TE WHARE WĀNANGA O
AWANUIĀRANGI

IRA TŪMOANA: BATTLING THE TANIWHA A MĀTAURANGA MĀORI SOLUTION TO TAMING METHAMPHETAMINE

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Heemi James Dean Brown

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Prologue

There is a true story of a chief from Ngāti Awa whose name is Ira Tūmoana. He is known as the warrior responsible for killing the dangerous taniwha (monster) Tarakura of the Rangitaiki plains (Ngaheu, 2012) in the Bay of Plenty. Such was the death and destruction caused by Tarakura. The taniwha analogy embodies the destructive nature of methamphetamine. Tarakura reflects the demon-like personality of the drug and its attack on individuals, families and communities around them. Ira Tūmoana challenges us to address the taniwha with urgency for the sake of those who struggle to overcome this modern-day taniwha.

I am a mokopuna of the Ngāti Awa tribe and would like to introduce myself by reciting prominent tribal landmarks using my native language:- ko Pūtauaki te maunga, ko Rangitaiki te awa, ko Mataatua te waka, ko Ngāti Awa te iwi, ko Ngāi Tamawera te hapū, ko Uiraroa te marae (Report, 1999). This is further supported using a haka (chant) beneath each chapter heading of this thesis. I live in the small rural town of Te Teko on the banks of the Rangitaiki river. Directly across is my marae Uiraroa named after the wife of the renowned ancestor Awanuiārangi. Presently, I am enrolled at our tribal university, Te Whare Wānanga o Awanuiārangi in Whakatāne, New Zealand (Te Whare Wānanga O Awanuiārangi, 2021).

My hometown and the greater Eastern Bay of Plenty region faces daily threats from the taniwha of methamphetamine use in the area. Te Teko has a traditional connection between the community and the ancestor Ira Tūmoana who demonstrates key principles for survival such as tikanga, mana and manaaki. Ira Tūmoana represents the clinician, or healer, who seeks to remedy the problem of addiction that plagues my people. The story of Ira Tūmoana provides a strong foundation for a new direction and alternative to the issue at hand.

In my former years I was a mental health worker and later became a sports coach with a strong determination to arm and empower others. Today I fight on behalf of my people seeking to overcome this drug phenomenon, armed with academic knowledge and supported with evidence based research. I am both a father and a son and the eldest of the family. My name is Heemi Brown and this is my tale of the battle with the taniwha to overthrow the power of addiction to methamphetamine.

Contents

Abstract

This study of methamphetamine hopes to deliver information about the types of treatment of the highly euphoric drug. Particularly the research analysis used for clinician treatment after 1990. The analytical approach is to undertake critical methamphetamine perspectives of treatment and carefully examine the success of users from that period until now. The project aim therefore is to deliver sound quality methamphetamine knowledge with a focus on the types of treatment being used. The objective is to draw on advice from four experienced clinicians and user workshops to demonstrate the success of addiction development systems.

A theoretical perspective seeks to provide an academic response to enquire which outcomes are best for users. In addition, a quality of life thesis requires the topic to investigate in-depth mental, emotional and spiritual needs of users seeking methamphetamine treatment by clinicians. This inquiry will reveal factual experiences between Māori clinicians and Māori users to provide grounded theory while creating a qualitative research guideline foundation and model.

The research will create accountability of services and provide more responsible and effective solutions. The research will clarify what effective measures are required to succeed. The contributions of outcomes will deliver better transparency of the clinical treatment models that exist. This study seeks to prove the need for more critical and beneficial pathways in narrowing the gap between the desperation of self-harm and harm to others.

CHAPTER 1

Introduction

Tēnā i hautia

This thesis study examines methamphetamine addiction. The focus is to identify solutions that are effective, fit for purpose and aimed at Māori users of methamphetamine. The study will evaluate practices demonstrated by clinicians in the Eastern Bay of Plenty and provide conclusive evidence that points to transformational change.

Background to study

The purpose of this research is to understand the desire for elicit substances and the threat that it poses on the human mind while seeking a remedy to overcome the attraction to methamphetamine. Key themes in this study points to dopamine in the mind and influenced behaviours. In our current dilemma, the world faces unprecedented challenges for the continued existence of mankind's interest with alternatives (Bishop, 2014). Since the beginning of time, there has been a fascinating discovery of development between humans, the spirit world and the earth (Bargh, 2007). Long before plants were considered notoriety, the spiritual, physical and mental connections, superimposed, a stamp on the mind (Mark, 2012). Therefore, we must commence with the journey of a person, the human and ask an intelligent question about connection with the mind and methamphetamine. In doing so, we will start with a supreme being, who created the heavens and the earth, according to the bible (Smith., 1611). In 1678 Barbot claimed that African slaves transported to the Americas declared a Supreme Being capable of manipulating anything in the world, including life and death (Villa, 2016). Māori also called out to the supreme by the name of Io, or Io-matua-kore (the parentless one), (Robinson, 2005). Whether we believe in the existence of a supreme being is irrelevant. What is important is to articulate a historical account to align us with the present.

Neuroscientist, S.T. Robinson, explains that there is a deep connection between the human body, mind and the earth (Robinson, 2005). Māori similarities confirm traditional interactions between the earth and all living organisms, notably an earthly spiritual being, named Papatūānuku (Earth Mother) (Alfred et at., 2017). Many Indigenous peoples continue to this day to practice traditional healing with plants and prayer. This was an important process for

the full restoration of a person's mental well-being (Te Aho, 2013), (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). Something that has been lost in the modern world of medicine and is slowly being re-introduced into the medical and mental health practices (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). All cultures have a history of proclaiming a mental, spiritual and physical bond with Mother Earth (Escohotado, 1999). According to (Isbouts J.-P. , 2019) in reflection of the bible, the body also has healing properties that are identical to the earth. Adam the ancestor most familiar with religious communities, is raised to life from the dust of the ground, by the voice of a supreme being. The voice breathes life into the nostrils and Adam comes alive. The ground is where you will return and turn back into dust, says the voice (Smith., 1611, pp. 1-2). Adam in Hebrew means Adama, also interpreted as earth (Isbouts J.-P. , 2019). The account outlines a relationship between Adam and his companion Eve, who appreciate a tropical paradise in the garden of Eden, flowing with unbelievable opportunities. In a sense one could interpret the couple as being the first people, also using today's terms native or Indigenous. Moreover, they are one with the land and connect with everything around them, spiritually, physically and mentally. In Māori the connection with all things is represented in the spirit of the mauri (life force), (Alfred, 2017). Both live in a world of peace, without addiction, disease, or pain (Smith., 1611), (Isbouts J. P., 2019). Nor is there conflict, oppression or depression as they are not affected by other groups. Paradise to Indigenous means a connection with the land, species and all things that encompass utopia. They give back through gratitude by incarnations and ultimately reward their self-belief in the guidance of something supernaturally powerful (Buck, 1994), (Elsemore, 1999). Remarkably, what happens next may enlighten health professionals as the parable changes.

Dopamine: The lure

According to biblical reference Adam and Eve are warned by God that a tree in the garden with fruit is not to be eaten, or you will die. Not literally, but possibly internally. What should be considered here is the response of Adam and Eve. They are in a position of trying something, never offered to them before. They are in a place of content, but also challenging an appetite in the brain, overwhelming their ability to remain grounded by this voice. They are fighting the brain's natural reward pathway, where dopamine is challenging the notion of pleasure, versus the 'warning' and temptation to engage (See, 2007), (King J. , 2014). Their stimulation and desire of the fruit is natural, but the urge to eat, regardless of the consequences, could be an explanation for cravings. What if the brain triggered a release of

dopamine at levels, that impaired responsibility? What if the words ‘do not eat’ or ‘thought of risk’ signals a reaction to indulge? According to scientific researchers, the crossroads of the brain’s neurological transmitters when enlightened with a strong urge can change dopamine levels so dramatically, that it overrides all reasonable choices (Isbouts J. P., 2019). Such as teenage lovers, who for whatever reason, show awkward public affection, fall in love, regardless of who is around, hoping the thrill will never end. This may pose some challenges to treatment. What if the same were true, of methamphetamine, then clinicians may be able to directly access, a person’s paradise state. Where everything that ever existed, in fantasies, dreams and real life, could explain the connection with the natural utopia that Adam and Eve so desperately tried to avoid (Hunt, Kuck, & Truitt, 2006). No doubt chasing fruit is different to methamphetamine addiction, but the mystery is in the natural reward of dopamine that alters a person’s behaviour.

The evidence points to the gravitation of the brains control system, such as possible weaknesses where the brain signals an alternative to our choice. But again, what if the brain has been oppressed by influence? Several questions may explain that the brain might be the key to restoring the person's addiction impulses. Counsellors in theory are not medically trained brain experts, they specialise in listening and offering advice (Covey & Taylor, 2008). For the most part, humans have been largely influenced by someone else’s decisions, living under a set of guidelines, laws and conditions. For clinicians, the treatment may be an obvious fix but could also be out of a clinician’s reach. What if the cure is identified as causations of inappropriate mental oppression? Then clinicians might be able to critique the proper treatment process if they have better access to the person's brain, history, and cultural makeup this thesis seeks to critique.

Disconnecting the mind

This brings us to the disconnection of the mind and what (Jones, 2018) states is why Indigenous peoples continue to participate with land issues, talking to it and teaching their children, to do the same. Inevitably, when Indigenous peoples were evicted from their customary land, so was the mind (Alfred, 2017). According to (Litchfield, 1985) the land confiscations were unjust. In New Zealand Māori were made to believe that they had rebelled, by defending their lands as an act of rebellion against the Queen of England. All propaganda of course, but this would provide a necessary alignment with settlers who would not feel the same emotional connection with Indigenous land uses, well not in Aotearoa, as it

was once called. New Zealand, the name more favoured, cared not, they wanted a colonist state, a colonial economy and continued for the dispossession of Indigenous identity, causing an Indigenous person's misery. In effect entrenched intergenerational bitterness of Indigenous people's land resource, economic and spiritual wellbeing for future generations (Caccioppoli, 2005) (Wynyard, 2019). Indigenous disconnection of land loss and the connection with drug use, are synonyms to curing the self, forgetting the pain and memories of the past. Admittedly, re-installing new aspirations, even if illicit (Reid, Rout, Tau, & Smith, 2017).

There is a long history of disconnected peoples in New Zealand who when they arrived were trying to connect to the land in some form. In doing so, accepted that at least confiscations were justifiable reasons to create some legislative process, re-establishing a new shift in policy and practice. The government of the day would co-exist on a strength of a taken equitable land base. The indictment would severe one group of people being baseless and cause the other to dominate. This is questionably the root of economic dominance governments have used to stir Indigenous communities around the world. The grassroots of society. (Alfred, 2017) reiterates, if those roots are damaged, unprotected, uneconomic and then upended by the law, they (the community) would try something else, like illicit drugs (Aldridge, Measham, & Williams, 2010). In the 1990s the largest cartels in the world came from Columbia but were short-lived after the U.S Government reinforced its trade with Mexico leaving Columbia abandoned. The Mexican Government boosted its maize market with the U.S securing contracts with elite businessmen. Loss of income for Indigenous farmers would produce the cartel trade the Sinaloa and Tijuana. All farming businesses were outdone by the government, the only option left was to grow illicit drugs. Once they did the industries were at the mercy of the law and enforcement.

The most grown plant was cocoa then opium and methamphetamine would eventually join later including fentanyl (Glusniewska, 2016). Researcher of New York University García Ponce made this statement, "greater emphasis on helping the most vulnerable farmers. The situation in rural areas and the incentives that exist for farmers to turn to illegal crops have been ignored by public policies" (Godoy, 2021, p. 1). What might be necessary is to deliberate two themes that took place, the new Spain (Government) and its strategic alliances for resources of Indigenous economics, which no doubt has been a widely criticised movement since its inception over the world. The 1863 Land Confiscations in New Zealand

can be held mainly responsible for political-economic advantages for the wealthy whilst disadvantaging the newly poor (Alfred, 2017). We cannot ignore colonisation practices; we must weigh in the political regulations that address the treatment to addiction situation today.

Under the influence

New Zealand's Government enforcement outlook has been tackling head-on illegal imports and tracking sophisticated gang intelligence. Contrary to the government's support for communities largely disconnects those who engage in drugs for recreational use are hypocritical. In 2020 funding of twenty million was allocated to drug treatment facilities in nine districts, including the Bay of Plenty (Radio, 2020). In 2021, more than three and a half million in assets were taken through raids all around the world. The FBI and government authorities used strategic technology to nab gangsters (Ensor & Sadler, 2021). The main pathways for transhipping into New Zealand have predominantly come from Southeast Asia and Mexico. On one hand there is a war of actions between whānau, health officials and enforcement to stop methamphetamine harming the community (Inglis, 2018). Yet the situation is never-ending between the government and cartel traffickers. The global methamphetamine business, once an epidemic, is a pandemic at the cost of government addiction treatment, justice and economy to be in the billions (Covey & Taylor, 2008), (Government, 2019). Keeping the drug out of the country is one thing, keeping it out of the community is another. The dichotomy presented is how to interpret an elaborate and more sinister ideology at work. What if the drug is a means to continue for the suppression of people, to prosecute, punish and pursue endlessly for economic benefits? What if the treatment system was justified because its only method is to devalue subconsciously a never-ending cycle of repetitious addiction and mental health behaviours through the enforcement and drug harms? (Costa & Widianto, 2021), (Foucault, 1977). In a sense, if you removed alcohol from society, wouldn't that solve nearly all crimes? (Anonymous., 1988). If the government decriminalised all drugs, ended prison sentences for minor crimes and instituted safe drug use illicit or prescribed? (Policy, 2015). Wouldn't that be a better plan than prosecution? Coincidently there is a two-part attraction with the current drug craze by governments and users alike.

Drug sales have been the glamorisation of a hyped lifestyle, motorcycles and liberation from what tends to be driven by the escape from poverty. The subculture of methamphetamine businesses has substantial risks and they are frightening. Increasingly Mexico's daily drug

related deaths occur from rival cartels and the government's military (Escohotado, 1999), (Inglis, 2018). There are documentaries of smugglers who endanger themselves trying to improve their social conditions by any means to generate income from a few kilos (Yaacoub, 2017). In 2009, New Zealand was faced with 216kgs to the value of $86 million seized along with guns (Mather, 2019). Statistics show from 2011, illegal imports increased until 2019 after severe police prosecution, but soon after seizures increased exponentially. The demand for methamphetamine has increased so significantly that the fight with drug syndicates seems a good justification for more confiscations including an immaculate gateway for accepting drug money (Parliament, 2018). Despite the controversies, this study presents a series of arguments to address the methamphetamine problems.

Aim and Research questions

The aim of this thesis is to identify new drug treatment approaches for Māori addicts. The research seeks to investigate first-hand experiences of methamphetamine users along with professional therapists who work at the front line of drug addiction in New Zealand. The analysis describes the problems with current methamphetamine addiction programmes for Māori. In addition, there are several treatment facilities that exist of which this study examines. This research looks to provide an answer to the following key questions:

What is the most effective treatment for Māori who use methamphetamine?

The aim as described above this study seeks to answer the following support questions:

1. What initiatives best support Māori to overcome methamphetamine addiction?
2. How do these services operate?
3. Why are they successful?
4. What opportunities are there for further development?

Significance of study

The overall value of this research is to help Māori with addiction to methamphetamine by finding an effective treatment for Māori by Māori. This includes enabling whānau to support the cause. The long-term position is to change policy within treatment programmes that do not address Māori addiction needs. Subsequently, reverse negative statistics, crime and

societal attitudes aimed toward Māori. This adds to solutions for methamphetamine addicts by providing a treatment programme that works for Māori and non-Māori.

Overview of methods

The methods used in this study provide an answer to the research questions raised in this document. This will provide a solution to the existing problems around methamphetamine addiction and treatment. This study presents a Kaupapa Māori approach to theoretical frameworks. It encompasses and is inclusive of mātauranga Māori and a Māori centric worldview. This document provides a newly developed framework specific to this research topic. It is called the Mauri framework. Also included are the principles that align with the four baskets of knowledge as known to the people of Ngāti Awa. This is further supported by interviews with Māori clinicians and observational practices with users of methamphetamine. This unique and authentic approach intends to provide valuable outcomes for critical analysis. This leads to discussion of the results to provide a conclusive ending to this study.

Thesis chapter overview

This thesis comprises of seven chapters. Research of the topic provides evidence of its history and presents a methodological approach to produce findings that are further discussed to arrive at a conclusive ending.

Chapter One – Introduction - The study begins with the topic of methamphetamine and the historical connection with the drug. The aim is to present a treatment alternative for Māori. The approach uses evidence-based research to provide the best healing remedy. The overall summary indicates that a new model is required for this thesis.

Chapter Two - Literature Review - Identifies leading scholars in this topic critiquing three key periods, the pre-Indigenous Western period of the 1490s - 1950s. The economic-political period of the 1960s - 1990s and the Māori period between 1990 and 2021. The research focuses on trade, science, social theory, politics and economics as a grounded hypothetical case for methamphetamine's rise in society.

Chapters Three and Four - Methodology and Methods – Presents a new Māori framework to support a relevant model for treatment. The model is strengthened by a Kaupapa Māori approach. The Mauri framework delivers four key elements: te kete tūāuri, te kete tūātea, te

kete aronui, te kete te kitea. An extensive critique is required to interpret Māori concerns. The methods are a qualitative approach, employing interviews and observations, with clinicians and addiction treatment organisations.

Chapter Five - Findings – Identifies key themes that emerged from relevant results when data was examined. This includes whānau group meetings, evidence from interviews and observations with the community involved. Alternatives are identified for further analysis to bring about clarity and greater understanding of addiction treatment and recovery. Clinicians will provide new insights to help users overcome their substance use.

Chapter Six – Discussion - Critiques the findings to offer current addiction treatment programmes a qualitative analysis of current trends. It seeks to identify opportunities and further solutions for users and practices. In this context it reaffirms to support existing treatments with new knowledge.

Chapter Seven - Conclusion – Summarises the research and raises key perspectives and the outlook of drug use in Aotearoa. The conclusion will offer reflections, highlight limitations and present recommendations for the future.

This concludes the introduction chapter outlining the aim of the study and key components that make up this research. The following chapter is literature review that provides further background to the complexities of this topic.

CHAPTER 2

Literature Review

Ki te ūi mai koe i poua mai au i hea?

The aim of this chapter is to examine critical perspectives about methamphetamine treatment. Leading scholars present methamphetamine cases whilst others present a historical narrative of drug history. All articulate forms of social influences that indicate a politically motivated scientific discovery. Critical to this study is the Indigenous perspective, socio-economic classes and significant developments in the last 500 years. Lastly this chapter critiques themes with relevance to the social construction of drug addiction.

Tranquilising pandemic (1500s - 1950s)

History shows sedative crop-producing plants from millennia has been used by many cultures. Afghanistan (Golden Crescent) today's largest producer of opium in the world in contrast alongside China and India has in the past helped to shape other nations economic systems according to the interest with plant alternatives and trialling experiments to follow. In the Americas, by the time Columbus arrives, this new idea, that heals Spanish soldiers is taken back to Spain, Europe and eventually England. The demand for new Coca healing properties is on the rise. With that in mind, the competitor plant opium will restructure science research with the assistance of war, legislation and people (Escohotado, 1999).

By the 1500s the Meso America's in which medicinal trade would emerge, would be challenged by Spanish rule. At the time of Columbus before Cortez and his conquistadors ravage the American tribes. Gold and silver according to (Leonard, 1968) are invaluable, not considered material but symbolic of traditional messages of ancestors, deities and stories of significance. The wearing of ornaments has no status, but of cultural identity were a normal part of daily practice. Exquisite art pieces handcrafted in all extraordinary features underpinned America's greatest metals work to triumph in European history. The affirmation by the Arawak as celebrated gifts, not items deemed to be locked in storage, commodified, or tradeable items. In Queen Isabella's mind for Columbus go for 'Gold, God and Glory'. The apparent disconnection of Indigenous identity in customary gold necklaces, beads and fine vassals is an addiction to precious metals that has little Indigenous importance. The

renaissance would lift Europe out of its miserable state shrouded in new melted Indigenous golden artworks. The belief is held in progress, an ideological concept the founders of theoretical knowledge in philosophy start to imagine. The old world and a new world are shaping up to critical inspiration for writers. There are wonders for both the Indigenous and European but one in which the other would be subjugated which is the Indigenous. The addiction rate for gold and silver sends a transatlantic shipping route for slaves and speed for imports. England is undergoing a climatic age for the exploration of new hope. The dreary run-down cities, steaming with pollution, disease, political corruption and the church are mentally challenging for all. The poor would need a new escape, a new world and a new start. How to get out would consist of imagination held by philosophers who challenge the state and the church. Printing agents would write stories of other worlds with tropical mysteries, of empty lands waiting for a titleholder. Anyone could be given that opportunity for a ticket on a ship. What some may consider a proposition for a healing remedy is the transition from poverty to immediate connection with free wealth. A gift from the Gods, God, or from the natives.

Native addiction

For Indigenous Americans addiction to anything was most associated with plant life, prayers and the earth. Yet natural addiction for Indigenous tribes is most associated with cultural ties to beliefs. Villa explains that tribal groups had different views on customary practices. Kings or emperors had warriors who went about capturing slaves and most of those slaves were agriculturalists and corn growers. One could say Indigenous life had a range of dopamine addictions until plants become a product. They considered threats of mental sickness to be inspired by God and most assumed the ill mental state or sickness to be a sin of some sort. Meso Indians in different parts of the Americas had enormous respect for the land and some groups considered the earth to require human sacrificial blood offerings to keep everything in balance. Furthermore, it enables the earth to continue the reproduction cycle. Critical thought might add that hunting humans for sacrifice may have been addictive.

According to (Ramirez, 2016) natives were not victims of self-inflicted trauma, but rather colonial impressions. Most notably they were the subjects of the impoverishment of self-trauma. (Leonard, 1968) argues in support of this claim when warriors caught slaves indicated that there was a mutual agreement between both. If caught a sacrificial death was accepted as a custom of shared gratitude, a great honour, that their sacrifice was a reward in

the next world. In principle, those deathly customs were regarded as obligatory traditions. Children were raised to prepare for capture, yet very little is mentioned of the practice of delighting ideas. Most often forgotten and removed from the rest of the world as ghastly and evil (Escohotado, 1999), (Leonard, 1968), (Ramsden & J., 2008). Ramirez points out that children after the oppression from Spanish cruelty committed suicide. This was largely due to an intergenerational burden to parents because the children no longer had anything to live for (Ramirez, 2016). Consequently, the impact of colonisation by arguing theorists does not position addiction to colonisation, rather embedded tribal trauma predating Western dominance (Alfred, 2017), (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020).

One could argue that addiction is subjective of a person's will to engage with a so-called illicit practice by colonisers that sought them as twisted. But then what does one make of voluntary acceptance of death? As in the practice of daughters who accepted themselves as a sacrifice, until Christianity intersected a young girl's notion to say, 'no more'. Is living for death, not a practice of addiction, when you think, believe and adjust your life accordingly? Even more, is practising colonisation not held with the same intent? (Elsemore, 1999). Argued by what Ramirez implies is the rationality of the oppressor. One must be subjugated to a lesser degree, whether one agrees or not. If the other disagrees, then send in the troops, if that doesn't work, change their laws, education and hope they know little about their civilisation. Thus, letting go of our guilty conscience, enabling their own (Ramirez, 2016). But is these the constructs of racial prejudice or control of political power? (Foucault, 1977). For centuries the Spanish conflict with the Indigenous finally produced the arrival of an edict of the Neo-Casta social class system.

The Peninsulares (Spanish aristocrats) would be at the top of the food chain, including property, politics and the military. Underneath are the Creoles (blood ancestors of the Spanish born in the Americas), then the Mestizos (Spanish natives) Mulatoes (African slaves of Spanish blood) Native Indio's (Indigenous) and Negros (slaves from Africa). By the middle of the 16th century, black slaves of Africa would replace native Indians for refusing the labour force, much to do with ongoing fights with colonial Mexican slave masters. One can assume that the disconnection between a class system of segregation is also shared among most Indigenous peoples of Meso America today. The class system would propel Indigenous peoples to the bottom. Fundamentally, dislodges native artisans for the works of

stone carvings and monumental feats of engineering brilliance. Monuments would have no employment, vacated by Spanish architecture, or shifted along without land in place of cattle.

The Indios were then indoctrinated into the servitude where one could gain access to social Spanish positions of rank, such as a farmer, but politics and business practices were only for the Aristocrats. Mesoamericans have few options or nothing. The Indigenous Indians made up of Mayan, Incan and Aztecan peoples are converted to Christianity and some held on to healing rituals called curanderismo which means the way of healing as described by (Villa, 2016). But according to him they vary between tribes and is made up of three distinct cultures of influence being the imported Western and African peoples with native Indian heritage. Still, small groups of Indio's continued for the practice of mental healing and spiritual prayers, as the only means to keep a connection with sanity (Ramirez, 2016). Paralleled with Mesoamerican reflections in 1769 was Captain James Cook's medical doctor who attended observations in New Zealand had noticed that Māori had two doctors. One, a tohunga (high priest) for karakia (prayer), and two, a Māori surgeon who used obsidian crystal glass. The observation led to incantations being performed whilst the doctor surgically removed a patient's artery in the neck then using ointment to cure it.

White addiction

In England, by the late 16th century, two schools of medical practice were being developed for the appreciation in Galen who focussed on native plants, and Paracelsus who preferred chemistry. This would replace centuries of old fairy tales such as wizardry, sorcery, or witches at work. The continued practice of aristocracy would form a new dialogue of customary feudal changes in the classes. The reformation and emergence of theoretical works such as Martin Luther's challenge against the Pope and the Catholic church inspired Henry VIII to separate creating the Church of England (Anglican). With that in mind new generational hopefuls, writers and philosophers experienced radical changes in England and Scotland.

The sciences exhausted the pre-inquisitorial mysteries of the past, for new terrifying surgical instruments (and one could hardly differentiate between hacksaws, scissors, hammers and plyers), the old devices of criminal torture (Foucault, 1977). One such statement can be found in the writing by Michael Scotus, a student at Salerno school, "when you need to cut or saw into a man, soak a cloth in it (the anaesthetic mixture and put it over his nose for some time"

(Escohotado, 1999, p. 44). Regardless experiments were finding a way into the medical practice from borrowed ideas of European history to new radical testing products. In addition, what transpired is the root of chemical testing on animals then humans. Once opium found its way into England more product was needed as a painkiller vital for the support of continued medical practices and the early stages of psychiatry. Alcohol was the primary sedative, slowing responses, but less effective for pain relief due to the speed of delivery. More powerful methods without liquid form would arise in pills and injections (Inglis, 2018). By the time opium arrives in Europe the medical science now has the answer to deal with pain. The beginnings of addiction to drugs, chemistry and science, evolve with the illegal drug trade (Inglis, 2018). Once notoriety for healing became a fixation for traders, governments and addicts (Bargh, 2007). The first drugs to enter New Zealand were imported from Britain that helped to establish the first chemist and pharmaceutical businesses which included heroin, morphine and cocaine which were all legalised in Britain (Inglis, 2018). Shortly thereafter, these drugs were being imported into New Zealand and legally sold as such.

The history points to a contradiction of agreements, particularly between Britain and China (Policy, 2015). The drug Opium was known for its illicit practices, smuggling duties and a culmination of (British and Hong Kong citizens) inter-trade suppliers (Lewis, 1974). In irony, the illicit trade practice began as a banned substance, but Britain legalised it under the house of commons (Inglis, 2018). China's reality for the protection of its citizens could not stop exploitation for profit. (Karsh, 2008). Britain did not want anyone else in the drug market and two Chinese Emperors did not want addiction rates climbing. Both put bans on due to the potency of the smoking epidemic. However, the ban was refuted by underground Chinese traders, of course, black market traders who lived on little needed a substantial living. Coincidently, this was not the first-time prohibition was used.

Asian invasion

In 1729 Yong-Zheng (Yun-Cheng) the Manchu Emperor prohibits sales to foreigners in favour of smuggling. The poor who used Opium for recreational use (mainly tea) were being penalised ahead of smugglers. An edict was summoned, banning all imports to assume protection of addicts (tea addicts) but instead made deals with the noble elite in which they would take over the import market or try to. Unfortunately, the Emperor creates underground exporting rings (Karsh, 2008).

Later the same incident occurs in which this time the British Government takes over the monopoly of the British East Indian company. They interfere with merchants picking up the tab among smugglers whilst a ban was in place. Large profits would help to put Britain out of debt and establish a new neo-capitalist regime for the expansion of more ports in Hong Kong. The British East Indian company would lose its market and the Chinese mainlanders, those in poverty would undergo a diabolical transformation. They would desire the drug, imported from Hong Kong, the same drug being exported out of by the British East Indian company. What was believed to be free, medicinal use is now revalued, branded and taxed, as a demand product (Karsh, 2008). All of which Chinese citizens became heavily reliant, realising its mind-altering potential as if nothing else mattered. Queen Victoria by letter is informed of the British tactics in Hong Kong and the impact of addiction on Chinese people. The Chinese administration received no reply (Blistein, 2019).

Nicholas Saunders historian quotes "These conflicts saw the British Empire officially trafficking Opium and using military might to force narcotic addiction on the people of China. During these years, Britain created the largest most successful and most lucrative drug cartel the world had ever seen" (Blistein, 2019, p. 138). The Chinese Government rebutted Britain in fixing the addiction mess. Their solution to heal their patriots was to blow up the British export ships which resulted in the loss of massive cargos of opium at sea. Consequently, this led to the second opium war having lost the first war settling with the Treaty of Nanking. Britain now involved new allied partners, France, Russia and America. England already in India having some power over the poppy and opium fields wanted more profit. In the end, China conceded and a new treaty is formed.

The Hong Kong wars of the 1800s saw exports increase significantly to 6,000 metric tons (Gibson, 2011), (Inglis, 2018). Alcoholics worldwide would now face a new addiction, opium. The cost to the people with addictions was inevitable and a new era in drug woes. In considering the earlier developments of drug science, trade and pharmacology. Psychiatry would enter the medical realm for exploration of the brain. The 15th - 19th century revolution is the background to the pursuit of European medical experiments on the body and the brain is a fascination. The mind is an impressionable object for a doctor's microscope of inquisitorial probing as explained by (Foucault, 2003). More importantly, the mystery of mental stresses, which caused the body to capitulate in many forms was an investigation of many scientific theorists. In the early stages of drug testing, amphetamines were being

administered as prescription drugs for children. Previously, animal pilots would now become child explorations as useful for research. Considering the examples of mental discovery were two key ideas, ‘disorder and attention’. This was claimed as a breakthrough according to Dr Alexander Crichton as a disease of the brain (Crichton, 1798). Counselling remained a new topic but did not eventuate for at least a century when the realisation of mental health and drug addiction became problematic.

The new insights for healing resulted from past experiences, disconnecting but re-institutionalising the same rhetoric in different ways. Until then, scientists were actively seeking experiments with native plants such as Ephedra, a native plant from China and South America begins an era of chemical creativity to solve interest in hyperactivity and calm. In 1887 a Romanian scientist living in Germany named Lazar Edeleano first extracted Ephedra, a plant used as a tea, and chemically compounded the plant into a drug called Amphetamine and named it Phenylisopropylamine (Escohotado, 1999). In the same period, two major superpowers emerged into the world war scene, Germany, and Japan (Blistein, 2019). New potentially harmful drugs were trialled for the medical practice and war. A new central nervous system stimulant arrived that was synthesised in 1893, by Japanese student Nagai Nagoyoshi, who called the drug methamphetamine, but this was shelved (Hunt, Kuck, & Truitt, 2006).

Narcotics Down Under

In New Zealand the involvement with the drugs industry begins in the early 1900s, at the time of importing cocaine, heroin and morphine (Government. N. Z., 1901). The Pharmacy Act of 1868 (America) would be established by the Pharmaceutical Society in 1841 (Blistein, 2019). In addition, the government passed the Quackery Prevention Act 1908 to eliminate any prejudice about chemist medicines, thus supporting the society (Government. N. Z., 1908). Those provisions under the Opium Act 1908 allowed for the process of a New Zealand chemist (Government. N. Z., 1908). Previously the year before the Tohunga Suppression Act 1907 was implemented to reduce harm to what the Māori Members of Parliament, who passed the act believed was the attempts by secondary Māori tohunga with supernatural powers, foretelling the future and treating cures with little safety. All were liable for prosecution if caught practising medicines or cures (Mark, 2012). Indigenous healing knowledge was being pushed aside with the introduction of pharmaceuticals, Māori tohunga healing strategies would decline (Bishop J. , 2014). Māori cures were not available for

addiction to chemical-based substances including alcohol and cigarettes. Prohibitions led by Māori Members of Parliament would eliminate would-be dangerous tohunga performing careless healing practices assuming the role of a qualified tohunga (Sigman, 2011). Thereby tohunga-ism was rejected, not entirely, as the practice would go underground (Elsemore, 1999). For users of opium, it would not be until the Dangerous Drugs Act 1927 which delivered a blow to users. They would not be able to freely purchase nor use in public (Government. N. Z., 1927). By 1934 the government introduced the Poisons Act. Citizens were no longer allowed to trade unless they were registered doctors or a chemist. Drugs at were not supposed to be addictive, including prescribed drugs (Government. N. Z., 1934).

After China, Japan would look for alternatives for their soldiers. China and Britain by 1907 had just broken trade agreements and reduced production and plantation exports directed to India. Addiction rates still prevalent would decline, however much of the controversies of drug addiction and political competition for keeping the trade alive was the influence of corruption within political circles (Escohotado, 1999), (Karsh, 2008), (Peterson, 1977). The opium addiction still re-occurring would vanish completely by Chairman Mao in 1949. Mao establishes a rule of law for the protection of Chinese citizens from drug overdosing and addiction use. In considering the effects on Chinese people systemises the mass execution of smugglers, corrupt politicians and capitalists taking advantage of the poor. In a way he solves the addict problem, the opium trade would move from China to Laos, Myanmar and Thailand creating the Golden Triangle (Collins, 2015).

In 1919, another Japanese student Akira Ogata synthesised what we now know today as Crystal Methamphetamine (Centers., 2021). Better known as ‘P’ for Pure Methamphetamine (Inglis, 2018), (Rasmussen, 2008). The innovation of methamphetamine established a crystal-like mix with ingredients iodine and red phosphorus made into a pill called Pervitin for Germans. The Japanese name was Philopon. Soldiers called it a miracle pill. Reports of overuse indicated there were high heart failures and fatalities (Coleman, 2015), (Hunt, Kuck, & Truitt, 2006). Consequently, the German Army was given this awake drug for days without sleep for soldiers in the front line. This also included the Japanese Air Force Kamikaze pilots flying long distances (King J. , 2014). Little or no treatment was available for deprived sleep, the body could not adapt to long periods of deprivation.

Forced treatment

Foucault explains the narrative of forced treatment by straightening the tree and grooming it into submission (Foucault, 1977). Most often than not, soldiers highly dependent relapsed often needing more and they had little control of the substance they were taking. The products themselves tended to be tested on soldiers. They were not willing to say no (Rasmussen, 2008) practically emulating Foucault's narrative by conditioning the body into control by altering the mind through a chemical brain stimulant.

By the end of the war methamphetamine was introduced to Japanese communities via soldiers. Hitler's soldiers were victims of methamphetamine abuse. Hitler himself, was also found to have methamphetamine pills in his possession at the time of his death. More importantly, two issues occurred in the war, a soldier overcoming fear and forgetting that death was everywhere. The potential of this drug had an astonishing mental effect, that could block out trauma (Holt, 1989), (Rasmussen, 2008). Alcohol was the former primary leading addiction to smoking. Most mental health treatments available were being offered for medical trial experiments. This was specifically for cancers and leukaemia so naturally funding for these drug treatments was considered first (Foucault, 2003). But the reality of addiction should not be blamed on imports. Home brewers make their own kits passing it along to friends to taste and enjoy its strength (Anonymous., 1988). No one knows what else is in the mix, but it can be assumed that it is unsafe.

Any community funding for drug treatment was not seen as an important fix for mental health. Drug addictions were a mental health issue, not a medical one, which in the case of that mental health treatment practices, also did not exist. Specifically, not the care of the person with an addiction. Medical practitioners often debated the resources available for care, notably because they were surgeons, not trained counsellors (Aldridge, Measham, & Williams, 2010), (Covey & Taylor, 2008). The epiphany was that treatment for addicts was not available in the first place, due to a lack of resources (Lewis, 1974).

Healthcare views that established their perceptions about individuals based on the gaze of personalities outside of the church (Foucault, 2003). Patients with addiction to drugs were historical notions of cultural inadequacy (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). Poverty groups were treated with less vigour and separated from the classes.

Marxist theory implodes the class structures, where those who come from poor rural or urban sectors to be held with less priority. Those sentiments are shared by theorists who dissect the system of care to be disconnected from the realities of the classes. Treatment facilities often supported the wealthy class. Therefore, Christians were more likely to afford proper medical care and so the institutions of medical experiments continued with little appreciation for counselling.

Religion and Politics

Foucault explains that the institution of the prison is isolation and surveillance. The Western medical profession of care and treatment underwent serious health impacts on people who needed the right treatment of care socially (Foucault, 2003). The church and science came out of the enlightenment where the church and scientific rationale divorced (Bishop J. , 2014). The church and state would be separate entities and the government would take control of society's physical, mental and social wellbeing. Not only, but the medical institution which in the 18th century was conditioned by biblical principles (Rosen, 1993). There is evidence to suggest the pathway of medical philosophy was built on three key ideas, scientific rationality, reason and progress (Abimbola, 1993). This is basically to claim discoveries, invent wars and package them with achievement toward victory (Blistein, 2019). At one stage in history organisations were bent on understanding the needs of individuals with physical disabilities (Collins, 2015). Sickness of the mind and mental health were thought to be criminal, sadistic, or decease related. Addictions were constructed as an evil spirit and religion divorced the realities of humanness (Newman, 2010). The church and government were historically tied to each other because the education system and curriculum were constructed mainly for non-Māori students seeking medical practice. But there were exceptions and Māori did become doctors (Bishop J. , 2014).

The best care offered for society in the 19th century would be the communities who underwent mental health wellbeing by themselves. Until then medical practitioners sought to experiment with treatment painkillers, seeking their answers (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). English practices of institutionalism when colonisation appeared to many Indigenous cultures, retranslated Māori knowledge through language. Māori language for hundreds of years was read through carvings (Bishop J. , 2014). That was the way writing was conducted and storytelling. New Zealand’s medical practices did not reflect care towards the families.

The dichotomy of institutional care and medical care was reflected in colonial English ideologies. The medical profession sought to create some forms of awareness around the need for better mental treatment of patients but lacked research on addictive substances. An emphasis on psychiatric drugs was encouraged as a recovery tool for mental illness, rather than a cure through dialogue (Kemp, 2012). In 1949, drug manufacturers capitalised on communities particularly women who wanted to lose weight. Drug addiction resulted in leading companies around the world who dedicated themselves to large-scale sales of amphetamine, which resulted in overdoses being overlooked in New Zealand. The result of unregulated misdiagnosis led by leading experts on drugs at an event held in Southland 1956 requested a push for recommendations of weight loss tablets to curb pharmacy prescribed dependency (Drugfoundation, 2016). In 1969 a visit by a leading professor from Britain urged New Zealand doctors to be aware of those wanting amphetamines for weight loss he stated "doctors were prescribing amphetamine type drugs for patients wanting to lose weight are guilty of malpractice" he warned (Sanctuary, 2018, n.p). Malpractice is a doctor's responsibility to care for patients using a drug that has a warning label. Although manufacturers must ensure they are approved and assigned the correct use such as weight loss to meet all safety requirements (Crisanti, 1998).

Illegal alien

New theories to help addicts were being tested where Curt Richter used rats by dropping them into buckets filled with water to test their resilience. The study found that domesticated rats lasted longer for survival than wild rats. In another study thirty-four wild rats drowned when they were considered to survive at all extremes but died within minutes. The aim was to determine whether resilience could be a motivation for surviving in what the bucket was conceptualised as the bucket of stress (Richter, 1957). Other studies with rats in the pursuit of experimentation and the link with human behaviours was the behaviour sink. John Bumpass Calhoun first started experimenting with rats on a farm for the national institute of mental health in 1954 (Ramsden & J., 2008). Further studies developed what he proposed to be a rat utopia where many rats could enjoy food, water and play ramps. Increased studies constructed ideas for the support of human populations and overcrowding. These studies helped the governments to understand and manage large communities with patterns of eating, drinking and hostility within a small space.

These studies would prove vital to solving mental health issues with individuals, families and communities. Burrhus Frederic Skinner known largely to the scientific community as B.F Skinner wrote the theory for behavioural social conditioning through an experiment called the Skinner Box method. Skinner reintroduced Pavlos's theory through his experiment. Skinner believed that the social conditioning of behaviour was conditioned by rewards (Adams, 2009). Skinner's book released in 1957 mentions the operant condition chamber used on rats to conduct responses reinforced weak or strong signals to the brain. The observations have been conducted on a rat pulling down a level in the chamber. The rat would then apply the level method and receive food. If the food is not released then the rat would become disturbed of which demonstrated the theory that the rat was now dependant or addicted. The research findings informed positive and negative reinforcement procedures for education systems and psychologists (Amy, 2003).

New age treatments (1960s - 1990s)

The 1950s saw the legal right to use psychotic drugs apart from alcohol was illegal. Marijuana was imported from ships around this time and users were mainly art and jazz lovers. Anna Hoffman was sent to prison for 6 months for supplying a police officer undercover. The New Zealand police believed that marijuana was linked to then beer house rivals competing for after pub drinking spots without a license. Two people were killed and police believed that marijuana was the cause (Mohi, 2019). During this time the government was on its way to introducing laws from insights by American law policies (Becker, 1974). American bikers during the 1960s introduced methamphetamine to the street scene. Soldiers who returned from Vietnam and overseas tours had few employment options. So cooking, selling and distribution made their way into biker communities, mainly the unemployed of society (Hunt, Kuck, & Truitt, 2006). In Hawaii amphetamines and methamphetamines found their way into the homes of Indigenous Hawaiians (Justice, 2002). The evidence points to Hawaiians unemployed being most affected and for most methamphetamine cases supply and sale have come out of the poverty-stricken suburbs.

The late 1960s in popular culture, sex, drugs and rock 'n' roll was a hit for partygoers at festivals looking for psychotic drugs and the need for addictive treatments was beginning to take a toll on most governments looking for solutions. Institutional care and hospital care were often met with force as police were not trained to respond to addiction (Hunt, Kuck, & Truitt, 2006). Neither were they able to ascertain the activity of the drug of the brain which

needed specialised education and training. More research was needed to explore the human condition concerning addictive substances and their causes.

Social experiments

In 1970 Bruce Alexander created a rat park becoming one of the most prolific studies on human attachment to drugs but specifically directed toward the environment. In the first experiment a cage for two rats was set up with two separate compartments. Each unit had a drinking container with water and heroin, both rats died. In the next experiment twenty-two, male and female rats were crowded together in what was described as a rat park. The results showed that only two rats rejected the heroin, even with treats, running on cylinders and through can caves (Alexander, 1985). The theory described the model of human crossroads where rats in cages, which resembles society, were identical to the regime of government. This theory gave some perspective of people in terms of change. Conditionally humans may not be motivated to change their circumstances if those environments are set up for people to fail. The idea was based on the social conditions that humans have been given to live in. Some theories argued this model reflected social groups mainly aimed at poverty (Gage, 2018). In reflection of Weber, a Western economist, aims at the institutionalism of past leaders who he did implore as radically responsible "Not Julius Caesar, but Caesarism; not Calvin, but Calvinism" (Gerth, 1946, p. 55). In a sense what he is stating is governmentalism.

It wasn't until sports athletes started featuring in the news providing full disclosure about their private life that regulations of drug use among celebrities was exposed. This was often met with the law but not so for prescription drugs or amphetamines. One race that would set the world alight was the 1988 Olympic final between Carl Lewis and Ben Johnson in the 100-meter sprint. Johnson at the time posted the fastest ever recorded time of 9.79 seconds in history (Jackson S. J., 2004). Johnson would be labelled, branded and disgraced. However, behind the athletes, the fall from grace including the coaches who supplied and influenced his drug-taking did not suffer the same public attention (Beckett, 1979). Ben Johnson admits when first encountering anabolic steroids (methamphetamine) he did not know what they were, but admitted using them, before being caught out. After that the first doping controls were administered in 1976 by the International Olympic Committee testing for steroids in blood. Despite the concerns temptations to use performance-enhancing drugs have remained an issue for the athlete. The lack of education for sports athletes involving amphetamine methamphetamine-type stimulants needed support after Johnson's admission. Since then,

research into coach influence, prevention and education has been conducted to improve the safety of athletes and coaches' knowledge of PEDS. In 2003 The World Anti-Doping Code was set as law so that cheating would be punishable as a crime (Kolt, 2012).

Pharmaceuticals

The suppliers of Germanies Pervitin as previously mentioned competed with America's Dexedrine (Collins, 2015). Amphetamine was responsible for treating depression in adults and boosting self-confidence. America found anti-depressants were being used by 11.4 per cent of adults and 6.2 per cent for young people between the ages of nineteen to twelve. The research pointed to amphetamines. Later amphetamines would be used to treat addiction to cocaine and heroin. Up until then pharmaceuticals mass marketed the prescribed drug and at that time the government did not regulate drug companies. Consequently, the market was saturated and treatment programs for addiction were being outdone. The governments were unaware of the dangers of amphetamine prescriptions, including the companies producing them, despite an explosion in sales. In addition, so did the methamphetamine black market operating underground. Initially, what started as an introduction by bikers, grew and competed with the supply of prescription drugs which became a nationwide problem for governments. Chemical companies started aiding gangs in the consumerism of methylphenidate and iodine by the barrels. Significantly, publications about prescribed drugs and the relationship causing fatalities were sorely missed. So too were the inquiries of ingredients for companies supplying chemical substances (Collins, 2015).

The controversies about pharmaceutical sales and stimulants brought awareness by movements against another amphetamine Ritalin. Resistance groups believed that Attention Deficit Hyperactivity Disorder (ADHD) was socially constructed to prove Ritalin was the cure. Movements tried to ban amphetamines against children, solely because the evidence suggested ADHD was nothing more than a money scheme. The movements expanded publications to assert knowledge about pharmaceuticals exploiting diagnosis for capitalism (Crisanti, 1998). Ritalin follows the true story of who this resistance was led out of, debated a doctor's wife named Rita. Noticing her slow responses to playing a game of tennis (Collins, 2015). The observation led the doctor to prescribe his wife a dose of amphetamine to help her with her reactions to what she believed was enhanced performance. The name was changed from methylphenidate to Ritalin. Coincidently, pharmaceuticals disguised methylphenidate as an amphetamine, which was really methamphetamine along with Desoxyn and Adderall also

use the same ingredients as dextroamphetamine (Covey & Taylor, 2008), (Leamon, 2003), (King J. , 2014). Methylphenidate was also used to treat addiction to cocaine including methadone to cure heroin addiction and drug disorders particularly against opioids (Arunogiri, Foulds, Lubman, & Mcketin, 2016). Though nothing had been found to cure methamphetamine addiction. Fatalities occurred between the medical profession and pharmaceuticals when doctors were overprescribing without any responsibility to ethical accountability. These drug treatments were seen as the answer to treating behavioural and body impairments. A study in 2009 by the Federal Drug Association (FDA) provided new insights into the drug Ritalin and the risks to children with ADHD (Levy & Siqueira, 2014). Evidence of sudden deaths was related to cardiac heart patterns (EMCDDA, 2019), (Arunogiri, Foulds, Lubman, & Mcketin, 2016). Other reports emerged of amphetamine fatalities when stimulants methylphenidate, Adderall and Dexedrine resulted in a total of twenty-six cardiac child deaths between 1992 and 2005 according to the FDA (Rasmussen, 2008).

Human experiments

The early history and introduction of nervous system stimulants and their effects should be classed as a history of catastrophic experimental disasters (Alexander, 1985). Treatments for the mind were offered by scientists for progress to match pharmacology, that is to say being rewarded by investment companies. Conversely, scientists were ethically relaxed instead of practising safe accountability. Given the nature of methamphetamine treatment, real insights do not begin until the 20th century. Medical trials in the early 1970s sought answers to cure cancer and leukaemia so studies on methamphetamine and amphetamines were largely ignored. The early years of treatment progress for the medical fraternity were more interested in how to find solutions for cancer diagnosis and finding the right chemical product that could be used as a formula against leukaemia in children (Aldridge, Measham, & Williams, 2010), (Becker, 1974). Another reason why methamphetamines should not be compared with amphetamine prescriptions in reports is that there are two types of methamphetamines used. They are similar, but not the same. The reasons for uses are different, addiction to amphetamine prescription tablets. They can be modified and crushed into powder then smoked or injected (Covey & Taylor, 2008). Crystal methamphetamine is predominantly confined to smoking from a glass pipe (King J. , 2014), (Raki, 2010). Amphetamine was a doctor's responsibility to act with care for the prescribed which became an underground illegal recreational drug like cocaine and heroin (EMCDDA, 2019). Notably, governments

were slow to react, so imprisonment was the only suitable choice to discourage use. In other words, the governments turned a blind eye with little or no response for drug education and acted as if the drug never existed. Admittedly, they got that wrong and pushed for amphetamine regulation, monitoring supply and then suddenly methamphetamine exploded into the night scene faster than any other drug used for recreation. Methamphetamine was the new cheap thrill being used intravenously, snorted and smoked (Arunogiri, Foulds, Lubman, & Mcketin, 2016). Methamphetamine became the 'walk-away' drug, predominantly because users left all material possessions, either sold or exchanged. This was known as a 'white man's cheap high', most used among poor Europeans (Crisanti, 1998).

The early 2000s undertook research for the support of users would start to take place. A national drug survey conducted in America in 2002 found 210 thousand children as young as twelve tried methamphetamine in 1991, by 1998 the number doubled to 454 thousand. The increase was a result of purchases of pseudoephedrine being sold in chemists over the counter. The US Government immediately banned the sale of counter sales and a drop in production by the Combat Methamphetamine Epidemic Act 2005 helped to eliminate communities from risk (Coleman, 2015). The first time that the US Government tried to fix methamphetamine addiction was by reducing product sales in Ephedrine (Laqueur, 2014). In comparison to America and the rest of the world seeking answers to a prolific crisis about to unfold, Portugal did something out of the ordinary. In 2001 noticing the complex needs of society and the harms of addiction to prescription medication and illegal drugs.

Deregulation

The government decriminalised all drugs formatting a new policy administered for minor drug offences to be rolled out through a Five-pillar framework of the prevention strategy. The key notions consisted of legal, diverting, reducing, treat and reintegrating (EMCDDA, 2019). The first major obstacle was a drug offence. This led the government to change how supply was being managed. Use and possession fell into a civil matter (Collins, 2015).

Any non-prescriptive drug is removed from the person/persons and must appear before the Commission for the Dissuasion of Drug Addiction (CDT), or government-appointed clinician, social worker, and solicitor (Hughes, 2010). Specialists will then report the findings of a person's overall health and well-being for reasons of use. An assessment may indicate broader social issues such as unemployment, family or economic stresses. The CDT can

advise Community Service providers for treatment therapy including professional help. Portugal also invested heavily in drug services to reduce harm through Public Health models (Felix & Portugal, 2015). Provisions sought to cater to the drug-related locations through better resourced community hubs facilitating free mobile health and drug advocates. Cost effective housing, employment options and day to day programs for users to occupy time (Felix & Portugal, 2015). The illegal production of methamphetamine also began a series of home cooking options when users were mixing more potent chemical products. New methamphetamine concoctions were being made using iodine and hydrochloride. What is more potent is new chemical ingredients that have devastating impacts on a cook or user. The brain's reaction to the new drug was also causing a wave of production manufacturing unknowns. More powerful than the first was now the most used recreational drug of all time. An epidemic was growing and it was coming out of the music, arts and manufacturing industries (Deyo, Fowles, & Kester, 2016).

Despite evidence from Portugal's successful results, other countries with high incarceration rates continued the battle for war by hunting methamphetamine gangs as the solution to stamp out the problem (Laqueur, 2014). Considering though that there was enough evidence, education and possibilities to enable care through addiction treatment. Many countries including New Zealand have decided not to consider decriminalisation to be an effective tool, which may be an option but you would think since 2001 that Portugal's results would be the motivation for every government (Police, 2021). Collectively they could find little or no grounds for treating users with a decriminalised perspective. To that end, criminalisation enhanced exponentially in countries wanting to develop more prisons, criminalise more gangs and solve the issue through the court systems (Justice, 2002). In reality the seemingly tried and tested approach is a waste of government resources and taxpayer funds. What Joseph McIvor alludes to is the social engineering of strategies that align and direct political messages toward drug use. In basic terms this is creating a supply and demand chain for a limited product legal or illicit called 'prestige pricing'. Companies around the world since 1953 have used this theory to manage competition through advertising, marketing and impression (McIvor, 2009). As Milton Friedman put it "See, if you look at the drug war from a purely economic point of view, the role of the government is to protect the drug cartel" (Glusniewska, 2016, p. 4). The cartels can smuggle into almost any country, get caught, raise awareness through the media, law enforcement and create a price trend in cartel circles. The hardest country to smuggle methamphetamine becomes the competition country. A kilogram

of methamphetamine in New Zealand would fetch between $150, 000 to $250, 000 (Police, 2021). Whilst New Zealand's borders are difficult to dent by imports, the theory of price hiking is an assumption of rarity and quality. The cartels have massive market power. They can dedicate thousands of smugglers for one large payday at the price of $1000 a kilogram made in their backyard, or basically somewhere in the jungle (Schneck & G., 2014). Until recently only four countries have decriminalised all drugs except for some states in America largely due to policy (Jesseman & Payer, 2018). According to (Arunogiri, Foulds, Lubman, & Mcketin, 2016) clinical based treatment for recovery were mainly centred from addicts to alcoholism with spiritual sin disease or just disease theory. This was not a winning formula because they were accepted as an illness, much like the flu. In the case of past research many clinicians were not aware of the time a drug was known to leave the system in the body. Therefore, professionals were not able to deal with highly vulnerable people coming down from a binge. Again, drug-related moral diseases could only be cured if the client was willing to admit fault and follow abstinence. You must stop. These aggressive arguments would reduce freedom of choice and impede guilt and shame on individuals who only wanted to be treated with dignity and humanness (Baier & Wright, 2001).

Popular to belief, some organisations and clinicians may continue to use this theory should beware of such deep traditions principally if they belong to a religious group. Critical Freudian theorist concepts also developed tools for a conscious acceptance of self by knowing the unconscious self. Freud posits anxiety as the motive behind unconscious desires that disable the function of the mind to behave when confronted with addictive urges. Addiction to substances therefore can motivate and centralise thoughts of achievement if the self agrees with its conscience is what Freud calls the false self. For someone to understand addiction one must first admit that there is a problem with the self being addicted. In addition to increased awareness of a person's past, one should treat self with mental toughness. (Holt, 1989) states that Freud attempts to build mental strengthening by the admission of the past and creating a new hope strategy where dependence on drugs and alcohol is now reversed and treated with acceptance and forgiveness. The interpretation of this example is that the conscious mind must operate based on understanding the past in terms of progress. The subconscious of ideas being held by the past must be brought into the present such as sexual victimisation, trauma and historical connection to family substance abuses.

The public system

In New Zealand several belief systems existed toward drugs, crime and recidivist drug use (Laqueur, 2014). Prison based drug treatment programs are relatively new in development and questions are still being considered around the impacts of the prisoner on the community (Dahlby, 2009). There is opposition. Until recently in the last decade, New Zealand has looked at implementing strategies for prisoners to adjust back into society as drug offenders by creating programs within the prison system. Voluntary groups will visit during the week to help prisoners talk about drug addiction in a group setting (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). Programs can be monitored by staff to prove that regular seekers of addiction are turning up and thus building at least some accountability to accepting a crime for using (Jones, 2018). That on one hand, is a model that may be working in the Justice system and proving to be working well through observations and reporting. But on the flip side, there is no reporting about the individual's experience of change. No indication that addiction programs on the inside are working at all (Arunogiri, Foulds, Lubman, & Mcketin, 2016). Critical reasons could be deliberate and that addiction and recovery programs should only be accepted by professionals outside of prison. This notion is somewhat in line with policy hardliners who still view prisoners caught with drugs as the scourge of society. Prisoners need to be cared for differently and treated with the harsh reality that if you use and disobey authority then you should be punished accordingly (Arunogiri, Foulds, Lubman, & Mcketin, 2016). Prisons, therefore, are not rehabilitation centres they are punishment centres for unwilling misfits who do not wish to conform to society's standards. The correct procedure is to accept that the misuse of drugs by use is also an act under the law that is punishable. The reform asks those who make the law work for the treatment of prisoners (Felix & Portugal, 2015). These beliefs are mainly held by authorities who believe that the drug is more criminally potent than the person’s ability to manage life without it. Statistics proved that offenders of use are classed in the same category as suppliers and dealers.

During the 1970s and 1980s the most reported crimes involved the use of drugs (Collins, 2015), (Lewis, 1974). Policymakers were convinced that treatment centres outside of the prison were not working. To reduce crime and drug addiction one should be locked up to create the will of a person to change due to other influencing factors outside the prison. Those factors included family, children and grandparents (Alfred, 2017). The mental disconnection and reawakening of the self-excluded from a drug users family should be enough to change a

person’s addiction to both crime and substance abuse. On the contrary, this could not be further from the truth. Currently prison sentences have tripled around the world in countries with poverty areas. Conditionally, more prisons are being built and less rehabilitation is being sought by governments (Cram, Te Huia, Te Huia, Williams, & Williams, 2019).

The Justice System and the Public Health System were largely disconnected by the government's response to challenging bad behaviour in the community. The Justice systems have been the first in line to deal with Alcohol and Other Drug (AOD) problems before mental health treatment practices (Gordon, 2019). In 2013, 64% of referrals from the court went to addiction services. 61% of people charged in court used a mental health service whilst 70% started with service after being in contact with the police. The complexities around drug harm are important to understand the differences (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). That drug harm to self should have been reviewed as a significant health issue, not a criminal one. Secondly that the drug position of selling is completely different and should be treated as another type of diagnosis for recovery, mostly acquainted with poverty (Felix & Portugal, 2015). The mental health and wellbeing of institutionalisation led to public perceptions of a lunatic or mentally unstable person having many critics attached to patients with supposed illness (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). Most illnesses assumed that one could not contain the use of alcohol moderately, so the courts found that treating people with the lack of willpower needed reinforcing and medication. This idea fuelled the pharmaceuticals for more drug dependant tablets to cure patients with alcohol syndrome but pushed asylum patients to addiction with prescribed drugs (Covey & Taylor, 2008). Later awareness and support for deinstitutionalisation started to gain traction for the closing down of these mental hospitals based on two factors. Cost to the ratepayers and the need for prescription drugs outside the mental institutions (Becker, 1974). More effective research is required for supported rehabilitation in prisons to assist with prisoners as human beings and to provide the connection between the human being and other humans in society (Foucault, 1977). Furthermore, the protection of communities should be met with better knowledgeable prisoners who would further develop other family members. Funding tended to be the problem between government spending with the Justice system and Public Health sectors (Becker, 1974).

Institutionalism

The issue for recovery and treatment had to do more with policies between the Justice systems critique of acknowledging offenders but referring them from the courts to health agencies (Schneck & G., 2014). Breaking the cycle of change created new Justice system creations separate from the public health system where the hospitals were the bed at the end of the cliff. Instead of acting on the belief that the court system for minor offences could lead to prison. The Justice system should have allowed for more consistency of AOD clinic-based approaches to countries that were already deinstitutionalising the systems of punishment such as Portugal (See, 2007). New Zealand instituted an American framework for two AOD treatment courts in 2012, also included treatment courts for youth (Williams, 2001). The implications of research-based answers to treatment was not always sought to discredit users and their ability to use without a prescription. The governments sought to discourage drug abuse rather than abuse, encouraging that use to be controlled even illegally. But governments focussed on the drug and the individual as the problem (Nui, 2010). In addition, the outcome the governments wanted to achieve was a practice of safety by eliminating the use once and for all. Treatment centres that were funded offered support for individuals through work-based treatments such as AOD clinics and outside of work. However, drug overdose problems did not stop users including recreationally users (Felix & Portugal, 2015). From the 1990s the welfare of addicts became an important discussion to eliminate overdose.

Short term stays in rehabilitation centres were not always successful and so more long-term stays were found to work better (Arunogiri, Foulds, Lubman, & Mcketin, 2016). Though centres were only able to cater for professionals willing to pay for long term stays and short termers could be picked up by the public health centres offering drug addiction help. This created a vacuum for recidivist users who needed long term support but could not afford the treatment (Borrowdale, 2020), (King J. , 2014). Not all drug addiction centres were available certainly not after hours of work. In effect many centres were not applicable for full time workers who could leave to get help and thus fell into a crash and give up scenario. This created the short-term addiction effect where addictive behaviours were treated within the hour. However, they could not maintain the longevity of quitting due to the uncompromising hours treatment centres had. Also, some centres turned away patients wanting treatment because they were not willing to spend extra time. Detoxing compared with prison was used as a similar method. The issue for treating methamphetamine addiction is withdrawal.

Methamphetamine is not like any other drug due to its chemical potency to change the mind within 15 minutes lasting for 6 hours. Yet according to former users it is possible to quit (Gordon, 2019). The withdrawals that doctors educate is crash within a 48-hour window, abdominal pain and sweating from coming down. The next period is between 3 to 10 days where the body tries to recover whilst craving for methamphetamine (Hunt, Kuck, & Truitt, 2006). The next stage is the fourteen to twenty day withdrawal where the mind is now tackling other thoughts finding solutions and asking questions about the self. Finally, after a month the depression and suicidal thoughts start to occur. No longer is methamphetamine an upper but has reversed the psychological damage to the brain (King J. , 2014).

Kaupapa Māori intervention (1990 - 2021)

History from around the world with the discovery of medicines, theories and treatments was becoming more prevalent to develop better treatment processes. Especially for cultures that had specific cultural needs (Dance, 2018). Mason Durie and other prominent Māori clinicians recognised the need for better health services and outcomes for Māori. Partly because the last 150 years had been delivered by non-Māori. Developing Māori programs that aligned more with non-Māori thinking would be a tough challenge. Many Māori researchers devoted their efforts to seek out the explanations of Māori illness, life expectancy, death rates, unemployment, education, qualification and household incomes (Gordon, 2019). In addition, more research had to be conducted on the grounds of trauma, colonisation and economic efficiency for Māori to compare historical injustices with addiction to alcohol and drugs. Also, what types of effective treatment were required especially since Māori treatments of the mind were not readily available and when they were, they lacked cultural significance.

From 2001 to 2003 a study measured data with females who used methamphetamine and showed that white females made up the larger proportion of use at 57% whilst Māori were at 31%, then Pacific at 8% and Asian at 4%. This study also compared alcohol to methamphetamine showing that Māori women out of non-Māori were 32.2 times more likely to engage with methamphetamine. The data was matched with American statistics where 40% white and Hispanic 25%, with Hawaiian at 18%, then Asian at 10% and finally Black at 5%. Out of all drugs marijuana, tobacco, alcohol, ecstasy and amphetamine, methamphetamine was used the most internationally with 94%. The second highest use of any substance was both alcohol and tobacco at 51%. America had the highest worldwide use of methamphetamine which was 97% (Borrowdale, 2020). The study was to prove female

mothers and fatal motor development in their children who had symptoms of methamphetamine and what those differences would be to children up to five years of age. The research also pointed to methamphetamine pregnancy being disregarded. Whilst Māori women and pregnancy are an issue to seek appropriate treatment, methamphetamine addiction treatment for pregnant Māori women remain largely unnoticed by the Justice system according to court documents proving that treatment is rather scarce for pregnant Māori women. Most Māori mothers are either incarcerated while pregnant or are about to lose their children through Oranga Tamariki (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). Services in the Eastern Bay of Plenty have been working alongside methamphetamine users particularly Māori organisations such as Ngāti Awa Social Services, Te Puna Ora and Tūwharetoa Health (Alexander, 1985). Other aspects of the national discussion around methamphetamine use should be noted that Northland, the Eastern Bay of Plenty and Christchurch had the highest levels of methamphetamine use found in data supplied by water treatment facilities (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). The crises though were brought to public attention when two major disasters struck. One, an earthquake in Christchurch followed by a volcanic eruption offshore from Whakatāne at Whakaari-White Island. This series of unfortunate events was further impacted by the pandemic outbreak of Covid-19. Methamphetamine use jumped but not in Northland with the highest rate. The government had reacted with a stimulus package for all three centres to concentrate on employment to those communities. Methamphetamine addiction is not so much about addiction but rather the control of the substance to create addiction treatment. In other words, admitting addiction is the correct answer for solving addiction problems for addicts (Dance, 2018). However, the government's response to methamphetamine addiction treatment needs more support by legal policies of care, rehabilitation facilities and education programs building awareness in the communities.

Government denial

The government is aware of the problems with illegal substances. What they can do better is implement intervention policies for users. They are arresting substance users when they use but not providing an alternative care such as rehabilitation (Borrowdale, 2020). The fact is the use of methamphetamine as an illegal substance is not as harmful as alcohol and tobacco (Becker, 1974). Studies can prove that the government positions illicit drugs toward poverty therefore punishing users in those areas (Yaacoub, 2017). The current belief is that the addict doesn't want any help, nor wants to get help. Therefore, the only way to deliver help is

through punitive criminal punishment. The government needs better strategies to readdress policy for transformational change to occur for Māori (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). Māori organisations are currently funded by the government to create authentic addiction treatment programs. However, the users will continue to be monitored by clinicians who provide data back to government officials. Critically, reporting is aimed at individuals who need treatment yet fail to recognise the efforts of families with addicts in their care. Largely this is a major downfall of policies around reporting especially if reporting is incorrect (Coleman, 2015). There is research by neurologist Dr Carl Hart who indicates that methamphetamine is no different from any other drug as an addiction. He emphasises the true risk is the lack of government interventions and treatments associated with the drug. (Hart, 2012) explains that the issues of the past were to rid the drug of the problems to society and its community due to its dangers. Like crack cocaine, the slums and low socio-economic areas that were causing threatening its communities. According to the research, evidence-based methamphetamine harms were inventions of hysteria. Hart proved that crack cocaine was more expensive than powdered cocaine and a report he concluded found that 90% of blacks were being arrested for powder, not for crack cocaine (Jackson S. J., 2004). Even more grossly found that crack cocaine and powder contained the same equal amount, yet blacks were the targets and mainly because crack cocaine was a white man's drug for those who could afford it. Similarly, whites who lived in poverty developed methamphetamine as a cheap alternative. Dr Hart believes that treatment should be about the known stigmas that are attached to minorities for enforcement (Hart, 2012), (Borrowdale, 2020). The treatment perspectives shed light on the political insights of the government's interaction with society drugs and the effects of addiction to prescription medication, illicit drugs, the law and addiction treatment. The government continues to irradicate illicit drugs. The government's response to drug treatment is to conveniently target poverty with enforcement as the last resort for care. The literature for this thesis points to a range of specific arguments about the use of treatment to the abuse of addiction of methamphetamines. The last twenty years, for Māori addiction rates, have been disastrous.

In conclusion the review of literature raised key concerns regarding the evolution and new revolution of methamphetamine worldwide. Treatment for methamphetamine has largely been ignored while in New Zealand. Therefore, what is urgently required for Māori and non-Māori is a new model. The next chapter will present a new framework in finding solutions to tackle methamphetamine and provide effective treatment.

CHAPTER 3

Methodology

I poua mai au i Te Awa o te Atua, i Rangitaiki, i Ōrini
i Ōhinemataroa e

The purpose of this chapter examines the methodology as an explanation of techniques and theoretical frameworks that explain a Māori and non-Māori theory definition. This chapter provides the evidence to justify the need for a Māori framework. In doing so presents a model designed specifically for this study.

The meaning for methodology is taken from the Oxford Dictionary website which means a variety of methods used in a critique of research explanations “methodology for investigating the concept of focal points" (Dictionary, 2021 n.p). The difficulties when researching is articulating the word ‘methodology’ even after identifying and simplifying the mechanics. Simply understood a methodology is the research of qualitative or quantitative inquiry.

Māori medical treatment

The history of Māori medical treatment was well advanced, specifically surgical precision (Buck, 1994). Observations led to other scientific research on the treatment of Māori medicines that Indigenous medicines were a Godsend (Blistein, 2019). Māori learned that the brain was an encyclopedia that holds a library of plant information and so repetition of the environment by naming was key to their survival (Robinson, 2005). (Mandani, 2004) explains even before New Zealand Indigenous experienced natural cultivation practices, medicinal uses were purposeful. The healing medicines and native plants remained seemingly unexploited (Inglis, 2018). During the time Māori health plants were being extracted for medicinal purposes only (Lewis, 1974). Māori health experts agreed Māori mental health was intact and no known addiction was sought to exist but plant life (Alfred, 2017). Therapy for illness, disease and psychiatric evaluation was deemed with little significance. The system of treatment remained a hierarchy of needs (Foucault, 2003). The medical profession maintained a deviant perception of any knowledge forms apart from the European medical practice (Rosen, 1993). Mātauranga would not be considered but also any other form of cultural care.

Recognising the problem

Clinical practices needed to be reviewed within the reforms of policy and services that offered New Zealanders opportunities in health but neglected Māori as its partner in how those services should be discussed (Caccioppoli, 2005). New Māori researchers Mason Durie and Graeme Smith were able to lead better research development for a broader inclusion of Māori health treatment research possibilities (Smith G. , 2003). Firstly, researchers needed to prove that there was an existing problem within the public health system that was not benefiting and reflecting Māori cultural needs. Secondly, Māori research support needed to be reflected by the government's response to the treaty and its partnership with Māori under those clauses (Gray-Sharp, Tawhai, & V., 2011). Thirdly, Māori statistics required better success stories, instead of the continued poor outcomes (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). That was due to the punitive policies not recognising cultural treatment delivery. In recognition of these ideas, Mason Durie implemented a guide under the CHI model to ensure health providers recognise cultural obligations when working with Māori. The framework included cultural safety, te reo Māori and cultural understanding. Cultural impact reports from several hospitals agreed that the cultural competency needs better evaluation and response to the needs of Māori as was North Health's summary in their report. In comparison with other drugs and services, even community events to discuss addiction to substances. Māori is still less likely to use addiction treatment services voluntarily. Treatment orders are more likely to encourage Māori as they are part of an order by the courts (Cram, Te Huia, Te Huia, Williams, & Williams, 2019). More specifically, programs and initiatives for methamphetamine clinics started to rise in the late 2000s because there was not enough information about methamphetamine addiction to support it (Borrowdale, 2020).

The reasons Māori do not attempt to seek help with methamphetamine is the notion of harm that the drug causes to the community. This also has implications where the social stigma of being accountable for a harmful drug in the community is affecting whānau and hapū. Although studies on methamphetamine stigma are not well researched as Māori postdoctoral fellow Dr Erena Wikaire explains in the Te Ao Māori News item, "as far as I can find, there are very few, if any, studies to date that ask Māori why they use these substances. There is very few Māori given the opportunity to express Māori concerns. However, there is a lot of non-Māori who voice issues concerning Māori. Not much research is being undertaken from people who have lived experiences with methamphetamine recovery (Tyson, 2020).

Mātauranga Māori

Mātauranga Māori as an appreciative work needs to uncover the methodology approach and what that Māori knowledge consists of. Even to use a Māori framework without critical thinking is an exercise for perhaps a non-Māori bias (Bennett et al., 2020). Distinguished Professor Linda Tuhiwai-Smith positions methodology to the scientific rationale of extraction and data of a people through identification and observational theories, mainly non-Indigenous perspectives. Kovac presents Indigenous methodologies as being qualitative procedures within the natural cultural environmental theory. Creswell argues that a methodology is a knowledge system being able to fit any worldview through a lens of knowledge (Dance, 2018). However, critique of critical theory further needed in-depth research study to explain how the context of a Māori methodology can exist without Māori knowledge. The methodology has a basis for making assumptions and a connection to many more generalisations. For example, using a framework to acknowledge methodological approaches in research can be confined to the research and the researched, not a Māori perspective.

The cultures are the key to constructing valid key points of what normally sits with the institution of knowledge. Kaupapa Māori frameworks for methamphetamine users can exist within the body of knowledge of a kaupapa theory (Dance, 2018). The difference between a methodology and a Kaupapa Māori methodology is based on the cultural theory of practice. Mātauranga reflects tapu (sacred knowledge) and should not be shared with anyone for disruptive purposes that could have an impact on the village (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020), (Sullivan, 2017). At times as a researcher's cultural alienation of being colonised can be the differentiating difference. An example of mātauranga is how to apply the tikanga of respect towards a participant or participants (Alfred, 2017). The tikanga to be considered include hongi or kiss, taking kai as a koha, removing shoes before entering a premises, acknowledging elders who are present, speaking te reo Māori when appropriate and being respectful of those who may not speak te reo Māori.

Kaupapa Māori

Kaupapa Māori perspective helps to shape the environment through an understanding of what is required through a Māori lens (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). Mātauranga also acknowledges concerning new terminologies such as the use of directs (affected by methamphetamine use) and in-directs (not affected by methamphetamine use).

To draw on a theoretical framework as a researcher needed to address key ideas on how to present a new model which in the first instance was to use an already established example within the health practice. The first process required scouring through resources to find a perfect (or near-perfect) framework to match. After several days of researching different models Whare Tapa Whā by Professor Sir Mason Durie, and the Te Wheke model by Dr Rose Pere the researcher felt ambitious enough to consider creating a theoretical model for this thesis and one that reflects a Māori worldview. The pūrākau (story) or taonga tuku iho (treasure) approach was a starting point. Validating this unique research attempt required insights from Māori Kaupapa theorists Distinguished Professor Linda Tuhiwai-Smith and Dr Marie Battiste, highlighting the importance of Māori methodology for this thesis. Smith posits the importance of a Māori existence in academic writing and why it is a must for articulating Māori validation of Māori Kaupapa as a base for research methodologies set against the backdrop of what was once a dominant Western paradigm of theoretical methodological inquiries. Māori methodologies as she explains have been viewed with less value than a Western framework. Yet established Māori scholars such as Distinguished Professor Graham Smith and Professor Sir Mason Durie along with other leading scholars of methodologies produced Indigenous perspectives, not without its challenges. Māori based knowledge systems that work on the marae in the home, on the farm, are not necessarily accepted in work, school, or in non-Māori professions. (Smith G. , 2003) reminds knowledge enthusiasts that Māori based methodologies as unhealthy examples became fixed narratives of people from anthropology. Research became studies about people who formerly existed and their knowledge.

Māori methodologies

Distinguished Professor Linda Tuhiwai-Smith critiques decolonising methodologies as a volume of messages that coincide with British colonising roots, tied to a writer's thoughts, specifically Indigenous people's minds (Alfred, 2017). Therefore, the methodology should indeed consist of a Māori body of knowledge, shared, valued and not dismissed. This allows for the natural inclusion of Māori principles, utilising a Māori worldview. Moreover, methodologies are theories of frameworks for solving an important issue. All cultures not specifically determined by one can demonstrate a cultural methodology (Dance, 2018), (Elsemore, 1999). A theoretical methodology was needed for the safety of how research theory can coexist within the topic of methamphetamine treatment. Firstly, how theories can produce non-discriminatory outcomes significant to the framework. Critical is the Māori

social interpretations of use and addiction and how colonial theories influence Māori solutions. The critical answer to why Māori users need addiction treatment is that the drug is a real concern. The social construction of addiction, therefore, is consistent with what Michelle Foucault describes through the lens of another. In addition, the narrative of taonga tuku iho as the handing down of knowledge from an ancestor is relevant to Māori. Notably, there was reluctance to create a new methodology, due to having no experience as a framework creator. However, after several attempts researching known frameworks, the idea was conceptualised with help from the supervisor Dr Reuben Collier to engage in a Māori known whānau concept. The result produced an arrangement of thoughts for completion and theorised as an original taonga tuku iho as the practice of passing on ancestral traditions.

Taonga tuku iho

In this Kaupapa Māori approach is the integrity of the story in which Ira Tūmoana is a factual person, so too is the taniwha which is consistent with whānau from Matatā and Te Teko. The marae Ira Moko based in Matatā is the son of Ira Tūmoana. The belief holds critical to the methodology philosophy as being traditionally acceptable to whānau who know the story. Therefore, the myth of Tarakura is not. Arguably, research may wish to contradict the story as needing proof but for evidenced based proof one could only validate the story to the past ancestors who passed on the story to the next generations. The story is the researcher's ancestral whānau concept. Included are two methods of research by whakapapa introduced by Kevin Richardson who incorporated historical genealogies and wānanga is a practice used by Dr Reuben Collier. The methodology is where each segment is discussed through spiritual guidance, illustrating the significance of kaupapa storytelling brought to light. Many descendants of Ira Tūmoana live in Te Teko and Matatā and reflect the time when Tarakura the taniwha (monster) was destructive. A warrior then rose to save the people of Matatā so they could take the deceased to the graves of the sacred mountain Pūtauaki (Report, 1999). Academic literature, including supportive investigative research can place and point to when and where these events happened concluding the truth of the narrative (Ngaheu, 2012). This is vitally important is the validity of the people in recovery who know the story.

The first part is to connect the ancestral story to the framework. The narrative tells the journey of the Matatā people who want to take a deceased body to Pūtauaki mountain to bury their dead in the caves of Niho Te Kiore. However, to get there they must pass through a series of areas within the Te Teko and Tāwera locations to avoid the taniwha Tarakura. They

have no warriors who are willing to protect the rōpu (group) so they must seek help from a high-ranking warrior who is extremely feared by all in Ngāti Awa his name is Ira Tūmoana. Significantly, the reason why he is the most feared warrior was that his victim's head trophies were placed on top of palisades around his marae known as Te Kupenga. The heads were a signal to warn off would-be intruders. The people of Matatā have few options to be killed, whether by Ira Tūmoana or the taniwha. At least in their thinking they can negotiate with a human rather than a monster. Ira Tūmoana agrees and takes several warriors and slay the monster. The people of Matatā can now lay their tūpāpaku (deceased) in the sacred burial grounds of Pūtauaki.

The methodology itself is a road map to recovery within an authentic grounded theory. In addition, it presents a whakapapa (genealogy) and landscape in which the fight took place. The methodology creates an awareness of historical information that is relevant for current times. The critical lens for this methodology narrative is when the story is a myth, is not the truth, or is believed to be a non-truth. For example, the story of a taniwha cannot be real from the perspectives of pragmatism versus scepticism. Pragmatism is only validated when accepted by the discourse which allows for the narrative to be a valid knowledge claim. In principle the cultural methodology may exist but not to the point where the constructs of knowledge pierce the belief in unclaimable existence (Elsemore, 1999).

The Mauri Framework

The methodology of a mauri (life force) signifies an Indigenous worldview according to Māori culture. The key parts of the framework signify four Baskets of Knowledge within the region of Ngāti Awa (Shortland, 2019) compared to other rohe who tell of three baskets.

According to Ngāti Awa the four baskets are identified as **te kete tūāuri**, **te kete tūātea**, **te kete aronui** and **te kete te kitea**. Each basket is key to establishing a treatment pathway to healing from methamphetamine addiction. This narrative follows the framework of all baskets together containing thirteen elements. The thirteen elements of this Kaupapa Māori theory is housed in four baskets of knowledge, connecting four critical stages of cultural identity to mental wellness. What is required is to align the values of each basket to address the problem. The key components inside each kete critiques current practices along with their core values to identify a knowledge gap. In doing so, a new pathway is developed to bind and strengthen old techniques with the new drawing from Kaupapa Māori.

Kete Tūāuri

Te kete tūāuri represents the starting point. The first key element is ‘Te Kore’ and begins with identifying that the self has nothing, is nothing and comes from nothing. Critically, one must start at this point to ask what the next step is. The second of te kete tūāuri element is Te Pō, where life begins in the unknown, in darkness, where the ideas of knowing start to take an important discovery of the self. Knowledge begins to appear like a seed in the ground, which is birthed by darkness to start creativity and explanation. Thirdly, the kete Tūāuri poses Te Ao Mārama (the light) by representing supernatural and spiritual guidance where divine inspiration is formed by this existence of unknown knowledge. A purity of coming to the light and being fully aware of coming out of the darkness.

Kete Tūātea

Te kete tūātea, the fourth element, begins with ‘moemoeā’ (dreams) which embodies the Māori philosophy of dreaming. Crucial to foreseeing the future includes having visions of prophetic encounters with the self. This theory is the belief that futuristic imaginations will come to pass. The fifth element in te kete tūātea is the mission and purpose to succeed. The key to this theory is the integrity of a person who will endeavour through stages of setbacks along the journey. The sixth element of te kete tūātea is the strategy to complete the goals of achievement, therefore planning and implementation.

Kete Aronui

The seventh element begins with ‘whakapapa’ which articulates the Māori whānau, kinship and identity to the self. Critical to whakapapa of Māori is who a Māori is and who they are connecting to and connected by their ancestors. The eighth element is pepehā, a proverbial introduction to local identity stating key characteristics of the tribal region belonging to Ngāti Awa. Pepehā includes the stating of maunga (mountain), awa (river), waka (canoe) and iwi (tribe). In oral traditions the importance of reciting your pepehā is significant to identity. The ninth element is taonga tuku iho (passing down of ancestral knowledge). Taonga tuku iho reflects tribal heritage that can be useful in solving modern day issues. It raises past examples of grief which can lead to formulating answers to problematic situations for the future. In essence we are able to learn from our past which are stored in oral histories.

Kete Te Kitea

Te kete te kitea holds the tenth element and begins with the ‘mauri’ (the life force) representing spiritual guidance. Māori believe the mauri is the existence of life in all things unknown and known. It is the fulfilment of everything to come and the life dependency on the energy of the creator. The Māori world views the mauri as the pinnacle of everyday life and values the contribution through a connection of traditional practices. The eleventh element is coming into the light. This is the life force that delivers a subsequent satisfaction of the self within the pursuit of change. This search for healing is not outside of the body but is held within. It is indeed spiritual rather than being solely dependent on the intellectual attributes. The twelfth element is the delivery from darkness and the renewal of the mind. It is a spiritual, mental and physical awakening of the individual. There is now purpose to ones being and renewed hope to fulfil future aspirations not only for the individual but also for the extended whānau, hapū and iwi. The thirteenth element is acknowledging a departure from the old self and accepting of the new. The new self must endeavour to not return to the old self. This will require a deep desire and determination to persevere on the road to recovery. The mauri restores and revitalises the individual giving assurity that there is hope beyond the horizon.

Key principles

The three core principles used in this framework are connected to each of the four kete. The principles align to the appropriate elements, according to Te Ao Māori.

Tika: the way in which Māori apply correctness to the whenua (land), to each other with honesty and integrity. This requires a proper process of Indigenous worldview and cultural tradition. One must always be sure to be accurate and appropriate in all circumstances. By upholding the values of tika one can be certain that the user’s intentions are true and correct.

Pono: the integrity of the person to be trustworthy and honest holding their mana and being accountable to whānau, hapū and iwi. This provides long lasting relationships both personal and professional. When upholding the values of pono one can be certain that purpose is authentic and honourable.

Aroha: the sharing of knowledge and understanding of differing circumstances. Aroha encompasses empathy and compassion for one another despite humanities diverse backgrounds. To act with aroha means to act with care, sincerity and kindness. The value of pono ensures that users demonstrate patience, tolerance and understanding.

Methodology overview

Treatment methodology can assist users with a mātauranga historical theoretical perspective reflected in this thesis. The methods and methodology can move toward environmental healing counselling practices, rather than indoor closed premises. Practices would need to evaluate locations outdoors to practice providing users and clinicians with access to the whenua (land). Evidence in this research can assist by connecting users to Papatūānuku (Earth Mother) who can sustain the body through a natural healing remedy between the feet and the brain. Participant clinicians believe that long-term recovery is the strategy that works best for Māori within a Māori framework. Overall, the evidence supplied for this thesis was limited by Indigenous and Māori statistics from traditionally based treatment examples. Not much information is written on Māori addiction before colonisation and community intervention models often receive little traditional information. More support for community data has limited research analysis for online reports. This includes traditional therapy models used by communities including core beliefs, values and their principles.

There is a non-Māori silence about the truth of addiction results in the public about more harmful drugs such as heroin and cocaine (Blistein, 2019). In addition, Māori need to showcase how successful addiction services deal with Māori methamphetamine addiction rates and reverse the trend of any stigma. Coupled with this is how Māori can reverse the trends of research data, stigma facts and provide credible insights for all. Research should provide an educational background for users to determine how users have been influenced providing guilt free treatment. How illicit drugs became legal then illegal and how we are to respond to the current methamphetamine pandemic through treatment. Not only, but how methamphetamine education can assist users, suppliers and Māori who are caught in the illegal trade which offers the promise of affluence from impoverishment. In addition, educate law enforcement, clinicians and policymakers about the decisions they make affecting new institutional policies. The issues about drug control, possession and supply are much more intricate and require critical understanding (Nui, 2010).

The current dilemma with Māori is the lack of economic and social realities in rural communities as research. Such as surveys and data from areas like Te Teko, Te Māhoe, Ruatāhuna, Ruatoki, Waiōhou, Galatea, Minganui, Māpou, Matatā, Edgecumbe, Tāneatua, Kawerau, Awakeri, Whakatāne, Ōhope, Kutarere and Ōpōtiki. Although some rohe connect from Tuhoe into the Ngāti Awa area many of these small areas have little known information for research use. They might be very hard to extract data from as well. Māori is already disadvantaged in society and this research perception may cause mental wellbeing to drastically shift toward enforced beliefs of colonial research practices causing more grief.

The limitation of Māori use in those areas would address drug harms for Māori service providers but not necessarily law enforcement. Methamphetamine information can be secured by Māori research organisations so rural research is not mistreated (Bishop J. , 2014), (Jones, 2018). For this research participants were selected from a marae wānanga. Two male clinician professionals who were former methamphetamine users between the ages of 35 - 50 with lived experience and two clinicians who are Māori health practitioners between the ages of 60 and 70 in organisational therapy were considered. This research intends to investigate the differences between funded Māori services and non-funded treatment programs volunteer community services.

The research involved four participant services, Tū Tauā in Rotorua, Mana Enhancing in Tāneatua and both Māori Health and Ngāti Awa Social Services in Whakatāne. The research conducted was a research analysis of the Eastern Bay of Plenty (EBOP) from Matatā to Ōpōtiki within the Waiariki District. Research conducted sought to clarify the success rate of users within treatment-based organisations and the information supplied by practitioners. The thesis then questions to draw on a hypothesis aimed at providing evidence-based research from clinicians and former clinicians who had experience working with methamphetamine users to clarify the high addiction use of methamphetamine among Māori (Covey & Taylor, 2008).

The inquiry focuses on treatments that worked most effectively. Critical to the inquiry of evidence is what information is available within the clinical practices that can report on the success and recovery rates. Apart from the already researched information supplied by Public Health, Corrections and the Ministry of Health little information of user rates from treatment exists. Part of the research was to uncover the hypothesis of why Māori was largely the result

of proportionate users of methamphetamine and what needed to be done to combat or provide more resources for Māori use to methamphetamine treatment (Caccioppoli, 2005). The study initiated a complex plethora of methodological approaches involving Mātauranga Māori, Māori Health, Kaupapa Māori theory history and partnership models (Bargh, 2007).

This chapter presents the critical analysis of methodology. The newly devised framework for this study creates an awareness of historical information made relevant for current times. The next chapter introduces the methods identified to best serve this inquiry.

CHAPTER 4

Method

I poua mau au i te take o Pūtauaki he ngārara te kai

This chapter presents the academic tools necessary to best complement the methodology. These are research strategies on how to research with a clinician and how to observe community efforts. The research is conducted with culturally appropriate methods, including ancient customs to bring traditional thinking to the fore.

Methods provide academic research tools and techniques that follow a qualitative or quantitative approach. Methods include surveys, experiments, interviews, and observations each producing a different result from each other. Each are dependent on the research topic and must be carefully selected then used for greater outcome of the inquiry. For the purpose of this topic the researcher implemented interviews and observations. The reason for this selection of methods was to combine both techniques to compare potential data that enabled outcomes to occur. Methods such as surveys and experiments were deemed as unsuitable for this research due to the nature of participants directly related to methamphetamine and the emotional trauma attached. Surveys tend to be cold and emotionless and there tends to be a disconnection with paper form compared with the kanohi ki te kanohi (face to face) approach. Case studies with users were not attempted either due to the length of time a case study could be monitored so observations were used as an effective alternative. A case study may have been used if there was a secondary subject such as a plan to position addiction treatment next to poverty. Notably, if rural zones are places that relate to poverty, drugs and crime then this process may be better suited for future research.

Method 1: Interviews

The methods for this work include strategies of how to approach participants using interview techniques in fieldwork. The focus of the research was on the quality of the outsider technique. The method critiqued a range of interviews over six months. The strength of the interviews was to provide analysis from clinical perspectives that operated within the context of methamphetamine drug addiction treatment. The researcher interviews were the primary technique included with a semi-structured approach. A Māori method approach was included to adopt hongi as a tikanga cultural element.

Part of the research technique was factoring in a secondary technique by discussing the evidence from the literature in the thesis to complement any additional research answers to the questions. The hope was to prompt further ideas about the questions from the history of methamphetamine treatment use, and abuse. Most importantly, the interview techniques required the researcher to adhere to the original questions so that the subject did not deviate. The parameters of the research questions asked were specifically designed to discuss Māori addiction suffering and what answers to treatment could be found. The questions were structured to suit the participant's knowledge of the treatment process. The study method focuses on the ability to extract qualitative data to strengthen the methodology in the process. The science of the interviews and observations build towards a Māori theory of knowledge. The collection, measurement and analysis of data provided a strategic implementation of each interview and carefully interpreted sampling. Therefore, comfortability was required as some interviews were not conducted at a café or township. Kevin R travelled to Te Teko and the options for the researcher to travel was mutually agreed upon and that the participant would travel instead. This placed more emphasis on the researcher to provide hospitality. The technique in asking the research questions was important to the overall interview process, by making sure that the participant was relaxed in the setting (researchers house), (Silverman, 2006).

Method 2: Observations

The methods for this research include strategies of how to approach participants using interviews. The practice of observing people allows the researcher to closely examine the behaviours of the group. In this case, observations were carried out in Te Teko, Tāneatua and Rotorua. Observing the clinician at work while critiquing his working environment and how users felt toward the seminars. Kevin H conducted his meeting in the kitchen at the marae. He started with a karakia (prayer) then introduced the treatment topic. He offers professional insights about methamphetamine harms through reading materials as well as illustrating his personal story of recovery. Whilst Billy M who runs his programme in Tāneatua offers tea and biscuits before the official programme starts then light refreshments to follow. Billy M begins with a karakia and reflects on his personal story which is very traumatic. Observing the reactions of the audience varies as many are users who are engaged. Noting the setting, the meetings with Billy M fluctuate between Tāneatua and Te Teko. Whereas Kevin H conducts most of his seminars in Rotorua. Activities were given by the clinicians to listen and stay focussed whilst a video or overhead projector image would be shown. Users were asked

questions and given a choice to answer. The researcher's use of the mobile phone was permitted for the purpose of recording and collating data. Though the phone did not video people in the room but was instead used for notetaking. Observations are of benefit because the observer can witness everything and get a sense of the atmosphere and context of the seminar or group meeting.

Participants

The two male former methamphetamine users now clinicians helped complete this investigation. Both had lived experiences with methamphetamine use and harm and had an already connection with current users in treatment. In addition, studies in the EBOP of Māori who were fully recovered addicts was hard to identify especially users under the privacy of organisations (Dance, 2018). Nor were there any results published by hospitals and police, with data that matched use, overdose, and crime in local rural districts. The contributions for this study aimed to get expert advice from practitioners to find solutions from their work with users in the space of methamphetamine. Two non-user clinicians were interviewed to provide information on Māori clinician treatment assessments. Analysing interviews of four clinicians would require in-depth research of the interview process. The following position for the researcher was to situate the questions and methods from the setting of interviews as the next process. Not all the interviews were conducted at the same location. Participant interviews were conducted at the researcher's home in Tāneatua at the Mana Enhancing building, Whakatāne hospital and Rotorua. In all, no other locations were used. All questions were critical to how Māori clinicians clarified treatment to the following techniques which would support the Mauri framework.

The first clinician for this study is Kevin H who is of Ngāti Hine and Ngā Puhi. Kevin is a former methamphetamine user now an accredited clinician helping communities with twelve years methamphetamine addiction experience based in Rotorua. The second clinician is Kevin R of Ngāi Tai who is a former Navy Officer and qualified counsellor. With no experience in methamphetamine, he has worked extensively in mental health services for over twenty years and is currently working with Ngāti Awa Social Services. The third clinician is Arona S of Tūhoe who works with meth addiction. He is the Director of Māori Health in Whakatāne with over twenty years of experience in Mental Health services and is also based in Whakatāne. The fourth clinician is Billy M of Tūhoe and Ngāti Awa descent. He is a former user of methamphetamine and a former Mongrel Mob member and now a

clinician based in Tāneatua. He fully supports methamphetamine treatment programmes in the Bay of Plenty. As the researcher several key themes in the methods were used. The location and the techniques for each interview were critical to the focus on this study.

Selection process

Finding candidates for this thesis was not difficult, but finding suitable candidates required further investigation. The selection was a little difficult because the researcher had to compare the clinician who has a methamphetamine background with a clinician who has no experience. Handpicking the best available persons were chosen through a series of observations. The researcher just happened to attend a conference in Te Teko about methamphetamine having no understanding of the drug. What transpired was a face-to-face meeting with Kevin H and Billy M, two former users turned clinicians. The ethics was easy to complete at the start with the first two participants but finding two more participants proved difficult. In the past, the researcher had dealings with Arona S (Māori Health) and Kevin R (Ngāti Awa) which created the four participants for the ethics proposal. Conversely, as a researcher, it was important to confirm a due diligence process by confiding in known health professionals who critiqued the participants. Furthermore, the ethics through a range of notifications such as emails, discussions and talks over the phone affirmed the four professionals as the right participants. Three Māori clinicians who lived in the EBOP except one who lived in Rotorua were chosen and all had a tribal based approach in the treatment services. The questions were delivered in a way to complement the participant's knowledge and was not trying to manipulate a participant into receiving information. Rather the questions are asked to help the participant pursue the knowledge that exists within the clinical field of treatment. Such a technique is how to deliver a question whilst enjoying the conversation of participation.

Research locations

Te Teko community meetings were held on Mondays between 6:00pm - 9:00pm and can have up to five to twenty participants. The locations can vary across venues such as the town hall, marae and rugby club which has been offered without charge. Funding has been given by a Māori Trust to cover costs. Most times the whānau of the participants would also bring a plate of kai. On Friday nights in Tāneatua a dinner is also held and there tends to be more women than men at both. In Rotorua Tū Tauā is an organisation that works with corrections and the police, so the dynamics are different. Rotorua is not run as a community programme

but as a professional event held at different sites for approximately eight hours in the day. The participants sit around tables with a pen and paper in hand and Kevin H conducts the seminar starting with a karakia. Sometimes a pōwhiri is conducted but most times the meeting starts at 9:00am until 12:00pm when lunch is provided followed by home time at 4:30pm. On Friday, interviews were held with Arona S for approximately 1-2 hours. Biscuits were taken to each meeting and Arona S would also begin with a karakia. All meetings were conducted inside the Māori Health building at the hospital and most of the time there were no interruptions by other staff wandering in. Arona S explained that the carvings presented on the walls were the key to connecting Māori to healing as they represented Māori stories of hope. This as he explained was the healing for Māori in drug harm. After each meeting with Arona S a karakia would be performed to end the interview session. Each meeting was booked at the office counter ahead of time, usually every two weeks. Apart from three interviews that were held inside, one interview was conducted outside in the fresh air. In addition a cup of tea was provided with biscuits overlooking the river. What transformed from that proposition was a connection to the environment as the setting outdoors became a technique. The participant interviewee and researcher critiqued further discussions about treatment to the whenua (land) and how the research of treatment to methamphetamine connection was similar.

Qualitative approach

The qualitative design was the researcher's guide to take notes, listen to interviews, record where appropriate and finished within the timeframe the researcher had allowed. Each meeting is a Māori approach known as kanohi to kanohi (face to face). Therefore, planning for interviews by conducting culturally appropriate methods was important. Interviews would also require following up from week to week to discuss any more important information that could be used as data. The important parts of the interview process were learning to remain calm and not hesitate but deliver a welcoming experience. This balance was recognised when speaking to the participant on other non-technical aspects which played their part, such as telling a joke before starting the formal interview process. Warming up the environment with light-hearted conversation is a good way to start before the more serious questions were asked. This can also be followed up by knowing when to engage and speak into a conversation using appropriate terms. Also refraining from interrupting but allowing the freedom for the speaker to engage in the question (Bennett S., Elder, Kingi, Lawrence, &

Tapsell, 2020). In general, clicking together or finding synergy where the participant can feel relaxed and at ease is critically important.

Limitations

Whilst searching the EBOP's methamphetamine treatment practices for appropriate interviews we identified scarce organisations that were willing to provide interviews for data mining. Clinicians who identified as having no experience in methamphetamine were plenty, but long-term recovery specialists were few such as clinicians with lived experiences. Organisations that were sent emails and phone calls did not respond to requests for interviews. Nevertheless, there were plenty of lived experiences of former methamphetamine users. However, they were not qualified practitioners for treatment. Therefore, no interviews were conducted with users following the thesis guidelines. In the case for surveys, experiments, case studies and focus groups were not necessary for this research specifically because the interviews were sufficient and most appropriate to complete this undertaking. The main reason was the geographical area from Matatā to Ōpōtiki were already covered by the four clinicians. In short, the information clinicians supplied on methamphetamine in the EBOP was not only vital but demonstrated an attitude of care.

This concludes the methods chapter and provides an overview of methods used to conduct this research. It discusses the advantages and disadvantages when carefully selecting the correct method for this study. The data gathered presents results to be analysed further in the remainder of this document.

CHAPTER 5

Findings

I poua mai au i te puāwāwātanga, o Awanuiārangi wānanga rau

This chapter shows the results of the interviews undertaken with four clinicians. In addition, it includes the observations of the participants seeking treatment at the community workshops. Moreover, the findings will show a connection to kaupapa Māori and advantages and disadvantages to this approach. Findings will give indications as to what works best for a Māori methamphetamine addiction treatment process.

Key trends in the meetings delivered similar discussions between users that often shared the same messages. Encouraging a user that they can trust the group or individuals was vital (Cook, 2018). Trust is the main theme of the meetings, so to confide in a public meeting requires conversations to be respected. This message was fundamental to Māori who attended the meetings voluntarily. Observing the rules of the meeting are the expectations that helped to address key findings. Participating in observations are complex at best of times but more so when trying to take notes and record vital clues. The instructions when attending meetings for observations included no recording by an electronic device accept in Rotorua.

The clinicians who contributed to these findings share their thoughts without condemning their continued effort to support substance users. Respectfully, merely pointing out, for awareness's sake, that one should cross examine trends in sentences sayings with consideration at least. New impressions could in affect have drastic consequences on future generations, substance users and whānau. In full support of the participants and observations which were conducted during the evening from 5:00pm to 8:30pm. For six months, weekly visits to meetings were conducted in Te Teko and Tāneatua under the community group Mana Enhancing and Tū Tauā in Rotorua. The process required a full concentrated effort as an approach. Meetings in Te Teko, Tāneatua and Rotorua represented a wide range of demographics within the group.

Tāneatua

The Mana Enhancing environment at Tāneatua had a kitchen and cuppa tea area for guests. There was often a coldish feeling when entering the premises of a commercial or organisation

that bestows a professional look. The objective was to deliberate the skill to create an atmosphere that a participant would want to engage with. Critical to an interview was a spiritual connection with karakia. A prayer to start each meeting was conducted. In Tāneatua Billy M was the clinician who helped to qualify the methods. Billy clarified that it was important when people who come to the Tāneatua clinical practice do so without their mental baggage so that they have a cleared mind and body. Which of course was another aspect of consideration in the interview process. Being healthy as a researcher must at least show a sign of respect to asking questions. Important was to turn up on time and being careful not to turn up to interviews feeling sick and spreading the flu especially with Covid-19 in the communities. Being prepared before meetings meant that the researcher came with a mask and asked the participant ahead what the requirements were for a meeting. Most times the participant also wore a mask which made it easier to identify with the participant needs.

Rotorua

Documenting data in Rotorua was allowed so keeping records on the mobile phone was easier to record, store and archive. Most of the people who attended the meetings had their own mobile phones in their hands. Users and non-users both felt comfortable talking whilst the device was in their hand, but users watched their phones most of the time. This may suggest that users needed a connection to something and their phone gave them a sense of safety within. The data collection at the time of each meeting observed the reactions of non-users and users. Non-users were often talking about the damage the drug had done in the community versus users who discussed how they were dealing with the drug on a daily, weekly, or monthly basis. Most hopeful peoples were users who heard stories of achievement and most non-users were optimistic, that change could eventually happen but not to the same extent as users (Covey & Taylor, 2008). Some users felt happy enough to be in the room with non-users and there were not any feelings of judgment. The theme of each kōrero was what the drug had done and what the drug can do to the community and what options there are for users.

Researcher pedagogy

This section outlines responsibilities of the researcher when undertaking techniques of inquiry. This builds toward greater discipline and quality research application to protect and best serve the interests of the community at hand. By doing so the researcher believes that this will influence community response and provide for better quality outcomes.

As an outsider the researcher was given the ability to speak at community treatment programmes but as part of the wider community support network. Part of that experience was to share in a user's journey about the knowledge of addiction and find out if the community treatment was a better experience than the one-on-one clinician experience. After several meetings over the six months of being involved in close observations, the inquiry drew new insights. The researcher had spoken once in a meeting about the thesis project but was reminded to 'keep hats off' an agreed rule to keep opinions to oneself. This is a term used normally for former users who have recovered, so they do not influence discussion but show respect to the different levels of users in the room. The opportunity to remain silent presented itself to learn. The key part of the observations was how users and non-users identified each other because users were known as Directs (directly affected using methamphetamine) and non-users were described as In-directs (indirectly affected by someone's use of methamphetamine). There are several ideas about why users come to a voluntary group. Most users were shy or quiet and that could be due to the location where meetings took place. Over a period of six months ten or more people would attend. The observations of meetings about methamphetamine addiction and treatment were much different. The technique of listening to users and non-users presented different data attitudes about the dangers of methamphetamine use. Some users were on a high, others coming down from a high while some were straight. Nonetheless, the observation was not to enquire about users who were high in a meeting but to critique how users responded to treatment when under the influence. Many of the users felt the same message of wanting to quit. Overall, this listening approach was not to give answers or participate but observe for cues to treatment responses.

The experienced and recovered methamphetamine users already had a set of notions and were discouraging in many ways, not all the time but there were times when interruptions took place. The advice was to listen and take notes and collect data after the meeting concludes. The reason is not to alarm or put anyone under pressure or make anyone feel awkward. There requires enough courage for people to enter the room but adding a research method would change the overall mood of the meeting. Collecting data was crucial to concentration and listening to each person's story. Most followed the same meeting rules subject to the groups formalities before a meeting started. They required 'mental hats' to remain neutral, but sometimes clinicians forgot and interrupted hoping to provide an answer. What was evident in the community meetings was that the users had answers, not the clinicians.

Te Waiariki

Four of the experts pointed to a range of clinical ideas that hope to offer lasting results for methamphetamine users. The Eastern Bay of Plenty (EBOP) shows an inquiry between organisations in mental health that support clinician interviews. Certainly, Eastern Bay of Plenty factual data needs to be incorporated to compare with the community and national data. Direct data to be matched with the high regions of methamphetamine use in Northland, and Christchurch. There is unmatched data with residential treatment centres in the EBOP because there is no on-site rehabilitation except for hospitalisation or mental health treatment where users are sent by the court (Dance, 2018). Currently, in the EBOP, no onsite beds exist for volunteers seeking recovery. The critical comparison between the three regions is that methamphetamine use went up significantly at three periods. When aligned with te kete tūāuri its important to address the circumstances and re-address the need for a new approach. In 2014, a 45% rise in addiction to methamphetamine rose compared with 7% in 2011 before the Christchurch earthquake. Significantly, the statistics showed an increase much more than the Ministry of Health indicated as nothing has changed. This meant that workers who moved away from their homes to work in Christchurch were dependant on staying awake for long periods to survive. At the time of the earthquakes 800 people had been arrested in four other cities for methamphetamine uses (Police, 2021). The rate of methamphetamine harm did not go down but instead went up. Therefore, the rates of treatment went up at the same time. Te kete tūātea requires a planning and strategy to implement the goals for achievement. Based on the principles associated with aroha organisations must act with compassion to meet the individual needs of users.

According to a report written by the government in 2012 tackling methamphetamine indicators and progress report (NZLCR31., 1994) looked at key points to challenge methamphetamine use. To control the supply, reduce demand and create treatment AOD programs from the profits of illegal drugs (Policy, 2015), (Drugfoundation., 2013). In addition, it must provide access to treatment and support community initiatives of education for whānau and users. The agencies were focused on eliminating and not reducing. In 2015 the rate of supply and demand for use went up astronomically (King J. , 2014), (NZLCR31., 1994), (Coleman, 2015). Access to community and agency programs indicated a strong disconnection by the state for recovery through drug treatment and access to beds at the time of a national crisis. The issues arising for Māori are that they are at the centre of drug

treatment and drug addiction. The fifth element of te kete tūātea is the belief that the decrease of methamphetamine will come to pass. Likewise, the principle of aroha is to encompass and to act with sincerity to help reduce use. According to government statistics, Māori has the highest drug addiction rates therefore they need more addiction treatment. Specifically, proving success rates of treatment to addiction so clinicians can better equip communities and organisations with methamphetamine data (Alexander, 1985), (Hunt, Kuck, & Truitt, 2006). This could then better match correct information about the region from accurate data supplied at the time of writing than from reports from the Ministry of Health that are five years old. Moreover, to better understand methamphetamine treatment from reports is better understood by researchers on the ground. Moreover, from the location in which clinicians who identify with their community live (Love, 1999). According to the second element of te kete tūāuri which indicates Te Pō, is that researchers who live outside the knowledge cannot explain the user's predicament. The principle of pono requires honest and transparent communication so the user feels safe.

Providing relevant based data from the region makes more sense to justify the results of use from that area than to produce one set of results from Wellington and assumed the whole country is in the same predicament. That is because the data being collected is by researchers who live outside the location that they are collecting data about. This highlights some concerns about the collection of data, the methods and whether the information is evidence-based. A collection of data by the Ministry of Health does not mean the data is accurate. Specifically, if other evidence for support is being found by journalists, media and organisations that work with methamphetamine addiction. The concern, therefore, is what need is there for reports from an area that works with methamphetamine treatment if the data from reports is not being utilised. Moreover, how can the government make amendments to addiction services if all regions work independently and differently? A one size fits all basket approach needs to be readdressed (Covey & Taylor, 2008). Currently what is working are the programs that operate in the Eastern Bay of Plenty. There is a delivery model in line with the Justice system and Māori Health services from Matatā to Ōpōtiki under the iwi partnership model. The second are clinicians who work with a user's progress through their program under Iwi Social Health providers. The third is methamphetamine addiction and support for users through tikanga prevention based models in the community which is largely underfunded or not funded at all. Instead of using that data to target users for prosecution, better resources of public money could be spent on those areas that require treatment

(Drugfoundation, 2016), (Drugfoundation., 2013). When matched with te kete aronui and its eighth element of pepehā it requires the acknowledgement of ancestral knowledge used in these organisations. Tika is the key principle that allows the Indigenous worldview to be included in all circumstances.

The low-level use of methamphetamine use was higher than cannabis and the highest criminality rate for cannabis was the Bay of Plenty with 60% convictions of low-level offences compared with the highest drug diversion rates in the South Island, Auckland City and Waikato. Critically, Canterbury, Bay of Plenty and Northland all faced similar patterns of court action. A greater need to have research capability in smaller rural sectors, there needs to be a better resource to approaches toward clinicians with lived experiences. Particularly, if lived experiences have messages of significance and attribute to better outcomes for Māori by Māori with those experiences (Love, 1999). Regrettably, there are not enough lived experienced clinicians, with qualifications to match. Services that support methamphetamine addiction needs should employ lived experience advocates, even train, and educate clinicians to help critique user familiarities. Not to say that non-user clinicians do not understand. Quite the opposite. Non-user experiences can have valid input, but users know the effects of the drug they have escaped from. Te kete tūāuri hold the element of Te Ao Mārama that addresses the known knowledge of the former users bringing them to the forefront. The principle of tika is that their cultural heritage connects to the users.

Māori engagement

Māori are likely to engage with drug treatment when conversation is backed with research data. As such the drug, has become a serious problem among Māori communities and most are aware of the product, and potential harms associated. The addictions for Māori in the communities are under more scrutiny because of the Māori world in which they live. The connection to colonisation, assimilation and disconnecting from the system attribute to substance addiction. There is an element of blame against the government, historical trauma and injustice of being constantly surrounded by whānau in poverty. Not only that, but there is a connection to discrimination and marginalisation of those circumstances. Their stories are often silenced by clinicians who work to resolve the underlying issue of why Māori use substances but do not connect colonisation and assimilation as a cause. Te kete aronui and the eighth element of pepehā is reconnecting to ancestral traditions of reconnecting to one's origins. Tika indicates the need to stay on the pathway and focus on the cultural perspectives.

Much of which is the disconnection in life and the reconnection with methamphetamine's ability to connect pleasure of some sort. Having said that, wealthy people who connect to luxury, material wealth and the highest of aesthetic pleasure, find themselves in a dopamine aphrodisiac experience, much like methamphetamine users. The difference is that natural dopamine is not a manufactured chemical ingredient. The poor are virtually the opposite of wealth appreciation and they need alternative morale. It seems reasonable that logic should play a part in support for the poor. Therefore, training and education in the communities are about the advantages for Māori. Māori clinicians who understand Māori drug addiction and the historical context in which Māori live can also connect to users through a kaupapa supported care of cultural practice (Bishop J. , 2014). The tenth element inside te kete te kitea represent the life force to restoring the person's natural energy and healing the mind, body and soul. When reaffirmed with aroha the self-aligns with the care of self and the care toward others. The drug methamphetamine has been described as just another like cocaine, heroin, marijuana and alcohol. In comparison to other drugs, methamphetamine is a stimulant that can be cured such as pausing use or ceasing use altogether. According to methamphetamine researchers, one take of the drug is not enough to permit addiction. Methamphetamine is a narcotic and can be grouped with addiction treatment centres in the same meeting room with other users of different drugs but the toxification is different.

Methamphetamine treatment requires a better understanding of the drug by trained experts. Users can join alcoholic's groups if they find that sobriety can exist in those places, but they are limited to methamphetamine experience and clinical insight. This might be a problem for methamphetamine users and clinicians may think that the addiction to methamphetamine and alcohol treatment are similar if they attend a meeting (Love, 1999). The differences between both drugs are that methamphetamine addiction is ten times more potent and can affect the mind dramatically within seconds. Also, methamphetamine methods of use are significantly more harmful. There may be assumptions to suggest that methamphetamine is not as harmful, but the evidence proves methamphetamine is more chemically harmful. Though this research is not suggesting that non-lived experiences cannot help. Non-lived experience can offer treatment from another viewpoint which may centre on approaches from an educational perspective. Māori support for treatment through kaupapa based addiction and education programmes is desperately needed. Te kete aronui possesses the characteristics of whakapapa, which is the eighth element, that encourages clinicians to recite and employ cultural practices and learnings of Māori knowledge. Tika is the principle that promotes the

integrity of the Māori worldview. Māori lived experiences may differ from clinician-based treatments where individuals are catered for should include Māori, whānau, children and grandparents who play a significant role in recovery (Love, 1999). The loss of children, or a child into state care are factors relating to methamphetamine harm that are often events Māori are caught in. Support systems that address the needs of whānau are best delivered by Māori in this environment.

Whānau support

The significance of whānau group meetings for Māori are the attached support mechanisms of the whānau model approach. Māori communal discussions are often delivered in this manner, but the models supported by government and health agencies are not. The public health statistics that use Māori data of individuals do not address the correct statistical information and tend to be biased. This bias can lead to discriminatory methods to reach a verdict of use among Māori. Therefore, when reports are drafted, they tend to look at the individual as the issue. More research on whānau meetings, whanaungatanga and manaaki can best describe outcomes that centre on the families' conversations in a meeting (Covey & Taylor, 2008). The tenth element of te kete te kitea depends on the mauri bringing the user out of the state of darkness and reawakening the mind towards future aspirations. Aroha is the principle that ensures the person's pursuit of change is sincere and authentic. Whānau members in a group focus can ascertain the individual's influence of quitting. The comparison would lead to the idea of what is more accurate in the data collection. Individuals are more likely to quit on their own from an interview. There is an element of truth in tough love approaches. Tough love, like an army camp, may not work for most people and this might be a process that works for Māori (Mcgregor & Sedorkin, 2002). Te kete tūātea also provides the purpose to succeed through the fifth element of the mission to succeed. Therefore, giving the person self-mana through acknowledgment of their past traumas. Lived experiences have the motivation to do something for users they couldn't find in other treatment centres. That motivation can influence other users to quit with this approach. Following some curbing techniques to stop using is tough love approaches. The notion that one needs firm grounding, a telling off and pushed toward determination. Such are some community groups who push for users to quit or find ways to challenge communities about the harm this drug is doing to families. The truth is alcohol and cigarettes are doing more damage. The attention of methamphetamine treatment needs reviewing but the challenge for users is how to quit. The communities are the key as mentioned in the observations. The significant challenge is to

reduce behaviours and modify them toward better outcomes. The tough-love approach is a theory that is often delivered by former users. The critical steps to ending methamphetamine use can be found in the programme. Te kete tūāuri holds the element of discovery and grows through the direction given by authoritative measures. Aroha supports this directive through values of compassion and empathy.

The steps to recovery based on the Mauri framework creates a new critique in Māori solution-based techniques. This requires Māori practitioners to be trained and aware of colonisation, assimilation and discrimination. For Māori who use that means learning about Māori history, European history and political influences which have shaped the Māori mind toward drug addiction. Te kete tūāuri possess the values of the unknown and is where the confusion of the self is situated between two cultures. Aroha is the key principles that commands a need to address the circumstances of Maori who fit into the dominant culture that suppresses the identity of the user. Many Māori know little or nothing about their history except for the mainstream history they have learned in school. The key is to combine both cultures together forming a Māori European explanation of the present situation Māori find themselves in. Then drug addiction may make more sense to the world in which they live. In addition, how mental health treatment programs are predominantly exercised for renters in a class society, much of whom are the minority who have fewer opportunities.

Methamphetamine users caught in an addiction cycle are frequent users of mental health drug treatment, court referrals and imprisonment. In te kete tūātea is the sixth element of strategy to plan new policies around treatment to strengthen Māori when faced with the Justice system. Upholding the principle of pono and accountability to their own mana as well as that of their whānau ensures that mana is kept intact. Methamphetamine addiction is like boosting morale, staying awake for longer and being confident. Most methamphetamine addictions are often associated with transforming the state of mind into a progressive independent immortal. Such is the feeling, that methamphetamine does. Other addictions to substance use fall under an unexplained broken relationship, a death, or job loss to name a few (See, 2007), (Inglis, 2018). For Māori and Indigenous peoples, that could mean reconnecting through the cultural history of traditional values, principles, language and land identity and affording better economic opportunities. The first principle inside te kete aronui requires identity and a connection to one's origins therefore investing in better economic provisions for the future of the individual, their family and the wider community. The principle of tika establishes the

reconnection to the land, its waterways and key landmarks that reaffirms the user's identity and mana. Clinicians and users with lived experiences have a greater impact on the community to resolve, restore and educate methamphetamine users and the consequences of methamphetamine harm. The clinician and user information are tools of cultural remedies to reduce fear in the community.

Methamphetamine addiction is not the only addiction that clinicians are dealing with as a raft of other addictions is also problematic. What the clinicians believe of users is the un-dealt with personal experiences of harm in a user's child history indicating abuse, neglect, family trauma leading to substance abuse within the home (Love, 1999). Te kete te kitea and the thirteenth element which signifies the departure from historical trauma commands the user to readjust by accepting a new pathway. The principle of tika requires the self to suppress memories in order to realign and make correct incidents of the past. Māori users often discuss the tragedies of family violence, alcohol abuse and addiction as a normal part of life in their upbringing.

Clinicians who work with Māori in the correction and law programmes face an enormous job ahead as drug abuses are escalating. Either way, users or sellers are trying to quit, and they are attending community programmes assisted by whānau members with that hope in mind. There is a sense of guilt for users which was felt in the meetings and the determination is just as real. Te kete tūātea encourages the user to journey forward with the support of their community when there are personal setbacks. Once again, aroha re-emerges as the prominent feature that encompasses affection amongst the group. The need to start with a positive step especially for the long proposition to remain free from addiction.

The exercise is transforming the disconnected mind. Exploring the depth of methamphetamine abuse to methamphetamine treatment requires a demolishing of internal doctrines, reversing old ones and re-establishing fresh oversight. Te kete te kitea strongly suggests that it's twelfth element of spiritual, mental and physical wholeness is upheld to embrace future aspirations. Aroha, yet again, dominates discussion through continuous expression of love, care, and kindness. Mātauranga can help to adjust treatment for users when attending community-based treatment programs voluntarily.

Battling addiction

There are still a lot of unknowns, about methamphetamine and you would think that there would be a drug to combat it, but there isn't. The drug a century old has showcased itself to the most vulnerable (Blistein, 2019), (Dahlby, 2009). Methamphetamine, for sale and use, is no different from what governments in the past have tried to battle. The war on a terminology illicit drug any drug for that matter, marijuana, cocaine, heroin, you name it. They are all connected with the dis-improvement from capitalists who view illicit drugs as a competitor. Methamphetamine does not have to be exclusive to imports. New Zealanders are making it in their homes, in their kitchens, bedrooms and sheds. Home laboratories can grow into a larger production facility or super lab (Hannan, 2005). Cooks are in demand particularly if one knows of the ingredients. Hence, the result of community harm for local supply is much harder to monitor when the police must monitor both.

Gangs tend to be the target of an ever-increasing dilemma with the state. Historically, gangs are also responsible for a new wave of gang capitalism (Welham, 2016). This does not tend to be the case presently with alarming statistics and whilst Māori tend to be the example of drug addiction, therapy and harm in the community, the notion of Māori stereotypes are much the same as they were twenty or so years ago. There is a growing number of Māori who no longer wear tattoos of whakapapa connected to heritage, but masks of assumed hatred a story hidden and aimed toward a system. Subsequently, graphic designs, well grafted into the skin are not images of tranquillity and harmony but rage, that no one dares to look at. Such are these facial expressions, even families fail to comprehend. Māori have never expressed themselves with artwork that rebukes, attacks, and implies to fear the person. Māori tattoos are a taonga (gift), an art of expressing, a tipuna or whakapapa. The issue points to systemic failures of law and order, policies and government who have controlled mental belief systems for continued attack (enforcement) into the heart of those communities, almost at will. Poor communities are the targets for police units, monitoring and surveillance (Foucault, 1977), (Jackson M. , 1987). In New Zealand, the state of despair is a revolving window of opportunities for the black market (Escohotado, 1999). Irresponsive to what the police may suggest Māori are at the top of the hit list of brutal force, which is backed up by evidence. Adding to that highly toxic drug, where Māori are playing a role as users and sellers, creates a police narrative. That drug history portrayed by the Justice system may be reflected in facial tattoos aimed at the state.

Importantly, why a methamphetamine review can critique those who sell methamphetamine versus methamphetamine use. In a sobering reminder, users, sellers, and cartels are people, they are whānau. They are different in attitude. Some sell for a decent living and others seek to get high. To fix this problem requires a whole rethinking, especially how to control the importation of drugs, border control and surveillance, without emphasis on imprisonment, especially for users. Methamphetamine is a problem, but the drug is not the problem.

Māori and Pasifika peoples face a humanitarian crisis for opportunities, mainly that Māori incarceration rates continue to be high (Becker, 1974), (Kiro, 2001). Thus, when coming out of prison, an employer has the right to due diligence, background checks and consequently decline applicants. Non-Māori are in the same boat, so to speak. Anyone who lives under the poverty line returns to normality from prison will struggle, as it happened in England before the arrival of settlers to New Zealand (King S. T., 2003). Methamphetamine treatment has a solution, but it does seem to be in the arms of the government. Although the government can help, little change will occur if the government continues to pursue traffickers and continue a fight. The reverse will happen. The drug will only increase for demand and price. The battle with cartels will continue and they will continue to export increasing the price. If the government decreases the battle by decriminalising use, the government can focus on illegal imports and educate dealers and traffickers.

Addicted to treatment

There is a reliance on addiction to drugs and treatment addiction. Largely because the health system in 1993 for all purposes created a model of the business market, selling contracts to providers. Notably, why Māori users were caught between clinical practices with little regard to cultural care (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). Clinicians should be informed the drug created last century is not the same drug according to (Covey & Taylor, 2008). Methamphetamine has changed in its potency more lethal than in the 1960s. The drug could be laced with other chemical drugs, opium, heroin and substitutes, sugar, salt, bath salts, ethyl and other unknowns, mixed with anything. The drug is more dangerous than previously thought and current drug treatment services may not be aware as well as recovery institutions who are not trained to deal with concoctions (Deyo, Fowles, & Kester, 2016). The system of healthcare is temporary unless provided by private treatment, such as residential facilities. Without public residential services for methamphetamine users, they largely lay

prey to incarceration. For example, the Eastern Bay of Plenty does not have a residential unit for A.O.D. This means further charges, prison sentences and a revolving backdoor into addiction and reliance on the Ministry of Social Development. Therefore, imprisonment and hopelessness are regurgitating facts (Caccioppoli, 2005). For example, users in Seattle (USA) are not prosecuted or sent to an addiction treatment program. The police have limited resources to use enforcement for care. According to charities and organisations that fund addiction treatment there is a disconnect between local bodies, health care and human dignity when accepting drug overdoses and homelessness.

According to (Cram, Te Huia, Te Huia, Williams, & Williams, 2019) destitution and substance abuse in America indicate, the same people convicted regularly, will be back onto the streets within 24 hours of being prosecuted. Out of 100 convictions for drug possession, drug harm, drug violence, only eighteen are charged. Though the problem with drug addiction and statelessness are most related to depression, lack of hope and loss of personal dignity. With the rise of rents more people became homeless, so did crime and drug addiction. Authorities for addiction treatment explain that there are enough solutions available for users. The hard truth is what the data around the world suggests, drug addiction will be more problematic in the next ten years (Alexander, 1985). Currently work in the local communities is detailed by communities that are willing to solve the government answers for treatment. The belief within the communities is that the government is not the answer. The public perception about drug addiction is mostly known to be communities protecting their own families (Mark, 2012). Drug reform policy and public spending around drug treatment are far deeper in deniability (Bargh, 2007). The governments around the world, are in cohesion, involving bureaucratic, legal and neo-liberal capitalistic agendas to serve one goal. The mission is to control state populations with drug treatment and surveillance identity strategies (Covey & Taylor, 2008). The realities of treatment need further addressing to protect and keep communities safe (Covey & Taylor, 2008). Evidence can prove Indigenous users are punished more severely, so the state is interested in how Indigenous treatments can be monitored through public reporting. Certain groups, in a politically correct contractual agreement like iwi organisations who report transactional counselling, define what took place and what the outcomes will be. This emphasises critical thought that treatment is a practice of keeping certain groups of people under control. Keep affording them treatment, use public messages, bulletins and address the dilemma with a Māori face. As blunt as that sounds, that is happening. Whilst we try to fix people with addictions the problem much more invisible.

The state of people's lives is at risk. It is not that the government does not care, they do, but more for a politically correct method of controlling government enterprises. In short has more to do with the economy than have something to do with Māori aspirations including people in low socio-economic places. The challenge is how researchers can reinvent the original wheel using an old system, demonstrated by communities. Looking at the bigger picture can sometimes offer just a little contribution for the sake of the few. Is it that hard to imagine a better community, rather than cope, tolerate and call the police. Nonetheless, that is the attitude that needs changing. The government also needs to act immediately as a more lethal drug for this conversation and it is killing thousands of Canadians. This street drug Fentanyl can end a person's life within seconds. The drug most common among doctors was used at a concert in Auckland. Currently, the opioid crisis happening overseas is a result of stronger painkiller stimulants (Gordon, 2019). Emergency services in Canada are overworked and staff are mentally fatigued for the race against use and overdoses. The hospitalisations in Canada for fentanyl are such a worry to the Canadian Government, that New Zealand should be warned. Protection for citizens and awareness planning needs further discussion to start immediately.

This chapter presents different methamphetamine treatment options. The data collected indicated the types of treatment used by clinicians and users. The results proved lived experiences, Kaupapa Māori and connection to a form of identity being the most widely used approaches. Importantly it presents several arguments for further discussion in the next chapter.

CHAPTER 6

Discussion

He uri mākoko ahau nō Ngāti Awa

This chapter discusses key findings aligned with the Mauri framework. The conversation will analyse the best treatments available for Māori methamphetamine addicts through a Māori lens. In doing so this chapter will define conclusive alternatives to methamphetamine treatments. Observations at meetings discovered a notion behind the construct of two words 'direct and indirect'. Directs are people who use and impact the self, community and others. In-directs have been affected directly by someone's (direct) use, a child, parent, or friend.

Discriminating Māori

In comparing the New Zealand Health Statistics (NZHS) data regarding Māori addiction rates the Ministry of Health data assumed the connection with amphetamine and methamphetamine to be the same drug. Not only but indicated Māori were most likely to use. The study did not compare with other agencies but an interview method of users between the ages of 25-34 years. One of the concerns for data collection is how reliable the collection methods and techniques were to create a valid report. In addition, Māori more than non-Māori are in the front line of those inquires. Therefore, evidence-based reports that do not highlight honesty can inflict long-lasting wounds on targeted cultures by making assumptions. Recent work found that the government had not updated any recent information on methamphetamine data for problematic use since 2010 according to the Ministry of Health website (Health., 2010), (Drugfoundation., 2013).

Searching for relevant data and statistics was outdated, although some methamphetamine projects were underway, nothing examined a critical perspective of research data relating to the exposure of problem use. Incidentally, this may be due to contracts given to third parties who research on behalf of the government. Especially, if the Ministry hires professional researchers to inadequately produce inaccurate findings of Māori (Covey & Taylor, 2008), (Mark, 2012). This then questions the validity of the researcher and employer of whom the government is lending contracts to complete evidence-based research. It is also clear that methamphetamine and amphetamine research is misappropriated. They are not the same drug, nor should they be classed together to provide statistics that state Māori is the highest

users of methamphetamine including amphetamines. They are similar but they are not used in the same manner. Not only is this insidious to acclaim fact. Māori are not the highest users. Instead, Caucasians hold that criminal stigma (Litchfield, 1985). It seems justifiable to suggest Māori considering some research examples only points to more discrimination by researchers who need results. They are not confirmed data but merged to assume truth, particularly when combining two drugs, amphetamines and methamphetamines. There is enough research in the world to state the fact Māori and Indigenous are strategically targeted and this was one of them. Māori methamphetamine researchers and data information that is reliable and credible need a voice. Māori users can better access first-hand knowledge by Māori for Māori even by user lived experiences with their knowledge. Considering non-Māori reporting could essentially create bias and strategically base the evidence of use without a full comprehensive inquiry. The criticism is who gets to authorise the authenticity of Māori research before it is made public. Non-Māori contractors? There are more than enough Māori researchers to get approval instead of commissioning non-Māori researchers. Such research has simply pointed out that there has been no change since 2010. In fact, since that time methamphetamine rates have skyrocketed according to news reports, local water treatment centres and police busts.

Deliberate misinformation

At one stage overseas criminal groups were paying insider authorities to accept shipments and bribes from the inside of a police station. Consequently, access to computer data can be used to solicit private information. The most common problem within the New Zealand police for corruption is written reports and ever-changing stories that indict a user. (Maxwell, 1998) informs that the corruption within the Justice system is so undercover that the prime minister would accept the corruption as a simple mistake. The police, courts and prison, all work together. They fabricate, lie, report misleading information, all whilst making a person feel comfortable inside a prison cell. They are not mistakes they are intentional with prejudice, especially if you're a Māori or Pacific Islander (Williams, 2001), (Yaacoub, 2017).

According to (Maxwell, 1998, p. 23) strategic discrimination was viewed by police against Māori opposing the word Pākehā. Though the findings for respondents in the report suggested a small group of police reviewed Māori negatively. Most of which was against the rights of Māori to preserve Māori customs and language, also when settling Waitangi Treaty claims, to improving social and economic conditions for Māori, and lastly when wanting to

develop a separate Justice system for Māori. The numbers to disagree went from 5% to 90%. In total most disagreed with Māori sovereignty of anything, land, culture and language (Maxwell, 1998), (Gray-Sharp, Tawhai, & V., 2011). Given the past twenty years the objectivity of stereo-typed groups are diminished and criminalised just for being Māori. Criminology may be coloured deep within a conscious bias, notably for the powerful who can at will determine everyone's fate by merely gazing within his or her own adopted discourse. To fix the other would need the retraining of the mind, punishment, discipline, education, and prison (Foucault, 1977). In comparison, Māori and Non-Māori co-existence is shared by a description of shared beliefs of greater importance to one with cultural implementations that do not necessarily agree with the other. In theory, the root of oppression and the oppressor is found within the classes of the bourgeoise, deeply entrenched heritage belonging to another group of peoples, not Māori. Therefore, when articulating systemic responses for Māori growth and development, a research inquiry must understand how the other in reflection works. As pointed out in Moana Jackson's report, He Whaipaanga Hōu, Māori educational mechanisms of shame are founded upon failures within unfamiliar experiences. To colonise the land is to colonise the mind, as found in the research data, explicitly regarding ethnic data. (Jackson M. , 1987, p. 23) states "if ethnic data collected by the police are to be widely used, then their ID objective should be stressed"

In reflection of the past, Māori crime has increased and police brutality, consisting of 33% Māori being tasered with 82 discharges in 2018 compared to half that of non-Māori. What is more alarming is how the police discharged three fifteen-year-olds and a nine-year-old yet a sixty-two year old person was charged. Data showed non-Māori were mostly handcuffed in awkward situations whilst Māori and Pacific Islanders for the same circumstances were pepper-sprayed and tasered (Neilson, 2019). Enquiring whether the Justice system has improved is unlikely. The attitude within the police today remains severely embedded in the belief that Māori does not deserve better aspirations (McDowall, 2012). (Maxwell, 1998) summarises Māori for discrepancies within the police of which half were positive but most disagreed with the culture. This includes positive relations, their education of culture, not allowing input into police policy, also ignoring emphasis on the Treaty of Waitangi, respecting Māori as a Crown partner as reflected by a policeman's thoughts when stating "I do not believe that we should lower our recruitment standards merely to encourage more Māori into the police. If we do all this does is lower the standard of the police" (Maxwell, 1998, p. 34). In another police statement, "There are stereotypical attitudes within police

younger staff' but this flows from anglo upbringing. The attitudes are built on ignorance, not hatred. Lack of contact is the biggest factor. The personal experience could change opinions" (Maxwell, 1998, p. 35).

Grounded

According to history, drugs have been reported from millennia in clay tablets, the inventing of alcohol and plant herbs for aches and pains. Western philosophers in classic history, such as Aristotle (brain) Plato (sensation) and Herophilus (anatomy) would present a case for the future development and pursuit of medicines by looking outward away from nature. Classical philosophy would remove the spiritual connection to the land and the environment in exchange by acquiring intellectual knowledge from other worlds and not without the support of the political-military force. Socrates wisdom, on the other hand, is questioning the pursuit of knowledge rather than looking outward by looking inward at the self (Whaanga, 2012).

Indigeneity introduced theories for nature under the rules of the universe with spiritual prayers and rites of passage to guide decision making (Inglis, 2018). Perhaps why Indigenous continue to this day performing rituals of acknowledgement to a universally accepted Indigenous super-being. Similarly, the practise of environmental medicine through prayers was often performed to demi-gods, not Io-matua-kore therefore being one in connection to the environment outward would allow Io-matua-kore to look within. None of these demi-gods was worshipped. Only one Superior being the parentless one was given that title and that entity was too great to mention. Even the word Io-matua-kore may have been too great for some. Therefore, smaller gods were given those roles, so life could exist with balance and freedom. When colonisation arrives in the Indigenous worlds the spiritual and plant healing worlds would be challenged and traded by philosophical enthusiasts for rethinking sickness, plagues and pain relief (Blistein, 2019), (Escohotado, 1999). The preservation techniques and sustainability for the conservation of nature is evidence of people groups who transformed the very heart of Indigenous life as an environmental classroom (Buck, 1994) critiques a universally accepted viewpoint, the continuation of education for offspring. Māori meant to produce well trained medicine men or women (Elsemore, 1999). In the grand scheme of Māori education children were taught that everything in the world is connected, the mind, the physical and the spiritual (Alfred, 2017). This is so that the culture continued to play a role in the connection with the land and its connection to all living things. The evidence points back to Adam who was once connected to the earth, he came from the ground. According to

(Cherry, 2005) the neurological system in the brain is also linked to the earth's electrons. Therefore, if you were to put your feet on the ground, the feet would react to the earth's electronic neurotransmitters, like the brain. Likewise, touching a tree, earth, signals in the brain to calm nerves and accelerate bioelectrical pulses reducing symptoms of pain (Chevalier, 2012). This could make much more sense to Indigenous peoples before philosophy pursued knowledge, disregarding an important equation. That the pursuit of knowledge is as Socrates first stated, the self. Indigenous peoples are mostly connected to the ground with their feet may suggest is the possible link between humans and earth, being lost in transition, with the invention of shoes. This connection is the path that leads clinicians to a better explanation of connecting the user to his or her state of origin starting with the mind and spirit (Bishop J. , 2014), (Robinson, 2005). Māori in the past was not exempt from karakia (prayer) though it was not a specific duty, practised in the morning, day and night. Sometimes all day. All were required to partake in forms of karakia that involved nature (Caccioppoli, 2005). This is why karakia is the most important aspect of the Indigenous person's wellbeing (Te Aho, 2013). The land that produces the plant is spiritual which might suggest why prayers are practised by migrations thousands of years old. Indigenous social outlook on health rarely describes addiction to plants (Dahlby, 2009). The land that provides is the healing centre. Therefore, Indigenous is grateful for their repairing reproduction (Ford, 2020). So, to harm the land or nature was considered sacred (Elsemore, 1999), (Love, 1999).

Ultimately the study of methamphetamine treatment for clinicians is to critically rethink the subconscious battle with the mind and alternatives and how one might reconnect them back to their original paradise wherever that may be. (Stroud, 2016) explains why methamphetamines' connection with the brain is so powerful that the natural chemistry dopamine which stimulates the brain's pleasure centre, is amplified many times that of dopamine's normal capacity (Hernandez-Santini, 2021), (Covey & Taylor, 2008). Retrospective of what many believe is inadequate people abusing is false. Methamphetamine users dare to declare the words addict, junkie, crackhead, substance abuser but instead the term user who is no different to anyone who purchases a packet of cigarettes or bottle of alcohol. Removing these label helps to empower users as normal human beings. Others can act with kindness and care with no judgement. Dignity should be at the heart especially for lawmakers and enforcement agencies. The difficulty is the historical attachments preparing to shape favouritism and socially engineering our bias. The way forward without alienating is to achieve acceptance of the person's character without the stigma attached to the drug. For

clinicians that may be easier than the Justice system. Society has grossly misled that the world we live in is shaped by the haves and the have-nots, a societal disconnection with users when intentionally, sometimes, as if in the mind, they should not exist, but disappear (Amy, 2003), (Foucault, 1977). The reconnection of the self is to move towards a fuller understanding of the Māori worldview to align with the user's mental stability. In doing so they acknowledge their methamphetamine journey into small increments in a positive direction for change.

Step One: Te Kore (The Nothingness)

Step one to recovery is Te Kore which symbolises the beginning of the journey from a state of nothingness and making purposeful attempts to restore the self. This important first step includes identifying the self through pepehā (identity) and whakapapa (genealogy) where someone comes from is important to the user. Knowing who they are and where their ancestors come from is vital to healing. This practice aligns to te kete aronui. It includes whakapapa and Māori storytelling to connect the user to identity. This incorporates their pepehā and bridges themselves to their whanau. This helps with moving forward making new progress. Speaking Māori is important but connecting through the mauri is tika. Once the user starts admitting that there is a problem with methamphetamine and working towards a reduction plan. The critical process for the step-in recovery is how the user can achieve the first goal. Kevin R explains that visions, dreams, and foresight create a real possibility where getting from point A is now doable, but explains they must be achieved through tika. The connection is to their ancestors handed down by kinship. Te kore is the first stage that could take several weeks to complete. The kete aronui reflects traditional customs and historical connections to the mind. It produces visions and moemoeā (dreams) and helps the user to progress through a spiritual awakening. An assessment of the recovery plan should be in place to journey with a user for setting the groundwork (Bishop J. , 2014). That work will consist of obstacles, progress, and open communication. In the first weeks, a user may experience withdrawals, coming down, pain and fatigue. The approach to recovery is that a clinician will remain compassionate, understanding and engaged. Te kete te kitea best aligns with the mauri and the persons dependency on a energy of spiritual guidance from the Creator. This brings satisfaction of the self within the pursuit of the life force. Progress is made by the user who requests the advice of a group who understand what specific help is required. Users do not have to commit to the services offered to support mental health treatment goals that are available. There is a consciousness to reflect the change for

methamphetamine users and the practitioner must be cautious, yet provide tika, pono and aroha under Māori cultural principles. The Māori clinician's role is to explain in this programme the Māori worldview. Users can then step into Te Ao Māori through the enlightenment from Te Kore. Te kete tūāuri begins the new change in the discovery of the self through cultural identity. This journey to wholeness is found in the mind. The purity is in the person's responsibility that they relinquish their vulnerability. In this concept the user is coming from a place of the unknown, not knowing where he or she is going and is in a state of confusion. There is nothing that the user can do to undo what has already been done.

Methamphetamine users may be at breaking point where disaster, irresponsibility, lack of sleep, no money, no children, no family, and a place of despair seeking answers to fixing the external problems. The first step for the user in clinical practice is to give the user a method that enables understanding of their internal issues. Where they are now, what they think they can do and what can be done to support their addiction. In this case clinicians using this framework do not accept that users attempting the first hurdle will fix their drug habit – not at all. Te kete te kitea requires them to accept themselves, accept their past and look forward to the future. This means renewed energy in their ability to want change. The aim is to bring the person into a state of acceptance, agreement that they need help and cannot do it on their own. That is why they are in the programme.

The first step is often the hardest because getting there wasn't easy (Covey & Taylor, 2008). Many people, friends and family may have helped them get to this stage. The job of the clinician is not to state that they will want to change. The first step for the clinician is that they attempted to change. The result is not conclusive nor is it a recommendation to consider a change in the future. Breaking these ideas about change is a step for clinicians to critique mental health stability for users. Placing unreal expectations on a user may force a user to withdrawal from clinical practices, from recovery and their future. The kete tūātea through proper planning requires the person to have a purpose for change. The mission is to encourage them through stages even setbacks to succeed and the belief of their goals for achievement. The position of the clinician is to give sound strategic advice through education, care, and slow development. Substance use can be addressed through help by others.

Step Two: Te Pō (The Darkness)

Te Pō represents the growth from emptiness to a state of darkness where the self begins to come into new knowledge and is empowered to progress ahead. Māori aspirations rely on responsible planning and achievable outcomes for delivery (Bishop J. , 2014). The principles of te kete te kitea helps users to connect to a Māori worldview. These strategies include traditional practices with purposes to assist them in life with all things that are in connection to the mauri (life force). Strategies should be set for users to engage with the community where change is acknowledged by the whānau, which includes karakia, waiata, te reo Māori and dual leadership. This is to explore mātauranga and Māori healing strategies that have worked in the past, which are more in connection with Māori thinking. There is also the aspect of decolonising treatment for Māori being revitalised through a range of treatment options that allow goal setting, short term and into the future. Billy M refers to pono being the purpose to which the user wants to quit. Clinician based practices should include a mission for the user to purposely achieve what is right for them (Love, 1999). The clinical practice should offer manaaki representing the act of kindness and care (Cook, 2018). The goal is to build capacity and resilience around the user. Te kete aronui helps this process through Te Ao Māori. Whakapapa of the ancestors guides the person's mana and the values that are installed in the pepehā. This programme is called Te Pō representing the awakening, the place of darkness where growth starts to take place.

A user will have completed a series of steps to get from daily, weekly, and habitual using to reduced levels. The user is supported by the team using the Te Pō in te kete tūāuri. Like a seed in the ground, Te Pō is the darkness the seed needs and once watered starts to grow life underneath. This strategy in the clinical practice focuses on further developments such as the keys to education by helping to get the person's health back to life. The challenges for growth are knowing that the past was completely disruptive, damaging and destructive to the user and others. Knowing this allows the user to see better opportunities. This means a job without substance, or time with family, friends, and better relationships (Love, 1999). Friends that use will not be part of the group of change. Critically, this is one of the hardest parts of change is peers who form the group of user relationships. Māori have a greater need for kin relationships because of their connection to each other. Te kete aronui talks about the pepehā and how those relationships are strengthened through identity. This is knowing your waka (canoe), your maunga (mountain) and your awa (river), all are crucial to knowing one's self.

This connection builds a closer relationship with whānau (family), hapū (sub-tribe) and iwi (tribe). Therefore, removing oneself from the inner circle can be very difficult. Women have a harder time removing themselves and trying to get out of relationships that are dependent on drug use. If male users are supplying women, then women may become dependent on the male, as well as the drug. Growth however is a lot stronger where family members, whānau, children and the wider community recognise the person's ability to want change. This produces success and fulfilment within. Te kete te kitea is the pursuit of satisfaction in the values, traditional practices of Te Ao Māori. The dependency is in the mauri that governs the person's desire for change. The challenges are how does the clinician deal with a person's relapse. The user should feel supported regardless of use. They may wish to restart at Te Kore for further motivation as the programme is a journey of episodes of where the person came from without emanating guilt. The progress of the user is to nurture their future to potential gains. What the user identified is a significant gain compared to any negative or mental losses. Further to developments the mauri pathways for the user can offer them a visual foresight to see more opportunities. One can gain educational training to earn qualifications to be better prepared to help others. Growth leads to more responsibility and accountability as users will always agree that the challenge of using again is just around the corner. They understand the temptation and they know their drug of choice and are much better informed about someone else's drug stage. Each step in the mauri helps the user to clarify the direction they want to take with each step.

Step Three: Te Ao Mārama (The World of Light)

The next stage is Te Ao Mārama which signifies the coming into the light where the user now sees the future more clearly. Once the user has been able to achieve the outcomes the key periods have now identified their purpose for being treated (Bishop J. , 2014). This is followed up by Arona S who instructs the clinician's care as being connected by customs and traditions. Te kete tūāuri shapes the person's self-confidence replacing negative thoughts with positive change. They now have a strong mental will over their circumstances. The key to their future is in their journey. Not only, but the emphasis is presented by the hope and success of the whānau. This means an array of contexts for the user to agree with. Furthermore, there is a connection with mātauranga Māori where the ancestral knowledge is brought into context and where users can connect to the land, even the stars. Coming from darkness, gaining new growth and becoming a light to others. The goals are an achievement and management of the self and mind. Arona S discusses the importance of a historical

context with users to identify where they fit into the world with Māori history. Te kete aronui demonstrates the success of the ancestors through the handing down of knowledge. This connects the person to their whakapapa and their whānau. Arona S illustrates Māori carvings as stories that talk about colonisation through panels. Each panel is a waka (vessel) which resembles Aotearoa. The chaos is the stories that are represented in each frame to point to how Māori started with nothingness. The stories are also important themes of treating Māori are not from a book, nor lived drug experience, but rather from a cultural landscape that connects Māori users to their identity (Love, 1999). In the same way Kevin R discusses the relevance of whanaungatanga, whānau support not individualism, to explain kinship collection not singlemindedness. The Māori identity, therefore, is grasped into a series of ideas that battle with the user's mentality. Firstly, that they are Māori and now they are being told the truth about themselves, their people, and the history to give context to the state of confusion and darkness they have. Māori practitioners are seeking to explore the journey of recovery with Reo Māori based treatment accompanied with Tikanga (cultural protocols).

The user's goals and the plan to remain free from substance is also dependent on both the clinical process and the availability of care for the user (Love, 1999). In managed detox or isolation, treatment management requires a new step in progress and the ability to know the harms of withdrawals and management process to get the user to a self-management stage (Covey & Taylor, 2008). Te kete tūātea describes the visions for success to achieve overcoming personal setbacks. The mission is to focus on the future by planning goals. This includes being strategic and imagining the outcomes for achievement. The first step encouraged the user to be dependent on the clinician, clinic and whānau as a practice of trust. The second step is to give reassurance that growth is the follow-up of the clinician's advice through accountability to peers and whānau. Self-managing and reliability to the whānau and clinic follow accountability. The third step is the self-managed process where the user is now independent of the clinic thus being educated about the consequences and freedoms from methamphetamine (Cook, 2018). The process however is not straightforward and reliant on a time frame. The steps are goals yet are not set in concrete (Bishop J. , 2014). Completing each goal will depend on each user's will, courage and determination. Some users will not experience the immediate desire to change whilst others will be at a different stage. Te kete te kitea represents the life force and the energy of the Creator. This establishes the values of the Māori worldview. It also includes the existence of life and all things unknown and known. Arona S states that mātauranga is the key to keeping a Māori user connected to all things.

Step Four: Te Mauri (The Life Force)

The Mauri is the spiritual awakening and is the last step in a series treatment steps that could take up to a year to complete. It's a journey worth the time in coming from complete chaos to complete freedom from addiction to methamphetamine. The important factor is journeying with the user from Point A to Point C. Time is not a factor, neither are the goals if they are not suited for the user. This last step is the most crucial where the user is now on his or her own but within the treatment plan. Te kete tūātea represents planning, strategy and purpose for achievement. Moreover, foreseeing the future is held in the implementation of the goals. Therefore, the self has imagined that it will come to pass. Not all but some users may not make a year's journey and step back into Te Kore and not return for help. Users have been given the tools to mediate the problems of methamphetamine addiction but for some reason have dabbed and fallen short, or for whatever reason could not continue after weeks of trying (Love, 1999). The other perspective which tends not to be observed so much is that addiction to methamphetamines is an enjoyable experience. Methamphetamine is highly addicting, therefore missing the drug, has huge impacts. The dopamine and adrenaline associated with it can be too attractive not to miss. Therefore, other possible strategies need to be in place to help users manage this most crucial part. The most discouraging part for users is the amount of work they have done when a user decides to leave the programme or has been admitted to a hospital, imprisoned, killed, or seriously hurt. The impacts can be devasting for family members to have to acknowledge that they may have failed a family member when they tried everything to help a person's use. Therefore, the last part deals specifically with vulnerability and how lived experiences can help users to achieve a year without methamphetamine use (Cook, 2018).

Lived experiences offer much support and it is not just clinical advice. The advice is spiritual. The journey from Te Kore on to kete te kitea is about how one has been accepted into a long difficult process of change. The journey of change is taking the next step in educational awareness (Covey & Taylor, 2008). Promoting the treatment as part of a rescue plan for others. In this way, treatment is not restricted to clinical practices but rather to communities who work together to deliver practices that help others achieve the same or similar results. This is because in a Māori context is utilising all the senses, good and bad. The person is no longer identified as a user, but free from this taniwha. In a sense, they have killed the monster that was killing them. Te kete tūātea holds the belief in prophetic encounters and foreseeing

the future. The visions they have will be of the mission to succeed. Therefore, this embodies the Māori philosophy of moemoeā (dreaming). The user now has self-control, whereby whānau together can walk in confidence without the drug that took the life of the user away. This is the meaning of the mauri and the life force that restores the person's heart to live, enjoy life and value others having life also. Not only but being able to eat properly, see without being drowsy, know where oneself is and be okay with feeling good is a healing remedy (Love, 1999). After such a long journey of this recovery for the new person. The mind has been coupled with the whenua as a treatment process. Te kete te kitea is the reuniting to the atua (Creator), the mauri (life force) and the whenua (land). The self is no longer abandoned but fulfilled. Therefore, the mind is now re-generated. In hindsight, the story of the mauri reflected all things and encompassed a Māori healing strategy by identifying key Māori themes by reconnecting the user back to the earth through the mauri framework. The earth is the treatment process for renewing the mind when aligned with the Mauri framework. The researcher draws a conclusive discovery that answers the research question posed at the start of this study. The aim was to provide background to the issues of methamphetamine addiction followed by identifying effective and ineffective treatments to find solutions to this global dilemma and in particular the Indigenous peoples of Aotearoa New Zealand. This research has shown the need for a move from existing models that are failing to produce successful outcomes to a new and redesigned authentic approach. This proposed model coupled with the clinician's professional input would enhance the benefits and outcomes for users who are suffering at the hand of methamphetamine.

Therefore, when answering the key research question of: What is the most effective treatment for Māori who use methamphetamine? The evidence provided in this thesis shows that lived experiences, from both clinician and user, when aligned with Kaupapa Māori theory produce an outcome that supersedes current mainstream treatment practices. When working with Māori users of methamphetamine it is strongly suggested that a Māori worldview be incorporated such as the Mauri framework. Such initiatives require political support and a willingness to amend existing policies to embrace the Māori approach to dealing with this phenomenal drug. Evidence highlights the success of Māori based initiatives that are used to address examples where discrimination and stereotyping of Indigenous peoples. The Indigenous approach can apply to the health system and also to other government departments where we see Māori models implemented in any social need, namely Oranga

Tamariki that deals with family harm, or the Justice system that deals with high levels of Māori incarcerations.

In closing, the treatment for Māori regarding methamphetamine should include qualified lived experiences rather than non-lived experience that are based on theory alone. A ‘by Māori for Māori’ approach is strongly recommended as both clinician and user can identify with each other and be more open and transparent to finding a solution to overcoming methamphetamine addiction and drug abuse. This chapter presents alternatives and discussion for treatment to methamphetamine addiction from a clinician’s perspective. The topic requires the right treatment solution to be addressed. In closing this debate will conclude a final result for the study.

CHAPTER 7

Conclusion

Ko Ngāti Awa te toki tangatanga i te rā e

The purpose of this thesis was to provide alternative insights into the world of drug use, addiction and treatment. Ideally to explain how the treatment is desperately needed to solve a worldwide problem affecting the family, employers and society (Peterson, 1977).

This study provides an explanation of amphetamines being a treatment drug and methamphetamines being an illegal drug. What this research finds, is that what originally happened with natural drugs becoming used for medicinal purposes is an exploitation of natural uses for profit. History shows sufficient evidence to highlight examples of key drug problems experienced around the world and here in Aotearoa. Knowledge of this subject can empower both clinicians and users and be further supported when implementing a Māori framework such as the Mauri model. Part of the framework strategy includes the concept of taonga tuku iho. This summarises Māori connection to their mountain, river, canoe, marae, tīpuna and of course themselves. Māori healing requires an effective intergenerational health treatment system that articulates accurate care from a cultural and accepted viewpoint. Health professionals working with addiction should not position users as weaker, non-intelligent people when in substance abuse. Rather the evidence points to creating space in their cultural context with tools for self-management, planning and support towards healing. Even, if that means still using but reducing (Raki, 2010). The shift is that Māori can care for whānau and friends who use them. Most often clinicians worldwide agree, users, want to quit. The critical factor is a stigma attached to some form of cynicism. Methamphetamine use in the community is not accepted, not among families who want healthier choices, but the drug is around. Some can quit and others are not in the right position mentally. The story presented with Ira Tūmoana and the people were willing to trust one another and receive healing. Nothing in this thesis suggested healing is an easy fix and it has many obstacles for one to overcome addiction.

The overview of chapters from one to seven demonstrates the need for treatment.

Chapter One – Introduction describes how methamphetamine can first impact the brain. This was raised through the initial examination of dopamine. It illustrates political infringements on communities including treatment ideologies and current issues being faced around the world, in particular Indigenous peoples.

Chapter Two – Literature Review identified leading scholars in this topic critiquing three key periods of the pre-Indigenous Western period of the 1490s - 1950s. The economic-political period of the 1960s - 1990s and the Māori period between 1990 - 2021. The research focused on trade, science, social theory as a grounded hypothetical case for methamphetamine's rise in society.

Chapter Three and Four – **Methodology and Methods** is an extensive critique of what is needed to interpret Māori concerns. The Māori framework helped to develop a new model for treatment. The methodology raised a Māori Kaupapa approach to the Mauri framework containing four key elements: te kete tūāuri, te kete tūātea, te kete aronui and te kete te kitea. The methods used were qualitative employing interviews with clinicians and observations with addiction treatment organisations.

Chapter Five - Findings identified key themes and trends to bring new results where data was examined. This included whānau group meetings, evidence from interviews and observation with the community involved. Proposed alternatives were identified for further analysis to provide greater understanding of addiction treatment and recovery. Clinicians provided new insights to help users overcome their substance abuse.

Chapter Six -Discussion critiques the findings to identify opportunities and further solutions for users and practices. The Mauri framework highlights areas of concern and identifies room to improve. This provides clarification for clinicians and users in adopting a new treatment model. In this context it seeks to support existing treatments with new knowledge.

Chapter Seven – Conclusion raises key points of the current health treatment processes and the outlook of future drug use. It includes critical reflections and recommendations while also highlighting limitations experienced while undertaking this research.

Recommendations

Clinicians explained what worked and did not work with users on a consistent level. Using literature approaches to methamphetamine addiction recovery analysis provides a substantial delivery model that is consistent with clinician interviews. Particularly, in the EBOP where methamphetamine addiction is high for Māori. As previously mentioned, evidence points to neutrons in the earth that can heal the physical body. Physical therapy, including walking with clinicians, talking and connecting with nature whilst being involved in a person's recovery. The Mauri framework methodology informs a natural perspective using energy as medicine. Though specific details about the length of time on the earth (feet) connection to dopamine in the brain have not been investigated as to the length of this study. As for reasons of self-empowerment for users regarding poverty counsellors may wish to invest in humanities or socio-political and economic studies, drug science and brain research to explain the current methamphetamine use. Emendations critique a series of counselling practices to inform and better qualify clinicians with a holistic approach from a mātauranga scientific approach. Neither stating mātauranga or scientific as inferior or dominant to each other. Both responses would allow Māori to experience methamphetamine recovery differently and offer a connection at least to their Māori methamphetamine history. The analysis of the discussion provides healing insights specific to Indigenous people's realities of addiction to drugs. Included is providing outdoor treatment practice for users who can re-connect on their own with the whenua. More research data from clinicians who work in the community or provide reports can help researchers in the context of methamphetamine use and recovery.

In addition to the research quality and assumptions identifies a lack of knowledge about differences between amphetamines and methamphetamines particularly when researching Māori use. Community proposals and projects being administered in the community, such as effective community hubs used to support the community rarely exist (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). Drop-in centres for addicts were replaced by social welfare, religious organisations and iwi models. In the past they were the hubs of the community, but now they are few and far between as they assimilate into the governments model of care. Local councils, schools and families have centralised drop-in centres through other forms of activities. There are more entertainment programmes and other activities that offer support to young people and their families. But treatment tends to be a growing

development. Zoom counselling is a relatively new concept that is working with people who enjoy social media discussion. More support for online meetings in this space for counsellors should be made available. Organisations can better prepare users with treatment programmes in a meeting that is Covid-19 friendly, keeping distance and safe. Users can come and go in a meeting and giving them more autonomy. Greater emphasis on online meetings will also critique usability and if meetings are adequate. Some users may prefer to wait for face-to-face meetings. However, creating a platform builds a framework around support and care but the Mauri framework connecting to the whenua would be absent.

Limitations

There are several limitations of this study that can offer some conclusiveness. Firstly, the recruitment strategy included two wāhine as according to the ethics. However significant restraints could not allow participant interviews. For instance, Covid-19 impacted the interview process with wāhine. Not only that but dates, times, emails and meetings could not be conducted. The research methods provided also could not produce any findings of the district (EBOP) user information. That was because the ethics could not allow the safety of the researcher and the supply of information to be authentically true if a user interview was matched. However, if Zoom was provided for the ethics it may have been justifiable for this thesis to match user-based evidence. This is important because users are the ones caught in drug addiction and to hear their stories is critical to any enquiry. Also, they have clues to their addiction that can aid evidence to support methamphetamine addiction treatment as relevant or not. Their story is most undoubtedly more important. The limitation of access to methamphetamine users tests factual experientialism only produced by clinicians and former users not current. In hindsight, if Zoom interviews were organised they may help shape recorded information better and create a new methodology approach.

In addition, what is unclear is the analysis of retention among users within the whānau group (Jones, 2018). Secondly, an issue raised in the literature and one that is apparent here is the uncertainty around any long-term change that participants may have experienced during their time in a whanau group (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). Future research aimed towards investigating these aspects of recovery from addiction would make a useful contribution to the field. There are some important questions to think about for the future of illicit drugs and community treatment harm. The limitations of this thesis expose critical arguments for drug use and misuse which highlights concern about the government

role in pursuing the war on drugs and modelling treatment which go hand in hand. More research for insights on the pursuit of government policing and law enforcement methods around drug control would complement this study, especially finding evidence to support Māori incarceration rates, force and discrimination. A thorough investigation could be proposed to interview judges, police commissioners and minister officials.

The collection of data that is being reviewed for this thesis was not able to explore doctor's reports, hospital, police and ambulance records to measure Māori links to methamphetamine. Furthermore, where does the information for those statistics go if there is not any real information given online or held by the government on their databases? Therefore, providing new insights into research in the local area needs a lot more attention. There is insufficient information in the community for users. Even local reports are only supplied by the newspaper such as the Beacon. Therefore, more research from local districts is required. For Māori, that means Māori organisations that supply local data within the process of privacy. Far more research needs exploring in residential treatment. Such reports can tell researchers a lot more about what is happening in the community with drug abuse addiction to methamphetamine and what treatments are working. Not only that, but also the effects of methamphetamine abuse to families and what damage is being solved. This would explain how communities are reacting to methamphetamine and treatment (Cram, Te Huia, Te Huia, Williams, & Williams, 2019). Testing an Indigenous rongoa (herbal) product that could deliver scientific research treatment could help to break and even reverse the effects of methamphetamine addiction. Currently no drug exists and therefore could lead to a discovery of a new scientific Indigenous drug to counter methamphetamine harm (Covey & Taylor, 2008). The prospects to reduce drug arm could see a future of Māori medicine emerge for Māori.

New pharmacy strategies are currently in place to strengthen the health implementations of Māori treatment medicines within ten years (Alfred, 2017). Under the Treaty of Waitangi this means partnership, protection and participation (Love, 1999), (Williams, 2001). The treaty could allow for Māori medicines to be part of the Māori addiction process where rongoa medicines help to reverse harmful addictive drugs. The safe practice of drug taking is not a treatment strategy that currently exists with users. Specifically, how to use safely which includes safe use of a pipe, intravenous injection and quantities of intake (Stroud, 2016). Treatment is not organised by clinicians to deal with use rather prevention of limited use.

Drug treatment is mainly sought to cover the prospect of eliminating harm to self through treatment programmes by way of abstinence. Privy to this the critique of addiction versus treatment is held within neo-globalisation of treatment constructions. Agreeing with the consequences of socially conditioned belief, that one needs to rely on the state for treatment help. No longer requiring the services of the whānau and friends (Bishop J. , 2014). The self has believed to be insignificant to the control of the government's platforms of mental health institutional recovery (Bennett S., Elder, Kingi, Lawrence, & Tapsell, 2020). All harmful legal and illicit drugs are state problems where the harms to communities are out of control. At one point the government was trying to control all types of illicit substances, whilst at the same time capitalising off poverty. Therefore, people have died or ended in violent abuses to themselves and others. The government takes little responsibility for advocating it. The hard truth in New Zealand is methamphetamine abuse is becoming such a problem for the government that they are needing urgent solutions. The health practices not only have to contend with abuse from users, but authorities seek to dismantle labs, cookhouses, supply and street sales to curb the war on drugs, do not see any value in education (Drugfoundation., 2013). The administration of policies that reflect somewhat the same as the other coalition countries within the boundaries of research follows the same suit. Government treatment plans, health strategies, treatment frameworks, foreign policy and legislation look very similar to each other. Although Māori is looking to add to that under the treaty partnership arrangement. Māori and Indigenous peoples around the world are still viewed as propagandists of use, of crime associated (Collins, 2015). Therefore, mainstream or non-indigenous models that do not reflect Indigenous outcomes continue to fail Māori.

Summary Conclusion

This thesis is to provide alternative insights into the world of methamphetamine use, addiction and treatment. In doing so the study constructed an argument for a treatment response by incorporating a Māori framework. This poses as an example template for users to connect, reconnect and disconnect from methamphetamine. Not to mention a critical perspective of treatment alternatives to the already existing clinical practices.
A Māori approach found examples of practices with clinicians that acknowledge and accredit the power of lived experiences. In deliberation of an answer to the methamphetamine pandemic, a one size fits all approach is not adequate enough. However, a reconnection of traditional experiences may give clinicians a better perspective on how to treat users. The Mauri framework presents a strategy, but it is not the sole answer to drug addiction.

Methamphetamine is supported by many societies, for use, income and treatment practices. In essence, the drug is a foundation for the Justice system, police and prisons. In reflection, a Māori kaupapa framework produced a result that provides hope for disconnection from drug use and a re-connection to Te Ao Māori as the source of healing.

The warrior ancestor, Ira Tūmoana, orders us to challenge the taniwha that enters into the Māori world and defend the people from further destruction. A warrior like spirit is what is needed to defend the village from outside influences and attacks. The mauri of our people has been oppressed and needs to be restored and regenerated to reach its full potential as described in ancient taonga tuku iho that was handed down to current generations. This research chooses to end with an ancient haka (war chant) that tells of a spiritual axe to take down and defeat the foe. This study concludes in the tribal tongue of Ngāti Awa and is relevant when facing today's most difficult challenges including the taniwha known as methamphetamine.

Tēnā i hautia.
Ki te ūi mai koe i poua mai au i hea?
I poua mai au i Te Awa o te Atua, i Rangitaiki, i Ōrini
i Ōhinemataroa e.
I poua ma au i hea?
I poua mau au i te take o Pūtauaki he ngārara te kai
I poua mai i hea?
I poua mai au i te puāwāwātanga, o Awanuiārangi wānanga rau.
He uri mākoko ahau nō Ngāti Awa
kia whita ki te aka matua o Tāwhaki nui a Hema
Ko Ngāti Awa te toki tangatanga i te rā e
Ana te ihi, ana te wehi, ana te mataku e, Hi!

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TE WHARE WĀNANGA O
AWANUIĀRANGI

06/07/2021

Heemi James Brown
2020 State Highway 30
Te Teko 3192

Tēnā koe Heemi,

Tēnā koe i roto i ngā tini āhuatanga o te wā.

Ethics Research Committee Application EC2020.38 Outcome: Approved.

The Ethics Research Committee met on Tuesday 06th of July 2021. We are pleased to inform you that your ethics application has been approved. The committee commends you on your hard work to this point and wishes you well with your research.

Please ensure that you keep a copy of this letter on file and include the Ethics committee document reference number: **EC2020.38** on any correspondence relating to your research. This includes documents for your participants or other parties. Please also enclose this letter of approval in the back of your completed thesis as an appendix.

If you have any queries regarding the outcome of your ethics application, please contact us on our freephone number 0508926264 or via e-mail ethics@wananga.ac.nz.

Ngā mihi rā

Shonelle Wana, BMM, MIS

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