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Contribution of Lifestyle Related Shaming in Drug Relapse Management in Indonesia

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Abstract
In the statistical calculation of the National Narcotics Board of the Republic of Indonesia or so called BNN, there were 70% of drug offenders with the status of drug relapse in 2019 reached (BNN: 2019). Such condition illustrates that the social rehabilitation mechanism for drug offenders in Indonesia still has the opportunity to present shameless people. Therefore, this study is intended to observe the significance of Lifestyle Related Shaming as an effort to reduce the number of drug relapses in Indonesia. Lifestyle Related Shaming is supported by 3 (three) macro theories, namely reintegrative shaming theory proposed by John Braithwaite, desistance theory proposed by Farral and routine activity theory proposed by Hiddlenlang The literature review method was applied here through the utilization and effort to develop an existing theory (grounded theory) by presenting certain concepts (variables) in accordance with the affordability of study data. In addition to qualitative approach, this research also performed a quantitative approach through survey method among respondents who experienced drugs relapse in Indonesia as well as in-depth interviews with drug relapse residents with various backgrounds and educational levels at the Center for Drug Rehabilitation of the Republic of Indonesia at Lido Bogor. It is expected that this study may provide a broad understanding to the government to prepare the best program for solving the drug relapse phenomenon, especially drug abuse in Indonesia. For the science, this study is expected to be a basis for the implementation of shaming in Indonesia. Furthermore, this study is also expected to be able to provide input in the process of drug relapse management in Indonesia, especially in an effort to prevent residents from falling into a shameless condition.

Keywords: Shaming, Reintegrative, Stigmatitative, Drug Relapse, Crime

1. Background

The National Narcotics Board of the Republic of Indonesia or so called BNN confirmed that there was an increase in drug trafficking during 2019 from the previous year by 0.03 percent. Most drug users were aged 15 to 65 years and the number reached more than three million people (Chaniago, 2019). As a comparison in accordance with the data derived from the Jakarta Metro Police, it was shown that cases of drug abuse tended to have an increasing

trend, with the highest total cases in 2017 of 6,287 cases and the lowest total cases in 2011 of 4,817 cases (see Figure 1).

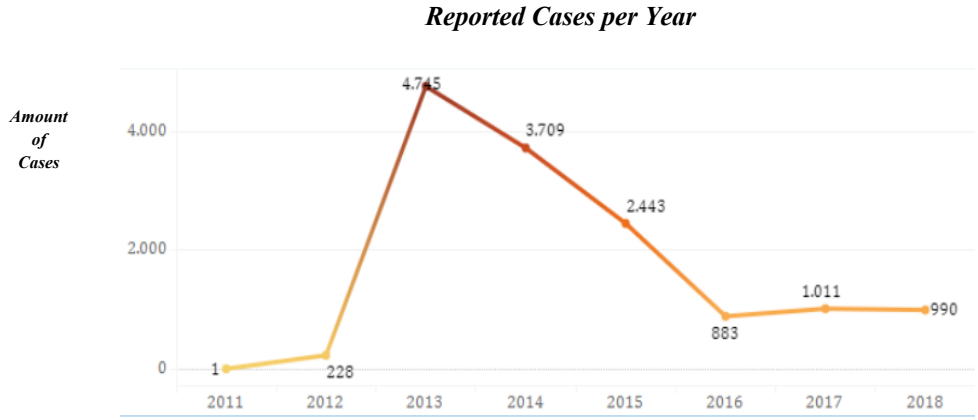


Figure 1: Graph on Drugs Abuse Cases Report in 2011 - 2018

Source: reprocessed by BNN (2019)

Various policies and work programs established in the long term by covering various approaches performed by BNN are intended to deal with drug abuse which is quite significant in Indonesia. There are several approaches that exist in Indonesia, namely the legal approach, the medical approach and social empowerment. In the legal approach, the government carries out prison sentences up to the death penalty for drug offenders. Since 2014, the government has executed death-row convicts including Indonesian citizens (WNI) and foreign nationals (WNA) for their involvement in drug crimes, especially drug trafficking (Herindrasti, 2018).

Meanwhile, in the context of the medical approach, it is carried out through medical and social rehabilitation activities according to Article 54 of the Narcotics Law Number 35/2009. In the article it is stated that narcotics addicts and narcotics abusers must go through medical and social rehabilitation. In addition, Article 55 states that parents and guardians must make a mandatory report and appoint a hospital for medical rehabilitation. Drug abuse rehabilitation patients as of 2018 reached 21,358 patients with a distribution of 1,710 patients at the Ministry of Health, 16,727 patients at the Ministry of Social Affairs, 1,196 patients at the National Police, and 1,725 patients at the BNN (BNN, 2019). The rehabilitation patients in Indonesia are spread across 31 provinces. West Java Province had the largest number of 3,202 patients, followed by North Sumatra with 2,083 patients, and DKI Jakarta with 1,797 patients. Meanwhile, rehabilitation facilities are available in 34 provinces, mostly in Aceh (73 facilities), West Java (70 facilities), and South Sumatra (68 facilities). More complete data on patients and rehabilitation facilities per province in 2018 can be observed in table 1. Based on the same data, the number of rehabilitation patients in outpatient service was 3,616 patients, in inpatient service it was 16,009 patients, in home therapy service using methadone it was 463 patients, and in home therapy service using buprenorphine it was 824 patients.

Table 1: Distribution of Patient & Rehabilitation Facilities by Province in 2018

No.	Province	Number of Patients	Number of Facilities	No.	Province	Number of Patients	Number of Facilities
1.	West Java	3.202	70	18.	Bangka Belitung	235	44
2.	North Sumatera	2.083	48	19.	West Sumatera	214	35
3.	Special Capital Region of Jakarta	1.797	55	20.	Lampung	212	67
4.	Central Java	1.310	37	21.	Papua	155	7
5.	East Java	1.230	58	22.	East Nusa Tenggara	145	27
6.	South Sulawesi	885	41	23.	West Nusa Tenggara	134	13
7.	South Sumatera	745	68	24.	Banten	125	12
8.	West Kalimantan	655	26	25.	Bali	110	16

9.	Riau	450	17	26.	Maluku	100	6
10.	Aceh	444	73	27.	North Sulawesi	95	16
11.	Jambi	425	34	28.	West Sulawesi	85	5
12.	Special Region of Yogyakarta	372	14	29.	North Kalimantan	70	4
13.	South Kalimantan	305	23	30.	Central Sulawesi	65	11
14.	Riau Islands	280	11	31.	North Maluku	35	5
15.	Central Kalimantan	260	5	32.	West Papua	0	2
16.	East Kalimantan	255	44	33.	Gorontalo	0	10
17.	Bengkulu	254	13	34.	South East Sulawesi	0	6

Source: reprocessed by BNN (2019)

Details of rehabilitation patients are divided into community component rehabilitation institutions and BNN rehabilitation services. BNN provides rehabilitation services at Lido, West Java; Baddoka, Makassar, South Sulawesi; Tanah Merah, East Kalimantan; Batam, the Riau Islands; Deli Serdang, North Sumatra, and Kalianda, Lampung. In 2019 the number of rehabilitation patients reached 13,046 people, wherein as many as 1,676 people received inpatient rehabilitation services at local wards/local offices and 11,370 people received outpatient rehabilitation at Provincial or District BNN clinics, hospitals and health centers. In addition, monitoring of rehabilitation patients was also classified into regular, advanced, and intensive post-rehabilitation services. Sequentially, the number of patients receiving post-rehabilitation services was 1,901 people, 1,568 people, and 349 people, respectively (BNN, 2019).

2. Literature Review

Reintegrative shaming communicates disapproval of crime in society. In simple terms, the offender's bad deeds are the focus of recovery, not the offender himself (Braithwate, 1989). Meanwhile, the stigmatization reaction has a tendency to treat the offender as a bad person and deserves a permanent negative stigma in society. Thus, there is a tendency for people who forgive criminals in a reintegrative way to have lower crime rates in society compared to people who reduce criminal behavior through humiliation (Braithwate, 1989). This idea also supports the argument that social aggregates are characterized by high levels of communitarianism and non-stigma shaming practices (Schaible & Hughes, 2011). Braithwaite (1989) assumes that shaming is a form of behavior that seeks to show social rejection to an individual so that it creates shame.

Shaming is expected to have the quality of moral improvement that builds the awareness of the offenders. In relation to the basic assumption of the theory of reintegrative shaming, it is stated that conveying a message of rejection through shame is the key to understanding the impact of the criminal justice system since the conventional criminal justice system has the potential to create reoffending.

In addition, dessistence theory discusses how individuals stop doing something, especially a short break from crime. Bushway (2001) defines desistence as a process of reducing the offensive level of crime. Since criminal acts are often dependent on indirect factors and opportunities, the desistence process should focus on changes that occur in the propensity for crime rather than on changes in crime. Farrall & Maruna (2004) distinguish primary and secondary desistance. Primary desistance is defined as a form of pause in criminal activity. Meanwhile, secondary desistance is characterized by a permanent cessation of crime and a change in personal identity. In addition, there are age factors that may influence the desistance process. Hoffman & Beck (1984) suggested that the relationship was due to the existence of an age-related phenomenon of saturation among criminals.

Lifestyle theory was developed by Hindelang (1978) and has been widely used in studies of victimization. This theory emphasizes the lifestyle that affects the occurrence of crime in a person. This argument is confirmed by the explanation that daily routines such as work to school can determine certain types of crime, including the risk of crime (Madero-Hernandez, 2019). Based on this understanding, lifestyle theory has an emphasis on people in risky time, places, and relationships in the context of victimization. Such people have a higher probability of being a

victim compared to people with low-risk time, place, and relationships (Pratt, 2015). The application in victimization studies lies in the exposure given by lifestyle. Hindelang, Gottfredson, and Garofalo (1978) describe the differential patterns of victimization that exist across demographic groups.

Support as a victim depends on age, gender, race and income. Furthermore, the variation of exposure to crime risk situations is determined by a person's lifestyle. This is in line with a study conducted by Schreck which found that self-control had a correlation with a risky lifestyle. The idea was that individuals with low self-control were more likely to engage in behaviors that made it easier for them to become targets (Madero-Hernandez, 2019). Such behavior can contribute to the potential for victimization because it leads the individuals to place themselves at higher risk than individuals with more conservative lifestyles (Dempsey, Fireman, & Wang, 2006). Lifestyle theory explains crime as a process that involves 3 (three) variables, namely intensity, opportunity, and choice (Walters, 2014).

3. Study Method

The discussion in chapter 6 also serves as an analysis that bridges the explanation of the relevance of reintegrative shaming in the context of drug relapse in Indonesia in chapter 4 and the explanation of the shaming mechanism that intersects with the application of the therapeutic community model of rehabilitation. However, there was a difference compared to the previous chapters regarding the methodological approach used in chapter 6. In chapter 6, the researcher used a mix method approach to support conceptual construction within the grounded theory framework. This type of study applies a set of systematic procedures to develop a theory inductively about a study or phenomenon. In the initial description, the analysis was conducted using quantitative technique through the SPSS (Statistical Package for the Social Science) based on data obtained from the existing respondents. After that, a comprehensive analysis of informants was selected through the total number of respondents through purposive sampling technique.

This grounded theory study is based on biased and unclear statements which in the end may produce a comprehensive theory or concept collected from various data. The context of the current study was based on the problem of rehabilitation for drug relapse, which experienced a dilemma regarding the use of shaming for drug relapse. With the appropriate formula and theory development, this study is intended to be able to overcome the gap between shaming and rehabilitation for drug relapse. The gap was formed by the findings of data collected based on case illustrations to the findings of a theoretical study of lifestyle-related shaming as the result of the elaboration of propositions from the theory of reintegrative shaming, the theory of lifestyle and routine activity and the theory of desistance. In the previous chapter, the formation and development of theories have been explained to develop an integration of theory regarding the phenomenon under study.

4. Field Findings

The current condition in Indonesia regarding Covid-19 pandemic led to division established in the Lido Drug Rehabilitation Center. There were areas that had been divided into 3 groups. This was applied due to the risky interaction with outsiders since the residents are vulnerable to being contaminated with Covid-19 and in order to minimize the spread of Covid-19 in the area of the Lido Drug Rehabilitation Center. Rehabilitation at the Lido BNN Rehabilitation Center is generally divided into 3 (three) resident groups, namely:

a. Red Group
   This is the resident group with medical rehabilitation through detoxification. This group is prohibited from meeting and interacting with outsiders during the Covid-19 pandemic.
b. Yellow Group
   This is the resident group in the transitional phase from the detoxification process which shifts to the community therapy phase or also known as the stabilization group. This group may have interactions with outsiders along with monitoring, except with family and close relatives during the Covid-19 pandemic.

c. Green Group

This is the group that undergoes a non-medical rehabilitation stage through various structured and group activities in the therapeutic community. This group comes from a re-entry background that is allowed to interact with outsiders but still along with monitoring for the process during the Covid-19 Pandemic.

Residents who were involved as respondents in this study could be categorized in drug relapse individuals who had gone through the stages of medical and non-medical rehabilitation. Respondents in this study were classified as residents in the Green Group category. The survey was conducted on March 24, 2021 at the Lido BNN Rehabilitation Center. Researchers distributed questionnaires to residents of the Green Group with a population of 75 people. The 75 questionnaires or 100% of questionnaires were returned to be processed by researchers as the study samples (N=n). In fact, all respondents of 75 people experienced drug relapse and have previously received rehabilitation either in BNN or outside BNN. Thus, the total population was the same as the number of samples taken in accordance with the description presented in the following table.

Table 2: Explanation of Employment Distribution

Information	Number	Percentage
The number of questionnaires distributed	75	100%
The number of non-returned questionnaires	0	0%
The number of questionnaires with incomplete answers	0	0%
Jumlah kuesioner yang pengisian data diri tidak lengkap The number of questionnaires with incomplete personal data	0	0%
number of questionnaires that can be analyzed (sample)	75	100%

Source: reprocessed by the researchers through SPSS

Questionnaires were distributed to 75 respondents with profiles data that could be classified into gender, age, education level, and type of occupation. An explanation of the respondents is needed in an effort to describe the 75 participants who were interviewed in the study who came from various backgrounds. In the sample calculation, 75 respondents answered 10 questions, in which there were no damaged or incomplete questionnaires. The following table describes the background of the respondents involved in this study.

Table 3: Respondent Profile

Data	Percentage
Gender	
Female	22.67%
Male	77.33%
Age Range	
21-27 years	20%
28-34 years	10.6%
35-40 years	69.4%
Level of Education	
Elementary	1.33%
Junior High School	4%
Senior High School	21.33%
D1	1.33%
D3	9.34%
Bachelor	62.67%
Type of Occupation	
Entrepreneur	38.6%
Trader	16%
State civil servants	4%
Public figure	1.34%

Advocate	2.67%
Journalist	1.34%
Doctor	1.34%
Sailor	1.34%
Driver	2.67%
Farmer	5.34%
Honorary worker	1.34%
Breeder	2.67%
Fisherman	4%
Unemployed	17.34

Source: reprocessed by the researchers through SPSS

Respondents involved in this study were mostly dominated by male respondents. Based on the table above, it can be seen that of 75 respondents who participated, 22.67% or 17 people were female respondents, while 77.33% or 58 were male respondents. The age of the respondents in this study was grouped into three ranges, namely the age range of 21-27 years with a percentage of 20%, 28-34 years with a percentage of 10.6%, and 35-40 years with a percentage of 69.4%. Most of respondents who participated in this study had an undergraduate education background with a percentage of 47%, while the lowest level of education was Elementary Schools with a percentage of 1.33%. Respondents in this study had a variety types of occupation. A total of 82.66% of respondents were employed, while the other 17.34% were unemployed.

Questions asked to respondents were regarding about shaming behavior which is an attempt to embarrass or not to make drug use a lifestyle. Data analysis was conducted to assess the extent to which lifestyle-related shaming contributed to reintegrative shaming in reducing drug relapse rates in Indonesia. The results derived from the questionnaire obtained were then processed using descriptive statistics. Descriptive statistics is an analytical process that focuses on managing, presenting and classifying data. Descriptive statistics is a type of basic statistics that is able to explain the basic characteristics of a group of data. Based on descriptive statistical analysis conducted by the author using the Statistical Package for the Social Sciences (SPSS) software, various data visualizations were obtained to explain the information that had been collected by the researchers.

The study was described based 2 (two) kinds of variables, namely the independent variable and the dependent variable. The independent variable used here was drug relapse. Meanwhile, the dependent variable used here was the indicators of lifestyle-related shaming. Both variables were interpreted using a Likert scale to obtain opinions from the respondents. Through this Likert scale, respondents were asked to provide answers by requiring them to show the intensity of a number of lifestyle-related shaming indicators. This intensity level consisted of 5 (five) scale options with a gradation level from Never (N) to Very Often (VO). The description of the variables is presented in the following table.

Table 4: Operationalization of Concepts Presented in the Questionnaire

Research Questions		
To what extent does lifestyle-related shaming contribute to reintegrative shaming related to drug relapse in Indonesia?		
Independent Variable	**Dependent Variable (Q)**	**Scale**
Drug relapse	Lifestyle-related shaming indicators 1) Felt ashamed as an addict 2) Thought about the impact on the family 3) Had a Feeling that the family didn't care 4) Had a feeling of being rejected and ostracized by peers 5) Had the Fear of God during rehabilitation 6) Tried to recover because of family 7) Forced to participate in rehabilitation center 8) Participated in rehabilitation due to negative response 9) Often got pressure 10) There was no pressure and burden as a drug user	▪ Never (N) for the value of 1 ▪ Rarely (R) for the value of 2 ▪ Quite Often (QO) for the value of 3 ▪ Often (O) for the value of 4 ▪ Very Often (VO) for the value of 5

Source: reprocessed by the researchers

5. Analysis of Survey Data Results

The results of data analysis applied descriptive statistical method to describe the character of the samples and provide a description of the variables. The study variables included ashamed feeling as an addict, thinking on the impact on the family, a feeling that the family didn't care, a feeling of being rejected and ostracized by peers, Fear of God during rehabilitation, effort to recover because of family, feeling of a force to go to rehabilitation center, rehabilitation option due to negative response, the pressure received and no pressure and burden as a drug user. The results of descriptive statistical test are presented in the table below.

Table 5: Data Processing

	Cases					
	Valid		Missing		Total	
	N	Percent	N	Percent	N	Percent
Shaming	75	100.0%	0	0.0%	75	100.0%

Source: reprocessed by the researchers

Based on the table above, it can be seen that there were 75 sample data, while there was no missing data. Thus, it can be concluded that the data was valid and the data could be further analyzed. There were 75 participants or respondents who participated in the questionnaire while the range of each variable was the difference between the highest and the lowest values. The minimum and maximum values indicated the lowest value and the highest value. Through analysis, it was also known the mean and standard deviation of the data set collected from each question variable, namely from the first question (Q1) to the last question (Q10). Based on the data above, it was revealed that the standard deviation was 6.153 or lower than the mean value was 29.81. Thus, it can be concluded that there were no extreme data in the tabulation as shown in the following table.

Table 6: Description of Data

			Statistic	Std. Error
Shaming	Mean		29.81	.710
	95% Confidence Interval for Mean	Lower Bound	28.40	
		Upper Bound	31.23	
	5% Trimmed Mean		29.72	
	Median		30.00	
	Variance		37.857	
	Std. Deviation		6.153	
	Minimum		17	
	Maximum		44	
	Range		27	
	Interquartile Range		7	
	Skewness		.111	.277
	Kurtosis		.005	.548

Skewness and Kurtosis are the benchmarks in determining whether the data is normally distributed. Skewness value in the survey was 0.111 which was indicated by the value of the slope of the normal data distribution. Meanwhile, the Kurtosis value refers to the sharpness of the data distribution. The kurtosis value in this study was 0.005 which meant that the data tended to be normal. Normality test results based on Skewness and Kurtosis values are presented as follows:

Table 7: Normality Test

Description	Point
Skewness Value	0.111
Skewness Std Error	0.277
Skewness Ratio Value	**0.4**
Kurtosis Value	0.277
Kurtosis Std Error	0.548
Kurtosis Ratio Value	**0.01**

The normality test was performed by the researcher to test the normality of the data by using the Kolmogorov-Smirnoff test. The description of 'exact sig' is shown in the data with the value of 0.2. Since the value was higher than 0.05, it can be concluded that the data were normally distributed. The data distribution test was also performed by looking at the 'Q-Q Plot' graph as shown in the figure below, wherein the distribution of points follow a straight line. Thus, it can be concluded that the data were normally distributed.

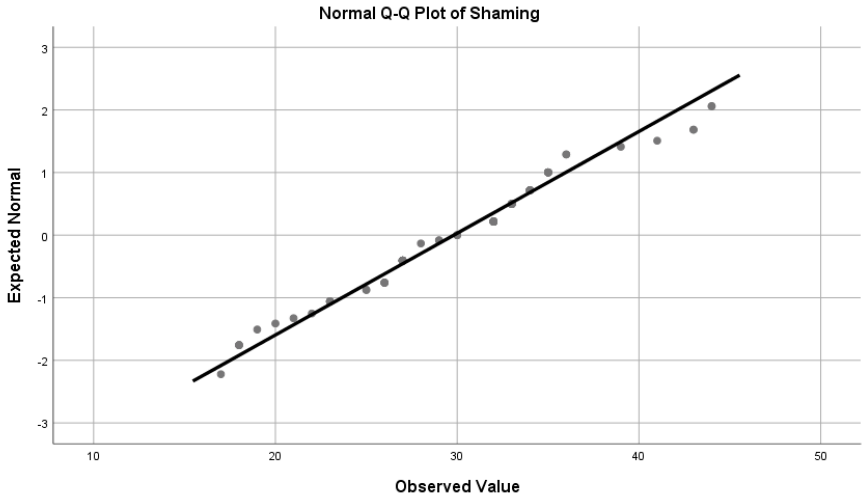
Table 8: One-Sample Kolmogorov-Smirnov Test

		Shaming
N		75
Normal Parameters[a,b]	Mean	29.81
	Std. Deviation	6.153
Most Extreme Differences	Absolute	.119
	Positive	.116
	Negative	-.119
Test Statistic		.119
Asymp. Sig. (2-tailed)		.011[c]
Exact Sig. (2-tailed)		.222
Point Probability		.000

a. Data was normally distributed

b. Calculated from data.

c. Lilliefors Significance Correction.



The Q1 variable regarding the respondents feeling of being ashamed as an addict obtained a minimum value of 1 and a maximum value of 5, with a mean value of 3.75 and a standard deviation of 1.357. The results showed that the standard deviation was lower than the mean value which indicated that the data distribution was evenly distributed. The Q2 variable regarding respondents' thinking that drugs would greatly affect the current family

condition obtained a minimum value of 2 and a maximum value of 5. Meanwhile, the mean value was 3.84 and the standard deviation was 0.806.

The Q3 variable regarding the respondents feeling that their family did not care about the current rehabilitation program obtained a minimum value of 1 and a maximum value of 3. The mean value for this variable was 1.19 and the standard deviation was 0.512. The Q4 variable which reflected the respondent's answer on the feeling of being rejected and ostracized by peers due to drugs obtained a minimum value of 1 and a maximum value of 4. The standard deviation of this variable was 0.684 and the mean value was 2.53. Furthermore, the Q5 variable regarding the respondents' fear of God showed a minimum value of 2 and a maximum value of 5. The standard deviation was 0.767 and the mean value was 4.08.

The variable Q6 regarding the statement of respondents of effort to recover because of the family obtained a minimum value of 2 and a maximum value of 5. The standard deviation value was 0.800 and the mean value was 4.15. The variable Q7 regarding the statement of the respondents that they were forced to go to rehabilitation centers obtained a minimum value of 1 and a maximum value of 5. The standard deviation value was 1.294 which was lower than the mean value of 4.4. This indicated that the data were evenly distributed. The variable Q8 regarding the statement of respondents that they attended rehabilitation due to environmental pressure obtained a minimum value of 1 and a maximum of 5. The standard deviation was 0.702 which was lower than the mean value of 4.56.

The variable Q9 regarding the respondent's acknowledgment that they often got pressure from the environment obtained a minimum value of 1 and a maximum value of 5. The standard deviation of 1.241 that was lower than the mean value of 4. The last variable Q10 regarding the statement of respondents that they were not under pressure and burden as drug users obtained a minimum value of 1 and a maximum value of 3. The standard deviation of 0.629 was lower than the mean value of 1.36

6. Conclusions

The theoretical work formulation of lifestyle-related shaming is derived based on elaboration of propositions from the theories of reintegrative shaming, lifestyle and routine activity, and desistance. Lifestyle-related shaming is an attempt to embarrass or not to make drug use a lifestyle. This was performed by refracting 3 (three) aspects, namely ethical identity, shame-guilt, and elements of drug relapse (nonutilitarian, negative, hedonistic). Therefore, lifestyle-related shaming plays a role as an effort to overcome drug relapse by using shaming, lifestyle, and desistence approaches (see Figure 2).

The researchers integrated such theories and approaches as follows:

1. Interdependence element was adjusted for variables such as age of >20 years, ever married, being employed and having a middle-high level of education (Junior High School to University). This element was explained based on observations on the demographic data in Indonesia, especially regarding the study site of Jakarta area as one of the cities with the highest drug relapse rate in Indonesia.
2. Communitarian element was adjusted for the addition of lifestyle variable. This element was studied by looking at the conditions in urban areas of Jakarta which is very closely related to changes in lifestyle among urban communities (Hindelang, Gottfredosn, & Garofalo, 1978).
3. The implementation of rehabilitation in the form of a therapeutic community aims to reintegrate drug offenders back into society. Therapeutic community as part of the method provided by the government for drug abusers in Indonesia was analyzed based on the macro theory of reintegrative shaming proposed by John Braithwaite.
4. Former addicts who have been declared "clean" are vulnerable to being re-exposed to the retreatism subculture (Cloward & Ohlin). This subculture is developed based on the lifestyle context which was a novel finding regarding drug relapse cases in Indonesia.
5. Former addicts who experience infiltration of the retreatism subculture have the potential to become drug relapse residents.

6. Drug relapse is faced with lifestyle-related shaming efforts. Lifestyle-related shaming functions as a form of shaming adapted from reintegrative shaming, desistance and lifestyle routine activities.
7. Lifestyle-related shaming has the potential to become a desistance for residents after drug relapse.
8. Desistence is able to suppress drug relapse residents to return to being a former addict.

Furthermore, the researchers developed provisional conclusions regarding the theoretical framework of Braithwaite's reintegrative shaming compared to the data findings.

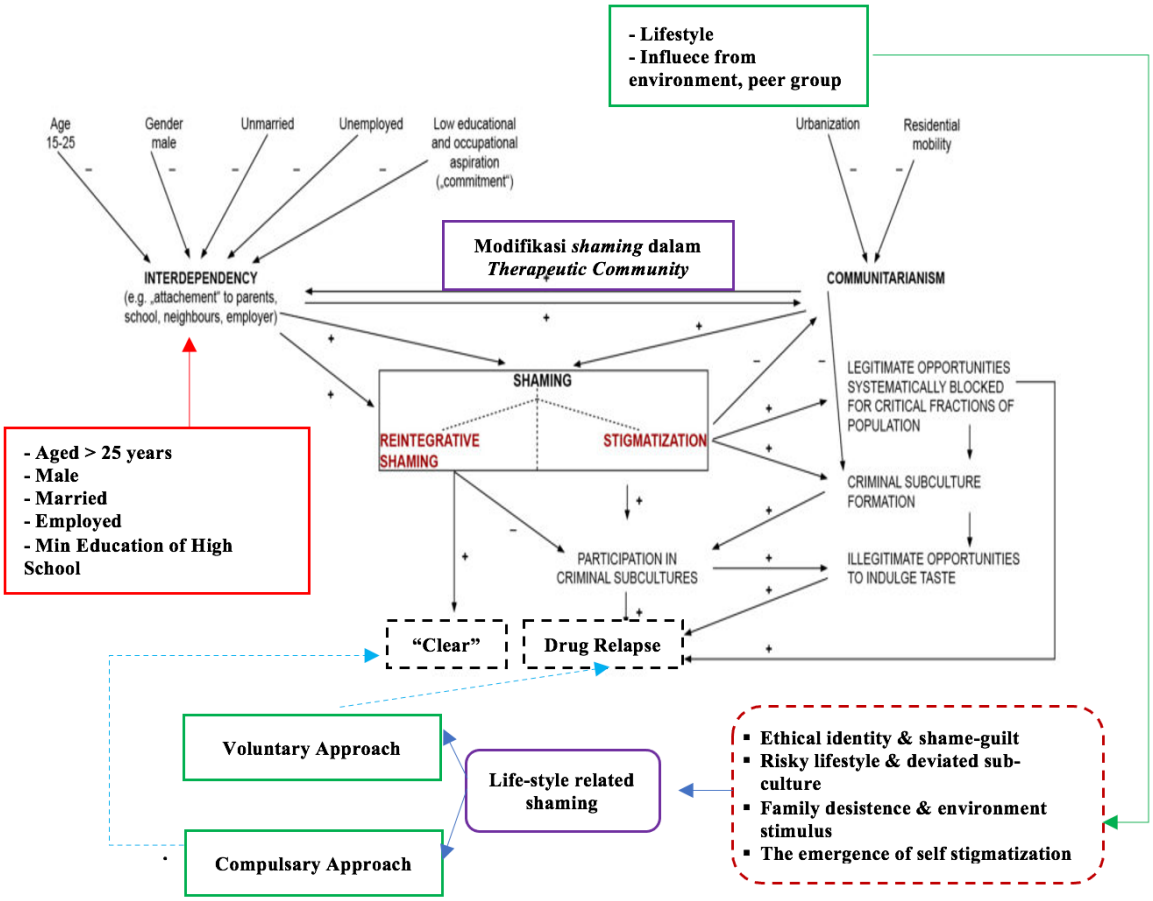


Figure 2: Illustration of Theoretical Framework for Reintegrative Shaming Based on Lifestyle Related Shaming

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