Interview 1's Childhood

Let me briefly introduce you to the childhood of a man I interviewed about his life and drug use.

'I-1' ('interview 1') was born in 1962 and grew up in rural New Zealand. I-1's parent's had a "*shotgun*" wedding in 1958 after his "*very attractive*" 18-year-old mother unexpectedly fell pregnant with I-1's older brother. But marriage and children did not prevent I-1's "*pretty non-existent*" sheep and cattle farming father from repeatedly engaging in extra-marital affairs. According to I-1, "*He didn't seem to see anything wrong with being a ram and running with the flock*".

Because his parents were "*emotionally distant"*, I-1 believes him and his three siblings "*all lacked love*". But because the parents firstly turned their attention away from the oldest brother toward his younger siblings then I-1's older brother "*turned the most wicked*". At 4-years older than I-1, he became a violent "*nasty sadistic bully*", who was '*sexually abusive, physically abusive*" and "*mentally abusive*" toward I-1 and his younger sister. I-1 and his sister became a "*team*" to protect themselves against their sadistic brother. Now almost 60 and "*on his last legs*", I-1's "*alcoholic*" brother brews and consumes his own ethanol "*trying to end it quickly*".

As a child, I-1 was "*terrified*" of his strict disciplinarian mother: "*What mum said went. We were under her strict control. We were well and truly little soldiers*". While other members of the small tight-knit farming community thought I-1 and his siblings were "*very polite*" and "*lovely kids*", they were "*all squished into a box*" and "*pretty controlled, but without the love, hugs, the cuddles, the chats*". Wanting her children to be "*little preppy kids*" who were '*all going to be doctors, lawyers, airline pilot*", his mother would "*beat the shit out of*" I-1's sister trying to turn her into a "*pretty ballerina*" (when she was actually a farm girl living on a farm). I-1 would run away if he did something wrong, because "*the punishment you could get would be horrendous*".

As "*a bit of sexual abuse went on within the community*", I-1 and his sister were also sexual abused by a male babysitter when he was 5 or 6 (he doesn't remember this but his sister does). He was a bed-wetter until 10 (and had an electrode tapped to his penis to stop it), yet "*always wondered why I wet the bed*". Between 11 and 13 he was repeatedly sexually abused by a classmate just one-year older. Then at 13 - whilst suffering "*horrific*" vengeful bullying at the hands of his older brother's victims while attending an elite private school – his parents suddenly announced they were divorcing, which was a "*significant event*" in his life-course.

Should we be surprised that throughout his life he has taken drugs to "*have a good time and to feel good*" because "I *can't raise myself to a happy place without it*"?

A Popular Narrative vs. The Life-Course View

"*New Zealand is experiencing a rising tide of mental distress and addiction*", so concluded the 2018 Labour-led government inquiry into mental health and addiction (Paterson, et al., 2018: 65). According to the inquiry, one in five New Zealanders experience mental health and addiction challenges at any given time, while in the past 10 years the number of people accessing mental health and addiction services has increased 73%. Meanwhile, the annual cost of the burden of serious mental illness and addiction is estimated to be $12 billion, or 5% of GDP. The inquiry's authors concluded, "*the pressures of modern life are clearly impacting on people's mental health and contributing to unhealthy behaviour and addictions*" (Paterson, et al., 2018: 66).

In order to promote the physical, social, cultural and spiritual wellbeing of individuals, families and communities, New Zealanders told the inquiry they want a mental health and addiction system that *prevents* mental distress and addiction, *intervenes* early and quickly when problems begin to develop, and *addresses* the social determinants of mental wellbeing. This more holistic approach views mental distress and substance abuse as a *recoverable* psychological, social, spiritual and/or health *disruption*, rather than a biomedical-based mental health *deficit* (Paterson, et al., 2018). New Zealanders also asked for mental health clinicians to stop classifying the mental distress they suffer whilst they battle modern life's storms as an 'illness' or 'disease', because this "reinforces a deficit mind-set and requires people to identify as sick in order to qualify for assistance" (Paterson, et al., 2018: 38).[1] Citizens also said they want to be active (not passive) participants in their recovery, and be encouraged and supported along their pathway to restoring and maintaining their wellbeing and sense of self. New Zealanders also complained that the biomedical approach tends to match individuals to a diagnostic label, thereby failing to see the whole person, and thus not addressing their overall life-course circumstances, personal histories, life-course challenges and/or traumas. In a move to shift focus toward mental and social wellbeing and community solutions, the inquiry's authors' 'wellness manifesto' advocated a transformational policy shift from 'big psychiatry' to 'big community' (Paterson, et al., 2018: 97). New Zealanders also implored the inquiry to treat addiction as a health issue, and not a criminal justice issue driven by harmful and ineffective 'tough on drugs' policies (which have led to gang control of drug supplies, and placed barriers to seeking help by pushing addicts and their families to the margins of New Zealand society). New Zealanders also called for addiction to be "destigmatised and recognised as a maladaptive response to stress, anxiety and trauma" (Paterson, et al., 2018: 46).

Since concerned citizens highlighted far too many children and young people grow up in a "toxic environment" of "multigenerational trauma, family violence, poverty, abuse and neglect", then a "strong theme" from the 5,200 submissions was that "prevention must engage more fully with life-course theory" and a "life-course approach"

[1] Contrary to the view that a medical diagnosis of mental health and addiction reduces stigma, experiments have shown that participants are more hostile and cruel to a person whose mental illness they thought was caused by a disease as opposed to being something that happened to them in life (Hari, 2018).

(Paterson, et al., 2018: 50; 83). Being able to intervene early in the life-course and at critical transition points to prevent "adverse childhood experiences" was seen as the "best medium- to long-term investment in mental wellbeing" (Paterson, et al., 2018: 50). But we require empirical-based research to help identify these critical transition points.

This research project – presented in the format of a '**10-episode meth drama series**' - is a direct response to that call by providing, for the first time, a life-course-based qualitative study of methamphetamine use in New Zealand. By bringing the person to the forefront, this narrative-heavy research can be seen as the qualitative complement to the quantitative survey data collected annually about 'frequent meth users' by the 'Illicit Drug Monitoring System' (which is part of the National Drug Policy) (Wilkins, et al., 2015).

Media stories about methamphetamine (or 'P') use regularly appear in New Zealand's newspapers,[2] where it is argued "the scourge of P addiction" is destroying individual lives and families throughout the country (Northern Advocate, 2017). From these media depictions, and everyday interpretations, a popular narrative has emerged that presumes meth to be so 'highly addictive' that it does not distinguish between gender, age, ethnicity, social class or any other background factor. According to this narrative, 'one hit of P' is all it takes for individuals to become 'hooked' on meth. This narrative was clearly expressed by an educator who has produced 'just say no'-based educational videos for schools in an admirable effort to tackle the demand side of the supply-and-demand meth chain:

> *The thing about P is that it has no class conscious. It doesn't decide who its victim will be. It just claims anyone and everyone. And it comes down to those kids to just say no in the first place. It is such a deadly drug. The biggest concern is that if someone tries meth, a big percentage will get hooked. And some cannot get off it, ever* (Quill, 2016b)

This view depicts meth as an "evil drug" that is a "destroyer of everything", while meth addiction is equated to a "virus" that indiscriminately infects homes and communities (Quill, 2016). As a policeman who mentors parents dealing with a meth using son or daughter stated, '*Addiction is an illness, not a way of life or choice. Like any virus you have to be disciplined in how you treat the illness if you want a successful outcome*" (ibid).

[2] The letter 'P' that is used as a synonym for methamphetamine is an abbreviation of 'pure', which was originally used to differentiate amphetamine or 'speed' cut with glucose or dextrose from uncut 'pure' amphetamine.

Adverse Childhoods & Addiction

While this popular narrative has been used historically throughout the world to stigmatise presumed 'highly addictive' drugs as a way to deter young people - for example, the above educator calls meth 'Voldemort' - this narrative actually runs contrary to the developmental life-course view of addiction.

As addiction expert (and ex-addict) Maia Szalavitz (2016) has shown, only 10-20% of meth, heroin and cocaine users actually become addicted, while about 90% of all substance addictions start in adolescence and most end by age thirty. According to Family Drug Support, for example, 15% of meth users in New Zealand are 'dependent' on the substance (Bayer, 2020).

Mere exposure to a drug with 'addictive potential' does not make a person susceptible to addiction. As addiction expert Gabor Maté states, the small minority of drug users who do become addicted become so because they were already at risk or susceptible. Extensive research has shown that children who have encountered 'adverse childhood experiences' (ACEs) have worse health outcomes and higher rates of addiction than others (and the greater the number of ACEs experienced as a child, the higher the risk of poor health outcomes) (Hughes, et al., 2017).

Since adverse childhood experiences are the key (but not only) precursors required to manufacture addiction, Maté believes the key question is not '*Why the addiction?*', but rather '*Why the pain?*' (Maté, 2008). This is because for Maté, hurt, pain, abuse and/or neglect are at the centre of all addictive behaviours, and so the addict is seeking both relief from pain and distress, as well as pleasure and excitement. Thus for Maté, addiction should be interpreted not as a sign of moral failure, but as a signal of distress. I-1, introduced above, said he takes drugs to "*have a good time and to feel good*" because "I *can't raise myself to a happy place without it*".

According to Szalavitz, addiction does not simply 'appear' overnight but 'unfolds' over time, while the road to addiction is paved with childhood trauma (along with a predisposition to mental illness). In essence, the more discomfort, insecurity, trauma, pain and hurt, the greater the risk of addiction.

New Zealand's Ministry of Health (2009; 2015) has identified the following as key individual, interpersonal and structural risk factors:

1.	Mental illness
2.	Exposure to traumatic life experiences such as child abuse and neglect
3.	Family violence and household dysfunction
4.	Belonging to a marginalised and lower-socio-economic group

Likewise, the 2018 government inquiry into mental health and addiction stated addiction is a "*counterproductive coping mechanism*" for economic deprivation, intergenerational and childhood trauma, sexual abuse, family and partner violence, abuse, neglect, anxiety, bullying, loneliness, isolation, social exclusion and disconnection (Paterson, et al., 2018: 44).

Thus to obtain and maintain mental and social wellbeing, New Zealanders require safe and affordable houses, good education, meaningful employment, adequate income, freedom from abuse and violence, reliable social support, equitable outcomes, and social connectedness. According to the inquiry's report, "mental wellbeing is most likely when we are safe and secure and feel connected, valued, worthy, accepted for who we are, and hopeful for the future" (Paterson, et al., 2018:82).

Natural Recovery from Drug Use

This research seeks to 'test' this popular narrative by placing the respondent's meth use in a life-course context. This popular narrative also presumes 'P addicts' will not be able to stop using meth until they have 'hit rock bottom' (lost everything they had); at which point they will require professional treatment if they ever hope to successfully recover. This view, however, runs contrary to the research on 'natural recovery,' which has offered valuable insights into how drug users successfully transform their lives without turning to professionals or self-help groups (Granfield and Cloud, 1996).

For example, combined survey results between 2006 and 2014 indicate that, on average, between 29%-32% of the frequent meth users accessed either a drug-and-alcohol worker, a general practitioner, or a counsellor (Wilkins, et al., 2015), while between 2009 and 2016 about one-third (31%) of frequent meth users indicated they needed "no help at all" to reduce their meth use (Wilkins, et al., 2017: 244).

As Granfield and Cloud (1999) show, recovery from addiction without treatment can occur when individuals develop a renewed stake in conventional life, invest in prosocial relationships, and avoid drug users and the situations and cues associated with drug use.

Likewise, the 2018 government inquiry into mental health and addiction stated "*every day, people recover from distress, overcome addictions and find strength in their lives*" (Paterson, et al., 2018: 67). The "simple but powerful things they did to climb out of a dark hole" of frequent drug use include:

sleep	nutrition	exercise
time outdoors	strengthening one's cultural identity	helping other

In fact, New Zealand citizens themselves told the inquiry that mental and social wellbeing is a function of:

good physical health	healthy relationships with family and community
meaningful work	strong connection to land, culture and history

Using a life-course approach, this research therefore seeks to understand the particular 'desistance strategies' 'people seeking wellness' use to initiate their desistance from meth use. 'People seeking wellness' (tangata whairoa), refers to those New Zealanders '*who experience mental health or addiction challenges and who are seeking wellness or recovery of self*' (Paterson, et al., 2018: 22).

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