these young women cut themselves, and they were also the reason they used drugs so aggressively. The similarities between young women’s descriptions of the function of their self-injury and their substance use speak to a broader issue: their worlds were unbearably painful and they were attempting to dull the pain. Not only was self-injury logical when its function was understood, so too was the move from cutting to drug use.

In the interviews, it was clear that the young women felt stigmatised about their self-injury. Many were surprised to be asked what they liked about it – it was clear that they had not met many, if any, people who were accepting of the behaviour. The same level of stigma was not attached to their drug use. Among the broader youth population, it has already been established that recreational drug use is a ‘normal’ activity (Duff 2005). For these young women, self-injury was a private activity that was done alone, whereas drug use was something that was done with partners, friends and family. These young women moved in a world where drug use was an accepted form of behaviour. Therefore, as they got older, it made sense to use drugs, rather than cutting, as a way of coping.

The young women were not seeking the recreational highs of ecstasy to enhance a night out in a club, they were seeking to stop the pain. Thus, they gravitated towards substances that had this pharmacological effect. Lisa’s experience illustrates well the appeal of drugs that that block the pain:

The problem is that I can still remember it [the sexual abuse]

KD: How have you managed since, to block it out?
Yeah, drinking or something. I don’t know. It still doesn’t make you feel much better. It does for a while, but it’s still there.

For Lisa, alcohol was soon replaced by heroin. When discussing the appeal of heroin, I observed that heroin is a, ‘very numbing sort of drug – it’s like a pain killer’, to which she replied:

Yeah, I think that’s the main thing that set it off in my brain. I didn’t tell mum for so long that I think I just needed some other way for trying to cope with it.

Lisa’s case highlights why the anaesthetic properties of depressant type drugs held much appeal.

Ebony, after graduating from self-injury, soon learnt that drugs could block out the pain of sexual abuse. The cost of drugs also saw her enact another lesson she’d subconsciously learnt in childhood: that her body was a commodity. When Ebony was first kicked out, she ended up in the red light district of Kings Cross. During this time, drugs quickly became a major issue in her life as she struggled to cope. Ebony was despondent toward her mother:

Mum knew too, and she didn’t do anything. She always called me a bad kid but she doesn’t [get it]. I tried to tell her why I’ve done what I’ve done, is because of, you know, that man. Everything I have done is because of that man ... I started everything when I was about 13. My first drug, heavy drug – I’m talking about heroin and stuff like that – was when I was homeless. One of the girls shot it up my arm for me ‘cause I was too scared to do it myself. One time, they offered me, but I was like, ‘Nah’, when I saw the needle. But the next time they offered, I was like, ‘Okay, yeah do it’, and it was shared that time ... I was 13 and she did it and I just thought, ‘This is so good’, you know, just forgets everything and then I ended up, shortly after, having an $800 a day habit.
Despite the problems which came from such a habit, the benefits of the drug use outweighed the negatives of raising the means to finance the habit. When asked what she liked about heroin, Ebony replied:

*Everything. Just the tingle in the nose; you don’t worry about anything; just everything – just being on the nod, yeah, I loved it, I loved drugs.*

Ebony’s childhood had been filled with physical, sexual and emotional abuse by her stepfather, and she had been abandoned by her mother, leaving her without an adult in her life who could provide her with a safe place in the world. Ebony liked drugs that made her forget.

Similarly for Lisa, drugs were a way of managing life on the streets after years of sexual abuse in after-school care. Like self-injury, substance abuse was never an intended path for these young women but it was, in many ways, a highly effective way of coping.

By the time I met these women, all were seeking to move on from substance abuse. Lisa articulates this well when she explains that drug use was ‘... just a fun thing to go and do when it wasn’t serious, and then it turned serious and it wasn’t fun anymore.’

**Conclusion**

This chapter set out to ‘look below the surface’ and to ask whether there was any link between self-injury and substance abuse. I began by reviewing two approaches that explain cutting. The first account views self-injury as evidence of pathological behaviour, whereas the second approach views self-injury as a strategy for coping with intense emotional pain. All 20 young women who had self-injured had experienced intense emotional pain, including 16 (80%) who had been sexually abused as children and 14 (70%) who felt abandoned by their mothers.

Focus then turned to the phenomenon of dissociation. This is a psychological defence mechanism that helps people to cope with abuse by separating mind from body. Emotional pain is internalised and the victim feels disconnected from her body or ‘without feeling’. Slicing one’s flesh with a blade made these women feel ‘alive’. At the same time, it symbolised ‘cutting out the pain’ and re-asserting control over their bodies.
As they got older, all of the young women moved on from cutting to substance abuse. In the interviews, it was clear that they felt stigmatised because they cut themselves, whereas there was less stigma attached to drug use. They started to mix in circles where drug use was an accepted recreational activity and drugs were easy to obtain. These young women had cut themselves to control emotional pain, and they used drugs for much the same purpose. Not only was self-injury logical when its function was understood, so too was the move from cutting to drug use as the women got older. For the women in this study, self-injury and substance abuse served the same purpose. They were ways of 'cutting out the pain'.
Chapter 7

Becoming a man

This chapter examines the dominant style of masculinity adopted by the young men who participated in this study, and explains how this shaped their drug and alcohol use. First, the chapter reviews four concepts that will guide the empirical analysis. The concepts are: working class hegemonic masculinity; working class machismo; and Erving Goffman's (1959) concepts of ‘front-stage’ and ‘backstage’. Front-stage refers to an individual's performance of ‘self’ in social situations, and backstage is when one is alone or not on stage.

Then I examine a range of factors that helped shape the masculinity of the young men. The most important factors were: the role of fathers in their lives; the examples provided by 'dominant' males in their peer groups; and their experiences in the homeless sub-culture and the criminal justice system.

After that, we go backstage and examine the connection between masculinity, emotional trauma and substance abuse. The chapter concludes that for these men, outbursts of uncontrolled anger and drug and alcohol abuse were different ways of dealing with emotional pain.

Four concepts

Connell's (2005) concept of hegemonic masculinity has become the dominant paradigm in the theoretical literature on gender studies. Hegemonic masculinity is a concept that is used to identify and describe social practices that ensure the privileging of men and subordination of women, and to explain the reproduction of these practices. The defining characteristics of hegemonic masculinity are male power, dominance, control and heterosexuality.

However, Connell points out that not all men exert a singular masculinity and that some masculinities hold more hegemonic power than others. Connell has emphasised that hegemonic masculinity does not infer that there is a singular dominant masculinity; rather, hegemonic masculinity may take a range of forms, particularly in societies where there are important class, ethnic or other social divisions. Thus, what constitutes ‘hegemonic masculinity’ is context dependent. As Connell explains:
'Hegemonic masculinity' is not a fixed character type, always and everywhere the same. It is, rather, the masculinity that occupies the hegemonic position in a given pattern of gender relations, a position always contestable. (2005, p.76)

In this chapter, I will use the concept of working class hegemonic masculinity to refer to the cluster of characteristics that are typical of ‘mainstream’ working class masculinity. These ideas cohere around the following themes: a proper man has a job, he is a hard worker, a good provider, and the main breadwinner in a family unit; a proper man believes in marriage, heterosexuality and 'having a family'; and a proper man should not show weakness or display emotion in the face of adversity.

Connell (2005) and Coles (2009) point out that these characteristics are not fixed because the construction of masculinity is an ongoing project for all men, and masculinity is both contested and reproduced. Nonetheless, the dominant understanding of mainstream working class masculinity revolves around the idea that men are workers, breadwinners, heterosexual and do not display weakness or emotional pain. In this chapter, I will use the terms working class hegemonic masculinity and mainstream working class masculinity interchangeably.

The second concept that I will use is working class machismo. Machismo refers to a public display of masculinity that emphasises toughness, bravado and an exaggerated show of assertive manliness. This is also referred to as 'hyper-masculinity'. Working class culture that is characterised by machismo does not celebrate proper men as ‘hard workers’, or ‘good providers’. On the contrary working class machismo celebrates men as ‘outsiders’, often engaged in dubious ways of earning money and taking part in activities that may be outside the law. These young men are in a working class culture that is characterised by machismo and also celebrates heavy drug and alcohol use, where to be a big drinker or a heavy drug user (or both) is to be a ‘real man’.

A number of studies have pointed out that men from minority groups often construct a version of hegemonic masculinity that celebrates male strength and toughness as a distinctive characteristic of their minority group. For example, Trimbur (2011) undertook an ethnographic study of an urban boxing gym. His research explored the relationships between trainers and their young male boxers. Masculinity was a central
theme. Trainers had a very clear understanding of how a ‘real man’ ought to act: a proper man was a breadwinner who must be strong and resolute in the face of adversity. Trainers used an approach which they referred to as ‘tough love’. Again, the absence of vulnerability characterised what it meant to ‘be a man’ in the urban boxing gym.

Bourgois’ (2002) ethnography of the street-based crack trade in East Harlem from the mid-1980's to early 1990s also drew attention to the role of physical toughness in the construction of hegemonic masculinity. Poor black males sought visible and confrontational expressions of power in the street scene, while simultaneously having virtually no power in the society which existed beyond their housing tenements. Bourgois wanted to understand how the young men sub-consciously reconciled their broader powerlessness with their want for dignity and power (and thus masculinity) in what he describes as ‘inner-city street culture’. He argues that there is ‘a complex and conflictual web of beliefs, symbols, modes of interaction, values, and ideologies that have emerged in opposition to exclusion from mainstream society. Street culture offers an alternative forum for autonomous personal dignity’ (Bourgois 2002 p.8).

There have also been studies of other marginalised working class men that draw attention to the importance of ‘toughness’ in working class male culture. The importance of men being tough and not showing weakness is a central theme in Jewkes’ (2005) ethnographic study of prisoners in the United Kingdom and she pays particular attention to how men go to great lengths to present themselves as physically strong and resolute to other inmates and prison officers. De Viggiani (2012) also explored what he termed ‘masculine performances’ in prison settings and discovered similar findings to Jewkes.

The final two concepts that I will use to shape the empirical analysis are front-stage and back stage selves which draw from the writing of Erving Goffman (1959). Goffman’s dramaturgical model proposes that how we behave and present ourselves in social interactions is governed by context-dependent cues such as social norms and cultural values. Goffman proposed that an individual’s intention in a social ‘act’ is to receive acceptance from their audience. This process is commonly referred to as ‘impression management’. Continuing in the theatrical metaphor, Goffman described two dominant presentations of self: front-stage and backstage. The former refers to the individual actor’s ‘performance’ of self in social situations (‘on stage’); and the backstage self is one’s real self when not on stage.
Several researchers who have explored masculinity and social class draw on Goffman’s model of impression management. Jewkes (2005) undertook an ethnographic study with prisoners in the United Kingdom in which many of the men discussed the need to ‘act tough’. Jewkes suggests that men in prison have two active masculinities which fit within Goffman’s concepts of front-stage and backstage. The front-stage masculinity among these prisoners was assertive and tough, and consciously performed. Simon, one of Jewkes’ participants, explained ‘You definitely have to wear a mask in prison—if you don’t you’re going to get eaten away … You have to act tough. There’s always the threat of violence’ (2005, p.46). However, when prisoners are presented with the opportunity to talk to a non-judgemental and impartial outsider, in this case a researcher, they let their front-stage mask drop and reveal their real selves.

De Viggiani (2012) also explored masculinity within prisons settings and, like Jewkes, found Goffman’s framework useful. He pays particular attention to how prisoners behave when they are front stage. De Viggiani found that prisoners must employ their ‘masculine’ persona when they are front-stage so as to not reveal their vulnerability. The enactment of their front-stage masculinity is an attempt to present an aggressive, powerful masculinity that demonstrates male dominance and control.

Backstage masculinity is where the prisoner is ‘himself’, a persona only revealed to trusted outsiders or when he is alone in his cell. This side of his personality reveals his emotions and vulnerabilities, which must be masked at all times when he is front-stage and interacting with other prisoners. As Paul, a participant in Jewkes’ study explained, ‘The greatest tool a prisoner can have is to stay … in control and not show any vulnerability’ (p. 59).

This chapter will use these four concepts – working class hegemonic masculinity; working class machismo; and Goffman’s concepts of front-stage and backstage – to shape the empirical analysis that follows.

First, we look frontstage and examine how these young men grew up in a world where working class hegemonic masculinity was taken for granted. Then we glimpse backstage, where another side of the men is revealed. Returning front-stage, we see why the men adopted a new form of masculinity as they grew older. Finally, we step backstage again: all is not what it seems and the jigsaw ‘falls into place’.
Front-stage: working class hegemonic masculinity

The first role models that most young men have of what it is like to be a ‘man’ are provided by their parents. In this section I examine some of the core messages about masculinity that these young men learnt from parents. These ‘messages’ varied in a range of ways, but one constant was that an adult male is a worker and a provider. Another constant was that men should be ‘tough’ or ‘strong’ and not engage in excessive displays of emotion.

Mothers and sons

Nearly all of the young men were raised with, and often exclusively by their mothers. Only seven (20%) of the young men were brought up in conventional nuclear families where their parents remained together until they finished school. The other 28 (80%) came from families where their parents had either divorced or separated, or their mother was a single parent and their biological father had never been present.

The young men seemed to take it for granted that their relationship with their mother was a constant in their lives, even where there was sometimes conflict between them. There was a tacit understanding that: ‘Mum would always be there’.

Despite many absent fathers, the young men’s discussions about parents often focused primarily on them, particularly the issue of their parents’ marriage breakdown. Some had watched their own father beating up their mother and this was very confronting for the young men: they were too small to protect their mothers from harm; at the same time they were learning that adult men beat up wives and girlfriends.

Some of the mothers had mental health issues or substance abuse problems and this created difficulties at home. Despite this, the young men were often sympathetic towards their mothers. Shawn, who had moved in and out of care, and whose baby brother died after his mother forgot to feed him (which led to her imprisonment), showed much compassion towards his mother, despite her failings as a parent:

_A lot of people don’t understand why I don’t hate my mum for some of the things that she has done – but it was the only way she knew how to do it._

Shawn was aware that he and his mother had experienced intergenerational poverty – his mother had also been raised in state care – and the structural disadvantage that this caused.
Jai’s story was similar. His mother was never violent, but she neglected her children when she was substance affected. When Jai was in primary school, his mother died of an overdose of heroin and benzodiazepines. He explained that her drug use was heaviest when her boyfriend was violent:

*That’s why she started doing drugs, to numb the pain; to numb the memories*

*... I understand why she did drugs; but when she was off of them she loved us all to bits and she’d do anything for us, so that’s the things that I like to remember.*

Will and his mother fought a lot and she had placed a restraining order against him. Despite this, she did not report him to the police when he came to the house to visit his sister. Will had insight into his volatile relationship with his mother:

*I’ve got problems, and she’s got problems – and we’ve both got really big problems ... my mum still does care, in a way. Yeah, she still does, but she just doesn’t show it. It feels like she doesn’t [care], but she does.*

Will’s goal for the future was to have a good relationship with his mother, although he realised that they would both have to change to make this possible.

Michael’s parents separated when he was three and he lived with his mother full-time until he reached adolescence. He then oscillated between his mother’s and his father’s places. The typical pattern would be that he would push the boundaries at his mother’s and reject her attempts at enforcing rules. Then she would insist that he lived with his father who was much stricter. Nonetheless, Michael was closer to his mother than his authoritarian father: ‘I wasn’t scared of Mum. I used to laugh when she’d tell me off’.

Simon also oscillated between his parents’ homes, but he was more comfortable talking about personal things to his mum. This taught the young men from an early age the heteronormative ideal that women are more caring than men, and that men should not display their emotions.
Fathers and sons

Some of the young men retained connections with their fathers even though they did not live with them. In some cases, they stayed with them occasionally when they were growing up or sometimes they lived with them intermittently during their teenage years. When fathers were involved in their sons' lives, they provided role models of adult male behaviour.

Michael's father had an expectation that his son ought to 'become a man, get a job'. Michael explained that men are expected 'get up in the mornings ... go to work every day'. The understanding that a man should work hard and be a breadwinner was seen by most of the young men as a fundamental requirement to be a 'proper man'.

This binary of men as providers and women as carers is a fundamental characteristic of working class hegemonic masculinity, even though most women are now employed in the labour force. The young men took it for granted that they would be workers and providers. When asked about their futures, the men's answers were remarkably similar. Andrew wanted: 'to have a house ... a good job and a girlfriend'. Michael was also sure and succinct: 'I want to have a job ... I want to get married. I want to have kids'. Beau had similar goals: 'To have a job, to get a nice house. Just the basics'. Nearly all of the young men wanted to get married and they all expected to be the main breadwinner.

Damian's father had instilled similar beliefs in his son through the example set by his own behaviour. Damian father had always risen early and was renowned for working long hours. According to Damian, his father had a 'go hard' attitude to all aspects of his life. He had been involved in competitive cycling and his sporting success was something Damian had sought to emulate.

There was an absence of affection between many of the fathers and their sons. Damian could not recall his father showing affection towards him. His father's sense of how he should be as an adult male was closely tied to his ideas about hard work and physical 'toughness'. Demonstrating affection to another male, including his own son, was simply not part of his father's emotional repertoire.

Luke's father had a white-collar occupation, but he also did not discuss his emotions with his son or display affection towards him. Luke's relationship with his father lacked warmth. His father was not intentionally cold or unloving; however, he spent long hours at work and appeared not to have learnt how to demonstrate affection to his wife or
children. Luke’s father was genuinely surprised when his marriage failed, because he felt he had fulfilled his obligations by being a good provider.

Shawn’s parents had separated when he was an infant, and Shawn had been brought up by his mother. He went to live with his father when he was 12 years old, soon after his mother was incarcerated. Shawn’s father epitomised working class hegemonic masculinity. He worked hard and he was a good provider. He was also emotionally disconnected from his children. After Shawn’s baby brother, who had a different father, died from malnourishment and dehydration, Shawn’s father explained to him that he had ‘one week to get over it’ and was then to never mention it again.

Shawn also had to hide his homosexuality from his father because, ‘If Dad found out I’d end up dead in the ground’. Shawn’s father provided stable housing and food for his family; however, his way of being a man was defined by heterosexuality, breadwinning and the denial of emotions.

Much of the time young men learnt what it was to be a man almost by osmosis, because the role models of adult masculinity were all around. Sometimes fathers also told sons explicitly what was expected of them. Michael recalled his father telling him:

\[
\text{Just be a man. What are you being lazy for? Sitting in bed and smoking choof ... Who the fuck do you think you are? ... Get a job!}
\]

The young men took it for granted that an adult man should be a ‘worker and a provider’.

**A glimpse backstage**

*Family breakdown: ‘that burst my fucking bubble’*

In this section we get the first glimpse of the backstage persona of these young men. Family breakdown had a lasting effect on them – much more so than the young women. The frontstage selves portended that ‘real men’ do not display their emotions, but there was an indicator that these young men were not handling their emotions well.

When I asked Jerry why he was getting into so much trouble, he replied: ‘I really don’t know. I was just a dick head. I don’t know. Maybe it had something to do with my parents splitting up when I was young’.
Luke was more affected by his parents’ separation than his sisters. Luke explained that at the time of the divorce, he did not want to attend counselling even though the rest of his family did. At the time he claimed that he was ‘fine’:

My parents split up when I was really young; when I was about six or seven ...
I remember that my brother and sister were crying, but I just took it in. I didn’t really show any emotions, I didn’t do anything.

Later, it turned out that he was not fine at all. ‘It really killed me – it did – but I just didn’t show anything at the time. I just bottled it up’.

Jake believed that he came from a ‘normal’ family, but this rapidly came undone when his parents announced they were splitting up:

It was a bit rough in grades five and six because my parents broke up at one point ... I had always thought that I had this normal home life. My parents always seemed happy. And then when the tables turned in grade five and all this shit was coming to the surface, then it all started piecing together ... that burst my fucking bubble, it was horrible. All I wanted was a normal home life and when I looked around, it really wasn’t normal at all.

During his parents’ divorce, Jake discovered that his father smoked cannabis and Jake began smoking cannabis too.

Jakey’s (distinct from Jake) parents had separated about a year before I interviewed him. He was dividing his time between them and the break up was reasonably amicable. This is noteworthy because his father’s infidelity was the impetus for the separation. When his parents first separated, his father moved in with his new partner and had little contact with Jakey:

I have never really been close with my dad so not having him around isn’t – well, I wish they were still together – but not having him around is not really a big thing.
I was unconvinced: on the one hand his father’s absence was ‘not a big thing’; but he also wished they ‘were still together’. Following his parents’ separation, Jakey’s drug use escalated and it was his drug problem that saw his mother and father begin to communicate again. Jakey and his sister both hoped their parents would reunite. When he was front-stage, Jakey claimed ‘indifference’ about his parents’ marriage breakdown, but backstage his views were quite different.

Jahl’s case was different in two respects. First, he had never had a relationship with his biological father, but had been very close to his stepfather. Second, Jahl was not ‘fine’ when his mother and step-father separated. On the contrary, he was ‘devastated’. Like Jake, Luke and Jakey, he handled the separation badly:

*They broke up when I was about eight and then I was a bad kid straight away ... When they broke up my life got bad from there.*

The dynamics of family breakdown are complex. What was common for these young men is that they had not yet worked through the emotions associated with their parents’ separation. Many had declared that they were ‘fine’ when they were not, and many of these young men were dealing with confused emotions and internal conflicts associated with their parents’ separation. Young men were faced with the dilemma that the person they had assumed to be a ‘good man’ was perhaps not so good after all.

Michael’s parents had separated because his father had had an extra-marital affair. His father was a ‘womaniser’, and in many ways this trait was something Michael admired. Michael spoke about his father’s appreciation of women’s company, and how he sought to treat women ‘properly’. At the same time, what constituted ‘properly’ was largely ambiguous:

*He broke up with one fiancé, and got another fiancé. He broke up with her, and then he was seeing a few different girlfriends ... he’s out on the weekends with girls ... what a sick cunt.*
Despite his admiration for his father’s liaisons with women and his own appreciation of women, when I suggested that he takes after his father, Michael emphasised that he ‘wasn’t that bad’ and explained emphatically:

*There’s a difference between me and my dad: my dad would cheat, I would never cheat. I honestly wouldn’t … You only need one girl.*

The pain of his father’s infidelity had left a permanent impression on him. Yet in other parts of the interview, Michael was at pains to emphasise that his father was a ‘good bloke’. It remained unclear who Michael was trying to convince of this. Michael was faced with the dilemma that perhaps his father was not such a ‘good bloke’ after all.

There were also young men who had grown up without fathers. In some cases, they were indifferent about the men who were their biological fathers. In other cases, they had tried to make contact with them, usually with high hopes for what this would bring.

Brandon had not had contact with his father for many years. Nonetheless, after becoming homeless, Brandon wanted to re-build his relationship with his father, with high hopes for the future. When they met, it turned out that his father was a very heavy drinker and he kept calling Brandon by another son’s name. Brandon’s anger quickly escalated to the point of physical violence. On one occasion, the police were called to separate the two men. Brandon told me his final words to his father:

*I just told him the truth. I said, ‘I’ll tell you the truth … you’re an arsehole, that’s what you are. You drink too much. My brothers said you’ve changed but to me you just seem much worse’.*

It is also important to recognise that young men make judgments about how well other men behave. This was obvious in Michael’s judgment that his father was both a ‘good bloke’ and a ‘sick cunt’, and in Brandon’s judgment that his father was an ‘arsehole’. In the same way that people make situated choices, they also make situated judgments about how well other men ‘perform’ masculinity.

So far, we have seen that these young men took it for granted that a proper man is a hard worker, a good provider, and the main breadwinner in a family unit. Along with
marriage and heterosexuality, these are central tenets of working class hegemonic masculinity. Closely tied to this was their understanding men should not show their emotions. However, we have also glimpsed backstage: these young men were not handling their emotions well.

**Front-stage: friends, drugs and machismo**

Now we return front stage. First we examine their friendships and drug use in high school, then we turn to their encounter with machismo.

*The ‘wrong crowd’*

The young women rarely spoke of friends and when they did, it was often in the past tense – friendships which had ended as drug use escalated. The opposite was true for the young men: sometimes the need to build friendships was the primary motivation to begin using drugs.

In their four studies of youth in Britain’s working-class area of Teesside, MacDonald et al (2011) found that youth who shared a combined ‘career’ of drug using and crime were disconnected from more ‘mainstream’ peers and in turn, entered a social network where drug use and crime were entrenched. This phenomena was apparent here also.

After migrating from Vietnam, Pailin went to an Australian high school. Unfortunately, he had little grasp of English. Classrooms were impossible for him to ‘fit in’, but he soon noticed the group of boys who were skipping classes. This group were appealing to Pailin who wanted to escape from the classroom and he also wanted friends:

> I couldn’t speak properly, and I met the wrong group of friends. I wanted to fit in, I guess. I knew no one, so I guess I just wanted to fit in.

These were the ‘wrong crowd’ and we will meet them many times in the narratives of the young men.

James had undiagnosed dyslexia which hampered his learning:
I got bullied around school because of my dyslexia and learning disabilities and that's why I ended up hanging out with the wrong crowd.

Shawn had changed schools many times and he was placed into a remedial class:

... and that’s how I got into the wrong crowd. ... all of the kids who were stuffing up and not doing the right thing were all put into the one class and kept separate from everyone else. We had a different lunch area from everyone else – we were kept completely separate.

The ‘wrong crowd’ were not doing well academically and they were into drug use, some petty crime, and occasional violence. Andy, like Shawn, had changed schools many times and he too had met the ‘wrong crowd’:

I went to four different high schools from year seven to year eight. I went to one in Berwick, one in Narre, got kicked out of the one in Narre and the one in Berwick, then I went to one in Doveton, and then I moved out of the area so I went to Pakenham. School wasn’t that good, getting into fights ... bullying ... I started hanging around the wrong crowd, the smokers down the back of the oval, mixing with the wrong crowd, hanging out with a few of them, getting into crimes after school, smoking a bit of weed after school, getting kicked out of school for smoking weed, those sort of things.

The wrong crowd usually smoked marijuana. As we saw earlier, Pailin sought out ‘the smokers’ because they did not attend classes. However, to join the ‘wrong crowd’ Pailin needed to engage in their recreational practices:

I needed to become one of the cool kids who smoked at school and that’s what I turned into.

Pailin’s inability to speak fluent English was a point barely noticed. So long as he participated in the group’s social practices, he was a member.
For some it took time to adjust to this new activity. Jake referred to his introduction to drugs as his ‘apprenticeship’. Jake didn't know what hash was when he was given cookies containing it:

I was like, 'What the fuck are these pins and needles through my body?'. I didn't like it ... I didn't try choof again until I had a bong. I didn't like it but I kept forcing myself to smoke to be cool. Literally, smoking to be cool.

Jake's explanation of not enjoying his early experiences of drug use was typical of a minority of the young men, but they continued to smoke because they wanted to be part of the group.

Similarly, Jakey did not enjoy drugs on his first introduction. At school, he made some friends who were ‘stoners’:

I used to do bongs with them, but I hated it. I couldn't stand it. I used to just do it, not peer pressure ... but it was kind of like, 'Oh yeah, I'll do it', but I always hated it.

He stopped hanging out with those friends because he did not want to smoke. Nevertheless, Jakey's initial need to make friends was still there. He later met another friend and found himself smoking cannabis with him.

As most of the young men explained, the ‘wrong crowd’ were a welcoming group. Pailin's inability to speak fluent English was barely noticed so long as he participated in the group's social practices. Some men liked the ‘wrong crowd' because there they met other young people who often had disadvantaged backgrounds like themselves. Chris shed light on this:

Wherever somebody feels they fit in, or feel comfortable with that group of people, then they want to do what those people are doing. That's pretty much what it is ... It's good to fit in somewhere, it's good to be a ‘type’ of person rather than different to everybody ... There's nothing better than meeting someone who is like you on almost
every level ... Smoking choof was about fitting in and I don’t regret it at all ’cause I have ended up having some great friends.

The young men liked the wrong crowd because it was here that they met people who were like them ‘on almost every level’. Their childhoods had contributed to them feeling like ‘outcasts’ and they gravitated towards friends who were ‘outsiders’ like themselves.

Others joined the wrong crowd because they wanted to be ‘part of the action’. Michael explained the attraction succinctly:

You just want to be a part of it – they are the macho boys ... they were punching-on ... they were the cool kids so I wanted to fit. Everything they would do I wanted to do.

Josh said matter-of-factly: ‘I just wanted to get in with a group of people that punched on with other people’.

Unemployment, homelessness and crime

Earlier, we saw that mainstream working class masculinity emphasises the importance of having a job and being a good provider. However, two-thirds (66 per cent) of the men had left school before Year 10, and another 20 per cent left school at the end of Year 10. Most of these young men became unemployed.

By the time these young men left school, they were all involved with the ‘wrong crowd’, but the social composition of the ‘wrong crowd’ was changing. Now they were mainly unemployed youth, engaged in regular drug use, often taking part in criminal activity, and many of them were homeless.

The young men were also moving into a sub-culture where there was much more emphasis on the machismo characteristics of working class masculinity. Machismo refers to a public display of masculinity. Typically, it emphasises toughness, bravado, aggression and an exaggerated show of assertive manliness (Jewkes 2005). Machismo downplays the importance of paid work and celebrates other male characteristics. The values encapsulated in machismo appealed to these unemployed teenagers.
Mick told how he started to meet people in the ‘wrong crowd’ who were into criminal activity:

> Then I met a lot of criminals that went there, a lot of fighters that went there and stuff. I shared my experiences with them and then they were like ‘Oh so you’re a little sick cunt are ya? Come on join us!’

Mick began to hang out with them and he got into ‘a fair few blues. Yeah, it got real hectic’.

Michael recalled an incident which perhaps epitomises the violence that is characteristic of working class machismo:

> Like I remember a fight ... Like, 30 of us jumped off a train. Fifteen ran from that direction, and about 10 popped out from cars, and there was 15 of them, and they were punching on and we literally smashed them all. I think me and my mate were the only ones to drop. One person, one of my mates was hit with a pole like five times, and he was harder, and he just smashed him, and everyone was just swinging at like five different people, and they were just cool kids ... Everything they did I wanted to do.

Michael was proud to have been involved: ‘Everything they did I wanted to do’.

Jerry remembered his time in the graffiti gangs: ‘I just looked up to all these older guys who are all pretty much in jail now’. The ‘wrong crowd’ were an amorphous group who appeared to turn up ‘everywhere’. But drugs, violence and crime were always ‘in the mix’.

Almost 70 per cent (24 of 35) of the young men had been involved with the criminal justice system, 10 of whom had been incarcerated. The number who had been in prison was high, because in Victoria custodial sentences are generally a last resort and custodial sentences usually follow non-custodial interventions such as Youth Supervision Orders and Drug Diversion Orders which seek to place the young person under the supervision of Youth Justice services without imprisoning them. The aim is to have reduced recidivism and higher rates of rehabilitation. The typical route that led these
young men to have contact with the justice system was a series of charges, most commonly for assault or theft.

Mick grew up with a firm understanding that violence between men was sometimes necessary, even between fathers and sons; but violence against women was never acceptable. His father had instilled this into him:

*My dad said, ‘If you ever hit a woman, I’ll break your arms, break your legs and I’ll break your neck’. I’ve just learnt, never touch a woman.*

When I met Mick, he was in a withdrawal unit. He explained to me that he had a history of quite extreme violence and aggression: an ‘uncontrollable rage’. However, he explained that this rage, although exacerbated during withdrawal, never extended to breaching his father’s instruction, suggesting that his rage was indeed controllable. Violence against women was abominable, but violence against other men was an essential part of ‘being a man’.

Mick had a long history of violent encounters with other men, both inside and outside of school. As a consequence, he had a great deal of contact with the police and had accrued multiple charges for assaults and burglaries in his teenage years. He had spent two months in custody and was likely to be incarcerated on other charges that were still outstanding. Despite his increasing criminal record, Mick did not question his entrenched view that violence was an inherent aspect of masculinity.

Andreas also spoke about violence and crime as an everyday aspect of manhood. His discussion about his impending incarceration was as casual as a conversation about the weather:

*I just keep getting arrested for stuff … I’ve got court on Thursday, I have a fair chance of being locked up. So I don’t know if rehab’s gonna work. … I’ve got the choice, probably Fulham prison or Port Philip prison. So I will go to Port Philip, ‘cause that’s where my mates are.*

Many of Andreas’s peer group were already incarcerated, and his brother also had a criminal record. The way Andreas remarked – somewhat surprised – that he ‘kept getting
arrested’, reflected just how normalised violence was for him. Violence was, after all, ‘just the way men deal with things’. For Andreas, his brother and his friends, involvement in the criminal justice system was part of a man’s life. Violence and incarceration were rites of passage; they were the expected path for young men, for ‘tough’ men, at least. And for these young men, a ‘tough’ man was a ‘real’ man.

Not all of the young men endorsed this extreme form of machismo. Jake was also held in a youth detention centre on remand and it was here that he saw himself as different from the other young people. He was witness to the excessive displays of hyper-masculinity that de Viggiani (2012) and Jewkes (2005) found to be typical in prisons, but Jake did not endorse this behaviour. His rejection of the jailhouse machismo set him apart from many of the other young men. This was sufficiently unusual that Jake felt the need to explain why he was different from other males: they were ‘hotheads, fuck-heads, egotistical maniacs’, and he was not. Valkonen & Hänninen (2012) point out that while some men distance themselves from the dominant form of masculinity, it still remains a point of reference for them.

When I asked the young men about their entry into criminal activity, few could recall a distinct first event. For many of them, there had been a spate of charges, typically robbery, resisting arrest, theft, assault, and possession of drugs, that had led to youth supervision orders, probation, bonds and custodial sentences. They seemed to have transitioned into violent and aggressive offenders as a by-product of being entrenched in a subculture where violence and crime were intrinsic to being a man. These young men knew they lived in a world where violence was illegal; but violence was not understood as ‘wrong’. Of course, these young men were making choices about how they acted out their masculinity – as we saw above, Mick would never hit a woman – but the young men were still constrained by their understanding of what it was to be a man.

Throughout the fieldwork, I took note of how ‘normalised’ crime and violence were. The young men had no reticence over disclosing their histories – they did not feel it an unusual aspect of their biography. In contrast, the young women had been cautious when first disclosing self-injury. Most tried to establish whether I viewed their behaviour as stigmatised, before revealing their story.

There was no such reticence on the part of the young men talking about engaging in crime and violence. It was an accepted, and acceptable, part of their lives. The young men’s accounts of their exploits drew on exaggerated stereotypes about masculinity. They
did not perceive their exploits as remarkable because they lived in worlds where they were utterly unremarkable – to be violent was to be a man. However, as we will see in the next section, this is only part of the story.

Stepping backstage: young men and their emotions

Trauma

Earlier, it was pointed out that Goffman's (1959) dramaturgical model proposes that when others are present, all people are 'actors' who engage in 'impression management'. Continuing in the theatrical metaphor, Goffman described two dominant presentations of self: 'front-stage' and 'backstage'.

I will now use Goffman’s theatrical metaphor to draw attention to how the men’s front-stage presentations of themselves revolved around the idea that men should be ‘hard’, ‘tough’, and not display emotion. At the same, many of them had a backstage understanding of themselves that was different. It revealed vulnerability.

Like many insights into human behaviour, my story begins with an unexpected event – an interview that at first appeared to provide few insights into my research question shed considerable light on the phenomenology of the young men’s substance abuse.

Larry was a complex young man both younger and older than his 20 years implied. I met Larry when he was staying in a residential withdrawal unit. His behaviour and demeanour showed him to be an angry young man whose incessant pacing and fidgeting made it clear that he was also highly anxious. His tone was loud and mannerisms dominating. I had met him a number of times when I had been 'hanging around', and I was surprised when he stated that he would like to be interviewed.

Larry’s interview was consistent with my assumptions about him: he swore a lot to punctuate his sentences and spoke mostly about fighting and asserting himself over other young men. Larry seemed to need to accentuate his toughness and aggression. I listened to endless stories about various standover tactics, his bravado and his violence. I continued to work through the interview schedule, taking occasional notes, but concluded that I was learning nothing new.

Larry mentioned his mental health issues early on in the interview. He seemed to accept that drugs had a psychopharmacological effect on him that was considerably
different from that of his peers. This had come to the fore when he was involuntarily admitted as a psychiatric inpatient with presentations of psychosis after consuming party drugs at a music festival. Larry had previously been seeing a youth mental health service, but had never been admitted as an inpatient. Larry's stay in the hospital was a pivotal point in his life, although not because there was any profound improvement in his mental health. First, being away from his friends forced him to evaluate the foundations of these friendships where drug use was a key part of their social activity. While Larry felt better in this period of abstinence, he was simultaneously aware that if he was to continue with an abstemious lifestyle, this could come with the cost of losing his friends. Talking about this prospect evoked tears from him.

Just as I had thought the interview was nearing an end, Larry's tears signalled the beginning of deeper revelations.

I am sure that Larry had not intended to cry in front of me – in front of anyone, I suspect – but once the floodgates opened, the torrent of tears washed away his tough, macho exterior revealing how Larry really felt. Larry's 'front-stage' persona was overcome by grief and his 'backstage' self was revealed.

Apart from the fear of losing his friends, the second and most critical explanation to why Larry's time in the hospital was so profound was because he met a girl there – Bec:

She was in there for depression. She, she cut herself, up-ways [which indicates suicide rather than self-injury]. I sussed it out. I didn't ask too many questions at the start. I thought it was just depression. I didn't click on that much. We just clicked. We hooked up. I got the story out of her, eventually. It was really hard for her to tell me, but I forced it out of her. She was raped when she was 16 ... she never got over it. Two years later, she started cutting herself ... Fuck, I tried to be calm [when she was telling me]. Not raging. Maybe I should have raged. I don't know. I never really raged with her. But shit, she told me, man she told me, 'You've got to find someone else. I love you, don't get me wrong, but I can't live, I can't live anymore'. That's basically what she said to me, yeah [long pause] ... she done it in the hospital. The third time she got readmitted.
Larry had been crying for a while now, but at this point he started sobbing. However, he kept on talking about this issue as the grief was, quite literally, pouring out of him:

*She called me the night before she did it, like final goodbye sort of shit, but I didn’t know what she was doing. That was the thing with her, she always had a smile on her face. Then I copped a call a week later, she’s on life support. I didn’t really get it, I thought she was fighting for her life [psychologically]. That’s what her mum told me, ‘She’s in Emergency, she’s fighting for her life’. And I’m like, ‘Yes, I know that’, but I didn’t really get the message ... I didn’t get it. Another week later and I hear, ‘Rebecca passed away’. Just like that. I wasn’t right after that.*

By this point, Larry’s sobbing was so uncontrollable that he was unable to speak. I asked him if he would like to stop the interview, but he was adamant that he wanted to continue. I told him that he was in a safe space and that I was comfortable with him crying. I sat quietly, allowing him to vent his grief. After a few minutes, he was ready to speak again. He started without prompting:

*The first time I heard the news, I was devastated. I didn’t know what to do. I felt like a dog because I didn’t really cry. I felt something, but I was like, ‘What’s wrong with me? I can’t even cry? Like, I would get teary, but I couldn’t even, I couldn’t even bawl.*

Larry had never grappled with the experience of death before, let alone suicide, and Rebecca was someone whom he cared about deeply. Larry had no idea how to handle grief or to deal with the intense emotions that welled-up inside him.

Larry had tried to speak to his friends about Bec’s suicide, but this was futile. They offered comments such as ‘suicide is selfish’ and ‘she was ugly anyway’. Larry’s friends did not mean to be contemptuous; rather, they were young men and also living in a world where emotional trauma should not affect a ‘real man’. They too did not know what to say or do. Larry had no one to turn to; and his drug use, violence, and mental health symptoms escalated. It was Larry’s interview which finally signalled the similarities between my
male participants: the young men’s ability to manage their emotions was deeply constrained by their notions of masculinity.

Death was a common part of these young men’s life-histories with 10 of the young men having lost a parent, best friend or partner. Jerry’s best friend died in a motorcycle accident when he was 18. Inexperienced at grieving, Jerry began managing the heavy emotional toll through drug use. It was almost immediately after his best friend’s death that Jerry’s heroin use escalated. Talking about his feelings was impossible when he did not have a vocabulary to express them, but heroin kills the pain immediately:

I couldn’t really talk about it. I found it so hard to talk about. I’ve only just started talking about it in the last few months.

Jerry acknowledged that he had not coped with grief: ‘I was really close to him [best friend] … and I was just fucked.’

Andy had also lost his best friend and struggled with understanding it:

My best mate passed away last year and he’s the one who taught me respect, manners, and all that stuff. It was hard … he got hit by a truck. He had a heart attack before he died … I didn’t cope with it. He was my best mate, that passed away … I was with him for two years. I was always told you could never make a good mate in a refuge, and I met this guy at a refuge and we were best buddies, we went everywhere together. Christmas, birthdays, New Year, and then he ends up passing away.

Andy’s narrative alludes to why his grief was felt so sharply – his best friend was his only key support. The death of a friend is not something teenagers typically experience. The intense emotions were overwhelming. While grief is an unwanted intrusion in anyone’s life, most seek comfort from their loved ones; but Andy did not have anyone to care for him.
Shawn had been on a road trip with his mother when his infant brother died. When they got to a petrol station, Shawn checked on his brother in the back seat to find him dead. The baby weighed less at his death than at his birth and the case was subject to a coronial inquiry. It had been six years since this event when I interviewed him and Shawn was still traumatised by the experience. Shawn had been given no time and no support to grieve properly. Following his brother’s death, his mother was jailed and Shawn was placed into the care of the state. Later, he was reunited with his father, but we saw earlier that his father had given him one week to be sad and after that, he was to not raise the topic again. A few months later, 12 year old Shawn began using heroin.

Several young men had lost a parent. Clark, Jai and Jackson had also lost their mothers and Will’s father died when he was in year eight. Two years later, Will’s 17 year old stepbrother also died. Asiah, a refugee who had fled war with his sister, did not know if his parents were alive. None of these young men had the supports needed to deal with the intense grief that accompanies the death of a loved one.

The link between bereavement and problematic drug use has been explored by Allen (2007) who found that ‘disturbing encounters’ (namely, sexual abuse) are common among people with problem heroin use. But also common is the experience of bereavement – what he refers to as a ‘disturbing episode’. Allen theorises that those with an abuse background use drugs to numb/manage their pain; whereas those with a bereavement background were searching for a sense of being in the world and were using drugs to escape the numbness of their existence.

**It's more common than you think**

Table 7.1 attempts to quantify the number of young men who had experienced various types of traumatic events. This is a fairly crude way of measuring the extent of trauma in young people’s lives, because it does not take into account the intensity of the experience, the length of time that the traumatic event lasted or, indeed, whether the young person had multiple experiences of that particular type of trauma. Despite these limitations, Table 7.1 provides an indicator of the extent of the trauma experienced by these men.
Table 7.1: Number of males with various experiences of trauma

<table>
<thead>
<tr>
<th>Experience</th>
<th>N=35</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Experienced homelessness</td>
<td>30</td>
<td>86</td>
</tr>
<tr>
<td>Involvement in justice system</td>
<td>24</td>
<td>69</td>
</tr>
<tr>
<td>Parent with drug problem</td>
<td>16</td>
<td>46</td>
</tr>
<tr>
<td>Parent with mental illness</td>
<td>16</td>
<td>46</td>
</tr>
<tr>
<td>State care and protection</td>
<td>14</td>
<td>40</td>
</tr>
<tr>
<td>Death of friend or relative</td>
<td>10</td>
<td>29</td>
</tr>
<tr>
<td>Bullying at school</td>
<td>9</td>
<td>26</td>
</tr>
<tr>
<td>Developmental disorder</td>
<td>8</td>
<td>21</td>
</tr>
<tr>
<td>Suicide attempt</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Refugee</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>131</td>
<td></td>
</tr>
</tbody>
</table>

Table 7.1 shows that three-quarters (86%) of the young men had experienced homelessness and 69 per cent had been involved in the criminal justice system. Many came from homes where their parents had serious problems: nearly half (46%) had a parent with a mental illness, and nearly half (46%) had a parent with a drug problem. Two-fifths (46%) been in contact with Child Protection, and others had experienced a range of other traumas in their childhood. One-fifth (21%) had a developmental disorder that affected their learning – typically Attention Deficit Hyperactivity Disorder (ADHD) or dyslexia. Another one-quarter (26%) had experienced bullying at school and five of the young men grew-up caring for a mentally ill parent. Damian explained that some days he would not go to school because he was worried that his mother might commit suicide: ‘They don’t teach you about that stuff at school’.
Table 7.2: Number of trauma-types experienced by men

<table>
<thead>
<tr>
<th></th>
<th>N=35</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>3</td>
<td>9</td>
</tr>
<tr>
<td>One</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Two or three</td>
<td>20</td>
<td>57</td>
</tr>
<tr>
<td>Four or more</td>
<td>11</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td>35</td>
<td>100</td>
</tr>
</tbody>
</table>

Three-fifths (57%) of the men had experienced either two or three of these trauma-types and one-third (31%) had experienced four or more (Table 7.2). Three people had experienced none of them, but two had serious mental health issues and the other was traumatised by his parents’ separation. The troubles of the young men were diverse, but in the next section I show how they managed emotional pain in similar ways.

**Managing emotional pain**

The sharp contrast between Larry’s ‘tough’ exterior and his later uncontrollable sobbing highlighted the fact that the hyper-masculinity expected of these young men normally prevented them from displaying their emotions. We saw earlier that Larry felt ‘devastated’ when he heard the Bec had committed suicide: ‘I didn’t know what to do. I felt like a dog because I didn’t really cry’. In the previous chapter, I explained how young women who had been raped internalised intense emotional stress such that they felt ‘numb’. Larry did the same when Bec committed suicide; he internalised his overwhelming emotional pain, experiencing dissociation. The interview had given him an opening to release that pain and it literally poured out of him in an uncontrolled torrent of weeping.

As the interview with Larry drew to a close, I asked him how he was feeling, to which he replied: ‘Yeah, better.’ He then spoke about how ‘pressure’ had been relieved by expressing so much emotion. He felt better having allowed the pain ‘to flow out of him’. The following week when I was back in the withdrawal unit, I made a point of checking in on Larry to see how he was doing. He greeted me warmly and thanked me again ‘for letting me download on you’.
These young men inhabited a public world where their masculinity was defined by being ‘tough’, aggressive and, sometimes, angry. The inability to talk about a much broader array of human emotion meant they often could not find words to express their feelings. For example, Brandon said:

_I feel lots of weird things, but I don’t actually know what they are [i.e. anxiety], so it’s hard when I go to talk to a counsellor or something because they ask me all these questions, ‘Have you got this?’, ‘Have you got that?’, ‘Do you feel this?’, ‘Do you feel that?’, and I don’t know._

According to Jerry, after his best mate died he felt ‘numb’: ‘I couldn’t talk about it. I found it so hard to talk about it’.

The young men often did not have the words to express the emotions that they were experiencing, and like the young women they had often internalised emotional pain. Not having the words to talk about their feelings allowed the pain to build up, and they released it through angry outbursts often involving violence.

Will could not explain why he ended up smashing things when he was depressed rather than talking about his problems. When Will’s mother had tried to punish him by taking away his computer games, he had responded by kicking a hole in the wall. Similarly, during an argument, his stepfather ripped a poster off Will’s wall. Will then pushed him down the stairs – this led to police intervention and involvement with the criminal justice system.

Brandon had experienced similar uncontrolled anger:

_I get depressed all the time. I get upset over nothing. I get upset over what’s happened, and then it goes to anger and I blackout and whatever happens, happens … I’ve smashed a lot of things, a few people—I’m always having trouble with cops._

Mick, who had a history of violent encounters with men, would deliberately pick a fight to release internal tension:
I’d go to a pub or whatever, pick on someone, wait until they’d fight me. I’d get smashed – I didn’t care; I loved it. I loved being hurt so much ’cause it relieved all the tension out of me and all that.

Mick’s explanation for the purpose of his violence was not dissimilar to the young women’s explanation for their self-injury – Mick was letting the ‘tension out’, or releasing emotional pain.

These young men had experienced a variety of traumatic events, and many of them had experienced multiple traumas, but they inhabited a sub-cultural world where men were expected to be tough and not to display their feelings. Displays of emotion were evidence of weakness, or the antithesis of what a real man should be. Thus men internalised the emotional pain they experienced and often did not have the words to describe their feelings. One strategy for releasing pain was anger or violence.

Another strategy for dealing with pain was to anaesthetise their emotions through drug and alcohol abuse. According to Andy:

Choof gets you stoned ... you can be happy instead of being angry all the time.

Shawn had not used heroin for eight months when his step-grandmother died unexpectedly. Two hours later:

I was laughing and having fun with my friends. Smack blocks out everything and you can just forget.

According to Matt:

[Drugs] numbed me, it was fun. I didn’t have to think about shit.

As Liam put it:

I loved alcohol ... I liked the effects ... as my anxiety became unbearable it blocked things out.

Mick had a history of violence and unprovoked attacks on other men. However, heroin was another strategy for dealing with unpalatable emotions:
I loved the feeling because straight away I got a huge head rush, you forget about everything straight away.

We can see that the young men were using drugs for a similar reason: to forget.

**Conclusion**

This chapter began by pointing out that the binary of men as providers and women as carers is a fundamental characteristic of working class hegemonic masculinity. These young men assimilated this message from many sources as they were growing up. They accepted that as adult men they should be workers and providers, in much the same way that they took it for granted that men should be ‘tough’ and not display their emotions.

However, in their teenage years it became increasingly obvious that there was no place for them in the labour force. Two-thirds (66%) of the young men left school before year 10 and another 20 per cent left at the end of Year 10 or early in Year 11. Most young people in their age group completed Year 12; the participants were simply out-competed in the hunt for paid work. Most of them became unemployed and some eked out an existence on the margins of the labour force. Others supplemented their income with petty theft and dealing illicit drugs.

These young men could not achieve some of the main goals of working class hegemonic masculinity: having a job; working hard; and demonstrating the potential to be a good provider, and a good partner. The failure to achieve a ‘respectable’ place in the labour force meant they were increasingly attracted to the ‘wrong crowd’ who celebrated working class ‘machismo’. This value system emphasises toughness, violence, criminality and excessive drug and alcohol use. Some of the young men became leaders in this sub-culture, celebrating working class machismo in all its forms. Other men were not ‘leaders’, but they were participants in this sub-culture and understood its values.

There were a number of consequences to this shift from working class hegemonic masculinity to the adoption of youthful machismo. The first was a dramatic over-emphasis on male toughness and the importance of not displaying emotions, or male ‘weakness’. The second consequence was that my participants rarely had the words to talk about their feelings. These young men had experienced many traumatic events in their lives, and much of their emotional pain had been internalised.
When the internalised pain was too difficult to bear, it led to outbursts of anger often involving violence, and excessive drug and alcohol use designed to anaesthetise the pain. Additionally, if given the right opportunity, it prompted an unexpected outpouring of grief as we saw in Larry's case. These young men were not 'bad'; they were much like the young women; they carried an emotional burden too heavy to bear.
Chapter 8

Moving on?

When I met participants, they were all engaged in drug treatment services and working to make changes to their lives. This chapter focuses on the challenges of ‘moving on’.

It is commonly suggested that change is a matter of individual will power – ‘If you really want to change, you will’. This ascribes total agency to an individual, but also starts from the assumption that an individual seeking change has sufficient emotional resource and social capital to enact change. This individualist understanding was the approach adopted by Nancy Reagan in her infamous ‘Just Say No’ campaign to prevent teen drug abuse in the 1980’s. Despite widespread dissemination of her message, drug dependence remains a significant issue in the United States (Gray 2001; Jensen, Gerber & Mosher 2004; Reuter 2013).

Another common narrative focuses on ‘recovery and redemption’. The ‘addicted’ individual hits a metaphorical ‘rock bottom’ from which they proceed to defy all adversity and go on to ‘redeem’ themselves. This has been the overarching narrative in a number of auto-biographical books (Burroughs 2004; Ferguson 2005; Frey 2003; Holden 2005). Unfortunately, only a tiny minority of people who recover from substance abuse go on to be successful authors.

There are diverse treatment options for people experiencing substance abuse, and all point out that problematic substance use is not simply a ‘free choice’. For example, proponents of the ‘disease’ model of addiction contend that the individual has very little control of their behaviours because of neurological adaption; whereas various 12-step models (Alcoholics Anonymous, Narcotics Anonymous etc.) believe that individuals are at the mercy of a ‘higher power’ (Alcoholics Anonymous 2005). And those who subscribe to a social-ecological model of health contend that drug abuse is but one factor of a constellation of bio-psycho-social factors at play in an individual’s life. The model draws from the Ottawa Charter of health promotion (World Health Organisation 1986).

Bruun and Mitchell (2012) have developed a therapeutic practice framework for youth alcohol and other drug services. Instead of proposing a single approach, they suggest that young people should be understood within evidence-based theories of
development and with attention to risk chains and protective factors in a person’s life. Drawing from clinical literature and an action-research project with senior clinicians, Bruun and Mitchell (2012) propose 10 characteristics of effective youth AOD treatments. Good programs/services will be:

1. Client centred/socio-culturally relevant
2. Relationship based
3. Developmentally appropriate
4. Comprehensive, holistic, ecological, multi-systemic and integrative
5. Family focused
6. Of sufficient duration and intensity
7. Adopting sound engagement and retention strategies
8. Behavioural, experiential and skill focused
9. Building on strengths
10. Use theory and evidence to guide program design and refinement

(Bruun & Mitchell 2012, p.7)

These characteristics are similar to the principles of the Adolescent Community Reinforcement Approach (A-CRA) used widely in the United States when working with young people experiencing problematic substance use (Godley et al 2001). A-CRA maintains that having the family involved in treatment, fostering ‘pro-social’ activities that do not involve drug use, and ensuring positive reinforcement in all aspects of a young person’s life are fundamental to successful pathways out of substance use.

In the United Kingdom, and increasingly in Australia, the concept of recovery capital has been a focus (Best & Laude n.d). Recovery capital refers to the amount of resources an individual has to draw upon in their pathway to recovery from substance abuse. Cloud and Granfield (2009) describe recovery capital as comprising four domains in an individual’s life: (1) social capital; (2) human capital; (3) physical capital; and (4) cultural capital. These domains seek to identify the resources an individual has available to them. It is hypothesised that those with greater resources and lower drug use severity are more suited to brief interventions, whereas those with few resources and greater severity require longer-term, more intensive supports.
All of these approaches to guiding effective interventions for people experiencing problem substance use have two key principles: (1) they frame substance use as one aspect of an individual's life; and (2) they understand that effective change is made more or less difficult by factors which extend beyond the individual's control.

This chapter begins by outlining how individuals identified their respective 'tipping points' for changing their drug use. Then the chapter examines three types of treatment available to young people in Victoria. After that, the young people's aspirations for the future are described. The chapter shows that 'moving on' is not easy for those with little recovery capital.

‘Tipping points’
For many young people, the transition from recreational drug use to a substance abuse problem happened slowly. The usual order of events was that drug use began with alcohol and cannabis, but it was several years before other drugs entered the mix. For most of the participants, their physical dependency on drugs came as a surprise. Jakey said:

> I stayed at a mate’s house and I didn’t take any choof because I wasn’t that hardcore – well, I didn’t think I was. Then I couldn’t sleep for two days and then I figured it out because I was going crazy and had to go home to get choof – that’s when I knew I was addicted.

Jakey had developed a physical dependency well before he realised it.

Chris was resistant to the suggestion that his drug use was a problem because he was in full-time employment. He compared himself to his friends who were unemployed and using, 'I thought, “I work full-time doing my apprenticeship and I smoke just as much as you” as though I was some sort of sick cunt! [laughing]’. Chris explained that managing heavy use as well as employment became increasingly difficult. Struggling to wake up in the morning, his day continued with an enormous effort:
I had been lying to myself that I had this energy ... I dragged myself out of bed, had a shower, if I could even be bothered doing that. Then the whole way to work ... I would just sit there thinking about how not to go to work. 'Just turn around, call in sick, quit your job if you have to'. And then the other voice in my head is, 'Nah, you've got to work, you've got to do this for five more years, you can't call in sick today'. I'd do that all day.

Eventually, Chris realised that his drug use was severely interfering with his ability to keep his employment – not only was he physically dependent, but he was also depressed. When I interviewed him, he was undergoing a two week residential withdrawal program.

Pailin also found that dependency crept up on him:

At first, using was only for fun, for friends ... I didn’t notice that I got hooked – that’s when I needed it every day. It’s a need now; it’s not a want anymore. I don’t want to get stoned; I do it because I need it. If I don’t, I’ll feel really sick.

The realisation that drug use was no longer pleasurable was a common sentiment. Will spelled out this conundrum in more detail:

I am not happy when I have got it – it’s hard to explain. I love getting smashed, but it doesn’t make me happy. I will be sitting there stoned out and I will be like, 'I need another cone', and even if I went and got a cone, I wouldn’t be happy ... When I am smashed I think to myself, 'You know what? This isn’t that good – what’s the difference between this and sober? It doesn’t make me happy. But when I am sober, it’s like all I am doing is chasing it. I can’t help it.

Will’s confusion as to why he was ‘chasing it’ illustrated the complexity of understanding dependency. He clearly had a strong psychological desire to stop. Yet his experience of physical withdrawal meant that when he was substance-free, his body’s desire for the drug drove his want for more, despite it not providing him with pleasure.
For some young women, participating in criminal activity was the point at which it was clear to them that their drug use was a problem. When asked when she felt her drug use was getting out of hand, Ashly was clear: 'When we started robbing for it'. Ebony's answer was similar:

> It started when I was 13, I just had an occasional habit. When I started working for it – selling myself – then I was thinking, 'Whoa, okay’ ... Then the first time I worked I didn’t want to do it ... I started selling myself; just buying drugs, taking heroin.

Jahl had only started to consider his drug use a problem a few months before I met him:

> I was all over the place. I realised that choof was ruling my life. If you’d asked me five months ago, I’d have said, 'Yeah, I am gonna keep smoking, I am loving life!', but now, no more.

Jahl explained that living on the streets saw him witness a dark underbelly of society, including experiences that he would carry with him for life. These experiences were the impetus for Jahl wanting to change:

> I realised, ‘You can’t live here’ ... after three months I got out of there. That’s why I am getting off the choof now – I am trying to get my life together.

Jahl also had an alternate activity – running – which he gained much from and which was being compromised by his drug use. Jahl had a natural talent which had attracted the eye of a successful athletics coach. Jahl’s enjoyment in the sport, and sense of achievement from success, saw his desire to use drugs dissipate. He had found a social activity where he felt a sense of belonging and it did not involve drugs.
In contrast, Jakey’s drug use had gotten to the point where it had isolated him from any social activity and this had affected his psychosocial wellbeing. This realisation was his impetus for change:

*I have one friend and I used to have a million friends ... I can't even talk to people. If I am stoned, I can't look people in the eye because I am too self-conscious about the way I sound and how I look. I just feel like I am a dirty drug addict ... I am not worth talking to when I get stoned ... if we were sitting here [stoned] now I would not be able to think about anything to say to you ... it's like I get trapped in my own head.*

Jakey’s description of feeling like a ‘dirty drug addict’ tapped into a theme which emerged in many of the interviews: that once one had developed a drug problem, there was a point of no return. This was not defined by physical or psychological dependence; but by the concept of one being a ‘junkie’ or an ‘addict’. The ‘junkie’ is a socially constructed concept. For many, it was defined solely by injecting drug use – once someone injected drugs, they had crossed a clear line.

For those who did inject, a ‘junkie’ was often defined more narrowly. Some felt that one only becomes a ‘junkie’ if one undertook sex-work or crime to support your habit. Those who did engage in sex-work reported that this was a lesser evil than other crime. Young people all had an idea of what a ‘junkie’ was, but their definitions varied. A ‘junkie’ was always a deeply stigmatised identity.

Jessica was frightened of becoming a ‘junkie’. She was unusual because she made the call to a drug treatment service of her own volition after her brother, who was previously a client, gave her the details of the youth withdrawal unit.

*I felt like if I didn't fix my life then I was never going to be anyone, and I'd either end up a junkie, or kill myself or something. So I felt like I had to do it ... when you feel really shit you get desperate ... [drug use] wasn't working for me anymore. I’d sit there, and my dad would be smacked off his face [on heroin], and I’d just sit there so angry and jealous, and that's not the way I want to live my life – I don’t want to be like that.*
Stacey was also frightened of becoming an ‘addict’. She explained that she was out scoring with her friends one day and saw them all use needles:

_We were sitting in the toilets doing all their things with their needles and one of them said to me, ‘This could be you’, she was saying, ‘Do you wanna use a needle?’. And I got pretty scared by it and I called up this place [detox] and was like, ‘I need help’._

For several of the young women a failed suicide attempt was a tipping point in their lives. Mary said:

_When I was in hospital [psychiatric], I sort of decided that the life I was living wasn’t really a life, and if I am going to make the choice to be alive – which is every second that I am living – then there is obviously no point in trying to destroy my brain. I might as well be dead if I am doing that. So I guess that’s my motivation. I don’t really enjoy being sober or pushing myself to do all these things, but it’s gotten less unbearable, so I guess that motivates me to keep going._

Mary expressed what all of the young women who had attempted suicide spoke of. They had not wanted to die, but felt unable to live. Suicide as a motivator to change was only reported by young women.

Another experience exclusive to the women was that ending drug use was a positive consequence of leaving a toxic relationship. Lisa had wanted to escape both her violent relationship, as well as the drug use:

_We were doing it all the time ... I just wanted to get away from the drugs. [Wanting to leave my relationship] just pushed me even more to sort my life out and get off the drugs. I don’t think you can have a relationship with someone when they use drugs a lot, because it’s just always fighting or anger._
Lisa’s partner’s violence toward her was extreme. In one incident, he beat her on a busy corner in the inner-city while people stood by and watched. As her head hit the concrete she heard her skull crack. She lost consciousness and woke up in intensive care.

We have seen that there is no magic formula for when young people decide to change their drug use. For some it is relatively early in their drug using ‘career’; for others it is much later; for some it involves multiple false starts; and for some the ‘dance with death’ is final.

**Interventions**

Participants entered drug treatment services in a variety of ways. For a lot of the young people, formal interventions were a seemingly fortuitous opportunity. Rarely were interventions sought out, mostly because young people did not know that services were available to them. Many of the men and some of the women were first referred by the courts. For a lot of young people, an initial recalcitrance about initiating contact delayed access to treatment for some time.

Participants often felt that they had ‘chosen’ to use drugs. Thus, it was their problem and they should deal with it themselves. For example, Stacey said: ‘I try dealing with stuff on my own, because I don’t like to ask people for help’. Similarly, Jazmine also avoided seeking out assistance:

\[
\text{I am not proud in the sense that I care about how I look like or anything; I am just very independent. I don’t like help which is stupid. I should get rid of that because everyone needs help.}
\]

The boys were equally as reluctant to initiate contact with a treatment service and were mostly referred through the court. There is certainly a connection between drug use and crime, which makes using the justice system as a vehicle for treatment logical. But there is not a strong case to be made for what, precisely, the relationship between the two factors is (Newburn 1999). The high number of young men who had been referred via the court demonstrates that the diversionary method may work; however, it is unknown how many young men without criminal histories are facing serious AOD issues.
Of the 35 young men, 24 had had contact with the youth justice system, and it was often through this that they were first referred to services for their drug use. This was typically as part of a diversionary order, so while treatment was ‘voluntary’, it was a ‘choice’ between a harsh punishment and a less harsh one. Consequently, engagement with the treatment system was often met with ambivalence.

However, when young people engaged with the services, misleading ideas about what ‘drug treatment’ entailed were typically dispelled. Few of the young people interviewed were still required to be engaged in treatment. For the most part, they had chosen to continue working with the service as a voluntary client after their mandated period ended. James was referred by his lawyer to ‘look good in court’, but once he started seeing a worker, ‘I realised that I actually do have a problem’.

In the interviews, many of the young people reported that being ‘forced’ into an AOD service had actually been of great benefit to them. Matty’s tipping point came about after involvement with the youth justice system. The court required that he access an AOD service, as well as placing him on a youth supervision order. In retrospect, he identified both actions as important agents for change:

*I am glad that I got the order and I am still out here [rather than incarcerated], because I would probably be a lot worse.*

Simon, too, had come into contact with the justice system and was now certain that he would not re-offend. He had been on a good-behaviour bond, but was uncertain if it had expired yet or not. He was indifferent about whether he was still on the order because he was adamant that he was ‘not going to get in any other trouble anyway’. Likewise, Amy was certain that she would not re-offend:

*I was on a five year good-behaviour bond, and then I was on a separate six-month one. I think I am off it now. I don’t get into trouble any more – last time I went to court it scared the shit out of me ... If I wasn’t pregnant they would have thrown me in gaol but that got me out of it – thank God. I don’t want to go down that path again.*
There are three modes of treatment available to young people in Victoria: outreach programs; residential withdrawal programs (‘detox’); and youth residential rehabilitation services (‘therapeutic communities’ or ‘rehab’). These are described next.

**Outreach programs**

Outreach is the primary mode of treatment in Victoria. Outreach workers go out to find and meet clients and pro-actively seek to engage them. Workers have access to cars and flexibility in their day’s structure so as to be able to meet the needs of the young people they work with. Given young people’s hesitations in contacting services themselves, having outreach as the key service modality makes sense.

In Victoria, youth AOD services started in 1998. In the mid-1990s there was a heroin ‘glut’ in Melbourne which saw cheap, high-quality heroin readily available. There was increased street trade, visible public use of heroin, and the number of fatal overdoses increased dramatically (Rowe 2002). There was a public outcry and the state government commissioned an inquiry into the issue, known as The Pennington Report (Victorian Premier’s Drug Advisory Council 1996).

One of the report’s key findings was that there were no youth specific AOD services. This finding received considerable media attention, and the ‘Kids at Risk’ headlines led to a swift response from the Victorian Government. Funding was provided for a youth-specific residential withdrawal service, as well as youth outreach workers.

Tasked with identifying clients, outreach workers focused on finding visible drug users on the streets. The outreach approach had continued because of its efficacy at being able to engage with clients who do not attend office-based appointments. This is often those who are most marginalised or who struggle to engage with more structured models of interventions (Forrell & Gray 2009; Priebe & Matanov n.d.; St Christopher House 2007).

Outreach allows the client to work closely with the same worker for as long as they need. This provides a therapeutic relationship which can be practically oriented (i.e. assisting with physical needs – health, housing, withdrawal), or psychologically oriented (counselling, self-development). For marginalised young people, their outreach worker is often their only ‘safe’ adult figure. Not surprisingly, this relationship can be of much benefit to them (Ungar 2013).
Alex lived in a home where she received very little support or encouragement. Alex explained that it was great when she started work with an outreach worker as she felt ‘more comfortable with my worker – I can open myself up a bit more’.

For Maddison, an outreach worker was the first person to validate her feelings about the abuse that was happening at home. Maddison had been seeking psychological support at school. She had seen her school counsellor and talked to her about some of the things that were going on at home. However, the counsellor did not ‘... have any advice and didn't investigate further’. Maddison concluded that, ‘my problems mustn’t have been as bad as I thought it was’.

James described how he found having an outreach worker:

*It’s a good means of support – it helps a lot. It helps you set goals; it helps me to look at stuff – my drug use and my issues.*

Roxanne had been homeless since she was very young and was still grieving the deaths of her friends and grandfather. She had not thought about the potential links between these deaths, her homelessness and her risk-taking behaviour:

*YSAS has helped me so much in realising why I do things; that I am not just an idiot, but that I do things for a reason. Everyone does things for a reason. And sometimes when you’re down and out you just need someone to tell you that you’re not a freak, that you are a human, and that you’re dealing with things okay.*

Roxanne’s outreach worker was able to help her make the links between her trauma and her drug use, while also validating her pain and promoting her self-worth. Ungar (2013) has concluded that it is beneficial for all young people to have positive relationships with adults, but the benefits are particularly significant for marginalised young people who have no family support.

**Residential withdrawal programs (‘detox’)**

Withdrawal stays are up to two weeks long and the withdrawal units resemble a house rather than a hospital, providing food, safety, medical services and other care often not
available to marginalised youth. There are seven youth residential withdrawal units in Victoria and there is usually a waiting list to get in.

Some people had stumbled across residential withdrawal accidentally. Roxanne had a friend who was accessing a residential withdrawal unit:

*I went to visit him, and they were talking to me and said I should go in, and I did, and that was probably the best thing I ever did for myself.*

Roxanne found there were both practical and psychological benefits from her stay in a withdrawal unit:

*It gives you a bit of a break and it gives you a bit to think more clearly about things that you couldn’t really think about when you’ve got to worry about money and a house.*

Simon was in a withdrawal unit when I interviewed him. He explained that he had often spoken about quitting drugs, but never managed to remain abstinent for more than a couple of days. The intense dreaming – which is common with cannabis withdrawal – was too difficult to bear. His decision to make a more permanent change married up with his new goals for the future that required controlling his drug use:

*The main reason that I am here is so that I can achieve being able to get up every morning and go to work. I want to start my first year apprenticeship.*

Kate was also in a withdrawal unit when I met her. She had been there several times before but this time she was determined to succeed. Previously, she had been unable to get past the third day. When I met her, she had been in the detox for a week and was planning to stay for another week:
The way I am thinking of it at the moment is that as boring as I might find it in here, when I get out, it's probably going to be just as boring. Sure, I can get into drugs or alcohol or whatever, but at the moment it's better for me to be here.

Lisa first stumbled into a YSAS drop in centre when her boyfriend told her about a place they could go to get food. Later, her mother found the details of a youth residential withdrawal service. Lisa was relieved to see that it was also run by the same people that gave her the food: 'I would probably still be on heroin now if I didn't find this place'.

Lisa had been in the withdrawal unit twice. The first time she withdrew from heroin and was placed onto a pharmacotherapy. This time she was withdrawing from the pharmacotherapy. I asked her if she missed using:

Not really; sometimes. But then I think about the consequences and I don’t want to get sick anymore. I really want to start putting on weight again – just be healthier.

The young person's readiness for change was a strong factor in the outcomes of their stay in a withdrawal unit. Jake had recently broken up with his girlfriend and was evaluating many aspects of his life:

The break up put me in this place. [After the break up] I was like, 'Fuck this' ... I just hammered it and I was going five days out of the week for a few months – eckies and speed and ice, but speed predominantly ... I hadn't slept in four days and I called here [residential withdrawal] and they were like, 'Come in and do an assessment’. ... then I got a short-notice call up three days before I came in so I just said, 'Yep'.

It was fortunate that Jake was able to get a place in a withdrawal unit so quickly. This capitalised on Jake's momentum for change following the end of his relationship with his girlfriend. Jake was ready to take action immediately.
For the young men especially, peer groups and social connectedness was an area of their lives which they generally did not want to step away from. However, when young people were able to distance themselves from their peers, changes to their drug use were usually more successful. Jake was separated from his peers by accident:

> A few weeks ago the phone company cut off my phone and that was probably the best thing that could have happened to me because the last three weeks I haven’t had any contact with the guys I was doing drugs with – I was away from the stuff, so that was good for me.

When I met Jake, he had been substance-free for well over a month and had much clarity about his immediate future. He was hoping to move onto a three month residential rehabilitation program after his stay in the withdrawal unit: ‘I don’t trust myself … [two weeks in the detox] is not enough. It’s a temporary stint. It’s not enough to break a cycle and a habit’.

**Youth residential rehabilitation models (‘rehab’)**

Youth residential rehabilitation models in Victoria follow the principles of a ‘therapeutic community’. Rather than the traditional 28-day hospital style stay, young people go and live on a property for up to six months and are able to work through their issues in a safe, secure environment. Trained staff understand the physical and emotional needs of the participants and undertake case-planning on an individual basis. The key focus of the program is on maintaining abstinence, group work, recreational activities, and improving physical and mental health.

Pailin realised he needed an extended period of time away from his daily environment to break the psychological aspects of his dependence and address the reasons why he used drugs so heavily. Six months in a youth therapeutic community allowed him to do this. Pailin transitioned from the residential rehabilitation to a supported accommodation program and was abstinent for more than two years. Unfortunately, he began using again following a personal crisis. Pailin was in ‘detox’ when I interviewed him.

Shawn, the young man whose infant brother died in the car, had remained abstinent for some months after completing a residential rehabilitation program. Undertaking this radical change was a massive commitment:
I gave up every friend I ever had – I don’t speak to anyone. I’ve moved to the opposite side of the city, I have changed my number and I don’t see anyone that I used to. I am trying to make new friends.

Giving up all of your friends when you are, for the most part, without any family support is an almost impossible task in the longer term. Shawn was gay and felt that the most common social thing other young gay men did was to party together – a scene Shawn was trying to avoid. Shawn was struggling to make friends in a new suburb, far from where he had grown up. It remained to be seen if his ‘radical isolation’ would be sustainable.

When I met Damian, he had not had a drink in eight months, nor smoked cannabis in the previous four. He was, quite rightly, very proud. He explained that he had been in environments with heavy drug use and still managed to abstain. Damian’s motivation to get out of this cycle was clear:

My mum and dad, the way they are is because they didn’t deal with stuff when they were young, so I am not going to do the same. They didn’t deal with their stuff and it all came out in the divorce, and it tended to ricochet off onto us kids. I have lived my life not wanting that to happen to someone else. If I have kids down the track, I don’t want that to happen to them.

Damian still had a lot to manage in his life. He had serious decisions to make about his physical health, one of which involved major surgery. The prospect of this had previously seemed unfathomable to him, but as time had passed, he had drawn strengths and resources which had made him feel that it was a possibility. After Damien left rehab, he had maintained contact with his outreach worker who was an ‘anchor point’ in his life.

Moving on?

By the time I met them, all of the young people were attempting to move on from substance abuse. However, it is important to remember that we are not dealing with a homogeneous group. The young people had two things in common: they had come to the realisation that they had a substance abuse problem; and they had undergone physical
withdrawal from drugs and/or alcohol. Nonetheless, they were not all the same. Next, I discuss factors that could affect their chances of rebuilding their lives.

First of all, some of the young people had only relatively short periods of abstinence under their belts whereas others had notched up many months of sobriety. Those who had achieved a sustained period of being ‘clean and sober’ had usually made more steps towards rebuilding their lives, and had greater self-confidence. On the other hand, some had previously achieved a sustained period of abstinence only to relapse when confronted by some major disappointment or personal crisis in their lives. Length of sobriety is an important factor but relapses are fairly common.

The young people also had different goals with regard to their drug and alcohol use. For most their goal was total abstinence, but for a minority the goal in the longer term was a substantial reduction in consumption. They wanted ‘more control’ and to return to recreational use like many other young people.

The young people varied in their maturity and world experience. The youngest person in the study was only 14, whereas others were in their late teens and some were in their early 20s. There was variation in their family circumstance. For a small number there was the possibility of returning to live with a parent, but most had ‘burnt their bridges’ with family, and some had no parents to return to. Finally, there was variation in their level of educational achievement and in their experience of paid work. All of these factors are likely to affect their chances of rebuilding their lives.

Learning from experience

Bearing the above factors in mind, it is not surprising that people learn from experience in different ways and at different speeds. Moreover, some lessons have to be taught more than once. Jazmine knew that she had had a troubled childhood and that she had made some bad decisions during her adolescent years. She said, ‘I am well aware that there was a problem and that I took drugs to block it all out and then I created another problem’. Jazmine had made an important step forward in that she now understood the function of her drug use. This was critical to her being ready to shape her life in a positive direction.

In contrast, Luke appeared to have a long journey ahead of him. When I met Luke his sense of self-worth was low:
I just feel like everything’s stuffed up for me from drugs – I’ve just lost so many friends and everything. Even they said that I am getting in too far over my head. I got to that point, and I still remember it; I wanted to catch up with them, and they just didn’t want to see me or what I was turning out like, because they could see what I was doing and they felt sorry for me. ... they didn’t really want to hang out anymore because I was changing so much ... I was always lying to everyone.

Luke felt isolated and unloved. During the interview he began to talk about his parents’ separation, and the subsequent acrimony that followed between different members of the family. At the time, his mother and his siblings received counselling, but he declared that he was ‘fine’ and did not want to talk about it. In retrospect, it seems likely that his parent’s separation had affected him deeply even though he was only dimly aware of this at the time. His drug use began soon after his father left the family home and this was probably his way of coping with the emotional turmoil in his head.

Jessica was further along the road to recovery than Luke. She accepted responsibility for her drug use, but at the same time she could identify external factors that limited her choices:

I always say that I made a lot of decisions: I decided to leave school; I decided to start doing drugs. I don’t blame my parents for the way that I am; but I know that at the same time, I wouldn’t be the way that I am without them making a lot of bad decisions.

Jessica accepted that she had made some bad decisions, but this was empowering her to feel that she could make decisions as well. She acknowledged that she had faced disadvantages beyond her control: her parents had made a lot of bad decisions that affected Jessica. Nonetheless, Jessica’s ability to take responsibility for her decisions meant that she did not express the same level of guilt and apparent self-loathing that Luke did.

Amber was now seeking to slowly withdraw from her pharmacotherapy as she prepared for the arrival of her first child. She had accepted the gravity of her past, as well as her ability to make the most of her own future:
I used to break down and cry and all that [talking about this stuff], and now I am trying to get over the past – which you have to do. You can’t keep the past with you your whole life. You have to get over it! And since I have been learning to get over it, I have been smiling more!

Another person who had made significant strides on her journey towards recovery was Lizzie. Following a stay in ‘rehab’, Lizzie had been off of drugs for 102 days when I met her. This was her longest period of abstinence with the exception of when she had been incarcerated. This time, however, the decision to not use drugs had been entirely her own. Lizzie’s goals were written out and kept in a folder that she had with her:

_Do the social work degree. Continue staying clean. Keep doing the 12 steps of NA. Getting my driver’s licence is on there, but I have done that ... a few goals for things around my house ... get a job in a month or two. Improve my memory. Improve my English skills. Join a gym – which I did. ... Continue to be involved with the charity that I am involved with ... I want to get the most out of my life. I want to be healthy, and be a social worker, and help people. I want to have a family one day._

Lizzie’s headspace was positive. She had permanent accommodation in community housing and was rebuilding her life.

As a way of fostering reflection, participants were asked what advice they would give to a younger version of themselves. Many laughed that they did not think they would listen to someone else’s advice at that age. Nonetheless, their responses to this question gave an insight into what they may have benefited from and what they had learned.

Jai, whose mother had died of a heroin overdose when he was in primary school, said:
Try not to be naïve. You’ll make all the choices that you make, they’ll become you. And hopefully you’ll make the right choices and don’t be down on yourself if you don’t, ’cause you’ll still get through life no matter how you do it, just look after yourself, and keep your health with you and your brain with you and you’ll be fine.

Mick was concerned his little brother was going to follow the same path as he had:

That’s just the one thing I don’t want to see: for him to turn out exactly like me. If he turns out exactly like me he’s got a whole lot of shit ahead of him.

Likewise, Shawn who was gay wanted for his younger brother to have a different life:

My brother is about to turn 13 – the age I was when I started using [heroin] – and he’s now just starting to go through stuff and I don’t want that. I don’t want to live like that anymore. I don’t want him to have a life like that – I’ve watched it completely ruin my family.

Shawn’s concern about what his brother might see if he follows in his footsteps gives some insight into what Shawn has witnessed and experienced in his own lifetime.

Amy’s advice was brief: ‘Make your own decisions in life – don’t let anyone tell you what to do. But don’t give up’. Ebony’s also showed this ‘never give up’ attitude:

Just keep at it. Don’t kill yourself – ’cause it’s not worth it. Just get support; stop doing stuff on your own – trying to give up [drugs] on your own. Get some balls and go and talk to people.

Asking participants to offer these reflections on their own pathways was fruitful. These young people very articulately captured why they feel they had developed a drug problem. When I asked Roxanne if there was ‘anything else that is important?’ she replied:
I have always felt like an outsider, that I’ve never fitted in. And I am always having to pretend that I am happy when I am not, and pretend that everything’s okay when it’s not ... I never thought I’d end up a heroin addict ... but if you keep getting beaten down ... there’s a certain point where it gets too much.

This research sought to answer why some young people came to experience problematic substance use. Roxanne had provided an important insight.

The future
When asked about their plans for the future, none of the young people had grandiose aspirations. Most participants had similar goals to Stacey who just wanted to, 'live a normal nine-to-five life'. People often used the phrase a 'normal life'. By this they meant such things as a house, a job, a partner and a family. However, we will see later that there were differences in the aspirations of men and women. Both sexes endorsed a traditional division of labour between men and women – that of 'home-maker' and 'breadwinner'.

The first priority for people who had only recently come out of detox was to maintain their sobriety and find stable housing. According to Riley, her goals for the immediate future were:

*Getting my drug use down, and my housing sorted, and just trying to cope with things – it's really hard ... I think, because I hadn’t dealt with a lot of my family issues, it all came out and I started seeing a psychologist ... then it was like, 'Oh, I've got to deal with all of this stuff'.*

Those who were still homeless were usually unable to plan ahead. When asked her goals, Mary replied:
To survive ... I don’t really know. I don’t have any definite plans for my future, but I guess, to cut down on drugs as much as I can and eventually be able to work.

Time in withdrawal units was often dedicated to finding a bed in a refuge or other housing arrangements when they left, but if these young people were unsuccessful, then they were acutely at risk once they were on their own.

Some young people had found stable accommodation. Ebony was living in a Christian boarding house at the time that I interviewed her. There was a strict ‘no sex, drugs, smoking, alcohol’ policy, but this suited Ebony who was committed to remaining ‘clean and sober’. Ebony’s single room was very modest, but it was stable and this provided her with a sense of ‘home’.

Maddison was living with her father, but this was problematic because she was convinced that he did not care for her. This was made clear to Maddison when she had an operation on her hand. Her doctor had told her not to wash the dishes, but her father expected her to do them when he felt too tired. Her father was also controlling: ‘I have to keep all of my food containers in my room because he thinks my stuff takes up too much space in the kitchen’. He was also mean: ‘He told me I go to the toilet a lot, so I should get my own toilet paper’. Maddison might have been ‘at home’ but there was no love in this house.

In terms of ‘getting out’ of their current lifestyle, women were likely to see education and training as essential whereas the young men rarely spoke of this. Men were much more likely to be looking for employment, preferably ‘as soon as possible’.

Table 5.1 showed that 61 per cent of the young people had left school by the end of Year 9, another 24 per cent left at the end of Year 10, and only 12 per cent completed their high school certificate (Year 12). Not only was this problematic for their own development, but they were part of a generation where more than 80 per cent of their peers completed secondary education. Not having a high school certificate was a major barrier to finding employment.

Many of the young women (and a small number of men) expressed a desire to work in the helping professions – aged care, youth work, social work. Often, this was because a good worker had helped them change their lives and they wanted to help others
in similar circumstances to themselves. They needed formal qualifications to work in these professions.

Many participants, usually women, had started vocational courses provided through TAFE.

Jess had completed many certificates in various welfare skills – aged care, community care, disability support – yet the criminal record she received after intervening into a fight her father had with the police precluded her from working in most of these professions.

Maddison left school after the end of Year 11 and also completed a certificate in aged care. She subsequently got a job in a nursing home which she really enjoyed. Maddison was beginning to re-build her life. She was studying at TAFE with the long term goals of working in nutrition and owning her own home. Her determination shone through.

Maggie was also working in aged care, after completing the same course. She was now studying nursing part-time and feeling positive about her future.

While several of the young people had completed further study – often accumulating many certificates – there did not appear to be a strong link between these and successful employment. Some women did gain employment in the same field as their vocational study, but most did not. Those who did were almost universally in aged care, which in Victoria is desperately under-staffed.

Apart from aged care courses, the other certificates young people had completed were often unlikely to benefit their career prospects. Often the skills learnt in these courses were so specific that they were not very transferable. Thus, the benefits of training were often not felt by these young people. This affected the women more than men, as the women were more likely to be seeking an exit through education and training.

Some of the young women had found casual employment as a consequence of their training. We saw above that Maddison was working in aged care, but this was a casual job, not a permanent position. We also met Maggie earlier. She was working in a nursing home while she studied nursing, but her employment was also casual. One young woman, Stacey, was undertaking an apprenticeship as a chef, which was likely to lead to a permanent job, but this was unusual. All of those who had gained employment were precariously employed. MacDonald et al. (2005) report similar findings. They challenge the oft-held view that marginalised youth are permanently unemployed, and instead explain that
gaining employment was achieved often, though maintaining work was the far greater issues.

Despite the young women often beginning or planning to undertake further training and education, their longer term goals largely did not involve work. Many of the women seemed to expect – or perhaps accept – that their future roles would be as stay-at-home mothers. For many of the women, the role of work was a peripheral part of their discussions of the future – none of the women spoke about needing to work as a way of supporting a family. Despite the fact that many of these women had been raised by single mothers, very few of them approached adulthood with a notion that they would, or could, be financially independent. There was an implicit assumption that they would have a partner who would be the main breadwinner.

Equally as traditional in their gender role expectations were the young men. Their desire to enter employment as soon as possible was closely tied to their belief that a ‘man’ should provide for his family. When asked about their futures, the men’s answers were remarkably similar. Andrew wanted: ‘to have a house to live in, to have a good job and a girlfriend’. Likewise, Asiah said: ‘I just want to get a job and to get some money. Hopefully in a few years’ time I will have a family’. Michael was also sure and succinct: ‘I want to have a job one day. I want to get married. I want to have kids’. Nearly all of the young men, except for Shawn, Jai and Liam who were gay, wanted to get married and expected to be the main breadwinner.

The women made little reference to the need to earn money, but this dominated the men’s narratives of their future goals. Will, for example, said:

*I have to get off drugs so that I can start saving for a car, save for the repayments on a house. You have to have a good source of income for even the deposit.*

Beau had similar goals: ‘To have a job, to get a nice house. Just the basics’.

For the young men, the ability to be a provider was often tied to their idea of being an adequate suitor. Andy wanted to ‘get a job, get a house’ so that he could then ‘get a missus and settle down’. For Michael, earning money was central to being a worthy partner:
You need to show her that you have money to spend on her and that you actually come from a good family.

The men were clear: they wanted a job, a home and a wife.

The young men were mainly working class and their aspirations for employment were wedded to their belief that a man is a ‘worker’. In contrast to the young women, about one-quarter of the young men had at some point participated in the work force, before their drug and alcohol use had burgeoned out of control. Most of their experience had been in blue-collar work.

Ben, for instance, left school at the beginning of year nine but found employment in landscape gardening shortly afterwards. Likewise, Simon was able to pick up work as a casual labourer with a friend – he’d ‘just call him up and he’d find stuff for me to do’. Brandon left school at the end of Year 10. Eventually, he gained employment, first in roof tiling, then carpentry and then cabinet making. At the time of the interview, Brandon was homeless and unemployed. He was hoping to get work picking fruit.

There was a similar series of events for Chris, who left school at the beginning of Year 12. After a few months of ‘bludging’, he began an apprenticeship in painting and decorating. He described the satisfaction he got from paid work:

It’s good. It does a number on your body, but it’s good. You begin each day and you get something done.

Jakey, who had just turned 20, left school in Year 11 and moved through various jobs. First he worked a call centre and then bricklaying. He had not worked for a year at the time of the interview. He had spent the previous 12 months ‘sitting in my room smoking dope, unfortunately’.

Few of the men spoke about careers or the desire to work for its own pleasure. There were some exceptions. Pupps wanted to be a writer and Jerry had recently completed a course to work in real estate. Jerry had a job arranged with a real estate
agent. At the interview, Jerry said that the real estate industry was at its lowest point in a decade and he was worried that this was not a good time to start.

As we have seen, most of the men wanted blue collar work. James eloquently summarised the views of the majority:

_I want to be a tradie or something like that. I don't really have too many high hopes, but I want to ... make money._

Gerald defined his future success by the ability to earn a wage:

_I don't want to be a fucking dead-beat on the dole for the rest of my life. I want to make good money. I am not really into the materialistic way of thinking, but I do still want to have my own home._

Gerald had left school during Year 7 with no formal qualifications but he knew what he aspired to:

_My mate, he's got a trade, he's paying off a house, he's got a girlfriend – he's living the dream pretty much._

For these young men their ‘dream’ was a job, a house, a girlfriend (or wife) and, later, children. How many of them will achieve their dreams is unknown, but their chances in the labour market are not good.

**Conclusion**

This chapter began at the point where participants realised that their own drug use had become a problem, and it identified the ‘tipping point’ when they realised that the negative effects of substance abuse outweighed the positives. This had led them, in a variety of ways, to drug treatment services. The three main drug treatment options in Victoria were described: outreach programs; residential withdrawal programs; and youth residential rehabilitation models. It was pointed out that court-mandated treatment appeared to have been effective in getting these young people into treatment, as too were diversionary orders and non-custodial sentences.
All of the young people were attempting to remain ‘clean and sober’, but they varied in their maturity and world experience. The youngest person in the study was only 14, whereas others were in their late teens and some were in their early-20s. There was also variation in their family circumstance with only a small number having the possibility of returning to live with parents. Furthermore, there was variation in their level of educational achievement and in their experience of paid work. All of these factors come into the mix when young people are attempting to re-build their lives. Bearing this in mind, it is not surprising that some young people were making better progress than others.

All of the young people were working toward a life free from problematic drug use and to live what they termed a ‘normal life’. To do this, there were two main routes: education or employment. Women were far more likely to be undertaking additional education. However, most had enrolled in vocational education which rarely led to a job. Young men aspired to enter the workforce and most of them were looking for blue-collar work. However, given their educational background and their lack of work experience, their prospects in the labour market were bleak.

These young men and women had begun to take the first steps towards sobriety and abstinence, but for all of them there was a long journey ahead.
Chapter 9

Conclusion

I have used this thesis to investigate how some young people come to experience problematic substance use. The research began questioning two dominant assumptions. The first assumption was that drug use inevitably leads to problematic drug use. The second assumption was that young people are unable to make sensible or rational decisions about their drug use. There have been various Australian studies that have examined youth with substance abuse issues, and this research has typically focused on identifying risk and protective factors (Hawkins, Catalano & Miller 1992; Loxley et al 2004; Loxley, Toumbourou & Stockwell 2004). This information is very useful, but keeps discussion of young people's drug use contained to these factors alone, which overlooks how these factors came to be at play in young people's lives. Focus on risk and protective factors constrains the capacity to understand why some young people find drugs so appealing at such a young age. One aim of this research has been to fill this gap.

Chapter 1 began with case-studies of Larry, Jerry and Lisa. Their biographies showed different pathways into problematic substance use. This had led me to wonder if problematic drug use was simply 'bad luck' so I explored what the 'drug problem' was. In doing this, it became clear that most people who use drugs do so without having a problem, so the assumption that drug use always causes problematic drug use was flawed.

The assumption that young people are not making reasoned decisions when they choose to use drugs was also challenged. While those with problematic use did appear to be engaged in reckless drug-using behaviour, closer attention showed that they were actually making 'situated choices' regarding their drug use. Critics of the normalisation thesis (Shiner & Newburn 1997) seemed correct when they said that normalisation theories over-simplified young people's drug use. It became clear that young people with problematic drug use did have very different drug use patterns than their more 'mainstream' peers, but this was because they were a very different cohort of young people. As I started to untangle some of the nuances, I sought to explore how it was that young people travelled their path into problematic use and drew on the theoretical concept of 'situated choices' to understand this. To do this, it was necessary to work backwards and look at young people who had experienced problematic use and trace their
biographies. I undertook life-history interviews with 61 young people aged 14 to 24 accessing a variety of youth AOD services across Victoria.

When I met the participants many of them were homeless and had been living lives that were full of risk. Crime and sex-work were accepted as ways of raising money. Life on the streets exposed them to considerable danger. Violence, overdose and the ever-present threat of sexual assault punctuated young people’s descriptions of their lives. On the streets, their youth and absence of support left them vulnerable to predators. We learned that these young people’s drug use had little to do with pleasure; rather participants wanted ‘to stop feeling’.

In Chapter 4, I explored their early childhood. This chapter revealed that the young people’s developmental years had been characterised by poverty, patchy schooling and family dysfunction. Half of them had been in state care and some of the others should have been.

While it was apparent that these young people had lived lives that were very different from their mainstream peers, it was unclear how they transitioned from childhood trauma to substance abuse. In Chapter 5, we saw that there was diversity in young people’s pathways, but there were several features that were commonly ‘in the mix’. The triple disconnection from school, family and home was a critical juncture that was significant in the transition from substance use to substance abuse.

Thus far in the thesis the focus had been on how young people developed problematic substance use. I then turned my attention to offer explanations for why this had occurred. To do this I examined women and men separately. In Chapter 6, we saw that young women’s experiences of sexual abuse and abandonment often led to dissociation and self-injury. They used cutting as a way of managing their intense emotional pain, before graduating to substance abuse.

Chapter 7 showed that the young men interviewed had very clear ideas about what working-class hegemonic masculinity expected of them. The realisation in their early teens that they had no place in the labour force saw them redefine this notion of masculinity to one of machismo, which celebrated crime and drug use. However, this style of masculinity dictated that men were never to be emotional or vulnerable. Young men masked their emotional turmoil with the presentation of a ‘front-stage’ self. In turn, young men found that drugs were an effective way of suppressing their emotions.
Both young men and women were using drugs ‘to stop feeling’, but their drug use had created other problems in their lives. Chapter 8 showed the participants attempts at ‘moving on’ from substance abuse. Young people’s aspirations for their futures were not grand; however, they faced many barriers in the path to achieving them.

Limitations
There are, of course, methodological limitations to this study. The first pertains to the generalisability of the findings. When this study began, there was no data available on the number of young people accessing youth AOD services in Victoria. It was estimated that there were approximately 600-650 young people at any point in time. This estimation was based on the distribution of funds with a caseload of approximately 16 clients for each funded position in the state. This estimation had been the general figure used in the sector for some time. Recently, there has been a Census of young people accessing youth AOD services (Kutin et al 2014). This had 1000 completed surveys and a response rate of 80 per cent, suggesting that the total number of young people in treatment is around 1250. Therefore, the sample in this study is comprised of five per cent of the population.

As much as possible, the sample was stratified for gender and geographic location. Nonetheless, when looking at sub-groups the numbers are small. Future studies would be strengthened by having a larger sample size, or by looking exclusively at particular sub-populations. It is difficult to verify the validity of data collected in qualitative studies, although the dominance of some themes (e.g. self-injury) suggest that the findings are reliable. Further, the findings in this study are consistent with those of the aforementioned Census which helps to triangulate the research findings.

An important qualification is that the current study only recruited those in treatment. It was shown that many young people only entered treatment by some sort of fortuitous happenstance, including involvement in the criminal justice system. This suggests that there are probably significant numbers of young people who may be in need of treatment but who are not accessing it. Therefore, it is unknown whether the findings of this study reflect the pathways of all young people experiencing problematic substance use in Victoria.

Findings of a recent study suggested that young women are particularly hidden from treatment, which may explain their greater severity in many domains (Daley & Kutin 2013). I have hypothesised elsewhere that only those at the very extreme end are involved
in services (Daley & Kutin, 2013). The young people in this study were also all English-speaking. Cultural minorities remain under-represented in all youth AOD services. It is likely that some groups, particularly those who immigrated to Australia as refugees, have a very different pathway into problematic substance use, though it is reasonable to believe that trauma and instability would remain consistent themes. Another minority group who are under-represented here are young people who identify as same-sex attracted. While it is known that they have a higher prevalence of drug use (Leonard et al. 2010) they are not proportionately represented in the service system. Future studies could undertake targeted-sampling to gain greater representation of these groups.

A final limitation pertains to the possibility of under-reporting. It is possible that some people were guarded about some aspects of their lives. This limitation is compounded by the fact that some of the issues that I have explored (e.g. sexual abuse, cutting) are stigmatised and young people may not disclose them. This is especially true for males who may feel reticent about disclosing sexual abuse and/or cutting. One way around this might be to spend more time getting to know participants, or perhaps by undertaking follow-up interviews.

**Implications for policy and practice**

The aim of this study was to provide a detailed account of young people’s pathways into problematic substance use. The intention was to provide important evidence that can be used to guide effective policy. It is imperative to understand young people’s pathways into problematic substance use in order to design prevention programs, as well as to design programs that assist people with substance abuse issues. Having mapped out these pathways, much was learned. What was striking was that the young people had experienced so many significant events. Sexual abuse was compounded by abandonment and homelessness. Grief was trapped in masculinities where violence and machismo were more normal than school or dinner. It was a constellation of compounding traumas that led to problematic drug use. Therefore, effective prevention and intervention initiatives need to be tailored accordingly. At a broader level, structural factors need to be redressed. These young people presented to treatment many years after their problems began and after having much contact with many services and systems along the way.

The research findings indicate seven points relevant for policy and practice:
• Need for early intervention
• Improved access to services
• Increased capacity in schools for youth ‘at risk’
• Consideration of the different needs of men and women when designing programs
• Increased focus on family interventions
• Increased resourcing in the care and protection system
• Availability of safe and secure housing for all young people

Substance abuse generally did not become an issue until participants had left school. This was usually in their early to mid-teens. However, it was clear that their pathway to problematic substance use was being paved much earlier than this. Young people’s biographies of early childhood demonstrated that poverty, abuse, neglect and parental substance abuse were more common than not. This information suggests that it would be possible to develop targeted early intervention initiatives. The family is often the source of a young person’s troubles and parents may not disclose the issues that their children are experiencing. Thus, other adults in young people’s lives need to be aware that responsibility may lie with them.

In identifying who would most benefit from early intervention initiatives, there are some young people who are fairly obvious targets – for example, those involved in the care and protection system – but in other cases it is less obvious. One group where some of the young people may be ‘at risk’ are those who have attended three or more schools. When schools enrol students who have attended many different schools, this could be used as a referral opportunity to the school welfare team. In addition, young people at risk of being expelled from school, or who are experimenting with alcohol and other drugs, may be part of the ‘at risk’ population, where some preliminary investigation might be warranted.

These early warning signs also point to the possibility of targeted prevention programs. These programs would need to focus not only on ‘risks’, but also on building resilience. A priority should be given to developing strategies that reduce the need to use drugs as a way of ‘stopping emotions’. The role of family in young people’s lives is always central. Including families in prevention and early-intervention programs is likely to lead to greater efficacy and sustainability. The efficacy of any intervention, however, will be influenced by its accessibility. This appears to be a shortcoming in the current system, with many teenagers not knowing about services.
It has been shown that the young people in this study benefitted from engaging with AOD services. However, we have also seen that many stumbled upon a youth AOD service by a stroke of luck, or some other seemingly accidental circumstance. This makes it likely that there are many more young people in need of these services than we are currently aware of. It is going to be challenging to ‘market’ services to young people more effectively, yet at the same time not to ‘promote’ drug use. This must be balanced against the risks of leaving teenagers with substance abuse issues to face their demons on their own. Models of ‘assertive outreach’ need to be widespread. Outposts in places such as child protection residential units, youth justice offices, schools and mental health services would be a feasible step.

There were gender differences in young people’s pathways and this is a relatively undocumented phenomenon. Very recently there has been some attention given to it in the Victorian media (Stark 2013), though there has been no investment of funds or commitment to programmatic responses. Young women need services that are equipped to work with their specific needs and to engage them in services earlier.

Regardless of how dysfunctional many of the families were, all of the young people wanted a greater sense of family connectedness. Sometimes this is not possible. Some participants were aware that it had been necessary to be removed from their parents’ care. Unfortunately, they often went from a dysfunctional family to a care system where there was no stability. This happens when teenagers are housed with other volatile young people who have considerable needs of their own. Greater attention to providing a sense of family connectedness would better cater for the needs of vulnerable teenagers.

More than half of the participants had been involved in the state care and protection system. Of those who had not, many should have been. There is no escaping the need for a state care system. However, there are many shortcomings in the current delivery of services, particularly for those children and young people placed into residential care. The structure of the Victorian Child Protection system is reasonable. However, the model of residential units is problematic because of factors such as ‘contamination’. Young people in these units are often so troubled that it is unlikely that they will recover unless they are provided with one-to-one care.

Residential units were but one part of a child protection issue. The most significant and inescapable fact is that there is a severe shortage of funding. While the structure of the system is reasonable, it is too poorly resourced to run efficiently. More young men in this
study graduated from child protection into youth justice, than graduated from secondary school. Investing in better care of children in Out of Home Care is essential to preventing them from experiencing the multiple issues that the young people in this study faced.

Finally, 90 per cent of the young people in this research had been homeless. It was clear that this contributed to mental health issues, disengagement from school, and an increase in drug use. Once young people were homeless, addressing any of these issues became impossible because the immediate need for both shelter and safety were not met. While housing will not solve these issues, it will prevent them from getting worse. It has been established that the longer one is homeless, the greater the likelihood that they will remain homeless in the long-term (Chamberlain, Johnson & Theobald 2007; Johnson & Chamberlain 2008). To curb this, greater housing options with security and stability, need to be directed to homeless youth. Similarly, workers need to enact assertive outreach programs to find the young people sleeping in squats who are unaware of youth services.

This thesis has demonstrated that there are multiple inter-connected issues which lead to poor outcomes for young people. It is established that holistic approaches to a client’s needs garner better treatment outcomes (Bruun & Mitchell 2012; Godley et al. 2001) nonetheless services often do not work together well. This is largely due to the distribution of funding for different services coming from different government departments. Certainly, redressing this would require significant restructuring of the current system. However, there is no alternate way that can achieve genuinely holistic care and best outcomes for young people.

The central argument of this thesis has been that problematic drug use is a consequence of chronic trauma and disadvantage that has been left unattended. The structures which constrained participants’ options – an education system which had rejected them; dysfunctional families; and a state care system that failed to provide adequate care for children – meant that they were making ‘situated choices’, but in very dire circumstances. They also had not had the resources to deal with intense emotional pain, thus they used drugs to stop feeling. As Mary said: ‘If people are happy with reality, they don’t try to escape from it all the time’.

These young people’s hopes for their futures were not radical. Their aspirations of having employment, a home, and a family, while seemingly ordinary, spoke to their appreciation of what most people take for granted but what they themselves had never
had: stability. This thesis began with a diverse collection of narratives; however, as more depth was revealed, their diversity faded.

The 61 young men and women in this study each had their own story; but collectively they also told a story. Their collective story made clear that problematic drug use was a consequence of trauma and disadvantage that was left without care.
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NIMH: See, National Institute of Mental Health


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Appendix 1

**Interview Schedule: Young People**

**Aim and details of the interview**

To gather a series of narratives from young people currently involved with a youth Alcohol and Other Drug (AOD) service. This interview seeks the “story” of each young person's life experiences prior to problematic substance use. There will be a specific focus on education, housing, familial support, Department of Human Services (DHS) involvement, substance use initiation and goals for the future.

Interviews will take approximately 60 minutes.

**The interview**

Thank you for agreeing to be interviewed today. To let you know a little about me, I am studying at RMIT University doing some research about problematic drug use in young people. Before this, I was an outreach worker at YSAS. My research is linked with YSAS and Barwon Youth, and I am focusing on the stories of young people's lives. All of the information that is most important to me is in your memory. Because the information that I am seeking is about your life and your experiences there are no right or wrong answers to any of my questions. Just to make it clear, your personal details such as your name and address will not be included in my documentation so you can be assured that everything that we talk about will be completely anonymous and I will not speak to anyone at YSAS or Barwon Youth about you. If during the interview something comes up that makes me feel
that you are at risk or there is a risk to someone else, then I will discuss it with you and explain what possible actions I might take to assist.

I would like to audio-record the interview, is this okay with you if I do this? I have listed out some questions that I want to ask you so that I don’t forget anything and I’ll use these to help keep the interview on track.

Generally I will be asking you about your experiences of school, housing and family but please mention things that you may feel are important that I haven’t asked about. This research is about you and other young people in similar situations so I want you to have as much say in it as possible.

A little later on I’d like to talk to you about family and growing up, but to start with I’d like to ask you about your experiences with school.

1. **Education**

1.1 :  What were your experiences of primary school like?

**Probe:** How many primary schools did you go to?

Did you enjoy primary school?

- **Good experiences**
  
- **Bad experiences**
  
- **Teachers**

1.2 :  Are you still friends with the people you went to primary school with?

**Probe:** (if yes) could you tell me about them?
(if no) why is that? E.g.: move away, separate high schools, drifted apart.

1.3 : Did you like moving on to high school?

**Probe:** Explore why or why not. Examples?

1.4 : I’d like you to tell me about your time at high school

**Probe:** How many high schools did you attend?

What were the schools like?

Did you enjoy school?

Good memories

Bad memories

Friendship groups

Teachers – really bad and particularly the really good. Influential?

What was your attendance like? (quantify this)

Any formal disciplines at school (e.g.: suspension, expulsion, requested to leave etc).

1.5: When you were at school, what were your plans for the future?

**Probe:** Uni, Apprenticeship, parenthood, TAFE etc.

1.6: Was there anything that you felt held you back from any of your dreams?

**Probe:** Why do you feel that x held you back?

1.7: When did you leave/finish school? (e.g. year level)
**Probe:** Do you feel that leaving school when you did was the best option? Explore this – why / why not? With the benefit of hindsight, what would you do?

1.8: Would you like to have continued study, or to go back in the future?

**Probe (if yes):** What type of study? Feasibility? What is it about this that interests you?

### 2. Homelessness

2.1: Where did you live when you were at school?

**Probe (if several):** Why did you move around?

2.2: Was your housing stable or unstable when you were growing up?

**Probe:** and why do you feel that way?

2.3: Do you remember any experiences of not having a place to call home at night?

**Probe:** is this with your family (e.g.: all homeless together) or away from your family (unable to go with/to them)?

2.4: Do you feel like your living arrangements impacted on other areas of your life?

**Probe (if yes):** In what ways? Could you offer an example?

2.5: Have you ever been homeless?

**Probe (if yes):** When was this (age)? For what duration? (altogether)

**Probe (if no):** How do you define “homeless”? (if sleeping rough is only definition, rephrase question to include other levels of homelessness, e.g: transient). Ask question 2.5 again.
2.6: Do you feel that homelessness and drug use are a common combination?

**Probe:** why/why not?

2.7: In your experience, do most people start to use drugs before they become homeless or after they become homeless?

**Probe:** Explain, examples?

**Probe:** What about you?

2.8: How do you find trying to do other things if housing is not stable? Explore

2.9: If you didn't have a permanent place to stay where would you go?

**Probe (if answer is friend or family):** And what about if you couldn't stay there anymore and couldn't stay at other friends?

2.10 Was drug use a problem before you became homeless?

2.11 When did drugs become a problem? (before or after homelessness)
3. Familial support

3.1: Could you tell me a bit about your family?

**Probe:** Parents and Step Parents

- Siblings
- Children
- Grandparents

3.2: What is your relationship like with your family?

Explore positive and negative family ties

3.3: Do you live with your family?

**Probe (if yes):** Explore dynamic

**Probe (if no):** Do you have much contact with them? Do you find it easier or harder to live away from them?

3.4: When you were at school, what was your relationship like with your family?

**Probe (if good):** Do you feel that this helped with issues that may have occurred at school?

**Probe (if not so good):** Did this make it difficult for you to handle other things, like stuff that might have been happening at school?

3.5: Do you know of any history of mental illness in your family?

**Probe:** explore depression, Personality Disorders, anxiety etc

3.6: When you got into trouble as a child, how did your parent(s) deal with it?
**Probe:** Do you think that this was an effective method?

3.7: Does anyone else in your family use drugs?

**Probe:** Explore types and quantities and who

3.8: How long have you known about this?

3.9: Does this include drinking?

**Probe (if no):** Why didn't you include this when I asked about drugs?

   Explore any drinking within the family

4. **DHS involvement**

4.1: Do you know what DHS is?

**Probe (if yes):** Can you tell me about what they do? How do you know this?

**Probe (if no):** Explain DHS to young person.

4.2: What do you think about DHS?

**Probe:** And why do you feel this way?

4.3: Have you ever had contact with DHS?

**Probe (if yes):** In what capacity (e.g. protective order, state-care, youth justice)

   Explore durations

   Initiated by who / why

*Only for participants with experiences with state-care*
4.4: How do you feel about your time/s in DHS care?

**Probe:** Explore – foster care or residential unit

Secure welfare?

Involvements with Streetworks

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5. Mental health

5.1: How would you describe your mental health?

**Probe:** not a problem / had a few issues / accessed treatment before / is a major issue

**Probe:** if ‘not a problem’, explore (how do they define what a ‘problem’ is)

5.2: If you have had some issues, could you please tell me about them?

5.3: Have you ever received a formal diagnosis?

**Probe:** What was it? When? Still current? Who made the diagnosis?

5.4: Have you ever accessed treatment?

**Probe (if yes):** Please tell me about your experiences of this?

(experience contact – frequency, voluntary or involuntary, ever been admitted?)

5.5: Have you ever had contact with the CAT team?

**Probe (if yes):** How many times?

    When?

    What for?
What was the outcome?

How did you experience this?

5.6: Have you ever been on medications for MH issues?

5.7: How do you feel about the mental health system?

5.8: How do you feel that your mental health issues have impacted on other parts of your life?

OR:

have other parts of your life contributed to decreased mental health?

Explore in relation to relationships, school, housing, drug use, criminal justice

5.9: Has anyone in your family or close to you experienced mental health issues?

6. Substance use patterns

6.1: Could you tell me about what was happening in your life when you started trying drugs?

Age?

Probe: Is this including alcohol and cigarettes?

Probe (if no): Why didn't you include these?

6.2: What substance/s did you try first?

Age?
6.3: How did you get this?

Explore consequences and effects

6.4: What was happening in your life when you first started trying drugs?

**Probe:** Who with?

How were you getting the drugs?

Where did you use?

Explore high risk use patterns (e.g.: poly drug use, using alone, being injected by others)

6.5: Could you tell me about your experiences with drugs from then to now?

**Probe:** Using with?

In what circumstances?

When did you feel that your substance use was becoming problematic?

What do you think triggered this?

6.6: Why do you think young people come to YSAS?

6.7: Do you think that drug use in young people is misrepresented in society?

**Probe:** Explain/Elaborate

Discuss emphasis on young people and binge drinking, 2007 ice epidemic

Influenced by sporting stars?
7. Youth Justice involvement

7.1: Have you had any contact with the courts, police and/or Youth Justice?

Probe (if yes): Can you tell me about this?

IF NO, GO TO 7.7

7.2: Are you currently on an order?

Probe (if yes): What sort of order is this? (Collect details of duration, expiration, has it been increased for non-compliance, what are the conditions etc)

7.3: How many separate occasions have there been?

7.4: Have you ever been incarcerated?

Probe (is yes): Details – when, where, how long, what for, how many times

Can you tell me about your time in FACILITY NAME

Explore consequences and effects

7.5: Where did you go when you were released?

Probe: Who with?

Homeless?

Relapse?

Pharmacotherapy

Recidivism?
7.6: What do you feel led to your involvement with the criminal justice system?

7.7: Has anyone in your family ever been involved with the criminal justice system?

**Probe (if yes):** Can you tell me about this?

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**8. Demographics**

8.1: How long have you been involved with drug and alcohol services?

8.2: What led you to these services?

**Probe:** (If via the criminal justice system) have you involved yourself more than what your order required you to? For instance, if you were to attend a Drug Diversion Program for three sessions, did you also complete a stay in a residential withdrawal unit (detox)? Or have you continued accessing services voluntarily?

8.3: What have been your goals whilst working with YSAS / Barwon Youth?

**Probe:** Do you feel that you have achieved a lot? Could you tell me about why/why not?

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**9. The future**

9.1: What are some of the things that you have accomplished since you have been working with the YSAS / Barwon Youth?
Explore this in detail – qualify and validate achievements and elaborate with participant on how this felt and why it is such a significant achievement. Ensure that participants do not denigrate their successes out of embarrassment.

9.2: Could you tell me about what you have thought about for the future?

Again explore, seek details of these plans with the young person and explore the significance of the plans.

9.3: What motivates/ inspires you to pursue these goals?

**Probe:** And why is this your motivation?

9.4: What would you suggest to other young people in similar situations?

9.5: I’d like you to tell me about things that you may feel are important but that I haven’t asked you.

9.6: Is there anything that you were expecting me to ask that I haven’t?

**Probe (if yes):** And what were these?

9.7: Why did you agree to participate in this interview to begin with?

9.8: And has it achieved what you had hoped/expected?

There is a possibility that I will continue researching this area and as part of this, may want to follow you up in the future. Is this possible? **YES / NO**

If yes, do you consent to me contacting you again in the future? **YES / NO**

If yes, how best I contact you? ____________

Please be assured that I will not provide your information to anybody else. Any future research will be undertaken by myself.
Thank you for letting me interview you today. If you need to contact me for anything, my details are on the project information sheet which I gave you. Congratulations on having achieved so much, and my very best wishes for you future.

**ALIAS:**
INVITATION TO PARTICIPATE IN A RESEARCH PROJECT

Project Title:
- Understanding Problematic Youth Drug Use.

Investigators:
- Kathryn Daley (PhD Candidate), kathryn.daley@rmit.edu.au 9925 9926
- Associate Professor Chris Chamberlain (Project Supervisor, Director of the Centre for Applied Social Research, RMIT University) chris.chamberlain@rmit.edu.au 9925 2956

Hi,

You are invited to participate in a research project being conducted by RMIT University. This information sheet describes the project in straightforward language, or ‘plain English’. Please read this sheet carefully and be confident that you understand its contents before deciding whether to participate. If you have any questions about the project, please ask one of the investigators.

Who is involved in this research project?
- Kathryn Daley is a student in the school of Global Studies Social Science and Planning at RMIT University.
- Associate Professor Chris Chamberlain is the Director of the Centre of Applied Social Research at RMIT University and he is supervising this project.
- This research has been approved by the RMIT University Human Research Ethics Committee and also by the executive committee of the YSAS and the management team of Barwon Youth.

Why have you been approached?
- We are seeking the views of young people who have been involved with YSAS or Barwon Youth to understand your life experiences before drugs became a problem.

What is the project about?
- This project is investigating whether people who have experienced problematic youth drug use have had broadly similar experiences growing up.
- The research will involve interviews with approximately 60 young people and will also involve interviewing 20 outreach workers about general trends in the young people they see.

If I agree to participate, what will I be required to do?
If you agree to participate, you will be required to be interviewed for approximately 60 minutes. The questions will be about school, housing, family and if it applies to you, experiences in state-care (or foster care). It will also ask about how your substance use became problematic and your plans for the future. The interview is looking for your “story”. If there are certain things that you don’t want to be asked or to talk about that is okay. Your participation is completely voluntary and you can withdraw at any time. If it is okay with you, the interview will be audio-recorded, but your name will not be included on the tape, nor will it be included in the research paper. Your surname is not required.

What are the risks or disadvantages associated with participation?
The interview will not ask about any histories of trauma or abuse. But some topics that arise might be uncomfortable for you. If you don’t want to talk about certain things, that is okay. It is also okay to end the interview. Things might also come up that make you feel embarrassed, uncomfortable or sad but that you do still want to talk about. If this situation happens, or if after the interview you feel distressed, you should contact your outreach worker who can follow this up with you confidentially, or can refer you to someone else that you may prefer. If you don’t want to, or can’t speak to an outreach worker, you could also contact your doctor. If you do not have a doctor YSAS Health Services have several that you are able to make an appointment to see. Alternatively, there are also some contact numbers at the bottom of this letter that you can call for.
What are the benefits associated with participation?

This research is to improve the knowledge that people have about young people with drug and alcohol issues. You may feel good after the research that you have been able to contribute and having been able to tell your story, but you may not. Barwon Youth and YSAS will be provided with a copy of the final report which they may use in developing their own practices and procedures in their work and its results may be published, distributed and/or presented elsewhere. It may also influence policies that affect you. You will be paid $30 for your time.

What will happen to the information I provide?

- All of the information that is collected about you will remain anonymous and data will be completely confidential. Only the research investigators will have access to this information. After the research is completed, the interview data will be stored in a locked filing cabinet until no longer needed (at least 5 years). After this time it will be destroyed.
- Any information that you provide can be disclosed only if (1) it is to protect you or others from harm, (2) a court order is produced, or (3) you provide the researchers with written permission.
- All of your information will be coded and not attributed to yourself. The research will be produced into a written report in which your name and other identifying features will not be included.

What are my rights as a participant?

If you agree to participate, these are your rights at all times:

- The right to withdraw their participation at any time, without prejudice.
- The right to have any unprocessed data withdrawn and destroyed, provided it can be reliably identified, and provided that so doing does not increase the risk for the participant.
- The right to have any questions answered at any time.
- The right to access your data which will include notes, tape recordings and transcription.

What other issues should I be aware of before deciding whether to participate?

- Be sure that you feel comfortable before agreeing to participate. If there are any issues that arise which you would like to discuss please contact the services listed below. If you have any questions, you should contact either of the investigators listed above

Yours sincerely

Kathryn Daley


Associate Professor Chris Chamberlain

B. Sc. (Soc). M.Sc. (Econ). PhD.

Support Services

Lifeline (24 hours): 13 11 14

YSASLine (Free call, 24 hours): 1800 014 446

YSAS Health Services, Primary Health Clinic: 9415 8881

Directline (Drug and Alcohol information/referral service, 24 hours): 1800 888 236

Any complaints about your participation in this project may be directed to the Executive Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001. Details of the complaints procedure are available at: http://www.rmit.edu.au/rd/hrec_complaints
RMIT HUMAN RESEARCH ETHICS COMMITTEE

Prescribed Consent Form For Persons Participating In Research Projects Involving Interviews, Questionnaires, Focus Groups or Disclosure of Personal Information

PORTFOLIO OF  Design and Social Context
SCHOOL/CENTRE OF  Global Studies, Social Science and Planning

Name of participant:

Project Title: Understanding problematic youth drug use.

Name(s) of investigators: (1) Kathryn Daley  Phone: 9925 9926
                      (2) Assoc. Prof. Chris Chamberlain  Phone: 9925 2596

1. I have received a statement explaining the interview/questionnaire involved in this project.

2. I consent to participate in the above project, the particulars of which - including details of the interviews or questionnaires - have been explained to me.

3. I authorise the investigator to interview me.

4. I give my permission to be audio taped  ☐ Yes  ☐ No

5. I acknowledge that:
   a) Having read the Plain Language Statement, I agree to the general purpose, methods and demands of the study.
   b) I have been informed that I am free to withdraw from the project at any time and to withdraw any unprocessed data previously supplied.
   c) The project is for the purpose of research. It may not be of direct benefit to me. The privacy of the information I provide will be safeguarded. The privacy of the personal information I provide will be safeguarded and only disclosed where I have consented to the disclosure or as required by law.
   d) The security of the research data is assured during and after completion of the study. The data will be submitted to RMIT as a thesis. It may be used for publication in journals or conference presentations or other publications.

Participant’s Consent
Name:  Date:  ___________________________  ___________________________
   (Participant)

Name:  Date:  ___________________________  ___________________________
   (Witness to signature)

Any complaints about your participation in this project may be directed to the Executive Officer, RMIT Human Research Ethics Committee, Research & Innovation, RMIT, GPO Box 2476V, Melbourne, 3001. Details of the complaints procedure are available at: http://www.rmit.edu.au/rd/hrec_complaints