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**Discovering Cessation Strategies Used Successfully by Individuals
Who Are in Recovery from Methamphetamine Addiction**

**A thesis
submitted in partial fulfilment
of the requirements for the degree of**

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Abstract

Methamphetamine (MA) misuse is a recognized health issue in New Zealand, and there is a lack of appropriate treatment available for individuals who are methamphetamine dependent. This research sought to gain insight from individuals in New Zealand who have experienced MA dependence and now identify as being in recovery, to discover which strategies, approaches or treatment appeared helpful in their recovery.

The participants in the research were seven adults who had abstained from methamphetamine for six months or more. Hermeneutical Phenomenological research was conducted through in-depth interviews, which were audiotaped and transcribed before being analysed. The data were analysed using interpretative phenomenological analysis, which has its theoretical origins in phenomenology and hermeneutics.

Four themes emerged to describe the lived experience of recovery from methamphetamine misuse: Getting Away, Support, Personal Sources of Strength, and Treatment. Each theme held importance in the participant's recovery from MA and provided insight into their journey in abstaining and being in recovery.

This research should provide valuable information for further research to be conducted on this important health issue. The findings may also be used to assist others who want to enter recovery but do not know how, or what may help them.

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Key to Transcripts

The following abbreviations and conventions have been used in the presentation of research findings, including the excerpts from the interview transcripts.

<i>Italics</i>	the words used by the study participants themselves
Names	all study participants are identified by the use of fictitious names
(brackets)	comments added by researcher to provide explanation or clarity
Bold	words or phrases emphasized by the study participants

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Glossary of Terms

ATS	Amphetamine-type stimulant – includes amphetamine, methamphetamine, methylenedioxy, and ecstasy.
CBT	Cognitive-Behavioural Therapy
CM	Contingency Management
CNS	Central Nervous System
DSM	American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders
GP	General Practitioner
INCB	International Narcotic Control Board
IPA	Interpretive Phenomenological Analysis
MA	Methamphetamine
MHS	Mental Health Services
SCT	Social Control Theory
SLT	Social Learning Theory
UNODC	United Nations Office on Drugs and Crime

Chapter 1

Introduction

Methamphetamine has had a great deal of publicity, with some of the headlines, images and news reports providing insight into some of the harm that use of this drug has been associated with. Recent headlines in New Zealand such as “Fleet double murder” in which an uncle and nephew were killed in 2017 after a botched methamphetamine cook (Owen, 2019), and “Meth psychosis blamed as man accused of killing his mum and torching her house” (Weekes, 2019), highlight the crimes that have allegedly been associated with individuals under the influence of methamphetamine.

Methamphetamine (MA) is a synthetic drug which is a member of a family of drugs known as central nervous system (CNS) stimulants, titled amphetamine-type stimulants (ATS), comprised of amphetamines-group substances (primarily amphetamine, methamphetamine, ecstasy and methcathinone). Other drugs in this class include cocaine, ephedrine, and methylphenidate (Weisheit & William, 2009). MA comes as a clear, crystal-like compound or as a powder that can be used by snorting, injecting, inhaling or ingesting. The powder can be ingested orally or by inhaling via the nostrils, and the crystal compound is normally smoked through a glass pipe. Methamphetamine powder or crystal can also be made into a solution and injected or inserted in the anus and absorbed via the anal mucosa (Fields, 2017).

MA is a substance that does not occur in nature and must be synthesized in a laboratory. There are many street names including speed, crank, crystal, ice, meth, chalk, chicken powder, peanut butter-crank, go-fast, crystal meth, shabu-shabu, glass, go qip, and chris depending on the geographical area, the dealer and the form, crystal versus powder (Fields, 2017). Despite legal restrictions that countries have imposed on methamphetamine, it is one of the most frequently used drugs worldwide and is recognized as an important health issue (United Nations Office on Drugs and Crime (UNODC), 2019).

Providing effective treatment for MA dependence is a growing need. There is knowledge that can be readily sourced on what the drug is, its effects, how it is manufactured, the seizure rates and trafficking of the drug, but less is known about the treatment options and

how well these are working. It has been established that there is a need to look further at treatment options and recovery (Stoneberg, Shukla & Magness, 2017).

If we would like to reduce the spread of MA misuse and have success in treatment and recovery from MA dependence, we need to identify what past users themselves view as having helped them beat the addiction. Service users have detailed knowledge and understanding of their own health status, support needs, and aspirations. These individuals know better than anyone else the pains and struggles of addiction and the excitement of successes and hold the understanding that could perhaps provide the information required to understand what strategies, approaches or treatment would be helpful for recovery from MA (Bloom, 2016).

Therefore, the aim of the research is to gain insight into the strategies, approaches or treatment that have been deemed helpful by individuals who identify as being 'in recovery' from methamphetamine dependence and have abstained from methamphetamine for six months or more.

I begin with a personal account of why I decided to conduct this research, then the remainder of the introduction provides relevant background on the health issue (history, the global issue with MA, health consequences), the nature of drug dependence (definition, diagnosis, models of drug dependence) and the experience of drug dependence and recovery (treatment options, experiences of recovery, drug dependence and recovery in New Zealand).

1.1 Background of Research

I have become increasingly aware over the last few years of the MA problem within New Zealand. From my own experience working in an organization dealing with clients that have mental health issues in New Zealand, I noted that many of these individuals had drug issues and I gained first-hand insight into the difficulty for some who were seeking appropriate treatment for MA use. It was difficult for them to find appropriate treatment services and they presented with a devastating form of dependence, that had led them on a downward spiral, and caused much destruction within their lives. MA stands out as a drug that has severe consequences and causes much harm and distress to the user, and also to the user's family, friends, and the wider community.

It was this insight from clients, the media, and individuals that I personally knew of or had heard about becoming affected by MA, and the harm caused in communities from MA, that led me to want to conduct research on this phenomenon of concern. I carried out a literature review to see what research had already been conducted on MA. I found available literature on what MA is, how it is used, initiation of use, and the effects of MA, but there had been less attention on treatment options and successful recovery outcomes. Most of the studies had been conducted overseas, and there was little to be found about recovery from MA in New Zealand, or the meaning of this from a consumer perspective. It became evident that there was a need for further research on recovery from MA and that the scientific field could benefit from this.

This prompted me to conduct an exploratory study and gain insight from individuals who have lived experience of identifying as being 'in recovery' from MA dependence to see what approaches have helped or contributed to their journey of recovery, in the hope that this would provide useful information for the scientific field. It was my hope that this research could potentially provide data that would prompt further research on the area of treatment and recovery.

1.2 History of Methamphetamine

Amphetamine was first produced in Germany in the late 1880s and has been named the 'parent drug' of methamphetamine, which was first synthesised in 1919, by a Japanese scientist (National Institute on Drug Abuse, 2018a). Amphetamine and methamphetamine produce similar physiological responses, but methamphetamine differs from amphetamine in that, at comparable doses, much greater amounts of the drug get into the brain, making it a more potent stimulant which has longer lasting and more harmful effects on the central nervous system. MA is also easier to make, and the powder is soluble in water, making it allowable for injection (Narconon International, 2019).

Nothing was done with the drug from its synthesis until the late 1920s when it was seriously investigated as a cure or treatment for nearly everything from depression to decongestion. In the 1930s amphetamine was marketed by an American pharmaceutical company Smith, Kline and French as an over the counter inhaler to treat nasal congestion, named Benzedrine (Weisheit & William, 2009).

During World War two, German pharmaceutical company Temmler marketed methamphetamine tablets as a non-prescription drug under the name Pervitin. This was provided to Japanese, American, British and German military personnel, as the drug produced adrenaline, heightened alertness and a willingness to take risks, and therefore the soldiers would use it to enhance endurance and ward off fatigue for long campaigns. American pilots also swallowed 'pep pills' newly marketed as 'methamphetamine' by global manufacturer Burroughs Wellcome (Roll, Rawson, Ling & Shoptaw, 2009).

When the war finished in 1945, ample supplies of the drug were available. In 1949, New Zealand drug companies, like their counterparts in Britain and America, began marketing pure amphetamine as an appetite suppressant. There was cause for concern when reports emerged among long-term users displaying paranoid and psychotic behaviours. Despite this, through the 1950s local amphetamine use continued virtually unregulated as new varieties, such as the Burroughs Wellcome global brand Methedrine, came on the market. The drugs on the market came under scrutiny in New Zealand when a New Zealander shearer died after taking Benzedrine to increase his chances when attempting the world shearing record. In 1956 the annual conference of hospital matrons at Invercargill requested the health department to impose some sort of control of the sale of slimming pills and that they be made available only by medical prescription (New Zealand Drug Foundation, 2016).

The pattern changed markedly in the 1960s with the increased availability of injectable methamphetamine and the US government began to impose restrictions, making use illegal by 1971. The 1970 Controlled Substances Act severely restricted the legal production of injectable MA, causing its use to decrease (Covey, 2007).

In the 1980s the US began to tighten regulations around the use and sale of ephedrine, a pharmaceutical precursor used to make a crystal form of MA. As a result, illegal methamphetamine laboratories turned to an easier to obtain precursor, pseudoephedrine, a chemical found in many cold medicines (Covey, 2007). This is around the same time that New Zealand was drawing up regulations to ban amphetamines, finally restricting their supply to hospital pharmacies (New Zealand Drug Foundation, 2016).

Despite the tightening of regulations, MA use exploded in the US in the early 1990s. Between 1994 and 2004, MA use rose from just under 2% of the US adult population to approximately 5% (Halkitis, 2009). Mexican drug trafficking organizations set up large

laboratories in California and from there it spread across the US and into Europe, through the Czech Republic and other parts of the world (Halkitis, 2009).

New Zealand's MA problem developed from the late 1990s and the growth in use was not identified or responded to swiftly enough, allowing for speed of drug market development with a high prevalence rate among the population. Methamphetamine laboratories were established in New Zealand in the early 2000s, and by 2005 the drug was truly established in New Zealand society (New Zealand Drug Foundation, 2016).

1.3 Global Aspects of Methamphetamine

Methamphetamine has been recognized as one of the most frequently used drugs worldwide, and an important health issue that requires close attention. International organisations such as the International Narcotic Control Board (INCB), United Nations Office on Drugs and Crime (UNODC), and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) work to produce accurate statistics at an international level on prevalence of use, production and manufacturing, costs associated with drug use, drug seizures and arrests, drug trafficking and more. These organizations work in collaboration and exchange information and knowledge, in order to enhance understanding of the global drugs phenomenon (European Monitoring Centre for Drugs and Drug Addiction, 2018).

Information from these international organizations, as well as other sources, have been used in this chapter with the focus of providing insight into MA trends from the time period of 1990 to the present. It needs to be noted that, when providing information on MA, data and statistics are often representative of the amphetamine group substances ATS, but statistics solely on MA are reported on where possible. The information provided will look at global trends, while also providing information specific to New Zealand.

From its explosion of use in the 1990s, there was a continuous increase in amphetamine and MA production, with production peaking in 2000. China and Thailand together accounted for 70% of global meth seizures in 2000-2001 and seizures from other Asian countries added another 15% of the world total (UNODC, 2017). It had been identified through the UNODC 2001 World Drug Survey that East and South East Asia had high levels of MA use, with Thailand ranking the highest, and Australia ranking second before America and Europe (UNODC, 2001). The import of MA into Australia started in the late 1990s and large-scale

shipments occurred from 2000/2001 allowing for an increase in supply and demand (European Monitoring Centre for Drugs and Drug Addiction, 2018). The Philippines also reported especially high use of MA, with an astounding 92% of all clients in treatment for drug abuse suffering from MA related problems in 1999, and an established link between the rising levels of use and unemployment being a cause for serious concern (UNODC, 2001).

The UNODC 2003 Global Drug Survey reported an estimated 34 (0.8%) million individuals had abused amphetamines, which was a slight increase on the previous year, with the highest abuse rates coming from the same countries; East and South-East Asia, Europe now taking second place, followed by Australia and the United States (UNODC, 2003).

Amphetamines were accounting for approximately 10% of treatment needs on a global level, and the number of globally dismantled laboratories used to produce MA had steadily increased from 547 in 1990 to 17,853 in 2004. An overwhelming amount of the laboratories were dismantled in North America, mainly the United States, and to a lesser extent, Mexico. They were also dismantled in East and South-East Asia, South Africa, and Oceania (UNODC, 2004).

The issue of MA in New Zealand, as in other countries, had steadily increased since the late 1990s and New Zealand's dismantled laboratories increased from 1 in 1998 and 9 in 2000, to 201 in 2003, before lessening to 182 in 2004 (UNODC, 2004). This caused a change in legislation with MA being reclassified in New Zealand in 2003 as a Class A drug, which gave police greater search powers and the ability to impose longer prison sentences. An increasing number of New Zealanders receiving treatment for drug abuse were identifying MA as their primary drug of abuse with 10% of treatment episodes in 2004 involving MA, and MA being identified as the third most commonly abused drug in New Zealand, following alcohol and cannabis (New Zealand Drug Foundation, 2016).

The global trends for prevalence of use indicated a slow rise from 2000 to a drastic increase in 2005, with stabilization of prevalence then occurring in the 2006-2008 period. This was attributed to the control programmes, prevention programmes, and growing awareness of the risks associated with MA. The ephedrine and pseudo-ephedrine needed for MA manufacture were also much more difficult to source than in the later 1990s and early 2000s when the market was rapidly expanding. The reduced availability of pseudoephedrine-based

cold medicines, combined with sustained law enforcement seemed to have had a dramatic impact upon domestic manufacture of MA in America especially (UNODC, 2008).

By 2008, the 2008 UNODC World Drug Report stated that approximately 20 million individuals used amphetamines within the last year, of which an estimated 15 or 16 million were using MA. This figure was similar to that for heroin or cocaine at a global level for 2008 data, for the first time in many years, as MA usually exceeded global levels of these drugs. The problem use of MA in Oceania was still documented as high despite signs of a declining trend, and still reported as one of the highest in the world with the prevalence of amphetamine use in Australia at 2.7% among the population aged 15-64 in 2007 and New Zealand at 2.1% or approximately 80,000 among the population aged 16-64 (UNODC, 2008). The New Zealand Arrestee Drug Abuse Monitoring programmes measure drug and alcohol use among people who have recently been detained by police and New Zealand found MA the second most commonly detected drug (10%) in 2008. (UNODC, 2010). MA related convictions in New Zealand rose significantly from 2004 when there were 1167, to 2009 when there were 2435. In 2009, the New Zealand government launched the Methamphetamine Action Plan, a response to the reportedly large number of MA users at that time (European Monitoring Centre for Drugs and Drug Addiction, 2018).

By 2015 national experts considered MA to be the most used drug in China, Mexico, Japan, Philippines, and Singapore. Quantities of MA seized increased by 12 percent to a record high of 158 tons. The amount of MA seized had been increasing over the last few years, likely as a result of increased law enforcement, but it was also a reflection of a growing market for the drug. In Oceania, quantities of MA seized increased in New Zealand from 15kg in 2013 to 0.4 tons in 2015 and in Australia from 2.3 tons to 5.4 tons over the same period (UNODC, 2015).

The New Zealand Drug Harm Index explores the costs and harm of drugs at a personal level and community level. It stated that in 2014/15 amphetamine-type stimulants caused a personal harm cost of \$256 million and a community harm cost of \$92 million. There was \$16 million put towards intervention costs and, in comparison with other drugs, this was the second highest overall, with the highest being cannabinoids. The government put \$15 million into initiatives to reduce the drug in 2016 but the New Zealand Police have reported that the availability of the drug has increased, and they have not been able to tackle the issue or have success in reducing it. Documents released to the press show police seized more than twice

as much methamphetamine in 2016 than any other year but this has had no effect on the availability of the drug (Meth Xpert NZ, 2019).

Up until 2016 New Zealand methamphetamine was mainly coming into the country from China and South East Asia. Since then Mexico has manufactured to New Zealand, having identified New Zealand as paying a high price for MA. To indicate the mark-ups and profit margin comparisons, in Mexico you can get 1kg of MA for \$1000, the USA pays \$5000-\$7000 for 1kg, and New Zealand pays \$150k-\$200k for 1kg. This kind of mark-up was tremendous (New Zealand Herald, 2019). The global drug survey did not show clear data for New Zealand, but the New Zealand Health national survey (New Zealand Ministry of Health, 2016) found 0.9% of New Zealanders (aged 16-64 years) reported using amphetamines in 2014/15, similar to rates found in 2011/12 and 2012/13. The most recent New Zealand Health Survey 2015/16 found that participants aged between 25-34 had the highest prevalence of methamphetamine use (2.4%), followed by 16-24 years (1.6%) and lowest in 55-64 years (0.3%). Male use was significantly higher than female at 1.7% versus 0.6% for females. Māori were found to have used more than non-Māori with 2.9% of Māori adults using, compared with 1.3% non-Māori (New Zealand Ministry of Health, 2016).

In 2016 the new president of the Philippines, Rodrigo Duterte, introduced the 'war on drugs' in which he vowed to eradicate drugs and individuals who used drugs by any means possible, including death. Since taking office on June 30, 2016, the anti-drug campaign had led to the deaths of over 12,000 Filipinos by the end of 2017, and in 2018 the president vowed to continue his murderous campaign (Human Rights Watch, 2018). About 275 million people worldwide, which is roughly 5.6% of the global population aged 15-64 years, used drugs at least once during 2016. 192 million used cannabis, 34 million used opioids, 34 million used amphetamines and prescription stimulants, 21 million used ecstasy, 19 million used opiates and 18 million used cocaine in 2016 globally. These statistics showed an increase had occurred in the use prevalence of global amphetamine use (UNODC, 2018).

The 2017/18 New Zealand Health Survey results for amphetamine use in the past 12 months indicate a prevalence of 0.7%, which is an estimated 26,000 adults. This is a lower percentage than 2015/16. The survey found that participants aged between 24-34 (1.5%) had the highest prevalence, followed by 15-24 (1%), and 55-64 (0.1%) had the lowest, which shows the same pattern as in past surveys. Māori use (2.3%) remains comparatively different

from non-Māori use (0.7%). The most recent government statistics show that the overall numbers of people who use MA in New Zealand have remained relatively consistent in the past five years (New Zealand Drug Foundation, 2018).

Anecdotal evidence suggests MA use is more concentrated in some communities than others and although overall usage of MA is low at a population level, misuse of the drug remains a serious concern, particularly in some communities (New Zealand Drug Foundation, 2018). Analysis of drug metabolites in wastewater has found rates of MA use in Whangarei are two to four times higher than in Auckland or Christchurch, which is consistent with anecdotal reports of high rates of use in Northland. The results showed an overwhelming dominance of MA with nationwide use equating to \$1 billion a year and an estimated \$20 million per week in social harm. The Assistant Commissioner of Police described the data as the "best information New Zealand has ever had" (Beynen, 2019).

ATS were the second most commonly used class of illicit drugs globally in 2018 and the decline in levels of use reported at the start of the decade in some regions of the world, had been reversed in recent years (O'Donnell et al., 2018). The 2018 World Drug Report (UNODC, 2018) indicates that markets for MA are extending beyond the usual regions and continue to rapidly grow, despite successes in shutting down popular trading platforms. Every year it seems there is an increase in seizures and a new record for the largest seizure number, however, MA continues to be one of the leading drug issues in many parts of the world.

So, what is methamphetamine doing to people? What sort of effects does it have on an individual's level of functioning, health and wellbeing, and what are the symptoms of such a substance? The next section provides information on the effects of MA.

1.4 Health Consequences of Methamphetamine Misuse

Individuals use MA for reasons which can include physical or mental performance enhancement, experimentation as a social activity, escapism from inner issues, or through peer pressure. There are aspects of an individual's environment, biology or own personality and genetic makeup that can cause them to be more susceptible to the drug. This can include mental illness, socioeconomic status, social relationships, culture/ethnicity, hereditary predisposition, and trauma-related events (New Zealand Drug Foundation, 2018).

Central nervous stimulants such as MA act upon neurotransmitters, which are chemicals that send information between brain cells. MA targets three neurotransmitters: dopamine, serotonin, and norepinephrine and all three play a role in the effects of the drug. Dopamine influences body movement, memory, attention, problem-solving, core body temperature, hunger, mood and the pleasure centres of the brain. Serotonin acts on influencing mood, sleep, sexuality and appetite and norepinephrine plays a large role in attention and ability to concentrate (Weisheit & William, 2009). When identifying MA users, some of the common characteristics include signs of agitation, excited speech, decreased appetites and increased physical activity levels. Common symptoms include dilated pupils, high blood pressure, irregular heartbeat, chest pain, shortness of breath, nausea and vomiting, diarrhoea, and elevated body temperature (Halkitis, 2009).

MA is a powerfully addictive stimulant that poses a great risk to overall wellbeing. MA has a short half-life (rate of time it takes for half of the drug to no longer be in the bloodstream) and therefore the user will often repeat use, which results in the onset of rapid dependence in comparison with other drugs such as alcohol. The cross over from the initial time an individual uses MA to when they reach loss of control and become dependent on the drug can be rapid for MA users, and generally the dependence on the drug occurs and takes a hold of the individual's life long before they acknowledge it or can see what has happened (Halkitis, 2009).

Gordon & De Jong (2018) state that once this dependence on the drug has occurred, tolerance to the drug develops quickly, with users needing to increase their dose, which in turn leads to magnification of the side effects. The seven stages of MA that individuals who have developed dependence tend to go through are:

1. High amounts of dopamine in the brain creates rush, excitement, and pleasure. This lasts 30 minutes.
2. High – focused and awake and gets a false sense of importance and intelligence. This lasts for 4-16 hours.
3. Binge - uncontrollable use of MA until nothing creates the high anymore. Lasts 3-15 days.

4. Anger, rage, and hallucinations take control. This stage is the most dangerous lasting hours or days.
5. Sleep – body function shuts down and the body enters a state of deep sleep, lasting 1-3 days.
6. Hangover – exhaustion, dehydration, and hunger cause mental and emotional damage, lasting 2-5 days.
7. Withdrawal happens or goes through the cycle again.

Heavy use can result in neglect of self-care routines such as sleeping, eating, personal hygiene and exercise, which can lead to sleep deprivation, malnutrition, and dental damage. Long-term use can cause anxiety, depression, and damage to the nervous system and susceptibility to infectious disease. The lack of sleep can induce drug psychosis, and intravenous use increases the risk of contracting diseases such as HIV/AIDS (Gordon & De Jong, 2018). Users can have occasional episodes of sudden and violent behaviour, intense paranoia, visual and auditory hallucinations. There can also be a tendency to compulsively clean and groom, and repetitively sort and disassemble objects such as cars and other mechanical devices or to spend hours invested in a hobby that includes use of the user's own handy work and concentration (Halkitis, 2009).

These effects have a devastating effect on an MA user's life as they often neglect their families, friends, and communities, and become burdens to society instead of contributing members. They then often lose their jobs, money, and family and can hit 'absolute rock bottom' before realizing they need to do something about the crippling effects this drug has had on their lives (Roll et al., 2009).

Chapter 2

The Nature of Drug Dependence

2.1 Definition of Drug Dependence

The definition of addiction or drug dependence and the difference between the two can be difficult to understand. Some organizations have different definitions, use the words interchangeably or even abandon both terms altogether. In this research, the terms 'methamphetamine misuse' and 'drug dependence' are mainly used in place of 'addiction', as these are less derogatory terms.

When the term drug dependence or addiction is used, this usually refers to a physical or psychological dependence on a substance. Drug dependence is marked by a change in behaviour caused by biochemical changes in the brain after continued substance abuse and characterized by the symptoms of tolerance and withdrawal. While it is possible to have a physical dependence without being addicted, addiction is usually not far from being reached. It is also possible to have psychological dependence, without physical dependence, as it depends on the type of drug used as to how the addiction and withdrawal symptoms work (Addiction Centre, 2019).

Addictions are persistent and drive individuals to continue to take substances that are harmful to them. Although addiction used to be thought of as a sign of moral weakness, it is now understood by the majority of organizations and providers working with drug use as a condition that is caused by changes in the brain due to the use of addictive substances. Addictive drugs stimulate pleasure and motivation pathways in the brain much more strongly than natural rewards and therefore repeated exposure to these drugs can cause the brain to prioritize substance use over normal and healthy activities (Drug Abuse, 2019).

2.2 Diagnosis

The term diagnosis means to identify the condition, disease, disorder or presenting problem. It has been established that MA is a highly addictive substance and when abused regularly it is possible for someone to become dependent on it. This means that the person is unable to control how much and how often they use it, they develop a tolerance to it, and they experience withdrawal if they try to stop using it (Roll et al., 2009).

When individuals disclose their MA use to a health practitioner, screening and assessment are initially important so that knowledge can be gained on current and past MA use, other drug use, level of dependence, physical and psychological health, withdrawal factors, social factors, trauma history and readiness for change. Gathering this information is important because it provides the background needed in order to help establish whether there is a drug dependence issue and the level of treatment that would be required. Alongside this information, in order to make a formal diagnosis, the American Psychiatric Association's Diagnostic and Statistical Manual is used (Gordon & De Jong, 2018).

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM) is a diagnostic guide used for psychiatric diagnoses, drug dependence disorders, and disabilities. The DSM-5 is the fifth and latest edition, which was created with more than 400 experts from 13 different countries and was published in 2013. The DSM-5 recognizes substance-related disorders resulting from the use of nine separate classes of drugs: alcohol, caffeine, cannabis, hallucinogens, inhalants, opioids, sedatives, stimulants (including amphetamine-type substances such as methamphetamine) and tobacco (Hartney, 2018). The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorder, fourth edition, had amphetamine use disorder and cocaine use as separate drug dependence disorders but these have been combined into a single stimulant use disorder in DSM-5. This change was made from the previous DSM-IV due to the similarity of effect for amphetamines and cocaine (American Psychiatric Association, 2018). In order to meet criteria for an MA related substance disorder (classified as a stimulant use disorder) the criteria in the diagnostic manual are as follows:

A pattern of an amphetamine-type substance, cocaine, or other stimulant use leading to clinically significant impairment or distress, as manifested by at least two of the symptoms in

Table 1 (American Psychiatric Association, 2018) below, occurring within a 12-month period.

A **mild** stimulant use disorder is defined as the presence of two to three of the symptoms.

A **moderate** stimulant use disorder is defined as the presence of four to five of the symptoms.

A **severe** stimulant use disorder is defined as the presence of six or more of the symptoms.

Table 1: DSM-5 Criteria for Substance Use Disorders

The stimulant is often taken in larger amounts or over a longer period than was intended
There is a persistent desire or unsuccessful efforts to cut down or control stimulant use
A great deal of time is spent in activities necessary to obtain the stimulant, use the stimulant, or recover from its effects
Craving, or a strong desire or urge to use the stimulant
Recurrent stimulant use resulting in a failure to fulfil major role obligations at work, school, or home
Continued stimulant use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the stimulant
Important social, occupational, or recreational activities are given up or reduced because of stimulant use
Recurrent stimulant use in situations in which it is physically hazardous
Stimulant use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the stimulant
Tolerance, as defined by either of the following: <ul style="list-style-type: none"> • A need for markedly increased amounts of the stimulant to achieve intoxication or desired effect • A markedly diminished effect with continued use of the same amount of the stimulant

Note: *This criterion is not considered to be met for those taking stimulant medications solely under appropriate medical supervision, such as medications for attention-deficit/hyperactivity disorder or narcolepsy.*

Withdrawal, as manifested by either of the following:

- The characteristic withdrawal syndrome for the stimulant (refer to Criteria A and B of the criteria set for stimulant withdrawal, p. 569).
- The stimulant (or a closely related substance) is taken to relieve or avoid withdrawal symptoms.

Note: *This criterion is not considered to be met for those taking stimulant medications solely under appropriate medical supervision, such as medications for attention-deficit/hyperactivity disorder or narcolepsy.*

It is important for health practitioners when conducting an assessment, screening tool or making a diagnosis, to ensure it is culturally appropriate. It is important for the health practitioner to have insight into what the individual's culture is and the cultural norms that surround this. For example, careful information gathering is required to determine the presence and content of delusions and hallucinations because when unusual beliefs or sounds (e.g., spirits) are described by indigenous people, it may be that these thoughts are part of their cultural beliefs so the content should be carefully checked (Jenner & Lee, 2008).

The withdrawal symptoms that are experienced by MA users, even after long periods of abuse, do not include physical withdrawal symptoms like vomiting and shaking. MA use creates more of a psychological dependence than a physical dependence and therefore withdrawal is more likely to produce psychological symptoms such as depression, anxiety, and cravings (Drug Abuse, 2019). Dependence and addiction are medically treatable conditions. The goal is to separate the individual from the drug in a slow and controlled way to allow the body to readjust to a normal level of functioning (Drug Abuse, 2019).

2.3 Models and Theories

Models and theories of drug dependence are used to identify causes and explanations for the development of substance use and addiction. These have been useful in providing a framework for clinicians in understanding addiction, guiding treatment approaches, and influencing how they work with clients and collaborate with colleagues (McCrary & Epstein, 2013). No single theory is sufficient in explaining drug dependence and therefore we look at a range of theories which provide different explanations for the factors and elements involved. There are a large number of theories and models that have been proposed by certain authors to help shape and understand practice, and therefore they cannot all be given mention, but this section provides a sample of some of the most dominant theories in the field. The main theoretical models of drug dependence essentially fit into four frameworks: Biological, Psychological, Sociological and Biopsychosocial (Teesson, Hall, Proudfoot & Degenhardt, 2012; Goode, 1993; Rassool, 2009).

Biological

The biological theories of drug dependence focus on physiological and genetic factors and include the Disease, Genetic and Neuroscientific theories. Disease Theory dates back to the 1880s when it became popularized through the development of Alcoholics Anonymous (AA) through the efforts of Bill Wilson. In the 1970s, the medical community and treatment professionals incorporated the Disease Theory into treatment programmes (Margolis & Zweben, 2011). This theory states that addiction is caused by a physiological deficit making the person unable to tolerate the drug. Certain races of individuals are more susceptible to certain drugs than other people. For example, some individuals may be highly responsive to the effects of MA after trying it once and develop a fast dependency, whereas some do not experience this. There are differences in individuals' levels of responsiveness to the drug due to the differing levels of reinforcement experienced, and the differences in the ability to physiologically deal with the drug's effects (Fisher & Harrison, 2013).

Disease Theory states that diseases are incurable, progressive and fatal if left untreated. The theory states that if the individual has the disease, it never goes away, and no treatment method will allow the addict to use again without the danger of a return to problematic use. Therefore, the aim of treatment is abstinence from all substances, as the belief is that ingestion of drugs, even small amounts, leads to loss of control (Lewis, 2014). The theory has

been challenged and criticized for being theoretically weak and unscientific, but the Disease Theory is considered more humane than some theories and has allowed for less blame to be placed on the individual with drug dependence which has enabled drug users to seek and receive treatment without fear of stigmatisation (Lewis, 2014).

Genetic Theory states that individuals have a genetic predisposition and vulnerability to using and developing dependence on drugs. Many of the studies testing this have been based on alcohol, rather than other drugs such as MA, and the degree to which genetic factors play a part in drug dependence needs further investigation, but a number of studies have been conducted in the form of family studies, adoption studies and twin studies. These studies have suggested that drug dependence is linked with genetic or induced biological abnormality of a physiological, structural or chemical nature and, depending on the substance, 40-70% of the risk in developing dependence can be attributed to genetic factors (Rassool, 2009; Teesson et al., 2012). Experts have discovered many loose relationships between genes and addiction but none definitive enough to declare a single gene responsible. There has not yet been a single way found to diagnose or provide prevention that is based solely on genetics (Fields, 2017).

Neuroscientific theories focus on the effects that drugs have on the brain. Neuroscience with the aid of neuroimaging is gradually revealing how the brain changes as a consequence of regular drug use (Fraser, Moore & Keane, 2014). Different drugs have different effects on the brain, and with regards to MA Teesson et al. (2012) state that "MA directly stimulates the release of dopamine independently of neuronal excitation. MA also inhibit the reuptake of the catecholamines and directly stimulate catecholamine receptors, increasing overall activity" (p. 37). Despite different drugs having different primary actions on the brain, there are two major pathways which have been implicated as being common to the effects of most drugs of dependence and these include the dopamine reward system and the endogenous opioid system (Teesson et al., 2012). Some addictive drugs, such as MA, produce more than 10 times the dopamine that is released naturally, making drug use pleasurable and rewarding. Dopamine responses decrease with chronic drug use as neural pathways adapt to the drug use and the brain responds to overstimulation by decreasing the number of neurons that are able to respond to dopamine which reduces the overall responsiveness of the dopamine reward system.

After drug taking ceases, the decreased responsiveness of the dopamine system explains the sense of withdrawal, depression, and lows that often follow (Fraser, Moore & Keane, 2014). The brain's endogenous opioid system is also involved with the increased dopamine levels and providing rewarding effects, but also has other functions including reducing pain, developing tolerance to the drug, and dysregulation when the drug is removed from the system (Teesson et al., 2012). Fraser, Moore & Keane (2014) explain the differences in the two systems by stating "The dopamine reward system is said to be associated with the incentive, preparatory aspects of reward, which are experienced as thrill, urgency, or craving whereas the opioid system is associated more with the hedonic aspects of reward, such as the feelings of enjoyment that follow use of a drug" (p. 38).

Psychological

Psychological theories can be grouped into Psychoanalytic, Personality and Behavioural Theories. Psychoanalytic Theory derives from the work of Sigmund Freud, who is famous for discussing the human mind and its role in unconscious behaviour. This theory suggests that individuals are driven by unconscious drives and that, developmentally, individuals go through a series of psychosexual stages as children, with drug dependence being attributed to conflicts in these stages of development, sensual satisfaction (avoidance of pain and anxiety), and conflict among the id, ego, and super-ego. The id is the biological component of the personality that includes one's instincts, such as sexual and aggressive drives and hidden memories. The super-ego operates as a moral conscience and the ego is the realistic part that mediates between the desires of the id and the super-ego (Rassool, 2009). Drug use is used to provide relief and the hypothesis states that, rather than simply seeking escape and euphoria, individuals are attempting to medicate themselves for a range of painful emotional states (Margolis & Zweben, 2011). There are major methodological problems with psychoanalytic studies and limited empirical evidence has been found to support the theory, but Freud's Psychoanalytic Theory has formed the basis for many other current theories (Rassool, 2009).

Personality Theory states the importance of personality traits in the formation and maintenance of dependence and asserts that there are certain personality traits that change the likelihood of an individual becoming dependent on drugs (Rassool, 2009). Hans Eysenck proposed a psychological 'resource model' in which drug dependence develops in order to fulfil a certain purpose that is related to the individual's personality. Eysenck suggests there

are three major and independent personality dimensions: P (psychoticism), N (neuroticism) and E (extraversion) and that for some individuals drug-taking behaviour holds benefits, even though it also produces negative consequences. Psychoticism refers to character traits such as aggression, impersonality, and impulsivity. Neuroticism refers to moodiness, irritability, and anxiety and extraversion refers to talkativeness, assertiveness, and excitability (Teesson et al., 2012). Some theorists argue that individuals have an 'addictive personality' and longitudinal studies of children have found that, in general, adolescents who are rebellious are more likely to use drugs. These studies suggest that personality vulnerabilities may lead to later drug use (Teesson et al., 2012).

The Learning and Behavioural theory states that individuals learn through observation/reinforcement and direct experiences. Individuals learn through observation that substances can be used as a form of coping, with stress, depression, anxiety or anger, to feel more relaxed or sociable, or to escape the pain. This can be observed through family, the media, friends, etc. For example, as children, they may observe their parents coping with stress, depression, anxiety or anger by drinking alcohol or smoking cigarettes. Substance misuse is a maladaptive coping mechanism but is common due to the effects that substances can have on altering an individual's state of mind. That teaches others who are observing this behaviour that substance use is a way of coping (Fields, 2017).

Individuals who observe this behaviour and see the outcome may decide they would like to try that as well. A lot of individuals haven't learned proper coping skills, so substance use can appear to be an attractive option when observing others doing it. If there is enjoyment and the substance use provides pleasure and reinforcement to want to repeat the behaviour, then the individual likely will (Fields, 2017).

These individualistic approaches to understanding drug use have resulted in the Moral Model. The Moral Model originated during the early 20th century. It was the predominant theory of substance abuse up until the 1930s and has driven treatment programmes for decades. A Moral Model has been advanced by practitioners, political leaders, and the general public to the present day and states that addiction or drug dependence is the result of moral weakness and a consequence of personal choice (Rassool, 2009). The theory describes individuals as capable of making decisions whether they use the substance in a problematic manner or not, and the theory states that individuals often use the substance to

cover up their negative feeling state or underlying pain, which can include associated character traits such as envy, anger, sadness, or pride. When individuals use the substance, it allows these feelings to temporarily go away which reinforces the choice to continue this action. Therefore, the more that the substance is used to escape the underlying problems, the more dependence on the drug develops (Fisher & Harrison, 2013).

The Moral Model holds that it is important for the individual to have treatment in order to work on the underlying problems and help them to live a fulfilling life, without making a choice to use drugs. This theory has contributed to creating a stigma about addiction and addicts and therefore is a controversial theory due to the confronting message it sends around accountability and self-ownership of the issue (Fisher & Harrison, 2013). Disease Theory differs from Moral Theory in that addiction is viewed as a primary disease and this can, therefore, help to reduce the stigma that drug users feel with the Moral Theory (Fisher & Harrison, 2013).

Sociological

Goode (1993) states that biological and psychological theories tend to emphasize individualistic factors whereas sociologists tend to make broader, structural factors the focus of their theories (p. 73). Theories that will be discussed include Sociocultural Theory, Social Learning Theory and Social Control Theory. The sociocultural theory was created by Lev Vygotsky and expands on the learning and behavioural theory by stating that the initiation of addictive behaviours is supported by influences in the environment, media, and social circles. The media is constantly trying to promote materialistic or luxurious items for individuals to purchase, and the 'popular' or 'cool' looking cars, and fashion, are displayed frequently in one's environment. There can be peer pressure in social circles to want to look good or prove something to others by the number of items one has when in reality what individuals truly need is a lot more basic (Fisher & Harrison, 2013).

The influences in one's environment can differ dramatically depending on the cultural environment, and with regards to substance misuse some family or social circles may be encouraging of this and some may not be, which can also impact on decision making. Relapse is common if there is peer pressure from social circles to continue using. The Moral Model explained drug dependence as a matter of personal choice caused by character deficiencies, but this theory provides factors that are external to the individual and includes

factors such as cultural, religious, family, social circles and psychological factors (Fields, 2017).

Social Learning Theory (SLT), theorized by Albert Bandura, suggests that drug use begins and continues through modelling, positive and negative reinforcement, expectancies, and an individual's own sense of self-efficacy (Margolis & Zweben, 2011). Modelling involves observing and then copying that observed behaviour. Observing drug use by others allows individuals to develop the sense that it is appropriate behaviour and learn how to successfully perform such behaviours themselves (Margolis & Zweben, 2011). The extent to which drugs are used or avoided depends on how reinforced or rewarding the behaviour was, such as experiencing euphoria or pleasurable emotions from MA, or how much negative reinforcement is experienced, such as comedowns and withdrawal symptoms (Goode, 1993). Goode (2011) states "If the rewards or reinforcement outweigh the negative reinforcement, the individual will develop, and continue to reinforce, patterns of drug abuse". Studies suggest that 'expectancies' can be a more powerful determinant of drug effects than the actual physiological properties of the drug itself, and that most individuals 'expect' they will have positive reactions after using drugs in the sense that they expect they will feel more socially assertive, competent, have pleasurable emotions and enhanced experiences (Margolis & Zweben, 2011). The greater the level of self-efficacy an individual has, the less likely they will respond inappropriately in a situation, and as a result individuals in treatment learn how to effectively deal with their stresses and issues, and learn to anticipate future stresses to avoid situations that may trigger states of stress and increase the desire to use drugs (Margolis & Zweben, 2011).

Social Control Theory (SCT), as developed by Travis Hirschi in 1969, suggests there are four major social bond elements: attachment, commitment, involvement, and belief. If individuals attain these elements in their lives through the social bonds they have developed within their families, communities, and environment then the theory suggests they are less likely to commit deviant acts such as using drugs (Goode, 2011). Deviant acts result from an absence of social control, weakened social bonds and SCT also argues that deviant behaviour is caused by childhood upbringing and the lack of parenting that promotes children to learn a sense of discipline and self-control (Goode, 2011). Walter Reckless, one of the first theorists to discuss this theory after it was developed, proposed two types of control that individuals use to restrain from committing deviant acts. These include inner containment

and outer containment. Inner containment is restraint from within a person and outer containment is a factor preventing a behaviour because of a factor within the environment. For example, these would both be present in the case that the inner containment was embarrassment, and the outer containment was a security camera being in place. These two elements may prevent an individual from using drugs in the family home (Bowser, Word & Seddon, 2014).

Biopsychosocial

The Biopsychosocial Model assumes biological, psychological and social factors contribute to drug dependence and all three components are recognised under this model. Many models of addiction could be criticized for failing to attend sufficiently to social and environmental factors, but this model takes into consideration a broad range of factors and recognises that biological, psychological and social factors are all important factors which interact in the result of addiction (Rassool, 2009). The Biopsychosocial model provides a holistic approach for health professionals to work with, and by adopting a multi-dimensional approach this model has provided a new conception of drug misuse that focuses attention towards a new set of questions about the nature and process of addiction (Rassool, 2009).

Chapter 3

The Experience of Drug Dependence and Recovery

3.1 Treatment Options

Methamphetamine misuse is a global issue and multiple sources repeat that further research is required to understand which approaches or treatments would be effective in reducing the use of methamphetamine (Jenner & Lee, 2008). The 2018 World Drug Report (UNODC, 2018) stated that drug treatment and health services continue to fall short with the number of individuals suffering from drug use disorders who have received treatment remaining low. According to the report, some 31 million individuals who use drugs suffer from drug use disorders, meaning their drug use is harmful to the point where they may need treatment.

The 2018 World Drug Report (UNODC, 2018) also reported international data that identified that users of MA reported high rates of wanting to use less or to seek help, second only to tobacco users. A survey in Australia of over 130 MA users reported that when given the choice of who they would be most comfortable to seek help from, 38% chose friends or family members, followed by 29-31% for health professionals such as a general practitioner or psychologist (Gordon & De Jong, 2018).

Despite their desire to use less and seek help, in a review of treatment research Halkitis (2009) states that MA users do not typically seek help until they present with severe consequences. This is typically because they are enjoying the drug's effects too much to want to seek help, and when things go on a downward spiral and they do seek help, they are then highly addicted to the drug due to the prolonged use (Jenner & Lee, 2008). The literature suggests there are a range of individual and service level barriers that can prevent MA users from getting treatment. Barriers can include embarrassment or stigma, lack of funding and resources, privacy concerns, lack of awareness regarding treatment options, limited access to services, and lack of supports (Halkitis, 2009). Another big issue undermining the success of MA treatment options is the significant shortage of providers with expertise in this specific drug addiction and an unavailability of appropriate services (Cannon, 2018).

Services generally have a poor record of attracting MA users into treatment in the first place (engagement) and keeping them in treatment (retention). However, research shows that overall outcomes for MA users are improved by establishing a firm relationship (rapport), family support for the user, greater treatment satisfaction, and longer retention in treatment (McKetin et al., 2017).

To date, no one modality to treat MA dependence has been identified as fully effective, either in community-based, clinical or research settings so this is already a barrier for individuals to be integrated into an appropriate and successful treatment. However, there are some treatment approaches with some evidence of efficacy, with further knowledge required to understand what else may be helpful. At present, the Matrix Model remains one of the most publicised and well-respected approaches to addressing MA addiction. Cognitive Behavioural Therapy and Contingency Management are also well supported counselling-based treatment approaches and studies show that the contingency management approach can be useful in conjunction with the behavioural therapy as it allows the individual to engage in other negotiated or contracted desirable behaviours (Weisheit & William, 2009).

The Matrix Model is an outpatient treatment approach that was developed in the United States during the 1980s in response to an overwhelming demand for stimulant abuse treatment services. This model was initially developed and applied with cocaine users and was then adapted to be applied with MA users in the late 1990s (Cobzaru, 2010). This is a comprehensive behaviour treatment approach that combines behavioural therapy, family education, individual counselling, 12 step support, drug testing, and encouragement for non-drug-related activities (Cannon, 2018). The Matrix Model has been refined over time and is implemented through dialogue between a clinician and clients/families in an outpatient setting. The focus is on developing insight through understanding how the drug affects brain function as well as elements of relapse prevention, behavioural changes, family communication, healthy environments and methods to use in maintaining abstinence (Cannon, 2018).

Cognitive Behavioural Therapy (CBT) combines behavioural and cognitive strategies to aid the client in changing thought and behavioural patterns. Cognitive behavioural strategies are based on the theory that in the development of maladaptive behavioural patterns like substance abuse, learning processes play a critical role. Individuals in CBT learn to identify

maladaptive coping strategies and behavioural patterns by applying a range of different skills that can be used to deter the drug use and address a range of other problems that often co-occur with it (National Institute on Drug Abuse, 2018b).

Contingency Management (CM) is a type of behavioural therapy rooted in the basis of operant conditioning. CM can be used as a stand-alone treatment or in combination with other treatment styles. This is an approach in which rewards are provided as positive reinforcement for desired behaviours. For example, vouchers or prizes could be 'earned' if the individual provided a methamphetamine-free urine sample (Halkitis, 2009).

Many addiction services offer a community-based home detoxification service which involves specialist addiction nursing staff visiting people in their own home during the withdrawal period to provide supervision, encouragement, and support as needed. MA causes users to develop psychological dependence as opposed to physical dependence, therefore the withdrawal symptoms will not be of a physical nature and this approach may be successful if the individual has support available through family, peers, and their health professional (Fields, 2017).

With regards to pharmacology, there is very active research on this, but no medication has yet been found to be effective for the treatment of MA withdrawal (Fields, 2017). Research into the effectiveness of a wide range of medications to treat MA withdrawal and relapse has not yet demonstrated the superiority of one drug over another because the medications may cause uncomfortable side effects, or lack of improvement in general (Fields, 2017).

Despite this, medications are sometimes prescribed to help manage symptoms of withdrawal (anxiety, sleep disturbances, etc.), help clients stay off MA, and treat other disorders such as mental or physical health problems. Dexamphetamine has been available for some time in the United Kingdom and is similar in principle to prescribing methadone for heroin dependence. Substitution therapy with this drug is generally reserved for MA users who experience severe consequences from use (Jenner & Lee, 2008). Antidepressant medication may also be helpful in combating the depressive symptoms seen in MA withdrawal, and short-term use of antipsychotic medications has been reported to successfully manage psychoses that occur in intoxication and withdrawal. Of the antipsychotic medications that have been adequately researched, Olanzapine has been

shown to be better tolerated than Haloperidol but both medications have been shown to be helpful in managing psychotic symptoms (Roll et al., 2009).

Residential rehabilitation centres have been evaluated in overseas studies for the treatment of alcohol and opioid dependence but their effectiveness for treating MA dependence has had less attention. However, some overseas studies have shown that residential rehabilitation is beneficial for some MA users who have unstable or no accommodation, poor or absent social supports, co-existing mental health problems, have had repeated failed attempts to cease MA use in the community and present as too severe to benefit from outpatient treatment options. These are typically abstinence-based, long stay programmes and include a variety of treatment models (McKetin et al., 2017).

Due to the rising number of MA drug-related offenses and individuals entering into prisons with MA dependence, one of the treatment methods in place for coping with this has been a slow but progressive change in introducing and providing services in prisons to treat with MA dependence. Prison officials, psychologists, and legislators have encouraged changes in prison systems so that prisoners can safely go through the detoxification process and receive further treatment (Fields, 2017).

If no one treatment modality has been identified as fully effective for treating MA, it raises the question of how individuals are managing to recover from MA dependence? The next section focuses on MA dependence and recovery within New Zealand to look into what options for recovery are being utilised.

3.2 Drug Dependence and Recovery in New Zealand

Information collected by the New Zealand Ministry of Health has indicated a general increase in the number of individuals attending mental health and addiction services with a diagnosis of abuse or dependence on MA. Between 2011/12 the number of individuals with a primary diagnosis of ATS abuse or dependence doubled, and significant numbers of those identified as having ATS use as a secondary issue when attending mental health and addiction services (New Zealand Ministry of Health, 2013). The pattern of contact with services in more recent years is also reflected in data provided by the Alcohol Drug Helpline, which reports that in 2013 they were receiving approximately 300 calls about MA use every few months. These calls were mainly coming from family concerned about someone else's

MA use which is consistent with the pattern of MA users not seeking help until they present with severe consequences (Alcohol Drug Helpline, 2019).

Depending on the length and severity of dependence on MA, some individuals may be able to successfully manage their own withdrawal symptoms in the community without external support, or with support from a GP, whereas some individuals will have the need for greater support when going through withdrawal. In New Zealand there are Community Alcohol and Drug Services and other agencies which offer counselling, family therapy, detox programs in a hospital or at home, medication, and referral to residential treatment programmes if required (Meth Xpert NZ, 2019). Despite there being services in New Zealand to cater for individuals who suffer from drug and alcohol issues, the problem faced by individuals with dependence on MA is the lack of services available or providers who cater 'specifically' for treating MA (New Zealand Drug Foundation, 2018).

Most research on methamphetamine misuse, treatment and recovery have been conducted overseas rather than within New Zealand, so utilising the knowledge discovered overseas has been essential in developing our own framework and guidelines. In 2009 the government made an action plan to address the rising issue of MA in New Zealand and as a direct result of this, the New Zealand Ministry of Health instigated that Matua Raki (the national centre for addiction workforce development in New Zealand) make use of the overseas research and write guidelines for treatment providers. In 2010, Matua Raki released the comprehensive report "Interventions and Treatment for Problematic Use of Methamphetamine and Amphetamine-Type Stimulants (ATS)". In 2013, Matua Raki released a further review in follow-up to the earlier report (New Zealand Ministry of Health, 2010; New Zealand Ministry of Health, 2013).

The reports were prepared to review what treatment for MA works and what doesn't and review current and emerging developments in the treatment of problematic MA use. They were intended to be a 'working guide' for those working with individuals affected by MA including frontline workers, Mental Health Services (MHS), police, general practitioners, addiction treatment providers, counsellors, and emergency departments. The report supports and recommends the few treatment modalities that have been recommended from overseas studies as covered in the 'treatment options chapter' including the Matrix Model, Contingency Model, and working with high dose users in rehabilitation treatment

centres (New Zealand Ministry of Health, 2010). There is support for these reviews from educational providers for MA such as the Dual Recovery Network in Christchurch who promote these reviews to help improve treatment in New Zealand and are advocating to support further use of the Matrix Model into the New Zealand health system (Dual Recovery Network, 2016). However, at present, there is still a need for an expansion in both the number of treatment services that are provided and awareness for the population group on what is available to them (New Zealand Drug Foundation, 2018).

The lack of available services has led to frustration in communities, which has led to grassroots type approaches in attempts at reducing the drug. There are drop-in centres in some regions of New Zealand run voluntarily by ex-addicts and supporters under a group called 'P Pull', treatment facilities which are stretched to capacity with long waiting lists, and there are a few rehabilitation centres which offer specialised services for MA users that have waiting lists and eligibility criteria for potential clients (New Zealand Herald, 2019). There is a rehabilitation centre in the Hutt Valley, near Wellington, which is called 'Red Door Recovery'. Red Door offers the 'Pipe Down Meth Recovery Programme' which is specifically designed to meet the unique and difficult challenges presented by methamphetamine (Red Door Recovery, 2018). There is a rehabilitation centre in Auckland called 'Higher Ground' which has an 8-bed contract through the Prime Minister's Methamphetamine strategy, as well as accepting methamphetamine clients into other funded beds in the wider programme. Findings from the Higher Ground 2011-2014 outcome review indicate that Higher Ground is effective in working with MA clients, with 94% abstinent when followed up at 3, 6, 9, and 12 months post discharge, and 87% abstinent at 12 months (King, 2014). Te Whare Oranga Ngakau is a residential alcohol and drug treatment centre in Rotorua which focuses on providing clinical services within a Kaupapa Māori framework. The 24-hour residential programme has 15 AOD beds and two methamphetamine beds and offers a 12-week programme, or longer if required (Māori and Addiction Treatment Services, 2012).

When looking at drug dependence and recovery, it is important to pay particular attention to which population group has the highest prevalence of use to target interventions for this population group and ensure there are appropriate services and treatment available. In the most recent New Zealand Health Survey, the highest rates of use were in males, people aged from 24-35 years, and people of Māori ethnicity. There was a study carried out in New Zealand in 2010 to discover the most commonly used interventions with MA from six

agencies who dealt with the treatment of MA. The most common interventions were discovered as being Te Whare Tapa Whā and CBT, followed by harm reduction, motivational interviewing relapse prevention, behaviour therapy, brief therapy, group and person-centred therapy (Cobzaru, 2010). Although the Matrix Model and Contingency Model were not mentioned, it is pleasing to see the wide use of Te Whare Tapa Whā which is a therapeutic approach that is culturally appropriate for Māori, and consistent with Māori values and cultural identity (New Zealand Ministry of Health, 2010).

Although globally there has been no medication that has yet been found to be effective for the treatment of MA withdrawal, there is very active research on this both overseas and within New Zealand (Cannon, 2018; Fields, 2017; Halkitis, 2009). Medications in New Zealand currently being considered for therapeutic effects include naltrexone implants and oxytocin, which have been observed to reduce the effects of MA in rats. Vaccines against MA have been developed and are currently undergoing clinical testing for safety, in order to provide individuals with a possible approach in order to combat drug dependence. The vaccines work by antibodies attaching themselves to substances to make their molecules too large to cross the blood-brain barrier (New Zealand Ministry of Health, 2013).

In summary, there is active research on pharmacotherapies globally and within New Zealand so future progress will be made in this area. There are a few treatment approaches which are recommended as being helpful, but further knowledge is required to understand what else may be helpful in the way of treatment approaches for recovery (Gordon & De Jong, 2018). It has been established that there is a further need for research into treatment for MA and a need to know more about recovery. What is the experience of recovery from the consumer perspective? The next section focuses on research exploring this.

3.3 Research on Experiences of Recovery

It is hard to know what 'being in recovery' is like, or to understand what this entails if you have not experienced it yourself (Fields, 2017). Hyshka et al. (2017) conducted a scoping review on substance use services and stated that the empirical literature is dominated by expert-driven approaches to measuring population need for services and service system planning rather than including consumer perspectives, and they identified that consumer-perspectives are critical in driving service provision.

When describing recovery or being 'in recovery', there has been widespread debate on how individuals with past substance abuse problems should identify themselves with regards to their recovery. Is there a point of accomplishing recovery? Or is recovery a lifelong process? (Doukas & Cullen, 2009). Multiple studies suggest that recovery is a life-long process and that abstinence is an important aspect of recovery, but not sufficient. Past users do not see an end-point to their recovery and instead see it as a continuous journey with productive milestones or successes (Costello, Sousa, Ropp, & Bush, 2018; Shinebourne & Smith, 2011; Bloom, 2016; Halkitis, 2009). Costello et al. (2018) discovered when asking former patients of a Canadian residential addictions treatment programme that what 'successful recovery' looked like for them included more than simply 'abstinence', and other areas important to their recovery included spirituality, social relations, psychological well-being, physical health, occupational needs, daily life functioning, and life satisfaction. It was seen that all of these areas were part of recovery and that recovery was multidimensional. For some this was regaining the trust of family members (social relations), returning to work (occupational needs), establishing a connection with oneself or a higher power (spirituality), positive changes in emotions and thought patterns (psychological), or improving one's health with activity or exercise (physical health). Improvement in one area was sufficient for some, while others indicated that change across multiple areas was necessary to fulfil one's own vision of recovery (Costello et al., 2018). Shinebourne & Smith (2011) conducted a study on women who had not used drugs for 15 years or more and were intrigued to find that they chose to continue to identify themselves as 'living with addiction', and to engage in the practice of 'recovering' after all that time. The multidimensional nature of recovery emphasises that achieving 'abstinence' is not to achieve 'recovery'. The concept of being 'in recovery' as opposed to 'being recovered' provides individuals with the ongoing responsibility to be working on the areas of their life that promote the ongoing status of being able to identify as 'in recovery'.

Halkitis (2009) states that substance use can cause severe consequences. Evidence shows that users of MA do not typically seek help or treatment until they are presenting with these severe consequences, such as the findings from a US study conducted by Herbeck, Brecht, Chistou & Lovinger (2014) in which qualitative interviews were conducted with adult MA users. The study found that serious consequences had led the MA users to want to enter recovery, with homelessness, criminal activity, hallucinations, and anxiety being commonly

reported. Many users had been threatened with the loss of their children, or had already lost them, and would likely go to prison if they did not dramatically turn their lives around. Another study by Alexander et al. (2017) identified the term 'Hitting rock bottom' as being the place MA users find themselves when realising they do need help. Hitting rock bottom means the user had nothing left to lose in terms of family, health, possessions, status, wealth. So, due to the negative consequences that have commonly affected multiple areas of MA users' lives, when they do enter 'recovery', it makes sense that there would be a lot of healing and work to do, rather than simply 'abstaining' from MA.

Treatment is an important aspect of recovery. A study in South Africa, in which 260 MA users were interviewed, found that 90% of the users did report they would like treatment but also reported multiple barriers to treatment, including beliefs that treatment would be ineffective and relapse would be inevitable in their social context (Meade et al., 2015). This has been an unfortunate but very real global issue for MA users wanting or seeking treatment, as there is lack of awareness regarding treatment options and no treatment modalities yet identified as being fully effective for treating MA (McKetin et al., 2017). While there is some evidence for the efficacy for psychosocial therapies, their real-world impact has been limited by poor retention rates and treatment adherence among MA users with high relapse rates and few effective preventative interventions options existing (O'Donnell et al., 2018).

Multiple studies talked about the social connections that were made within the 'user community' and the feeling of 'loss' that is experienced in recovery due to the impact of the loss of the 'community of users' that had provided the drug user the experience of feeling accepted and fitting into a community group (Vandermause, 2011; Lay & Larimer, 2017; Costello et al., 2018). Vandermause (2011) conducted a hermeneutical phenomenological analysis of one US woman's story on MA addiction and recovery, in which the experience of 'connecting' was an important theme in why the woman had continued to use, as she found some connection in her drug-using with other users, but realized that their common interest was mainly simply the drugs; in her recovery, she strived 'for an identity that was wholesome, and the desire to feel whole'. There is a common theme of individuals wanting human 'connection' and having their social needs met through the 'user community'. A study using seven stages of meta-ethnography in a US-based study to look at the turning points of MA recovery by Brookfield, Fitzgerald, Selvery & Maher (2019) found that many

individuals move to a completely different location to get away from the social connections they have made, in order to protect their recovery. One of the most common causes for relapse was reconnection with drug using social contacts and the desire to stay 'connected' with the 'community of users' could be strong, so in order to break this cycle it was common for relocation to occur. This is congruent with Sociocultural Theory which states relapse is common if there is peer pressure from social circles to continue using (Gordon & De Jong, 2018).

So, if recovery is a lifelong, non-linear process that encompasses personal growth, learning, challenges, and achievements, how do these individuals remain supported through this process? Radcliffe & Tompkins (2016) focused on understanding how individuals from six recovery communities in the UK were motivated and inspired in their recovery and found that internal motivation, peer support, social networks, and daily structure were integral to supporting individuals to achieve and maintain recovery. Research on the processes of recovery over a long period of time indicates that recovery experience is a complex and dynamic process that changes over time and, for many, ongoing commitment to a recovery program was essential to their recovery (Costello, Sousa, Ropp & Rush, 2018). A US study by Brecht & Herbeck (2013) found that when looking at relapse following treatment for MA use, 13% of the sample of 250 MA users in recovery achieved at least five years of continuous abstinence from MA, whereas 61% relapsed within the first year following treatment, with considerably declining relapse rates in subsequent years. This indicates a high relapse rate for MA use and supports the need for effective treatment and ongoing support being readily available (Halkitis, 2009).

Bloom (2016) conducted a phenomenological study in the US using photovoice (<https://photovoice.org>) to focus on 'turning points' in addiction recovery to help understand how people are motivated and inspired in their recovery. The research showed that turning points were not always big life events and could be as small as waking up early or walking down a certain street. In discovering important aspects of recovery, four main themes emerged which were deemed important to recovery. These included activities, relationships, reflection and motivation, and environment. To have an environment which is conducive to recovery, relationships with family, friends and support networks to access as needed was seen as a necessary aspect of recovery. Structured activities were seen as helpful to setting a new routine without substance use and focusing on the mindset and

being able to think more clearly and focus on things unrelated to drugs was an important and positive aspect of having a life without substance use. A similar study was undertaken in the UK in which 32 individuals were interviewed from six recovery communities about what recovery meant to them. Internal motivation, peer support, social networks, and daily structure were integral to supporting individuals to achieve and maintain recovery. Key benefits of recovery included positive relationships, a sense of belonging, increased self-worth and confidence, employment, and education (Radcliffe & Tompkins, 2016).

In summary, the research shows that users of MA usually want to recover or enter recovery when they have severe consequences such as homelessness, losing their families, jobs and becoming involved with criminal activity. It has been established that recovery is a lifelong process and multidimensional in the factors that are involved. It is difficult for users to walk away from the 'user community' that they have socially connected with and some users see no option but to move location in order to get away from the drug in its totality. There needs to be a strong motivation to stop using, and relapse rates are high so it has been acknowledged that recovery rates would be improved by having effective interventions and treatment options available.

There is a shortage of qualitative research aimed at understanding the lived consumer perspective of recovery from methamphetamine dependence, and none that could be found within New Zealand specifically, which means there is a wealth of experiential knowledge that lies uncovered. Therefore, the aim of this research was to gain an understanding of the strategies, treatment or approaches that individuals living in New Zealand perceive to have helped them recover from methamphetamine dependence.

Chapter 4

Methodology, Theoretical Framework and Presuppositions

4.1 Qualitative Methodology

This section explains the philosophical baseline, theoretical framework, and methodology that was chosen in order to conduct this research.

The research is intended to capture the 'lived experience' of MA recovery. Miller, Strang & Miller (2010) suggest qualitative research is important in capturing how substance use and addiction are lived and uncovering what the experience of recovery is like for individuals. Recovery from substance use is a complex issue, likely too complex or hidden to be easily disentangled by quantitative methodology, and therefore qualitative methodology was used for this research (Hennink, Hutter & Bailey, 2011).

Qualitative research is useful for understanding complex issues, and qualitative methods are particularly suitable for examining sensitive topics such as drug misuse, due to the process of rapport building and the exploratory methods used (Roll et al., 2009). Individuals who take part are referred to as 'participants' as they are seen as participating in the research and telling their story in an interview. Due to the in-depth nature of qualitative research, only a few study participants are required, as the purpose and aim is to achieve a depth, rather than breadth, of information (Hennink, Hutter & Bailey, 2011).

Qualitative research searches for an understanding, or at least an 'interpretation' of the lived experience, with the purpose of gaining a detailed understanding of a certain phenomenon (Moustakas, 1994). Mills & Birks (2014) suggest that qualitative researchers understand the importance of this set of beliefs as well as philosophical assumptions, which provide a framework for understanding assumptions. The research conducted aligns with the philosophical baseline of phenomenology. Phenomenology aims to find the essence of 'lived experience' and therefore all of the research questions need to be about experience, with the aim of uncovering how it shows itself in consciousness (Savin-Baden & Major, 2013).

There are two main theoretical frameworks when determining which phenomenological framework is used. This includes Husserl's transcendental phenomenology and Heidegger's hermeneutic phenomenology. Edmund Husserl formally introduced phenomenology, rooted

deep in the work of philosophers, at the beginning of the twentieth century. Husserl suggested that reality could be grasped by and through structures of consciousness by applying 'intentionality', or intentionally directing one's focus to describe reality (Moustakas, 1994). Husserl proposed that researchers would be required to do phenomenological reduction (the process of bracketing) in which all judgments, pre-understandings, and biases were suspended so that when they were learning about the phenomenon, it was as if they were learning about it for the first time (Savin-Baden & Major, 2013).

Martin Heidegger was a student of Husserl's who branched off to create his own phenomenology which was 'hermeneutic'. Mills & Birks (2014) state "phenomenology becomes hermeneutical when its method becomes interpretive rather than purely descriptive, as is the case in transcendental phenomenology" (p. 184). The notion of *Dasein* 'being there, of being in the world' is central to Heidegger's hermeneutic phenomenology and the concept refers to the fact that there is an aspect of human-ness which is capable of wondering about its own existence and inquiring into its own being. It was from this position that Heidegger rejected Husserl's notion of bracketing, believing instead that in order to understand a phenomenon, the person must first acknowledge his or her own presuppositions or pre-understandings of the phenomenon (Cohen, Kahn & Steeves, 2000)

Heidegger's proposed 'hermeneutic circle' encompassed his philosophy on how the phenomenon can be interpreted. The hermeneutic circle involves an understanding of the 'whole', and 'parts'. Heidegger believed that interpretation was a constant revision, and when analysing the data and finding themes the data can be broken into parts and then synthesized. The researcher would then look at the entire transcript again (the whole), which forms a new understanding. Through that analysis, the parts make sense of the whole and the whole make sense of the parts and the circle continues on and on (Cohen, Kahn & Steeves, 2000).

Heidegger suggests that, as a researcher is interpreting the data, they have their own pre-understanding of that phenomenon. As it is interpreted, there's a revision of their pre-understanding and, as new information is received, they revise that understanding. The researcher revises their understanding of the 'whole' data as they grasp the individual 'parts' of the data, so revisions of meaning happen as the whole meaning emerges from this movement. Therefore, the technique of the hermeneutic circle is for researchers to make

their pre-suppositions or pre-understandings of the phenomenon explicit (Mills & Birks, 2014).

It was determined that hermeneutic phenomenology would be the theoretical framework for this research, after considering the differences between the two theoretical frameworks and the researcher's alignment with Heidegger's views.

This section has introduced qualitative methodology and provided reasoning for why it was utilised for this research. The origins of hermeneutic phenomenology were explained, including the hermeneutic circle which is central to how the researcher understands and interprets the data. The hermeneutic circle emphasises the importance of the researcher identifying their own presuppositions or pre-understandings about the phenomenon, and therefore the next section will provide the researcher's own pre-understanding.

4.2 Presuppositions or Pre-understandings About the Phenomenon of Inquiry

When thinking about how much knowledge I had on MA and MA recovery before undertaking this research, I realise that it was not a great deal. I had completed a semester of papers on alcohol and drug misuse within my postgraduate level papers at university, but MA was not a drug of focus. I also had not worked closely with clients who had entered into rehabilitation for substance misuse. However, when facilitating treatment for mental health clients within an organisation over the last few years, I did gain first-hand insight into the prevalence of MA use and the need there was for suitable treatment. There is an overlap of substance use and mental health when working with mental health clients, as there are a large number of adults with mental health issues who do have struggles with substance use, which needs to be addressed alongside other presenting issues. I cannot pretend to fully 'understand' what it is like to have drug dependence on MA, since I have not personally experienced what the participants in my research have.

Some of my earlier beliefs of MA had developed through the influence of social media, news reports and the horrific acts I had witnessed on the news when the individual being charged and prosecuted was proclaimed to have been under the influence of MA. This, however, didn't mean I fully understood the drug use and abuse, the social, physical and cultural

setting of drug users' lives, along with the symptoms they experience, barriers, and stigma attached with using drugs.

One overarching assumption and pre-understanding I had about MA, was that the drug could have very dangerous consequences for people, and it was a drug that people readily got caught up in and then struggled to discontinue use of. I associated the drug itself as 'devil-like'. The drug appears to take such a 'hold' over the users that they would do anything to keep using, even if it meant losing everything.

I was unsure how individuals could recover from MA or which strategies would be most useful. I knew there was a lack of treatment options and it was seemingly hard for individuals to get the support they required for their drug dependence.

The multidimensional nature of recovery was a very interesting discovery for me, because, naively I had always assumed that achieving 'abstinence' was to achieve 'recovery'. I found the concept of being 'in recovery' as opposed to 'being recovered' interesting as it provides individuals with the ongoing responsibility to be working on the areas of their life that promote the ongoing status of being able to identify as 'in recovery'.

In this research, I have been able to acknowledge the assumptions and pre-understandings I held about drug dependency at the outset, but also the knowledge I gained throughout the process of the research which helped to educate and review my earlier understandings. The next chapter will cover participant selection, data collection, data analysis and ethical considerations.

Chapter 5

Methods and Ethical Considerations

5.1 Participant Selection

Seven participants were interviewed for this research. The purpose of qualitative research is to gain a detailed understanding of a certain phenomenon and therefore this requires a small number of participants, so that the phenomenon can be explored in depth, through their lived experience (Moustakas, 1994). The participants were four males and three females. Ethnicities included European, Samoan, and Māori. Their ages at the time of interviewing ranged from 32 years to 53 years, with a median age of 36 years.

Qualitative research is not intended to be representative of the general population and participant recruitment is not driven by the need to generalize findings to a broader population or to measure the prevalence of an issue. Therefore, random selection of participants is not relevant and will not enhance the robustness of the study findings, as it more important to ensure participants are selected for the richness and depth of 'perceived influences and experiences' through the lived experience that they have (Rice & Ezzy, 1999).

The criteria for participant selection was that the participants were over the age of eighteen and had abstained from MA for a period of six months or more. The participants needed to be both willing and able to articulate their lived experience of identifying as 'in recovery from MA misuse' and the strategies, treatment or approaches that they have found helpful in allowing them to achieve this.

Snowball recruitment was the method employed to recruit participants. This is a common recruitment strategy for research on sensitive topics such as drug use, in which the researcher needs to find individuals from 'hidden population groups' to conduct research with. Snowball recruitment involves finding a participant, interviewing them and then asking if they know others with the experience who may be potential participants for the research and asking them to provide those potential participants with some information on the research, and to contact the researcher if they are interested in participating (Flick, 2014). This was a successful recruitment method and enabled the researcher to source the seven participants.

5.2 Data Collection

Each individual that expressed interest in being a participant in the research was checked to ensure they met the criteria and was either emailed or posted an information sheet to read. The information sheet (Appendix A) outlined what the research was about, what they would be asked to do, what the information would be used for, and what they could expect from the researcher. Participants were given the opportunity to read the information sheet and provided with the researcher's contact number and email so that they could make contact if they had any questions or concerns, or to confirm that they would like to participate in the research. It was made clear that any questions or concerns could be discussed before a decision was made about whether they chose to participate in the research or not.

Once there was confirmation that the potential participant did meet criteria and consented to participate in the research, a suitable time was arranged to undertake the interview. The expected duration of interview time was approximately one hour, as explained in the information sheet. The researcher commenced the interview process with an introduction, overview of ethics and participant rights, and ensured they read and signed the consent form (Appendix B). Each participant was asked whether they would like to use a pseudonym throughout the interview. None of the participants took up this option, but all consented to a fictitious name being used in place of their real name for the purpose of writing the report and keeping their identity anonymous. Once the overview of ethics and their rights had been covered, the researcher ensured the participant was comfortable to proceed before starting the digital voice recorder and the interview.

Mills & Birks (2014) suggest that Interviews are an essential piece of data collection in most qualitative methods of inquiry and there are different interview types that can be chosen. A basic premise of the hermeneutical phenomenological method is that a driving force of human consciousness is to make sense of experience. The understanding people have of their world and life situation and the meaning they have made of this is usually contained in the narratives or stories they tell, first to themselves to make sense of their own experience, and then to others (Cohen, Kahn & Steeves, 2000). These narratives are in-depth and inherently meaningful and hence in-depth interviewing was chosen as the method for this research. This type of data instrument can elicit narrative data from interviews, and this type of data is of most interest when using the hermeneutical phenomenological method. The format is semi-structured rather than being structured, and the emphasis of the researcher

is on listening to whatever the informant says as opposed to guiding and controlling the conversation (Mills & Birks, 2014).

The researcher used the same interview guide for all of the conducted interviews (Appendix C). The format was semi-structured, and focus was placed on allowing the participant to tell their story and provide their experiences. On completion of each interview the researcher explained what would happen with the information, which included the data being transcribed and analysed in order to form research findings, and how it would be stored. The participants were asked if they would like a copy of the transcript to ensure they were happy with the data and make any edits they saw necessary. It was explained that if they chose to do so, they would be given a copy of the transcript once it was available and would also be sent or emailed an 'Authority for the release of transcripts' document to sign (Appendix D). It was also explained that once the transcript had been sent to them, if the researcher did not hear back within two weeks, it would be assumed that they were happy with the data and did not want to make any changes. None of the participants chose to have a copy of the transcript.

The participants were each gifted a \$30 voucher as a token of appreciation for their participation and informed they would receive a 'summary of findings' on completion of the study. The participants were provided the option to contact the researcher if they had any questions or had any further information they would like to add.

5.3 Ethical Considerations

Before commencing any data collection, a full ethics application had been submitted to the Massey University Ethics Committee outlining the research, any safety concerns, and how these would be mitigated. The application was approved by the Committee (Appendix E) following a meeting to discuss the research and some slight subsequent alterations to the research documents.

Qualitative research methods are often applied to topics on sensitive issues, and on asking interviewees about these experiences they may have to revisit painful memories or events in their life which can cause emotional distress (Hennink, Hutter & Bailey, 2011). Therefore, one of the primary responsibilities is to ensure that the potential for harm to participants is outweighed by the potential good of the study, or benefit, to participants or society (Savin-

Baden & Major, 2013). Conducting interviews with individuals who have experienced drug dependence poses a risk of causing triggers and distress through conversing about the topic, and therefore it was imperative that potential risks were mitigated, and safeguards were in place in the event that the interviews did result in negative impacts for the participants. In order to do so, the researcher acknowledged in the information sheet that, in the event that the research did cause distress, the participant should discuss appropriate support with their own general practitioner or contact appropriate support agencies. Contact details were provided for helplines and a local drug and alcohol agency that provides free services, so that they were aware of these available support services. It was not expected for participants to be caused harm, but this was a precautionary measure that was taken to ensure that any harm that could have been caused by the research was dealt with in the right way. It was anticipated that participants would find the interview to be a positive or empowering experience, in which they were provided with the opportunity to share their story of recovery and be a part of research that may lead to helping others in their own recovery.

The information sheet was crucial to ensuring that the participants were fully informed. This is an ethical consideration that involves demonstration of respect for people. This meant that they had an understanding of the eligibility criteria, what the research was about, what they would be asked to do, what the information would be used for, and what they could expect from the researcher. It was important that research participants were fully informed about the procedures and risks involved in research participation before giving their free and uncoerced consent to participate. (Miller, Strang & Miller, 2010).

Privacy and confidentiality were discussed with each participant, and it was ensured that the participant's privacy and confidentiality was respected. Confidentiality assures that any identifying information about participants will not be made available to anyone who is not directly involved with the research. The protection of anonymity ensures that participants will remain anonymous throughout the study. This protection is often used in studies of illicit drug use to ensure that participants do not experience any social harm from taking part in the research (Miller, Strang & Miller, 2010). Data was kept in an anonymized form, by using pseudonyms and having no identifying information available. Each participant was assigned a fictitious name which was used in the research findings and consent forms were kept locked away in a filing cabinet.

Ethical challenges in qualitative research may be more pronounced due to the nature of qualitative research. Phenomenologists recognise the human connection that is developed as lived experience is discussed and the responsibility this connection holds for both parties. The responsibility for the researcher is to establish a rapport but also maintain professional boundaries and balance the need for gathering information and ensuring that participants are not left distressed after discussing a sensitive topic (Cohen, Kahn & Steeves, 2000). This involves careful consideration of the above-mentioned ethical principles, and careful consideration was taken in applying these to the study.

5.4 Data Analysis

Interpretative phenomenological analysis (IPA) was chosen as the type of data analysis that was conducted due to being an approach to qualitative research that has an idiographic focus, which means that it focuses on phenomena that relate to experiences of some personal significance to individuals, such as drug dependence (Savin-Baden & Major, 2013). IPA was developed by Jonathan Smith, and has its theoretical origins in phenomenology and hermeneutics, with key ideas from Heidegger often cited (Savin-Baden & Major, 2013).

IPA is intended for a small number of participants, between 3 to 15, so was ideal for this study with seven participants. With IPA research, the researcher analyses in detail how participants perceive and make sense of phenomena. Therefore, it requires a flexible data collection instrument, which makes the semi-structured interview chosen for this research a good option (Smith, 2008). Once each interview had taken place, the researcher immediately began transcribing the interview before reading and scrutinizing the data, in order to cluster the data into common themes, to develop the descriptions of experience (Moustakas, 1994).

Each interview was transcribed and analysed one by one, as Smith (2008) suggests “it is advisable to begin by looking in detail at the transcript of one interview before moving on to examine the others, case by case” (p. 67). Analysis in IPA is ‘bottom up’ which means that the researcher generated codes from the data, rather than using a pre-existing theory to identify codes that might be applied to the data. IPA studies do not test theories but are often relevant to the development of existing theories (Smith, 2008). Each interview was read, listened to, and analysed a number of times to ensure that the researcher had a good understanding of the information the participant had provided.

The researcher used a data analysis software programme to code the data. Once the data was coded and themes were found, the emergent themes were listed on a separate document so that the researcher could look for cross-participant themes. This stage involved a more analytical and theoretical ordering, in which the themes were ranked in order of prevalence. There were 10-12 themes that emerged. Some of these themes were clustered together, which reduced the findings to four main themes, with some emerging as superordinate concepts (Smith, 2008).

These themes were developed and formed the findings of the research (Smith, 2008). This form of analysis is iterative and involves a close interaction between reader and text. Smith (2008) argues "It is important to remember that qualitative analysis is inevitably a personal process, and the analysis itself is the interpretative work which the investigator does at each of the stages" (p. 67).

Chapter 6

Introduction of Findings and Themes

The findings section will begin with a summary of the participants' initiation into using MA, their using, the consequences of using, and the main recovery strategies or approaches employed. This helps to understand the background of their using history and initiation into recovery, before focusing on the analysis of the recovery data.

6.1 Initiation into and use of MA

The age at which the participants first used MA ranged from 15 to 30 years, with the median age they first used MA being 21 years. All participants said that they were first offered MA in a social setting from a friend, partner or acquaintance. The majority of participants admitted they didn't know what MA was when they first tried it. Some said it wasn't a drug that they understood to have had much coverage in the media or within society at that time, but that lots of people seemed to be doing it (the late 1990s - early 2000s).

Heidegger's analysis of 'being-in-the-world and understanding your own world' is *Dasein*. *Dasein* is the German word for 'being there' and the term refers to the human capacity to comprehend our own existence. Each person has the ability to construct their own existence, from their background and the experiences they have had, and also has the ability to comprehend it (Cohen, Kahn & Steeves, 2000). The experience of the participants' drug dependence has a starting point. To better understand this, participants were asked why they thought that they had initially tried MA. Some participants revealed that they wanted to use the drug to medicate; to not have to deal with their issues at the time. Some said it was the 'cool' thing to do and they wanted to fit in socially with others, and some wanted to purely use it for experimentation of the effects they would get from the drug. The majority of participants stated they had started with trying other drugs such as alcohol and marijuana and had graduated from those drugs on to trying harder drugs, such as MA.

After having tried MA and used it recreationally, the majority of participants found that their usage of the drug increased over time, which developed into dependence on MA. The majority of participants reported that over time the usage increased to using MA daily. Some of the participants admitted that their dependence on MA was so strong that they felt they

needed it to function; to go to work, to get through the day. Despite this, some reported that they were enjoying the effects of the drug at the time.

All participants emphasized that it was an easy drug to get and, through using MA, the majority of participants had become immersed in the 'user community' associating only with other MA users; sharing the commonality of 'using' with these individuals. Heidegger states this can be seen as being rooted in being-with-others; dissimulating one's self-responsibility in terms of conformity with the they-self, which creates an environment in which addiction can flourish (Heidegger, 2010). Despite the drug being easy to get, there was a cost attached and the everyday use meant they needed money to be able to keep supporting their habit. Some of the participants began to associate with gangs to source the drug more easily and a majority decided to deal the drug to make money, and support and feed their own habit.

The participants in this research had used MA for a period of between six months and seventeen years, with the median length of time using MA at six years. Participants talked about their experiences of MA use and the consequences this had on their lives. Participants expressed that they stopped caring about other people and that it was all about them, and the drug. The majority talked about being in unstable and unhealthy relationships throughout their time of using. They became estranged from their friends and family and socially withdrew from them due to the ongoing dependence they had on MA. Participants talked about their physical health suffering: becoming very thin from not eating, barely sleeping, pimples/scabs on their body, trouble with their teeth, and one participant has permanent lockjaw which he believes is from MA use.

Participants said that they struggled with terrible 'comedowns' from MA and the majority experienced psychotic episodes or paranoia from the prolonged use of MA. For some participants, the paranoia and psychotic episodes resulted in violence, aggression and getting into criminal activity and trouble with the law. Some participants also suffered from mental health problems while they were using MA and were trying to manage this alongside their MA use.

Participants also spoke about seeing the first-hand consequences that MA had for other users such as health damage, immorality, illegal behaviour, and suicide. These observations and insights were enough to encourage them to analyse their own lives and assess that

perhaps that was not the lifestyle that wanted to lead or the type of future they saw for themselves. This helped them to want to enter their recovery journey.

6.2 Recovery Period

To better understand how the participants managed to successfully recover from MA misuse, it is relevant to provide some insight into the recovery routes or approaches that were used by the participants. This gives an overall understanding before going into more detail in further chapters.

The seven participants all spoke strongly about 'support', 'cutting ties', and 'getting away' being important in their recovery. Of the seven participants, four had outpatient treatment, two had inpatient treatment (in rehabilitation centres) and the remaining three participants did not have any treatment. The participants that went into rehabilitation centres were provided with support with abstaining from MA and entering recovery. The three that did not have any treatment chose the method of going 'cold turkey' or reducing use over time, with a key factor for most participants being family or partner support and having a safe and drug-free environment to recuperate within. Outpatient treatment was also utilised, and this proved helpful for one participant who was given a diagnosis by his general practitioner and put onto medication that was effective in enabling him to function on a better level and abstain from MA.

6.3 Emerging Themes

We will next discuss the analysis of the recovery data. Four themes emerged as being significant to the participants' recovery from MA. These were labelled: 'Support', 'Getting Away', 'Treatment' and 'Personal Sources of Strength'. The first theme, Support, describes the importance that support from others had in their recovery journey. The second theme, Getting Away, describes how participants sought to stay away from other users and dealers, moving location, and cutting ties. The third theme, Treatment, incorporates the participants' inner issues, treatment, and education to better understand how these have impacted on their recovery. The last theme, Personal Sources of Strength, discusses factors that participants expressed as being helpful to their recovery. Included are the sub-themes of motivation and strength, fitness, spirituality, and smoking marijuana. These themes will be discussed in detail in the following chapters.

Chapter 7

Support

All participants identified support as being crucial to their recovery. Support was identified as coming from family, partners, and treatment services. For some of the participants, their first step into recovery was surrendering and admitting to family that they needed help with their MA use, after realising that they no longer had control over it and were experiencing negative consequences. This was a huge step because whilst using MA many of the participants had distanced themselves from their own families and friends. Therefore, when deciding to seek help and support, they would be reaching out to individuals that they had knowingly hurt throughout their time of using MA. This was a brave step in recovery, as participants had to tell the truth, which hadn't always been the case when they were busy trying to hide their drug use. Heidegger relates truth to the Greek word *Aletheia* and states we have a conception of truth as a process that leads from concealment to unconcealment, hiddenness to revelation. Truth creates openness and allows for a new sense of *dasein* (Kemp & Butler, 2013).

Some of the participants interviewed spoke particularly highly about the support they had received from their mother, who had been the one that they turned to once they had decided they wanted to commit to their own recovery from MA dependence. Having this support was a huge aid to their recovery, as expressed by participants in these following exemplars:

I made a decision in my heart that I just had enough. You know, I just couldn't keep doing this. I text my mum, despite my family relationships having had fallen out again, and said to her "Can you come to pick me up?". She text back asking where I was and she came and got me. And I remember sitting in the car and I hadn't had a shower for many days. I was homeless at that time and I'd been asleep for a while, so I was just a mess. She took me home to shower and gave me food to eat and helped me. Ronan

Yeah, I remember we'd go up to mum's (her and her partner). She was a big support. And I'd go up there when I initially was coming off, for days and just kind of eat and sleep and eat and sleep. Yeah, probably for a while actually. Like the beginning part, I can't even really remember to be honest. Yeah. And then slowly, my levels started to

come right and yeah... functioning a bit more normal. Yeah. Because you're going from the night owl time of being awake. And eating better food and all that kind of stuff.

Zara

*I knew it had to end as well, like I couldn't keep living like that and I thought right, well now I actually have something to fight for now (getting back his children) and look for you know, it's sort of made me want to get clean and I talked to my old lady and she was fucking devastated obviously, she knew it was killing me. So, she kind of helped me, grabbed me out and she brought me up here (to her house, in a different location) but she was real good, you know? I said to her "look It's gonna be pretty fucking nasty when I actually start fully coming off it" and shit but she was really supportive. She got me off it. **Brian***

It is important to note that some participants who had family members that knew about their MA use did describe their families having 'reached out' to offer support and encouragement to abstain from MA but the participants were not 'ready or wanting to hear it' at that time. When they did seek the support, it was on their terms and at a time that they had determined was right, to enter into their own recovery. In all of the participants' cases, this was after a period of heavy use and negative consequences that had been experienced.

Having the support from family, for Zara and Brian, meant being able to reside at their parents' house whilst they initially abstained from MA, providing them a safe and drug-free environment in which they could experience withdrawals and comedowns, rest, eat and recuperate. For Blake and Ronan, their parents supported them with going into rehabilitation centres. It's clear that the participants' families wanted to help and aid in the recovery process, and whether it was through providing the help that they could within through their own homes, or supporting the participant into an appropriate treatment facility, that support and love really enabled and fostered hope in these participants lives at that time of initially entering recovery.

Participants also talked about their partners and the role that they played in supporting them. Two participants had partners who were also using MA at the same time; four participants had partners who were not using MA; and one participant decided not to engage in relationships during his recovery. Those with partners who had also been using

MA talked about the importance of discussing abstinence from MA with their partners and making a commitment to starting the recovery journey together.

*Yeah, I think as I say I prepared myself and I think I owe a lot of credit to my partner for the friendship or companionship to help each other through it. So yeah, so I guess just having that support system. Big or small is a big thing. Yeah 'cos I guess in a way we were each other's AA support partners. **Zara***

In the end, he did stop because I basically gave him an ultimatum but he reckons he stopped because he wanted to, that's his story but I think it was because I just said "look I'm not gonna be with a crackhead", you know I chose that life so. We bailed out.

Cathleen

Having someone that understood their recovery journey and could do it alongside them provided comfort and support for these participants. Zara talked about the desire her and her partner had to be achieving things that they saw other couples their age (twenties) achieving, such as buying a house and establishing a career, and the desire for a better lifestyle and future together. She felt the cost of MA and the dependence on the drug was deterring herself and her partner from being able to achieve things in life, so that was a motivator to support one another in changing that.

*And yeah, just wanting to better ourselves, like we never really wanted that lifestyle and we already felt like we were behind the people that are our age you know, that and in regards to having enough money for a deposit on a house and having enough money to go on holidays and stuff. It's a shithole life really. **Zara***

Other participants talked about new partners, whom they found on their journey of recovering from MA, and the impact and help this support had. Allowing a partner into their lives who did not use MA was allowing for a relationship that gave these participants a sense of new direction, with someone whom they believed would treat them well and was not a part of the community they had come from. To Heidegger, the basic relationship between human beings and the world is that of care. Finding a partner whom we believe will provide us with care is significant for one's sense of value and concern for one's self (Davis, 2010).

Yeah. Nah he was because he's a really, really accepting sort of loving guy. Yeah. And, you know, he, he put up with a lot of shit, especially over that time, you know, I was

completely, you know, I was completely fried. But, he just, really loved me and just, you know, he's a bit of a saint when it comes to sort of stuff. I mean, he's not perfect. He's got his own his own crap too, but yeah, I think that was a big thing. Having a guy that just really had my back and not always feeling so vulnerable. Anna

I think the recovery thing is quite cool. Because I've got a story there to tell as well, like, you know come this year? Christmas Day? I was on a beach with this real beautiful girl. And you know, we had an awesome Christmas together and I thought to myself shit you know I could really make something of my life and so I thought fuck it I will you know. Mitch

In summary, the majority of participants 'reached out' for help when their MA use got beyond their control. Partners and family (particularly mothers) were described as being the main supports throughout recovery. Prior friends did not typically form part of the support, as they had become distanced through the period of MA use due to the user instead immersing themselves into the user community. Nor did former associates from the user community provide any support when abstaining and recovering from MA addiction, as the user had cut ties with them in support of their own recovery. Therefore, family and partners provided support at this time. The other people who provided support, through appropriate treatment services, were health practitioners. The role of the treatment and practitioner support will be discussed further in Chapter 9

Chapter 8

Getting Away

8.1 Getting Away Overall

All participants said that the main thing required in 'getting away' from MA dependence was to remove themselves completely from the places, people and associates with whom they had become involved with while using MA. The majority of participants stated that when they were using MA, they only associated with other MA users and became immersed in the 'user community'. As established, they would often push away family or friends who tried to reach out or would isolate themselves and barely see those people due to wanting to remain 'hidden' from being identified as a user by their loved ones. The longer the use, the more the dependence grew and the more they became immersed in the 'user community' with others that were also using. Heidegger (Davis, 2010) terms this 'everydayness' and explains it as "the way we care and what we care for govern our lives to a considerable degree. The energy in our dedications measures the intensity of our lives, and what we commit ourselves to gives our lives their direction and character. Usually, people appear to concern themselves with what most others around them show concern for" (p. 59).

In the following exemplars, the participants describe their experiences and comprehension of needing to get away from the 'user community' within which they had immersed themselves:

*I had to cut people off. You can't do it otherwise. **Anna***

*Yeah, staying away from people that I used to know and be friends with. So, I don't answer any calls from any old people that I know. Um deleted all the numbers. And just, just got to refrain, try and stay away from the place where I was using a lot of meth in the area I lived, so I stay well clear of that place. Too many familiar faces. And yeah, not a good place to be for me. **Blake***

*Just staying away from the people that did it. So, if they ring me up and invite me over, I would make excuses not to go so I just sort of avoided the situation of it. And also, just saying no. I've got quite a strong mind so I can say no, I quit. And they will have to accept that. **Cathleen***

*I changed my phone number and I also have a very private Facebook page with a different name so people couldn't find me. I have kept it low key and cut my ties. **Brian***

*Yeah, I didn't go to like any of the same. Like, you know, places where we would hang out. And then so yeah, so I definitely avoided different places. I'd pretty much like fallen out with, you know, most of the people in that scene anyway, as you do. That's pretty normal in that scene. **Anna***

Emphasis was placed on the need to alter technology and social media so that people from the user community could not find them. This for some meant getting a new phone or deleting contacts and ignoring phone calls. Some deleted Facebook or made sure their profile information and security settings were highly anonymous.

Cathleen said that she did try to remain friends with individuals who were still using MA initially, but when she had decided to abstain from MA the pressure others placed on her to continue to use MA made things harder for her. This reinforced to her that she would need to remove herself from these people. Here is her account:

*It was hard with the pressure, yeah, the pressure was hard because literally everyone was still doing it, so it was like “**God, can't everyone just stop**” you know. Someone would offer me a pipe and I'd say no I quit that, so I'd get used to saying, “oh no thanks, I quit”. And then they're like, “are you sure, you can” and they do that “come on, just one”. I said “no, no, I'm honestly quit”. **Cathleen***

When listening to the personal accounts that the participants gave about their being-in-the-world, and the social connections they had with the user community throughout that time of their lives, it was clear that it wouldn't have been an easy thing to then shut the people completely out of their lives. Being so immersed in a community seemed to provide or give a sense of ‘connection’ and ‘companionship’ amongst these people. The participants had isolated themselves from their families and prior friends in order to hide their lifestyle of using MA but knew there was no reason to need to hide it from fellow users. One participant talked fondly about some of the friendships and experiences he had with other users at that time:

It's a different kind of life. You can pick up your phone at 2 or 3 am in the morning to send a text and it's not like ‘oh’, you know there are certain people that will be awake

*at that time and it was like a little network kind of. Yeah, it was cool. Yeah, I miss some, ya know, there were people I met and genuine, I enjoyed hanging out with them and there was a natural friendship there but still know that it's just tough. Like can't go back there, can't hang out with them. It would be too triggering but yeah there is definitely a little community there that goes along with it. **Brian***

However, it became clear when talking with the participants that some of them had better memories of that time of their life and the social interaction they had with other users than others. They didn't all feel like Brian did and some participants expressed feeling quite keen to rid themselves of the individuals that they had come to know whilst using MA, as one participant said:

*It wasn't a sad thing for me to get away from those people. It wasn't like I was losing a whole lot of dear friends. I didn't really like anyone in the scene. They were totally fucked up. Suicidal you know. Quite a lot of them kill themselves. And it was just horrible. **It was just awful. All of it was awful.** And they were all on drugs. It was just a mess. **Anna***

One participant said that to move forward in recovery from MA, he had the realisation that it would be necessary to associate with a different type of crowd. A type of crowd that would move him forward in life, and support growth and change. As Ronan explains:

*Yeah, I did cut people off. But it was easy. Yeah. You know, the last time around, it was really easy. You know, because I'd learned from, you know, from the first time around, jumping back to the same people and back to the same behaviours, that you know, I learned that it wasn't a good thing to do. You know, so the last time round, it was so easy, you know, but I guess because I'd found this new, being inside of me, that I was attracted to people that were going to move me forward in life. Yeah, you know, and, and I was, **I was definitely put off by anyone who was going to disrupt my life, because I found this new motivation to move forward in life, that I didn't want anyone or anything to disrupt it, you know. Ronan***

In summary, the most prevalent message from all participants when asked how they entered recovery from MA dependence was that it was essential to 'get away' from other users and the 'user community' to be able to move forward and recover from MA dependence. For

some participants, this was easier than others due to the relationships formed with other users through that period of their lives, but participants believed they could not have moved forward with their lives unless they did so.

8.2 Moving Location

Another main finding was the need to remove themselves from the location they had been living in and the places in which they had been using and dealing in MA. Heidegger suggests that to change one's existence and being-in-the-world, this would need to be constructed through the individual's motivations and intentions, understandings and motives moving forward (Davis, 2010). For some of the participants this meant having to move location. They saw this as the only way to remove themselves completely, from the situation and the triggers. This often meant moving to stay with friends or family in an entirely different country, or a different part of New Zealand, and effectively 'starting over'.

I moved 4-5 hours away. And one of the only ways you're going to even think about quitting is removing yourself from the situation. You can't see the same people. You can't be in the same area. Like even half an hour or an hour's drive is not enough. You will drive an hour to go get some you know, but when I moved away, I didn't have anything, I'd sold my vehicle and I had nothing, so I was at the point of being stranded.

Brian

Yeah, I've moved in with my partner to a new location. So, I mean, it didn't stop me. But it's definitely a lot easier just to live a nice relaxed lifestyle up here, rather than being down there (his location when he was using) where it's everywhere and I know too many people. **Blake**

*We just had to move ourselves away from friends, places, I mean still now we go to town and there are places we remember **stuff**. So yeah just fresh beginning, just cutting ties with everything and friends and any associations to that lifestyle.* **Zara**

I thought that if I moved to Australia that might you know; I'd move into a better life. I had friends over there and I thought that would you know, that might be a good thing for you know, for my using and that. So, I left her (his partner) and then moved to Australia. **Ronan**

Participants expressed that moving location was their escape from MA and the life they had been living and that the support in the new location from family would be essential to their recovery. They felt they needed to re-create their sense of being-in-the-world from their environment, to social connections, and removing themselves from easy access to MA.

Chapter 9

Treatment

9.1 Rehabilitation

Of the seven participants, four had outpatient treatment (treatment within the community) and two of those also entered into inpatient (residential) drug and alcohol rehabilitation treatment centres. The remaining three participants did not have any treatment. Of the four that had outpatient treatment, three of them became engaged in the treatment after having gone through the court system due to facing charges whilst they were using MA. They were then referred for treatment to help in combatting their drug and alcohol issues. There was just one participant that voluntarily sought treatment but admits that in hindsight, he was doing it “to keep his family and partner off his case, by leading them to believe that he was trying to curb his MA habit when in fact he states he had no real intention at that time of giving it up and would get high before and after his counselling sessions”.

It was interesting to hear and learn about what their experience of treatment with regards to MA dependence was like and whether it had helped their recovery journey. The participants described feeling that outpatient treatment had not helped them enough, and they did not feel they had treatment that was specific enough for their issue with MA dependence, or that it had enabled them to enter recovery.

*There is no recovery out there. There's no recovery to help people with their problem. Yeah, there's the mental health but they're not very well. We know in New Zealand that you know, you can only think you know you've got to seek a doctor if, you know if things carry on that's all there is to it. You can see your GP; they can refer you on to see a shrink or anything. Talking didn't necessarily help me, helped some other people, you know, they can go deep dark into other people's auras. And they can help them, but it didn't help me. It didn't help my situation. **Mitch***

Yeah, I had outpatient treatment. I was able to use the public health system and get a counsellor in Wellington that I was seeing, but they weren't really doing much for me at all. They would just listen to what I was getting up to really. It wasn't really a help at

all.... I think it was more just a counselling service. Yeah, yeah. They didn't really know too much about drugs and alcohol. Blake

*No, not really. I mean, they, they, I guess they give you some good tools and that to use, like I remember that, they'd always talk about triggers. It was always all about triggers, you know. But yeah... Yeah, so they mean well but their stuff's crap. **No-one's going to come out of the outpatient treatment offered with a new life.** You know what I mean? Yeah. Ronan*

No, No. They didn't really help me to like, it wasn't even it wasn't even really like much help with like, anything to do with the drugs. I you know, I feel like the main thing we were like trying to work on was like more like childhood trauma and. Yeah. Yeah, not really any, like, strategies for dealing with using. Anna

It was clear that the participants had not found the outpatient treatment services offered to them within New Zealand to be sufficient for their needs with the issue of MA dependence. Some participants described feeling as though the drug and alcohol services provided didn't seem to have much knowledge about MA dependence or know how to help them combat it.

After not having success with outpatient treatment, two of the participants, Ronan and Blake, with the support of their families, opted to have more intensive treatment and entered into drug and alcohol rehabilitation centres. Blake entered a programme for one month and Ronan entered a programme for eight and a half months. Both completed their programmes but lapsed after getting out. Blake returned to the programme for a further three weeks and has not had any relapses since. Ronan returned to his programme for four weeks, then relapsed again, which led to another five months in the rehabilitation centre. He has abstained from MA ever since.

Both Blake and Ronan said that inpatient treatment was a positive experience for them, one they found to be very helpful. Blake emphasized the education on drug dependence provided within the facility as being something that really helped him, in understanding his substance dependence and how to combat it. Ronan found inpatient treatment essential for being able to work on his inner issues and resolve these with the clinicians that were available through the service. They provide their accounts of what inpatient treatment was like for them in these following exemplars:

*I found rehab was really good. That helped heaps. I was a live-in patient for four weeks the first time. And we were educated on side effects of drugs, and what damage can be done to your body and ways of coping when we left. **Blake***

*It's a very good rehab. I just went in there full steam, you know, like I was there to do whatever it took to change my life, you know, and I did when I was in there, for five months. **Ronan***

9.2 Mental Health

Some spoke to their GP about concerns they had for their mental health and wellbeing, as they were using MA but were concerned about having mental health issues at the same time, and whether there was some help they could get with this. Heidegger believes that individuals try to escape their reality and inner pain by engaging in numbing activities. The activity creates what Heidegger calls *Uneigentlichkeit* (inauthenticity) which leaves a void within, because of the detachment from *sein* (being). When the individual cannot numb the void inside themselves anymore with those easy activities, individuals turn to using drugs. These activities are even more numbing and lead even further away from *sein* (Steiner, 1978).

It's well known that drug use can be an escape for some individuals, a way to not have to deal with inner issues or emotions, or an escape from mental health issues they are experiencing, without realizing that drug use often exacerbates or is not helpful for mental health conditions. And this is how resolving these inner issues and addressing the mental health issues and getting the right treatment or medication for these issues becomes imperative. Anna and Ronan talked about their experiences with visits to their GPs when they expressed that they felt they had depression:

*Yes, I think I was pretty much on antidepressants that whole time. I first went on antidepressants when I was about probably 19. Yeah. Yeah. I don't think I need them now. **Anna***

*I went to the doctors, like so many times depression, depression, depression. And they don't, they don't really know. There's only so much they can do you know, like, they'll say "we can put you on antidepressants or we can we can point you in this direction". But there's nothing they can do really. **Ronan***

Anna explained that her GP was not aware of her drug use and she was using the antidepressants while using MA and was on them for a number of years before ceasing use of them. She feels her mental health has improved since entering recovery from MA. Ronan described feeling as though the type of support his GP offered him was not effective for him at that time.

One participant's GP was very helpful in enabling a prescription of Ritalin. This support allowed him to recognize that he had been using the MA to help with his symptoms of ADHD and helped him to learn how to function without MA:

The shrinks - yeah, spoke to them about it yeah and the special doctor that prescribes the Ritalin. I spoke to him and he said that he didn't really say much he just said, you know, try this. See if it helps. I told him that's how I got onto it, though (MA). onto the Ritalin. He was you know, he said, "Well, this is going to have the same kind of effect but without any comedowns or anything on it. You'll feel a lot smoother". ...So it does work. You just got to have the right person. it's just it's more like umm I don't know it's like taking drugs. You just got to try to find the right one until you've got it you know, it was the Ritalin that I needed you know, the methamphetamine made me feel good made me stay up made me you know, react with people but it had the bad come downs and stuff it made me feel like crap the next day. The stuff I get from the chemist makes me feel like I can carry on with everything and I don't feel like shit the next day even though it's addictive. I know I'm going to be on it for the rest of my life. But yeah.

Mitch

Having the correct diagnosis and being put on medication that works was really helpful and life changing for Mitch and enabled his recovery from MA. Inpatient treatment was very helpful for both Ronan and Blake but the outpatient treatment has not appeared to be as effective for the other participants, with the majority claiming that they did not find it effective for the presenting issue of MA misuse.

The three participants who did not seek treatment put it down to being stubborn and believing they didn't need treatment to quit the drug, but they had other approaches and strategies they used which they deemed to be very helpful for them, and these will be further explored in the following sections.

9.3 Resolving Inner Issues

Some of the participants explained that they started using MA to cover up inner issues and as a way of not having to address or deal with them at the time. Some participants realised that addressing the inner issues was an important part of understanding initial decisions to use the drug. They believed that addressing these areas could certainly help with their long-term recovery journey and give them an opportunity to make drastic changes within their lives, as explained by one participant.

Yeah. So, to change your life, you have to change everything. You have to really dig underneath, underneath what's going on for you? You know what, you can't just look at the surface stuff. You have to go underneath that, and then underneath that, and then underneath that until it hurts like hell, you know. Ronan

Ronan's recollections provide insight into the hard work he put into understanding his issues and gaining the understanding that he had been using MA for so long, in order to cover these up and not have to face them. When he did face them, he was able to change his life drastically and this was an important part of his recovery. Heidegger (Davis, 2010) suggests that a part of understanding and working on oneself is uncovering the issues that are underlying. He states “Dasein is a being whose essence is determined by what it makes of itself. What I am is what I have created, what I am creating, and what I will create” (p. 75).

9.4 No Treatment

The three participants who did not seek or receive any treatment—Carlene, Zara and Brian—all spoke about other factors that enabled them to cut down or go cold turkey from the drug, and these factors are covered within the other themes and sections. Carlene defined motivation and determination, cutting ties, fitness, smoking marijuana and spirituality as helping her recovery. Zara found moving location, family and partner support, cutting ties, spirituality, motivation and determination, fitness, and smoking marijuana as aiding her recovery. Brian found moving location, cutting ties, family support, smoking marijuana, education and motivation and determination aided in his recovery.

Chapter 10

Personal Sources of Strength

Participants spoke about 'personal sources of strength' that they had utilized in enabling their recovery journey. These personal sources of strength included motivation and strength, fitness, spirituality, and smoking marijuana. All of these things were seen as being helpful to the recovery journey, for reasons that will be explained using exemplars from the participants.

10.1 Motivation and Strength

All but one participant expressed the pivotal role that motivation and strength play in recovery. This personal attribute is something that is seen as required to be able to abstain from MA and enter into recovery from MA dependence. The dependence on the drug and loss of control had become clear for some of the participants, so when they decided there was a need to abstain from MA, they expressed that this had not have worked until they made a firm decision, and utilised motivation and strength in order to stick to that decision and see it through. Heidegger states that individuals become products of their own choices, and the personal attributes they deem to be important, contributes to their sense of self or 'I' and being-in-the-world. Individuals need to see the significant amount of mental stamina required in making changes to their very nature of existence and through this, one's life will be seen at its end to have had some meaning, some significance, some value (Cohen, Kahn & Steeves, 2010).

For some participants it took a few attempts, and for some it took many attempts, at giving up MA before they were finally able to do so. When reflecting on this and why the initial attempts had not been successful, participants admitted that they were not motivated enough at that time. As further attempts were made, their motivation level increased until it was sufficient to enable them to be strong and follow through with their recovery journey. As explained by two participants:

I guess you have to want to get off it. You have to want to change. Zara

I've just been strong in saying no and wanting my friends to respect my wishes. And just sticking to that "no means no", don't push me. Don't tell me to do something I just said I don't want to do, yeah. Cathleen

It became clear from speaking with participants that there needed to be a strong want and desire for a different life to be able to have the strength to let go of the dependence on the drug. Some participants had the additional aid of treatment services but those who didn't solely relied on their own level of motivation and determination to enter recovery and stay in recovery. One participant talked about how they managed to use their motivation and strength to combat their dependence on the drug without having any treatment services:

Nah, I'm kind of stubborn like that. I just went cold turkey eh. Cos I was still very, it's hard to explain, but very opinionated, and almost arrogant. Like I thought, you know, even though I wasn't high, it was still in my system and I was still really, you know it makes it very full of yourself. You know, you think you're untouchable and that. So, nah you know it wasn't in my headspace. It's kind of like, I made the decision to do it, so I could make the decision to put it down. Brian

In summary, mental strength through self-motivation and determination was a key factor for participants in their recovery from MA. For those who didn't have treatment, the mental strength and determination was a crucial factor in successfully entering and being in recovery. For those that did have treatment, it was deemed crucial for having enabled them to enter into it, and to remain in recovery after having received that support.

10.2 Physical Activity

Some of the participants explained that physical activity helped distract them from using MA and helped them to feel better mentally and physically. This also linked in with getting outdoors, being in nature and feeling more physically alive and able. They said this helped them to feel healthier and have more hope for their future while their recovery journey progressed.

Fitness did help a lot. You know, with anxiety and stuff like that. Meth, you know. Later on, in life, I learnt what fitness was. I never had done any fitness. Mitch

Definitely, like keeping active and stuff and going to the gym. I didn't really go to the gym too much near the, because I put on a lot of weight obviously afterward, from being on it and then being depressed and then just sleeping and then just being quite reserved and stuff. Yeah, but still getting out, like we bought bikes and just getting out there and getting active and walking the dog. Zara

10.3 Spirituality

For some participants, spirituality was a part of their recovery journey, in which they established a connection with oneself or a higher power. Ronan experienced spiritual enlightenment when finding God and Christianity through his rehabilitation period and has now fully embraced religion into his life. Cathleen expressed the holistic wellbeing and centeredness she tries to embrace for her sense of spirituality within, which is important to her. Zara talked about being raised with Christian faith and believing the prayers of her grandmother are part of the reason that she has made it through her journey and is still alive to tell her story. For those participants, spirituality was a part of their recovery in differing but equally important ways.

And I was just going over the past. The past couple of years, that were probably the worst. And, and. And I remember making a bed and I remember actually saying a prayer that night. And I remember saying, "God, I've had enough. I need you to step in. I've had enough". Ronan

Yeah, because I was just like right there so many times something could have happened to me and there is where I, sounds a bit cheesy, but believe in like my grandma's prayers or angels or something because there are so many times I've put myself in situations, and my partner, where we shouldn't have come out in one piece or not scathed at all. Spirituality was a big help for me. Umm, I was brought up Christian Catholic. And I've got a real religious grandma and when she was around, she would pray all the time and fast for us and things like that. So looking back on it now I feel like maybe all the prayers and things like that probably helped. Yeah. It has to for some of the shit. Zara

Well, I am quite a generally quite healthy person, so I am into like meditation, naturalness, going out in the bush ya know just really chilling and getting nice quality time. **Carleen**

10.4 Alternative Drug Use

To abstain from MA, and cope with the withdrawal symptoms and psychological cravings for MA, some of the participants said they smoked marijuana. In recovering from their dependence on MA they recognised the need to abstain from MA, but in doing so, they used marijuana to help with this. They explained that this could be seen as trading one drug for another but emphasised that it did help them, as in the words of the participants:

I found smoking a lot of weed helped (to abstain from MA). I've heard that about other people as well. When they come off, that weed really helps. I mean, maybe replacing one for the other but it does sort of help build that kind with the rigidity, the anxiety when you have the jitters and can't sit still and feel agitated. Have a few puffs and it helps with that. **Brian**

Yeah, it helped by taking the edge off. Yeah, it helped. That (weed) helps. Yeah. **Zara**

Oh yeah. It's not like I went straight – I was smoking heaps of pot. I guess what I did was kind of swop one for the other. But I didn't swop one for the other because I was still using all that stuff when I was using the P. It helped to deal with the downers. **Anna**

Some participants also smoked cigarettes heavily in the initial stages of abstaining from MA but did not say that cigarettes helped with their withdrawal symptoms in the same way as marijuana did.

The majority of participants who went 'cold turkey' without treatment emphasised the role marijuana had in helping them with their recovery, over and above participants who were in treatment. Blake and Ronan were in rehabilitation centres, where they were expected to detox within the treatment environment and marijuana would not have been allowed. Blake was allowed to smoke cigarettes in his rehabilitation treatment centre, whereas Ronan was not, and all other drugs were not permitted. Blake did express that when coming out of rehab, he did occasionally smoke marijuana and has continued to smoke cigarettes. Ronan

has abstained from any type of drug, also giving up cigarettes which were a long-term habit for him.

Chapter 11

Summary of Themes

There were disparate ways of coping described by the participants and it was discovered that recovery is multi-dimensional in nature. Whilst the participants were on MA, they experienced negative consequences and entering recovery required them to try to understand the reasons behind their MA misuse such as escapism from their personal issues, or because they enjoyed the effects of the drug. MA is a drug that destroys people's lives and therefore drastic measures are needed in order for people to get away from it, such as moving location entirely and cutting all associates. The participants were at varying stages of their recovery processes, all identifying as being 'in recovery' and having abstained for six months and more. They were able to share the aspects that they felt helped them.

To conclude these findings, it is valuable to also share the participants' thoughts on how they feel about their lives now that they are in recovery, and what they see for their futures. Heidegger suggests that good can come from one's past experiences, past hurts, difficulties and setbacks. Getting through those hurdles allows for hope for the future and the possibility to have things to look forward to (Heidegger, 2010). The participants' lives have changed from living in a world of dependence, to now being able to live the way they want to live, without the need for MA.

In the participants' words:

*It's quite hard to think about now. Because I've stayed away from it for so long. It's not something that's sort of drilled into my brain now. Back in the day, it was drilled into my brain. The minute I woke up that was the first thing I thought about and when I went to sleep at night, it was the last thing I thought about. Yeah, and pretty much every minute of every day was thinking about where my next hit's coming from or how I'm going to sort this bag out or how I'm going to get someone some drugs to make my own drugs or yeah, so yeah, it's definitely a good thing. It was a horrible drug to be hooked on. **Blake***

*I'm a lot happier. A lot slower. So no jumping out of bed at 1130 at night and going for a drive to get drugs. My life doesn't revolve around drugs one bit anymore. It revolves around my family and my work. And yeah, yeah. So looks a lot better. **Blake***

*Yes, things are pretty good now. Yeah. Yeah. No, I'm definitely, you know, glad that's the past, I don't ever want to go back to feeling like that, you know, it's just it's just horrible. You know, the things you see. And that sort of scene it's just real dodgy. It is just horrible. It's just real depressing. **Anna***

*Yeah. That's part of my recovery. Recovery is actually doing something with my life. You know when you go through some really fucked up situations, you can come out looking like a flower. Ha ha ha. Well, I haven't managed to do it yet, but I am getting there you know. **Mitch***

*Pretty wild you know, crazy weekends (sarcasm), the kids. Yeah, just living it up with our two boys and trying to keep energy with them. And yeah. hopeful for the future, I guess. And just trying to keep them busy. **Zara***

So, I just don't want it anymore. I literally don't want it anymore. I'm much better without it; don't like it. Still think about it, but pretty easy to deal with the thoughts and throw them out the door really. Yeah.

*Yeah so, I've got my own place, got a new car, you know, fully furnished, got all my TVs and got my gear back so yeah, have really come a long way. **Brian***

*Yeah. Our friends now, that knew us back then are like "you guys have done so amazing". So that makes you feel kind of awkward, but you know yeah, I guess it's a good, yeah, well it is a good thing. Yeah, it's just amazing. **Zara***

Yeah. You know. And, and now it's been four years. And you know, it's like, I can breathe. Fresh air, you know, and I've been four years without anything. You know, the only thing I have now is coffee. Yeah. But no cigarettes, no smoking, no drinking, no drugs. No woman. No anything aye. And it's got to a point now where, you know, like, about two years ago, it came to a point where I didn't want a relationship anymore, you know? And I just become so in love with my life. And myself, you know, and, and it's just like, I don't want to jeopardize it with anything, you know. And, you know, I

thought, I just didn't know this life existed. Yeah. And, and but it does, you know, yeah. And I was always, people and counsellors would say, "you work hard, and you will reap rewards for it". Yeah. And, man it's so true, you know. And it's funny, because everything that you read in the Bible, in the recovery sense is just so true, you know, and, and just the peace, you know, and I just, I just, I just love life, you know. Ronan

Chapter 12

Discussion

12.1 Discussion

Many theories and models exist to explain the phenomenon of drug dependence, but it does remain a subjective human experience. This research captured the 'lived experience' of MA recovery through the philosophical baseline of phenomenology, and the theoretical framework of hermeneutic phenomenology. The research findings have been consistent with the multiple overseas studies that suggest that abstinence is an important aspect of recovery, but not sufficient. In this study, four significant themes emerged in the experience of the participants: Support, Getting Away, Treatment, and Personal Sources of Strength. These themes and findings will be discussed and analysed in more depth within this chapter.

Support

For Heidegger, Being-in-the-world is Being-with-others and to be Dasein at all means to Be-with. "People, Heidegger says, always find themselves thrown into a world and so 'thrown' into the situations of a given culture as well as into the inevitabilities of being human" (Davis, 2010, p. 59). Marginalization or stigmatism can occur with users, hence why they feel more comfortable to stick together and avoid judgment or concern from others about their drug misuse. Each culture or society has its own norms. The 'user community' has different norms as a societal group than non-users and therefore the participants' sense of Being-in-the-world and Being-with-others shifted when they decided to exit the user community and enter recovery from MA (Wheeler, 2011).

Humans are social beings and the participants found themselves vulnerable and reaching out for support when they cut ties from the 'user community'. Despite the participants becoming distanced from loved ones whilst they were on MA and immersed in the user community, the majority did reach out to their families when they experienced what Heidegger terms 'the voice of conscience' and had determined that the negatives were outweighing the benefits to their drug dependence and entered into recovery (Wosnewski, 2012). Having support from others was emphasised as being helpful by the participants.

Heidegger (2010) suggests that the basic relationship between human beings and the world is that of care. When the participants entered recovery, they wanted to feel care and there was a need for support. The participants said that family, particularly mothers, partners and treatment providers had been the ones to provide this support during their recovery journey. The family support that they talked about receiving included emotional support, staying in the family home which provided a safe and drug-free environment, parents sourcing professional help for the participants, and encouragement for their ongoing recovery. They fondly remembered and spoke about those who helped them through their initial period of recovery from MA dependence and the importance and significance this support had.

All but one of the participants grew up in family homes that did not have drugs present. Participants talked about not knowing about MA or becoming involved in MA misuse until their teen years and onwards. It should be noted that this will not be the case for all users of MA within New Zealand (New Zealand Ministry of Health, 2013). There are some users of MA who have likely grown up around drugs and may not have families who are in the position to support them or to provide them with a safe and drug-free environment to abstain from MA.

Participants that had partners who were also using MA talked about deciding to abstain from MA together and that 'doing it together' provided support and understanding for each other's recovery. Participants that found new partners talked about the safety, acceptance and belonging that this provided them, which supported their ability to be in recovery from MA.

The two participants that entered in-patient treatment talked highly about the support they received from the practitioners and treatment providers within the rehabilitation programmes they were receiving. The support they received included emotional support, psychological support, and knowledge about addiction and recovery. The finding of support being important for recovery of MA is consistent with overseas findings such as Bloom's (2016) study in which 'turning points in recovery' included having an environment conducive to recovery, relationships with family, friends and support networks to access as needed.

Getting Away

All participants emphasised that to abstain from MA and enter recovery, it was essential to 'get away' from the user community and the associations made through it. The companionship gained through the 'user community' meant it was not easy for some of the participants to no-longer associate with those individuals. This is consistent with findings from Vandermause (2011) which suggests that social needs can be met through the user community and there is a sense of loss when losing this. Heidegger suggests (Davis, 2010) "The call of conscience happens as a mood in Dasein, an immediate and indelible feeling of disjunction and homelessness in the world. Amid everyday familiarity and identity there occurs a subtle, quiet, speechless mood of something lacking, or profound instability, of angst" (p. 64). This helps to describe the feelings that some participants may have had, and the vulnerability felt when cutting ties with their known community and entering recovery.

Heidegger explains that the 'care' felt for the user community means there was concern, uncertainty, desirability of responsibility and dedication (Davis, 2010). The decision to enter recovery meant their sense of Being-in-the-world needed to change and they felt they needed to get away from the triggers and the easy access to MA. Despite the care and comradery that some of the participants felt with the 'user community', there needed to be a separation and a divide for their sense of being to create a new future.

To 'get away', some of the participants deemed it necessary to move location entirely. Heidegger believes that one's Being-in-the-world is partially determined by the dwelling in which one lives and emphasises the importance that this has on one's life. "To dwell in a house is not merely to be inside it spatially in the sense just canvassed, Rather, it is to belong there, to have a familiar place there. It is in this sense that Dasein is in the world" (Wheeler, 2011). Moving away from the location allowed them to be away from some of the triggers, limited their access to MA, and allowed them to start their recovery journey with new supports and a 'new beginning' in a new location. These findings were consistent with Brookfield et al. (2019) who found that many individuals move location to protect their recovery. One of the most common causes for relapse was a reconnection with drug-using social contacts and the desire to stay connected with the community of users, so to break this cycle relocation was common.

The barrier with living in a small country such as New Zealand, which has a much smaller population than the countries in which the overseas studies have been conducted, is that it can be harder for MA users to 'get away' from the user community or associates they have made. Also, not all MA users have the option to easily move location, due to limited funds, support, or access. For Māori, the collective culture means that whanau tend to predominantly live near one another, often in the same regions. This could make it harder to move to a new region, away from whanau.

In the case that individuals are struggling to get away from MA dependence within their community or region, overseas studies suggest that residential rehabilitation centres would be beneficial. Especially for MA users who have unstable or no accommodation, poor or absent social supports, co-existing mental health problems or have had failed attempts in the community (McKetin et al., 2017)

Treatment

The study indicated that most of the participants did not seek treatment voluntarily and tended to end up in treatment once they were experiencing negative consequences from MA dependence or had been directed to through the courts from criminal offences that occurred whilst on MA. This finding was consistent with Halkitis's (2009) review of treatment research that suggested MA users do not typically seek help until they present with severe consequences.

The participants interviewed did not deem outpatient treatment (treatment for substance abuse issues provided within the community) to be effective or helpful in treating MA dependence. The two participants that entered inpatient drug and alcohol rehabilitation centres found the treatment helpful and a huge aid to their recovery. The participants that did not have any treatment found support through family and partners, and their own personal sources of strength, to be crucial to their recovery journey.

It was concerning to learn that the participants had not found outpatient treatment to be helpful or effective in aiding their recovery. One participant found his general practitioner to be helpful in formulating a diagnosis and putting him on medication which aided in his recovery from MA, but it was suggested by the participants that the drug and alcohol services that provide counselling and support do not obtain the knowledge or provide the

approach needed to enable recovery from MA. This research did not obtain in-depth information about the type of treatment, or treatment modalities that were provided when the participants had outpatient treatment. The information gathered is based on the participants' experiences and opinions.

It could be suggested that there is a barrier in New Zealand with treatment for MA dependence not being easily sourced. There are a limited number of rehabilitation centres that provide treatment specific for MA dependence and these have criteria to meet before being accepted for entry, with possibly waiting lists, and financial payment required. It also seems that individuals are not sure what treatment is out there or available to them if they were to try and seek it.

The findings cover different types of drugs including illegal and prescribed. Some of the participants found their Being-in-the-world was plagued by low moods and bouts of depression (which is a cause of long-term MA use) so they sought help from their GPs. The GP was generally unaware of the MA use and would prescribe anti-depressants for these participants. It seems the antidepressants taken alongside MA was not replacing the need for MA or fulfilling its meant purpose, so the participants did not talk about having success with that approach. One participant was given a diagnosis and placed on medication accordingly, but the GP was aware of the MA use and able to effectively transition him onto the prescribed medication.

The illegal use of drugs has been mentioned as some participants found marijuana helpful and continued to use this whilst in recovery from MA. Some participants also spoke about continuing the use of alcohol or other drugs but abstaining from MA. Although the participants felt that the alternative drug use was helping them, Heidegger's thoughts on drugs are that people use them to escape basic thoughts and escape the truth by engaging in numbing activities. So, although they are abstaining from MA and using another drug, it could be suggested that if they instead worked on their inner issues it may enable them to not need the use of any drugs. Heidegger states that even moderate use of drugs will push yourself away from *sein* (being) (Davis, 2011).

There are also different implications for these two categories of drug use. One form is legal, and one is illegal. The prescribed medication can be managed and overseen by a health professional whereas illegal drug use cannot. The anti-depressants and Ritalin spoken about

works to help the functioning of the central nervous system whereas marijuana produces a range of psychological and physical effects.

The participants did not mention pharmacology as being one of the approaches or strategies used. As mentioned, there is very active research happening both overseas and within New Zealand to decipher whether pharmacology could be helpful for MA recovery. If it is deemed appropriate, pharmacology and vaccinations will likely be implemented and available in the future to provide further possibilities for treating and preventing MA misuse.

Personal Sources of Strength

It has been acknowledged that there are more aspects to recovery than abstinence alone and that recovery is multi-dimensional. There were aspects of the participants' recovery that they felt helped and strengthened their ability to enter and stay in recovery from MA. These were labelled as 'Personal strengths'. These sources of strength included motivation and strength, fitness, spirituality, and smoking marijuana.

The participants interviewed all had different experiences within their recovery journey, and despite having similarities, no two experiences were the same. The participants used different approaches and strategies when entering recovery. For some participants, their conscious and disliking and judgment of their dependence and lifestyle was enough to know they wanted to change their being-in-the-world. They displayed the authenticity to acknowledge there was a need for change. The individuals who did not have any treatment relied more heavily on their own personal strengths, such as 'motivation' to be successful. There was a motivation and determination in some of these individuals that meant they could abstain from MA, without treatment, but they created a sense of being in the world that was conducive to getting away from their lifestyle, whilst finding other approaches that helped them. Heidegger suggests an authentic way of existing is one that requires individuals to take responsibility for their attitudes and actions. If people allow authenticity, it better enables them to source the personal sources of strength required for them to feel they can combat drug dependence (Davis, 2010).

Past research has shown that spirituality, physical activity, and motivation are contributing factors to an individual's ability to recover from MA dependence (Costello et al. 2018; Radcliffe & Tompkins; Bloom, 2016). Bloom's (2016) study classed internal motivation as

integral to achieve and maintain recovery. This was echoed by many of the participants within this study, especially those who did not enter treatment and relied on their decision-making and abilities. Fitness and physical activity had not been a priority for some of the participants whilst using MA but became a focus whilst in recovery and allowed them to start nurturing their bodies in a way that stimulated positivity and wellness. The effects of drug dependence can mean that their bodies sometimes managed to function with little food or other nourishment, due to drug use and effects. Their Being-in-the-world had changed in a way that they now were able to care for themselves more positively. In the words of Heidegger (Davis, 2010), "In the mood of Angst, Dasein occurs as immediate awareness of its own indefinite possibility and care. It summons itself to care for itself". (p. 65).

Spirituality was spoken about by a few of the participants, who felt there was significant meaning from a higher power that had helped them in their recovery. Heidegger suggests that faith is the believing-understanding mode of existing in the history that is revealed. He insists that whether the account of creation in the bible or any other religious system be true or false is immaterial. Heidegger states (Williams, 2006), "Philosophy can be no more theistic than it can be atheistic. This is not because of any indifferent attitude but out of respect for the limits which have been set upon thought as thought". In the context of drug dependence, faith is an event of participation of the believer in what is believed and the help this provides them is acknowledged (Williams, 2006).

Less documented has been the contribution that marijuana has in enabling MA recovery. The finding that having marijuana had helped participants with their recovery was not a finding I had come across in my literature review of the available research on MA recovery. It was the majority of the participants who did not seek treatment that sought out marijuana and used this to cope with withdrawal symptoms and the initial stages of abstinence and recovery. They emphasised how much it helped them. It could be suggested that there would be risks with the drug leading back into other drugs and possibly lapse and relapse, however.

Overseas studies and research have also found aspects including daily structure, increased self-worth and confidence, employment, social networks, and life satisfaction as areas that

were part of recovery. These aspects were not among the main findings within this research but are acknowledged as aspects that have been found to also be helpful in past research.

12.2 Limitations and Strengths of the Research

Some important limitations are recognised in this research. Firstly, the quality of data that is collected can be highly dependent on the skills and observation of the researcher (Mills & Birks, 2014). This was the researcher's first time conducting qualitative research, so the lack of experience is acknowledged but the researcher ensured a sufficient amount of knowledge was gained before conducting and analysing the data, to produce quality research that provides benefit to the scientific field.

As outlined in Chapter 4 covering methodology, this research is qualitative in nature, with the methodology used being Heideggerian hermeneutical phenomenology. The methodology allowed the researcher to gain knowledge on the participants' lived experience of the phenomenon of drug dependence recovery and interpret their lived experience into findings. The quality of the data gathered in qualitative research is highly subjective. Having individual perspectives and interpretations can lead to detailed data but can also lead to data that is generalized or subjective to one person's view which differs from others. As there was one researcher involved with the data collection and analysis on this research, this was the researcher's interpretation and therefore interpretations can differ among different people, which does cause a limitation. It is subjective in the sense that what one researcher feels is important data may not be considered important by another researcher. In the research process, the researcher made no attempt to conceal her pre-understandings and assumptions and has instead acknowledged them, and in doing so, subjective understanding was lessened.

This research included seven participants. The small sample size does cause a limitation because this number of participants is not representative of the general population, but nor is it meant to be. Because individual perspectives are often the foundation of the data that is gathered in qualitative research, the intention was to gain knowledge from individuals who have rich lived experience on the topic. The data created from qualitative research is not statistically representative and although the findings are valuable, it is not always accepted by the science community (Smith, 2008). The scientific community wants to see results that can be verified and duplicated to accept research as factual. This can be difficult to

accomplish with qualitative research (Grbich, 2013). Another limitation with the small sample size is that it does not take into consideration enough the differences between ethnic groups, age groups, or social groups. The experiences of individuals from other ethnic groups clearly may differ.

The participants spoke about their lived experience, but a limitation is that they only met with the researcher once, for approximately one hour. Although the researcher worked to build rapport, openness, and trust in this time, this may have been further developed had there not been the time constraints, which may have evoked further information and findings. In addition, it is acknowledged that participants were speaking about their pasts and retrospective self-report data may result in some inaccuracies being recorded. However, the participants' apparent very clear and detailed recall of their experiences are highlighted as a potential mitigating factor (Smith, 2008).

Although some important limitations have been recognised within the research, there are also strengths. The strengths of the study were obtaining insight into the experience from individuals who could provide rich depth and information. This allowed the researcher to interpret the experiences they communicated and the approaches, strategies, and treatment that they had found effective or non-effective in their recovery journey.

It has been imperative to learn and get knowledge about MA, as much as possible, and gain insight from the direct source. In doing so, there has been an understanding of the recovery journey and what this looks like, in a sense that could not be as descriptive as a textbook on MA dependence, but from lived experience. Conducting phenomenological research allowed for a process of naturalistic inquiry that sought an in-depth understanding of the phenomena of MA recovery, through lived experience. It allows for participants to be evaluated with greater detail (Grbich, 2013)

The findings of this study are raw and real and provide more in-depth information than data formulated from quantitative methods. Quantitative research is excellent for collecting data but lack the depth of information that is provided from qualitative methods (Savin-Baden & Major, 2013).

The themes and information that have emerged from this research have added to the knowledge about MA and recovery from it, especially with relevance to New Zealand, with

this sort of research not knowingly having been conducted here before. That in itself is a strength and adds to the scientific knowledge base.

12.3 Suggestions for Future Research

It has been established that there is available literature on what MA is, how it is used, initiation of use, and the effects of MA. There is less research available on treatment options and recovery. The majority of the available literature has been conducted overseas, and there is a shortage of research on MA treatment and recovery within New Zealand. It is an important health issue within New Zealand, so further research conducted within the country would be beneficial.

New Zealand's MA problem developed from the late 1990s and the growth in use was not identified or publicly acknowledged swiftly enough, which allowed for the development of a high prevalence rate among the population. Health promotion and prevention strategies were not in effect and the rising availability of the drug has still not been successfully tackled within New Zealand. Research is required to enable effective prevention strategies, intervention strategies, and harm reduction assistance with the aim of decreasing the number of individuals that are trying MA for the first time and reducing the prevalence rates of MA users.

The research on MA treatment and recovery that has been conducted overseas has been utilised to develop guidelines for New Zealand health professionals who work with MA users. These guidelines were released in 2010 and 2013 in the form of comprehensive reports written by Matua Raki. Future research could further explore whether the recommendations within these guidelines are being implemented by New Zealand's organisations and health professionals, and to what level. Are organisations implementing the recommendations made, and the treatment modalities that are recommended for MA recovery? It could also be beneficial for updated reports to be written and released.

This research had a small sample size and although this does have its advantages for qualitative research a small sample size is not always representative of a larger population demographic, even if there are deep similarities with the individuals involved (Smith, 2008). Future research could follow up with a larger qualitative or quantitative sample so that data points can be tracked with more accuracy, allowing for an expansion on the findings to be

made (Mills & Birks, 2014)). An example of where this could be helpful is with one of the findings that came out of this research which was that outpatient treatment was not deemed effective by the participants. Future research could be conducted to further analyse the treatment modalities and approaches that are being provided and the effectiveness of outpatient treatment for MA users. Further analysis could also endeavour to uncover whether health professionals are given adequate knowledge and training required to provide appropriate assistance for MA users seeking support? Are professional development and upskilling required in this area?

Māori have a higher prevalence rate for MA use in New Zealand than non-Māori and therefore there would be benefit in examining and uncovering the patterns within Māori culture, to better understand how to target strategies for this cultural group. Are there cultural barriers that Māori are facing when seeking help, support or treatment? How are whanau being impacted and what are the consequences within the Māori communities? What can be done to help them?

Future research could be conducted to further analyse the finding that smoking marijuana helped some participants to abstain from MA, exploring the risks and benefits involved. In addition, future research could also be conducted on different groups that have been affected by the experience of drug dependence, such as children, adolescents, parents, and providers. This would provide more understanding of the lived experiences that these groups have—how they are being impacted and what they would like to see change.

Chapter 13

Conclusions

This research set out to investigate what approaches, strategies and treatment were deemed helpful for individuals who identified as being 'in recovery' from MA dependence. This research was deemed necessary and important due to the wide-spread scale of MA misuse that occurs within New Zealand. Most studies on MA have been conducted overseas. To the researcher's knowledge this is the first study completed in New Zealand which undertakes qualitative research on the strategies, approaches or treatment deemed useful by the service users themselves.

It was discovered that recovery is multi-dimensional and, although abstinence is important, so are other contributing factors. To uncover these factors, Hermeneutic Phenomenology was employed which allowed for lived experience to be uncovered, by going straight to the source. This provided information with rich depth and allowed individuals to have a voice and share their stories and experiences of MA dependence and recovery.

The data provides narratives and insight into the participants' drug dependence and recovery journeys; a time of their lives that alludes to a completely different sense of being-in-the-world. It was courageous for the participants to talk about this time of their lives, which for some held dark memories, chaos and times of extreme instability.

This research does not provide all the answers on MA recovery, but it provides first-hand insight into the approaches, strategies, and treatment that the seven participants deemed helpful for their recovery. The lack of knowledge on appropriate treatment and recovery for MA in New Zealand is a concern, and one this researcher wanted to highlight and bring attention to. This research should provide a valuable base of information on which further research can be conducted. It has been identified that further research on treatment for MA and recovery from MA is important, and further research would help to expand the opportunities for combatting this serious health issue.

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Appendix A

Information Sheet Provided to Potential Participants



COLLEGE OF
HUMANITIES AND
SOCIAL SCIENCES

Recovery from Methamphetamine Misuse

INFORMATION SHEET

WHO AM I?

My name is Yvonne Gordon, but I go by Eve. I am a postgraduate psychology student undertaking research for a Masters Degree in Psychology at Massey University and would like to invite you to participate in a study of people who identify as 'being in recovery' from methamphetamine misuse. For the duration of the research I will have two supervisors, Professor Christine Stephens and Dr Andy Towers who, along with me, can be contacted if you require any further information or have any questions, using the contact details below.

WHAT IS THE STUDY IS ABOUT?

Methamphetamine is a substance that has become a recognised health issue for our country. Therefore, in order to gain knowledge about how to help people who have developed dependence on the drug, it is helpful to understand what has helped people that have once been dependent themselves, but are now in recovery.

This study is about recovery from methamphetamine misuse and talking with people about their experiences and what helped them in their recovery journey. This information and insight can help to provide knowledge on how methamphetamine misuse can be prevented and helped.

WHAT YOU WOULD BE ASKED TO DO?

I would ask you to take part in an interview (for about one hour) in a hired room at the local community centre or a similar location. During the interview I will ask you to tell me about your recovery journey. I would like to hear about anything that you think is important to share about your experiences. You would be gifted a \$30 gift card in appreciation for your participation.

WHAT WILL THE INFORMATION BE USED FOR?

The interview will be recorded with a digital voice recorder. The recording will be transcribed and I will read through the interview information to look for patterns or themes. The themes will provide the data required for analysis. This process allows me to get as much information as I can from the interview, and helps to form the research findings.

Your confidentiality is important and therefore, identification codes will be made for each participant and kept in a locked filing cabinet. Audiotapes will be transcribed using the identification codes and documentation pertaining this research will be locked in the filing cabinet. The consent forms will be kept separately, and no identifying information will appear on the transcripts or in any published report.

When your interview has been transcribed, if you wish, a copy will be sent to you to review. If you do not wish to make any changes you can dispose of it. If the transcript is not returned within two weeks, I will assume you are happy with the information you have provided.

ARE YOU ELIGIBLE?

To participate in this study you must be both willing and able to discuss your experiences in methamphetamine recovery, and be above the age of 18. At the time of the interview, you will need to have abstained from methamphetamine for a period of six months or more.

WHAT CAN I EXPECT FROM THE RESEARCHER?

If you participate in this study you have the right to:

- Refuse to answer any particular question at any time
- Withdraw from the study at any time
- Ask any further questions about the study that occur to you during or after your participation
- Provide information on the understanding that it is completely confidential to the researcher, unless the researcher becomes aware of real threats to the safety of individuals or the public. Identification codes will be made for each participant and kept in a locked filing cabinet. Audiotapes will be transcribed using the identification codes and documentation pertaining this research will be locked in the filing cabinet. No identifying information will appear on the transcripts or in any published report.
- Be given a summary of the findings on completion of the study
- Ask for the recorder to be turned off at any stage during the interview

If you require any further information on the study, or wish to contact me for any reason, here is a list of contact details:

- Yvonne Gordon (me) - Yvonne.Gordon.2@uni.massey.ac.nz, [REDACTED]
- Professor Christine Stephens (Lead Supervisor) – C.V.Stephens@massey.ac.nz, 06 951 8059
- Dr Andy Towers (Supervisor) - A.J.Towers@massey.ac.nz, 06 356 9099 ext.83504

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern A, Application 19/27. If you have any concerns about the conduct of this research, please contact Dr Negar Partow, Chair, Massey University Human Ethics Committee: Southern A, telephone 04 801 5799 ext 63363, email humanethicsoutha@massey.ac.nz.

Thank you.

Eve Gordon

If you choose to participate, I look forward to interviewing you. I expect that the interview will be a positive experience but, in the event, that it causes any distress, please note it would be advised to discuss appropriate supports with your own general practitioner or appropriate supports such as:

Phone lines that can be called:

- The Depression Helpline – 0800 111 757
- Alcohol Drug Helpline – 0800 787 797
- Lifeline – 0800 543 354
- Samaritans – 0800 726 666

CareNZ is an organization that supports anyone concerned about their own or someone else's drug use. CareNZ Wellington, Hutt Valley and Kapiti Coast Community Services can be contacted if you require assistance and support:

- Kapiti Coast – 0800 682 468
- Lower Hutt – 0800 385 151
- Wellington – 0800 385 151, wellington@carenz.co.nz

Appendix B

Consent Form for Participants

Recovery from Methamphetamine Misuse

CONSENT FORM

I have read the information sheet and have had the details of the study explained to me and I understand what is required of me as a participant.

I understand that I am free to withdraw from the study at any time, or decline to answer any particular question.

I agree to provide information to the researcher on the understanding that it is completely confidential, unless the researcher becomes aware of real threats to the safety of individuals or the public.

I agree to the interview being recorded.

I understand that I have the right to ask for the digital voice recorder to be turned off at any time during the interview.

I agree to the researcher using quotations in the final report on the understanding that I will not be able to be identified.

I understand that I have the option of having a copy of the transcription of the interview given to me to review and edit. I understand that if I do not return the transcript after two weeks with any changes, the researcher will take that as consent to include the data.

I wish to participate in this study under the conditions set out on the information sheet.

SIGNED:

NAME:

DATE:

Appendix C

Interview Guide

Recovery from Methamphetamine Misuse

INTERVIEW GUIDE

General Questions about the background of the interviewee:

- What is your age?
- What is your ethnicity?
- Are you in work at the moment?

General Opening Question:

- How were you first introduced to MA?
- How long did you use MA all up?
- How much MA were you using?
- What changes did you notice in your life when you were using MA?
- How long have you abstained from MA?

Key Questions:

- How do you know today that you are in recovery and what does recovery look like for you?
- Was there anything that prompted you to want to stop using MA?
- Is there any on-going recovery group or therapy that you are attending?
- Did you get any support from any agencies or services?
- What sort of things helped you to manage to stay away from MA?
- Was your first attempt at letting go of the drug successful or was there times of lapse and relapse?
- Were there any rehab, counsellors or walk in centres you used to help you get away from the drug? Or any other type of service?
- Was there anything that was important to your recovery and getting away from meth?

- Were you able to stay away from all drugs when you gave up MA or did you continue using other drugs?
- If yes, do you think you've kind of replaced one drug for another or you feel you really don't need to use any drugs anymore?
- Have you faced any challenges in your recovery from MA?
- Were there any of your own personal attributes or strengths that you have noticed about yourself that helped you to get through?
- Tell me about a time when you knew you were in recovery from MA?

Closing Questions:

- What does life look like for you now?
- How do you feel about your future?
- Do you have any current or future goals?
- Is there anything else you would like to add about your recovery from meth or things that have helped you to be able to be in recovery?

Appendix D

Authority for Release of Transcripts

Recovery From Methamphetamine Misuse

AUTHORITY FOR THE RELEASE OF TRANSCRIPTS

I confirm that I have had the opportunity to read and amend the transcript of the interview(s) conducted with me.

I agree that the edited transcript and extracts from this may be used in reports and publications arising from the research.

SIGNED:

NAME:

DATE:

Appendix E

Massey University Ethics Approval



Date: 06 June 2019

Dear Yvonne Gordon

Re: Ethics Notification - **SOA 19/27 - Recovery from Methamphetamine Misuse**

Thank you for the above application that was considered by the Massey University Human Ethics Committee: **Human Ethics Southern A Committee** at their meeting held on **Thursday, 6 June, 2019**.

On behalf of the Committee I am pleased to advise you that the ethics of your application are approved.

Approval is for three years. If this project has not been completed within three years from the date of this letter, reapproval must be requested.

If the nature, content, location, procedures or personnel of your approved application change, please advise the Secretary of the Committee.

Yours sincerely

Professor Craig Johnson
Chair, Human Ethics Chairs' Committee and Director (Research Ethics)