IT'S ONLY WORDS: THE CRYSTAL METH DILEMMA

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ABSTRACT

Crystal meth has been an illicit drug for many years but did not surface as a problem until the 1990s. Between 200 and 2006, a number of provincial documents were produced in British Columbia, Alberta and Saskatchewan to examine this problem. A shift appeared to have occurred in terms of how to handle this situation. Traditionally, illicit drugs such as crystal meth were dealt with by the criminal justice system; however, in this case, provincial health departments prepared these documents. The intent of this thesis is to examine these documents by providing a discourse analysis and applying concepts from Foucault, vanDijk and Phillips and Hardy. Three questions are asked: (i) who are the voices of these documents? (ii) who is identified as being at risk? and (iii) how is crystal meth socially constructed and what solutions are presented? All three provinces identify the same at risk population, our youth. British Columbia and Saskatchewan construct crystal meth as an educational and health problem, while Alberta focuses mainly on crystal meth as being a criminal problem. This research concludes that the solutions offered by the various experts from these provinces are unrealistic. The social determinants of health such as adequate income, housing and employment opportunities are discussed in these provincial documents however, nothing concrete is provided. Saskatchewan is the only province to commit money to finance new programs to assist with the crystal meth problem.

DEDICATION

I dedicate this thesis to Aryn and Jesse. May you both continue to be happy and productive in your new leases on life.

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CHAPTER 1: INTRODUCTION

Drug use in Canada has a long history of regulation. Starting with the enactment of the *Opium Act* of 1908, a long list of illicit drugs was incorporated in subsequent legislation, which treated drug use as a punishable offence. In the 1950s and 1960s, however, an alternative, non-judicial, discourse emerged which emphasized drug use as a medical problem requiring treatment rather than punishment. Although treatment did not become part of provincial drug policy at the time, by the time crystal meth was identified as a problem in Western Canada in the late 1990s, there was a definite shift in the official discourse of drugs. The emphasis was placed on drug addiction rather than drug use as a criminal problem. The aim of this thesis is to look at contemporary official discourse on crystal meth. I look at crystal meth use in the provinces of British Columbia, Alberta and Saskatchewan to determine who the voices of these documents are, its prevalence among particular social groups who are defined as being at risk, how it is constructed by some groups as a problem and what, if any, impact, this construction has had on formal responses to crystal meth use. To answer these questions, I critically examine official documents produced by the governments of British Columbia, Alberta and Saskatchewan between 2002 and 2006.

There are limitations to my research. Manitoba has also produced research on crystal meth, however, I have chosen to address these issues in the provinces of British Columbia, Alberta and Saskatchewan. This research is

personal for me, as I have loved ones who have been involved with crystal meth. I also have a background in adolescent psychiatric nursing, emergency room nursing and twenty-five years of working in corrections in Alberta, with both adults and young offenders.

My intended audience for this thesis is workers and policy makers in health, justice, and community and social services. In the remainder of this chapter, I provide the context in which my research is examined as well as the history of crystal meth, my literature review and a brief summary of my chapters and conclusions.

1.1 Contextualizing the Research

The first piece of legislation in Canada to deal with illicit drugs was the *Opium Act* of 1908. This Act was the result of new social forces emerging such as new moral reform movements, the international movement to stop opium trade with China and hostility towards Chinese immigrants. In 1911, the *Opium and Drug Act* replaced the Act of 1908.This was the first Act to initiate narcotic control in Canada and the first Act to begin the process of 'criminalization' of individuals using and trafficking illicit drugs in Canada. In 1920, the Act received another new name and became the *Opium and Narcotic Drug Act*. By 1929, the Act evolved from a two-paragraph statute to an eleven-page document. New punishable offences such as illegal possession and trafficking became part of the list of illicit drugs. Opiates and cocaine became part of the list of illicit drugs in the 1911 Act and cannabis became listed in 1923. It would be decades before cannabis would present itself as a problem. In 1969, the Act became the *Narcotic*

Control Act. Between 1911 and 1969, this Act had sixteen amendments. In June of 1997, renaming of the Act occurred again. The *Narcotic Control Act* became the *Controlled Drugs and Substances Act*. Over the course of these years, more and more illicit drugs were defined as controlled substances. As early as 1969, methamphetamine and amphetamine became a part of the schedule of controlled drugs and were listed as dangerous (Giffen, P., Endicott, S. and S. Lambert, 1991:1-4).

The treatment movement emerged in Canada in the 1950s. This movement began looking at drug use as a medical problem and not a criminal problem. The focus was on treatment not punishment. During this same period, an alarm occurred in Vancouver over the increasing use of narcotics, especially among teenagers. As a result, three inquiries emerged between 1952 and 1969. The reports from these inquiries varied from supporting treatment efforts, like The Ranta Report of 1952, which suggested voluntary drug rehabilitation and free clinics for users to receive minimum dosages of their drugs. The Senate Committee of 1955 did not support treatment. The LeDain Commission was appointed by the federal government in 1969 to look at the non-medical use of cannabis and hallucinogenic drugs (Giffen et al., 1991:517-20). Like The Ranta Report, the authors advocated less punitive measures for cannabis users. It was not until 1972, when a charge of possession of cannabis could result in a dismissal of the charge. It would still officially be recorded and the individual would have a criminal record (Erickson, 1996:66-7). In the 1990s when crystal meth surfaced (Canadian Community Epidemiology Network on Drug Use-Vancouver

Site and Addictive Drug Information Council, 2003:6), it appears that another attempt was made to tackle the drug problem as a medical or health problem.

1.2 The History of Crystal Meth

Buxton and Dove (2008:1537) provide the following definition and information about methamphetamine. "Methamphetamine (MA), a central nervous stimulant, was first synthesized in 1919 as a synthetic substitute for ephedrine. Occult methamphetamine laboratories emerged in California in the 1960s, d-methamphetamine hydrochloride (crystal methamphetamine, crystal meth), which is crystallized, smokable and more potent form was developed." In the 1960s and '70s amphetamine, which is also known as 'speed' or 'uppers', became known as a drug used by athletes, college students, motorcycle gangs and truck drivers (Frontline, nd: 1). Crystal meth enhances mood, body movement, heightens sexual performance, encourages weight loss and sustains the ability to perform by allowing you to stay awake for long periods of time (Vancouver Coastal Health, 2005:7). The Canadian Centre on Substance Abuse (hereafter called CCSA), which focuses on alcohol and drug-related harm on a national basis, described the drug's production as being "produced in clandestine laboratories using commonly available chemicals and over-the-counter medications such as ephedrine, pseudoephedrine, phenlpropanolamine, iodine, red phosphorus, hydrochloric acid, and anhydrous ammonia" (CCSA, 2005: 1). The Canadian Addiction Survey (CAS) indicated that the reported percentage of highest lifetime use of speed to be in the province of Quebec at 8.9%, followed by British Columbia at 7.3% and Ontario at 5.5%. Saskatchewan

was at 4% and New Brunswick and Manitoba were at 4.5% (CAS, 2005:79). Jobe-Armstrong (2005:16) found that Asia and North America had the highest number of illicit users. “Methamphetamine use is particularly concentrated in the western and mid-western states with a reduction in age of initiation from 22 years to 18 years (Jobe-Armstrong, 2005:15). According to the Alberta Alcohol and Drug Abuse Commission, (hereafter called AADAC) “crystal meth produces a longer ‘high’ than other stimulants” (AADAC, nd: 1). This is especially true if the drug is injected. It has many street names including “chalk, crank, crystal, fire, jib” (CCSA, 2005:2). The effects of the drugs can last up to twelve hours or more. There are many effects associated with this ‘rush’ such as “increased wakefulness, increased heart rate and respiration, decreased appetite and increased body temperature.” Negative effects include “tremors, mental confusion, insomnia, hyperthermia which can cause convulsions and irritability and aggression” (CCSA, 2005:2).

In 2005, Health Canada also produced a fact sheet on methamphetamine. This fact sheet addresses what methamphetamine is, how this drug affects individuals taking it, its health risks, and who uses it. The question is posed, “How many people in Canada use meth? ” (Health Canada, 2005:2). The general population surveys used telephone interviews and student surveys completed in schools, which showed a low prevalence of use. Hard-to-reach populations have likely been missed such as street youth and Aboriginal communities in remote areas, which makes it hard to determine the prevalence of use of methamphetamine in Canada.

While the CCSA indicates that experimental or one time use will not lead to dependence, MA (methamphetamine) users can develop a strong psychological dependence in a short period. A document from Alberta stated that, "Former users and addictions counsellors shared how difficult it is for an addict to make the decision to seek help. Some youth said they had to go to jail more than once and struggled with meth on and off for years before they finally decided to get clean" (Government of Alberta, 2006:23).

The British Columbia Ministry of Health Services (*Crystal Meth and Other Amphetamines: An Integrated BC Strategy* (British Columbia Ministry of Health Services, 2004: 5) indicated that, "British Columbia experienced high amphetamine usage in the 1960s, 1970s and 1980s. AADAC (2006:8) indicates, "In 1997, Canada's *Controlled Drugs and Substances Act* replaces the *Narcotic Control Act* and some sections of the *Food and Drug Act*; amphetamines and their derivatives, including methamphetamine, are listed as controlled drugs under the act." Between 1998 and 2003, the seizure of clandestine methamphetamine laboratories in Canada increased almost tenfold: 4 in 1998 and 37 in 2003 (CBC, 2006:1).

It was not until the late 1990s that the Western provinces began responding to this problem. Crystal meth was receiving heightened media attention, suggesting the creation of a moral panic. Cohen (1972:9), defines moral panic as a "condition, episode, person or groups or persons emerges to become defined as a threat to societal values, and interests; its nature is presented in a stylised and stereotypical fashion by the mass media; the moral

barricades are manned by editors…politicians and other right-thinking people; socially accredited experts pronounce their diagnoses and solutions; ways of coping are evolved (or more often) resorted to; the condition then disappears…" In this case, crystal meth and its users were defined as a threat to societal values and the mass media began writing about this situation, which was responded to on all political levels. Health Canada, the CCSA, the RCMP, the Western Ministers of Health, Justice and Public Safety, the provinces of British Columbia, Alberta and Saskatchewan and TV networks such as CTV and CBC all began writing and producing exposes on crystal meth. High profile magazines like *Newsweek*, "…described meth as "America's Most Dangerous Drug" (Cosh, 2005:1). In the province of Saskatchewan, a provincial MLA went public about his daughter's addiction to crystal meth (CBC, 2006). This announcement, coupled with urging by the Saskatchewan Party to do something about the crystal meth problem appeared to have set the wheels in motion for the province of Saskatchewan to examine seriously the crystal meth problem. The premier at that time, Lorne Calvert, of the NDP party, spearheaded the Western Minister's Conference in June 2005 to explore the problem of crystal meth. The British Columbia, Alberta and Saskatchewan provincial governments produced documents, which examined crystal meth. The last province to produce a document on crystal meth was Alberta in 2006. In 2007, the Saskatchewan government of Lorne Calvert was defeated and the Saskatchewan Party was elected. While the Saskatchewan Party had previously urged Lorne Calvert to address the crystal meth problem, there appears to be little that is being done to

address the crystal meth problem today. Since 2006, there has been little discussion about crystal meth. Even so, I argue that crystal meth still presents as a serious problem. While it does not now receive the same media and political attention, it requires continued attention from our communities, and our municipal, provincial and federal governments to assist in addressing this problem.

1.3 Summary of Chapters to Address the Official Discourse of Crystal Meth

Chapter one addressed the research context and history of crystal meth. To address the official discourse of crystal meth, I am providing the following detailed overview of chapters two to five. In these chapters I address my thesis questions to determine who the voices of the documents written on crystal meth, the prevalence of crystal meth use among particular social groups and I examine how such use is constructed by some groups as a problem and ask what, if any, impact, this construction has had on formal responses to crystal meth use. Chapter six addresses my conclusions.

In chapter two, I examine the literature on drugs in Canadian society, in relation to key issues, policies and discourses. I also examine theoretical approaches, utilizing Foucault's notion of power and discourse. My theoretical approach also incorporates vanDijk's and Phillips and Hardy's Foucauldian methodologies of critical discourse and social construction. Chapters three, four and five provide my critical discourse analysis of the documents from British

Columbia, Alberta and Saskatchewan between 2002 and 2006. In chapter six, I present my conclusions.

In chapter three, I examine and analyze five documents from the province of British Columbia: *Methamphetamine Environmental Scan Summit: Final Report* (Canadian Community Epidemiology Network on Drug Use-Vancouver Site and Addictive Drug Information Council, January, 2003), *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction* (BCMHS, May, 2004), *Crystal Meth and Other Amphetamines: An Integrated Strategy* (BCMHS, August, 2004), *Crystal Meth and Other Amphetamines: An Integrated Strategy: Six Month Progress Report* (BCMHS, April, 2005), and *Methamphetamine* (Vancouver Coastal Health, April, 2005).

In the fourth chapter, I examine and analyze four government documents from the province of Alberta: *A Community Stakeholder View of* Crystal *Meth in Edmonton: Trends, Strategies, Challenges and Needs* (Goldblatt, February, 2004), *Stronger Together: Coordinated Alberta Response to Methamphetamine* (AADAC, April, 2006), *Methamphetamine: What we know about it, What we're doing about it* (AADAC, June, 2006) and the *Premier's Task Force on Crystal Meth: Fighting Back* (Government of Alberta, September, 2006).

In the fifth chapter, I examine and analyze four documents produced by the province of Saskatchewan: *A Strategic Plan for Crystal Meth and Other Amphetamines in Saskatchewan* (Saskatchewan Health, June, 2006), *Healthy Choices in a Healthy Community* (Addley, June, 2005), *Premier's Project Hope*

(Saskatchewan Health, August, 2005) and *Premier's Project Hope: One Year Update* (Saskatchewan Health, August, 2006).

In chapter six, I present my conclusions. I find that British Columbia, Alberta and Saskatchewan view crystal meth as being a problem. Experts, such as professionals and academics help define the problem, though often through limited anecdotal and statistical information. The main population identified as being at risk are youth. Documents in British Columbia and Saskatchewan socially construct crystal meth as a health problem and an educational problem. Those in Alberta are more punitive and define crystal meth as a criminal and educational problem. One document, which is from Alberta, suggests social policy changes need to be made to address the many issues users of crystal meth, such as affordable housing, employment and more affordable income (Goldblatt, 2004). One of the BC documents, *Methamphetamine* (Vancouver Coastal Health, 2005:20-1) points out research gaps, which affect "appropriate treatment programs for MA dependence. We need to better understand the characteristics of the user, the varying degrees of use patterns…and the risk factors associated with its use. It is also important to understand the impact of the social determinants of health such as poverty, homelessness, education and employment." While British Columbia identifies the social determinants of health such as affordable housing, better incomes and education, they offer no policy solutions to address this. Saskatchewan also identifies these issues and provides twenty-three million dollars to address some of them through *Project Hope* (Saskatchewan Health, August, 2005).

Goldblatt's document (2004) also points out significant gaps related to staff and public education, which would assist in the recognition of the signs of meth use, and gaps in timely access to treatment. All three provinces make recommendations concerning increasing the education of crystal meth. British Columbia recommends 'community capacity building,' which is in keeping with the neo-liberal ideology of doing more with less. The state, in this case, the province, identifies the problem and then turns it over to the community and individuals to come up with a solution. All three provinces discuss regulation, but it is of greater emphasis in the Saskatchewan and Alberta documents. These documents produced by 'experts' appear to avoid the real issues that the marginalized individuals identified as being at risk are faced with. There appears to be significant gaps between the recommendations offered and the realization of the solutions as a result of this. The authors of these provincial documents give legitimacy to their actions and make it appear as if something important is being done for these people. The social reality of the crystal meth problem for the users of this damaging drug has been created in a way that is not meaningful or helpful to them.

CHAPTER 2: THEORETICAL AND METHODOLOGICAL FRAMEWORK

2.1 Introduction

In this chapter, I address the theoretical and methodological issues that inform the analysis of the documents on crystal meth. Over time, the use of illicit drugs appears to be regarded more as a health problem than a criminal problem, at least at some levels. After an attempt to assist addicts by giving them treatment in the 1950s, and the LeDain Commission in 1969, where an attempt was made to de-criminalize cannabis, little seemed to be done until the late 1990s. This is the time when crystal meth was recognized as a problem and where once again a shift appears to have occurred. I examine what has changed and why. I present the theoretical and methodological orientations using Foucault (2002) and the perspectives he raises on discourse and power. I also present the theoretical and methodological orientations of Phillips and Hardy's (2002) discussion of the social construction of discourse and the theoretical perspectives in discourse analysis. I examine vanDijk's (1993) examination of critical discourse analysis. I use the methodological orientations of these theorists on discourse, power and the social construction of crystal meth. I provide first a brief history of the sociological discourse on drugs in Canada, and then I present the theory I use to examine these documents. In my methodology, I examine the themes or context of these documents and how they are

connected to the other themes or discourses. Using Foucault, I examine the relationships between the authors of these documents, which Foucault (2002) would call the primary relations and their connection to what Foucault calls the secondary or reflexive relations. In other words, how are the authors able to reproduce the social situations of the object of this discourse, which is crystal meth and its users? I will also use Fairclough's (1992) three-dimensional approach (cited in Phillips and Hardy, 2002:4) to the study of discourse analysis by examining the text, discourse and context of these documents. I examine how crystal meth is constructed as a problem. I examine the social context in which the texts of the documents are found and the discourses they produce. I critically examine these documents, using Foucault (2002) and van's (1993) critical discourse analysis, where discursive activity focuses on constituting and sustaining unequal power relations. I use the above theoretical and methodological orientation to identify a shift over time in the discourse of drugs as a criminal problem to a health problem.

2.2 Literature on Drugs in Canadian Society: Issues, Policies and Discourses

Canadian legislation was initially concerned with the identification of illicit drugs and the punishment of drug users. The first piece of legislation constituted as drug law in Canada was in 1908, directed at Chinese opium smokers. Green, (1979:46), outlines the history leading to this first drug law in Canada. The Chinese came to Canada on the 1860s and 1870s during a rapid period of industrial expansion and were a cheap source of labour. By the early 1880s,

employment opportunities decreased because of the decline in railroad construction and the end of the gold rush. The Chinese were willing to work for less money than the white labourers and became the object of public resentment. The use of opium did not become apparent until the Chinese became competitors for jobs held by white people. In 1885, a federal Royal Commission on Chinese Immigration was appointed where a fifty-dollar head tax was imposed on every Chinese immigrant entering Canada. A second Royal Commission was appointed in 1902, which recommended Chinese immigration be prohibited. In 1904, the Chinese head tax was increased to five hundred dollars. A large anti-Asiatic demonstration took place in Vancouver in September 1907. This demonstration was inspired by the occupational insecurity of white labourers. MacKenzie King, the Deputy Minister of Labour was sent to Vancouver to investigate this demonstration and "to make reparation to Asians who suffered property and business losses as a result of the rioting" (Green, 1979:45-6). While MacKenzie King was in Vancouver, he conducted a personal investigation of the opium trade in British Columbia. The Chinese indicated that opium was not only used by the Chinese but by whites, both men and women. After learning this information, MacKenzie King recommended to Parliament that the importation, manufacture and sale of opium should be prohibited. He suggested the only exception should be the use of opium for medicinal purposes. This legislation reflected anti-Oriental sentiment. Sneiderman (1999:87) suggested it was directed to the "heathen Chinese consumers of the drug even though there was no evidence that recreational opium use was a problem." Because of its limited

scope, this first Act proved to be ineffective. Giffen et al. (1991:78) pointed to the shortcomings of this first Act and stated that this Act "dealt only with crude opium, powdered opium, and opium prepared for smoking…this legislation achieved little because it penalized only the supply side and this created the opium conditions for highly profitable smuggling. (Green, 1979:50) observes that, "The *Opium and Drug Act* of 1911 appears, ultimately, to reflect Parliament's concern for effective law enforcement directed to the suppression of "drug trafficking and use… and the scope of new controls were broadened with cocaine, morphine and eucaine joining opium scheduled substances." This was the first Act to initiate narcotic control in Canada and the first Act to begin the 'criminalization' of individuals using and trafficking illicit drugs in Canada. (Green, 1979:42) further states that, "It appears that no Western nation used criminal law to prohibit the distribution of narcotics for recreational purposes until Canada's pioneering effort of 1908." In 1920, this Act was re-named the *Opium and Narcotic Drug Act*. In 1923, marijuana was added to the schedule before it came to be defined as a social problem" (Giffen et al., 1991:179).

There are many different sociological interpretations of the Canadian narcotics legislation. Boyd (1984) examined the creation of this law in its historical context. He suggested that the creation of the law was "viewed as the product of a process of social conflict" (Boyd, 1984:102-3). He identified two opposing arguments. The first argument by Chambliss (1975) and Dolinski (1979) suggests the causes of the anti-opium legislation are the changing nature of economic relationships. The second argument by Small (1978), Solomon and

Madison (1976-77), and Green (1979), identified pluralist conflict as the cause of this prohibition of the use of opium. After reviewing the evolution of narcotics legislation, Boyd concluded that both of these arguments, the materialist and the ideational analyses, were not competing but complementary in the creation of Canadian narcotics legislation (Boyd, 1984:102-3).

Green (1979:51) identified other diverse factors of significance, which have affected the evolution of narcotics legislation in Canada, including "international treaty obligations, American social and legislative developments, continued racial paranoia, reformist campaigns, prescribing indiscretions, recurring police demands for greater enforcement powers, the creation of a federal control apparatus, and, occasionally, the courts' reluctance to construe Parliament's enactments as liberally as did the police" Giffen et al. (1991) also examined the social origins of Canadian narcotic legislation. They examined five factors, in particular: moral reform movements, foreign immigrants moving to Canada, the influence of the international opium movement, racial hostility to the Chinese, and bureaucratic influences.

Giffen et al. (1991:151) stated that moral reform movements led by members of the Protestant clergy lobbied for legislation to prohibit gambling, drinking and prostitution. Moral crusaders like Emily Murphy in Canada "championed a variety of moral causes such as liquor prohibition…and the problem of drug addiction." The Temperance movement also was a part of this moral crusade; directed, in part, at women who drank. Immigrants who came to Canada with different lifestyles and speaking different languages were viewed as

posing a threat to Anglo-Saxon groups. The international opium movement, which started in Great Britain as a reaction to the Chinese Opium Trade, influenced decisions about the handling of narcotics in Canada, placing an emphasis on ‘criminalization’ and ‘punishment’. Giffen et al. (1991:22) stressed that, “Probably in no other sphere have independent nations been so thoroughly told by others what they should be doing.” This international influence was attributed to two main reasons. The first was the rise of the anti-opium movement of the late nineteenth and early twentieth century and second was the creation of international agreements like The Hague Convention of 1912, which created obligations between the countries involved to adopt some domestic controls. Racial hostility, mentioned earlier, was another factor. The last factor Giffen et al. (1991) identified was the bureaucratic influences of drug prohibition. At this time, there were no civil servants specializing in narcotic control, although criminal justice officials were consulted and their suggestions were incorporated into legislative drafts. MacKenzie King, the author of Canada’s first Opium Act, relied heavily on what the police had to say (Giffen et al., 1991:96).

Green (1979) also suggested that the 1914 *Harrison Narcotics Act* of the United States had an influence on Canada. Both countries were parties to the Hague International Opium Convention of 1912. The United States complained that Canada was legally importing opiates and then smuggling them to the United States. This compromised the *Harrison Narcotics Act.* Canada then agreed to make the necessary changes to appease the American government.

It was not until the 1950s that the treatment movement arose in Canada. This movement attempted to shift attention away from criminalizing and punishing drug use. Attempts as early as the late 1920s were made by the federal department of health to encourage the provinces to set up institutions where addicts could be held for treatment. Giffen et al. (1991:362) indicated that several provinces did set up provisions under their respective mental hospital legislation, but they were rarely used because “addicts were hard to manage.” Not until the 1950s, were there appeals for a new approach to treat addicts, but mainly from individuals such as E. E. Winch who was a Co-operative Commonwealth Federation (CCF) member of the British Columbia provincial legislature. He learned that a close friend’s son became an addict while serving a term in a prison reformatory for joy riding. As a result of this experience, he became an advocate for medical treatment for addicts (Giffen et al., 1991:362). There was also tension between the judges of trial courts and the enforcement officers (Giffen et al., 1991:364) also stated that, “Several Vancouver judges became disenchanted with repeatedly sending addicts to prison, and said so both in court and in the press.”

In the 1950s in Canada, because of the growing use of narcotics, especially among teenagers in Vancouver, three significant inquiries emerged: the Vancouver Committee, the Senate Committee, and the LeDain Commission. The Vancouver Committee was locally based and produced The Ranta Report. On July 30, 1952 this report offered two major recommendations: voluntary drug rehabilitation and clinics for addicts, where they could receive minimum dosages

of their drugs. This second recommendation was heavily disputed. The argument was that a minimum dosage would not satisfy these addicts and they would return to crime to get the rest of what they needed.

The second inquiry, by the Senate Committee was undertaken by a BC Senator and had representation from across Canada. The Senate Committee held hearings across Canada between March 15 and June 17, 1955 (Giffen et al., 1991:373). The committee did not support the ending of incarceration of addicts and suggested that if addiction was a health problem, it came under the jurisdiction of the provinces and should be dealt with at that level (Giffen et al., 1991:374).

The LeDain Commission was appointed by the federal government in 1969 to look at the non-medical use of drugs. There was growing concern over the use of marijuana and hallucinogenic drugs, especially by the younger population. "Before 1969, limited sentencing options in the Narcotic Control Act meant half of all cannabis possession offenders were imprisoned. The courts were overloaded with several thousand of this new breed of 'cannabis criminals' (Erickson, 1996:66). The LeDain Commission recommended the decriminalization of cannabis possession. Finally in 1972, the government acted on this and "it did provide a new sentencing alternative of a discharge (which still imposes a criminal record) in a *Criminal Code* amendment (Erickson, 1996:66-7).

Historically, the view to punish addicts certainly outweighs attempts to treat them. The Canadian prison system adopted a rehabilitation model until the

mid 1970s, when, because of high recidivism rates, it adopted a new justice model emphasizing retribution not treatment (Giffen et al., 1991:574). The criminal justice system, especially those in the 'corrections' business, found that rehabilitation had no marked effects on recidivism. As an example, Garland (2001) examined shifts or 'currents of change' occurring in crime control and criminal justice in the UK and US, which are relevant for this thesis. Garland (2001:3) indicated that economic, social, cultural and political changes impacted crime control especially since the decline of 'penal welfarism' in the 1970s. With the rise of neo-liberalism in the 1970s, social and economic policies changed and were in opposition to penal welfarism. Garland identified many penological shifts as a result of this, such as the decline of rehabilitation "which had been the field's structural support, the keystone in an arch of mutually supportive practices and ideologies" (Garland, 2001:8). There has been a shift to more punitive sanctions. "The new discourse of crime policy consistently invokes an angry public, tired of living in fear, demanding strong measures of punishment and protection" (Garland, 2001:10). Another dominant theme was protection of the public and as a result, parole hearings come under extreme scrutiny, as an example. Garland (2002:13) emphasized that crime policy has become politicised such that, "A highly charged political discourse now surrounds all crime issues." Garland (2002:13) suggests that crime policy has become a prominent issue in electoral campaigns and no longer a bipartisan matter "that can be devolved to professional expert." He also stated that other changes influenced these shifts, including the restructuring of the family, changes in the make-up of cities and

suburbs, the rise of mass media and the democratisation of social and cultural life (Garland, 2001:88).

While Garland (2001) wrote about the UK and the USA, what he says is applicable to Canada as well. As an example of this punitive shift, the current government of Canada is attempting to "impose Canada's first mandatory minimum prison sentences for drug crimes-removing discretion for judges to sentence as they see fit…Several witnesses have warned the House of Commons justice committee the proposed legislation will fill jails with drug addicts rather than drug kingpins…" (Tibbetts, 2009:A9). If this government is successful, they remove the discretion allowed judges to sentence individuals as they see fit. One report, for instance, observes that, "Retired Quebec judge John Gomery says the Harper government's plan to create mandatory minimum jail terms for drug crimes is a "slap in the face" to judges…" (Canwest News Service, November 26, 2007:3).

In the 1970s, the economic boom declined in Canada. By the 1980s, neo-liberal ideas influenced all political parties. The new Conservative party, which had merged the Canadian Alliance party, and the Conservative party in 2004, "made neo-liberal economics the cornerstone of its policy" (Finkel, 2006:285). The Liberal government under Trudeau, however, began the trend of cutting social spending in the mid 1970s. In 1977, the federal government ended the guarantee of matching funds for provinces' expenditures on health care and post-secondary education. Most provinces subscribed to some form of neo-liberal ideology after 1980. (Finkel, 2006:281) suggests that," Conservatives attributed

the latest crisis in capitalism to alleged overspending on social programs. The solution, they argued, was to return to "liberal," that is marketplace, economics that required a dramatic reduction in government regulation of the economy and provision for the unfortunate." Finkel, (2006:293) further stated that "Ralph Klein became the neo-liberal poster boy by slashing health spending (almost 20% in '94) and reducing welfare by over half in a single year" In Ontario, Mike Harris was quick to follow Klein's example in 1995. He was committed to making tax cuts for the wealthy and cutting social programs. Even the New Democratic Party elected at various times in Ontario, Saskatchewan, Manitoba, and British Columbia had policies influenced by some forms of neo-liberalism. By the 1990s, programs such as family allowance and federal spending for social housing had disappeared (Finkel, 2006:285). Balancing budgets and getting rid of the deficit seemed to be of higher priority to both provincial and federal governments than funding social programs. The economic impact of neo-liberalism has caused drastic shifts in social spending affecting the penal system as well as programs for the poor. These shifts, as argued in this thesis have made an impact on the management of drug use and addiction.

2.3 Theoretical Approaches

(i) Discourse Analysis

In this thesis, I use discourse analysis by examining the works of Foucault, vanDijk, and Phillips and Hardy. Phillips and Hardy (2002:3) use a definition by Parker (1992) of discourse "…an interrelated set of texts, and practices of their production, dissemination, and reception that brings an object into being"

(Parker, 1992 as cited in Phillips and Hardy, 2002:3). I examine Foucault's analysis of discourse and power and Phillips and Hardy's theoretical perspectives on discourse analysis as well as their investigations on how a social problem is constructed. Lastly, I examine vanDijk's (1993) work on critical discourse analysis.

Foucault (2002) is interested in the formation of objects of discourse. In this case, I am interested in the formation of crystal meth as the object of discourse. Foucault (2002:45) asks, "What has ruled their existence as objects of discourse?" I am examining who has discussed crystal meth as an object of discourse. Foucault (2002:45) states that, "First we map the first surfaces of their emergence: show where they may emerge and then be designated and analyzed." I have traced the history of crystal meth and examined how it emerged and how it has been designated and analyzed. Foucault (2002:45) further states, "We must also describe the authorities of delimitation." I learn who has placed or provided the boundaries in the use of crystal meth. Early on, the legal system in Canada provided boundaries, such as criminal sanctions, however, as time moves forward, there appears to be a significant shift occurring. What was once solely treated as a legal problem has shifted more so to a problem of health and education. Foucault (2002:46) then examines the "grids of specification". He states, "These are the systems according to which the different groups are divided." Foucault writes about madness in this piece; I write about the abuse of crystal meth. How are they "divided, contrasted, related, grouped, classified, and derived from one another as objects" (Foucault,

2002:46)? I examine how statistical and anecdotal information provided by the documents I examine have identified the users of crystal meth.

Foucault (2002:49) suggests that the conditions necessary for the appearance of an object of discourse "exist under the positive conditions of a complex group of relations." Relations are established across a broad network of institutions such as those involving the economy and social issues". In the case of crystal meth, provincial government officials who make policy and decide which social issues need to be addressed. There are many social issues facing provincial governments, however, if the personnel of these governments are not experiencing these issues themselves, it may not be viewed as that important. Foucault (2002:50) states, "these relations must be distinguished from what we call 'primary relations' and a system of reflexive or secondary relations and a system that properly might be called discursive." Foucault saw the problem in discourse analysis as trying to analyze these discursive relations or the themes of these different texts and the interplay between the primary, secondary and the discursive. In other words, who occupies what Foucault calls the primary relations or the ability to communicate and transfer knowledge about crystal meth and who occupies the secondary relations or the position to which the primary relations are referring. In this case the provincial governments of British Columbia, Alberta and Saskatchewan occupy the primary relations and the users of crystal meth occupy the secondary relations. When I examine the discursive relations or the themes in the documents produced by British Columbia, Alberta and Saskatchewan, I ask as Foucault does, "Who is speaking? Who, among the

totality of the speaking individuals is accorded the right to use this sort of language? Who is qualified…what is the status of the individuals who-alone-have the right, sanctioned by law or tradition, juridically defined or spontaneously accepted, to proffer such a discourse" (Foucault, 2002:55)? The institutional sites offering discourse on crystal meth would be what Foucault would call 'primary' sites. In this case, most sites are provincial health departments. The subject of the discourse, in the case of crystal meth and according to the government documents I examine, are marginalized people and would occupy 'secondary relations' in the discourse process.

Foucault's theoretical and methodological assessments of power assist me to see how they relate to my study of government documents written about crystal meth. Foucault is interested in power and relationships. He asks, "How is it exercised? And what happens when individuals exert (as we say) power over others" (Rabinow and Rose, 1994:135)? He looks at what characterizes the relationships between individuals and between groups. For Foucault, "It is necessary also to characterize power relations from relationships of communication that transmit information by means of a language, a system of signs, or any other symbolic medium" (Rabinow and Rose, 1994:135). Foucault defines the exercise of power as "a 'conduct of conducts' and a management of possibilities" (Rabinow and Rose, 1994:138). For men to govern men, they must be free, since "Power is exercised only over free subjects, and only insofar as they are 'free'. By this we mean individual or collective subjects who are faced with a field of possibilities in which several kinds of conduct, several ways of

reacting and modes of behaviour are available…there is not a face-to-face confrontation of power and freedom as mutually exclusive facts…but a much more complicated interplay" (Rabinow and Rose, 1994:139). Foucault analyzes power relations by examining a number of different points. First, he examines "the system of differentiation" or who is acting upon whom. Secondly, he examines what objectives those in power are pursuing to act upon the individuals involved. Thirdly, he examines what he called 'instrumental modes' or how the power is being exercised, such as through economic disparity. In other words power is exercised in such a way that some individuals are more privileged than others. Fourthly, he examines what institutions are involved in exercising the power. Is it the state itself or a branch of the state? Lastly he examines what he calls the 'degrees of rationalization' or how the power is communicated to the individuals involved (Rabinow and Rose, 1994:140-41).

Phillips and Hardy (2002) explore the theoretical perspectives that contribute to discourse analysis. They examine the works of Phillips and Ravasi (1998), who found that studies of discourse analysis could be categorized according to two key theoretical dimensions. The first dimension focuses on the process of social construction that constitutes social reality and the second focuses on power dynamics (Phillips and Hardy, 2002:19). On the constructivist side of analysis are two perspectives: social linguistic analysis and interpretive structuralism. Social linguistic analyses examine specific examples of text and talk. The goal of this work is to examine the text being studied to provide insight into its organization and construction. This type of research examines the

themes discussed to create the social reality of where decisions are located in the discursive activity. The constructionist aspects of texts help us understand "how social phenomena-decisions, organizations, identities-are produced by specific discursive actions and events on the part of the particular actors" (Phillips and Hardy, 2002:23). Interpretive structuralism is also a constructivist approach and focuses on the analysis of the social context and the discourse that supports it. The ways in which broader discursive contexts come into being are examined in this particular perspective.

The second dimension of discourse analysis involves critical discourse analysis and critical linguistic analysis. Critical discourse analysis examines discursive activity in "constituting and sustaining unequal power relations" (Phillips and Hardy, 2002:25). Individual pieces of texts are examined to understand how structures of domination are implicated in the text. Critical linguistic analysis, while it focuses on individual texts, has a strong interest in the dynamics of power surrounding the text (Phillips and Hardy, 2002:27). Individual pieces of text are examined to understand how structures of domination are implicated in the text.

Phillips and Hardy examine how social reality "is produced and made real through discourses, and social interactions cannot be fully understood without reference to the discourses that give them meaning. As discourse analysts, then our task is to explore the relationship between discourse and reality" (Phillips and Hardy, 2002:3). In order to study discourse, Phillips and Hardy suggest that we

must look at the text, discourse or theme of the text and the social context in which the text is found which produces the discourse.

Probably the most valuable insights Phillips and Hardy (2002:83) offer me in my research are the following: "Researchers must take care to remember that language constructs, rather than reveals, reality…researchers should ground their research in historical processes to understand how things come to be the way they are…researchers should allow different voices to pervade the text, with particular consideration of voices that are normally silenced."

vanDijk, (1993:249) like Foucault is interested in discourse analysis. He examines the criteria for critical discourse analysis, which he states "presuppose a study of the relations between discourse, power, dominance, social inequality and position of the discourse analyst in such social relationships." He discusses the role of discourse in terms of the challenge of dominance. He defines dominance "as the exercise of social power by elites, institutions or groups that results in social inequality, including political, cultural, class, ethnic, racial and gender inequality" (vanDijk, 1993:250). vanDijk states, "Critical discourse analysis wants to know what structures, strategies or other properties of talk, text, verbal interaction or communicative events play a role in these modes of production" (vanDijk, 1993:250). He examines the 'top down' relations of dominance. "What is involved in dominance are questionable conditions of legitimacy or acceptability, including what is usually called 'abuse' of power, and especially also possibly negative effects of the exercise of power, namely social inequality" (vanDijk, 1993:250). vanDijk (1993:254) also examines the nature of

social power and finds that, "Social power is based on privileged access to socially valued resources such as wealth, income, position, status, force, group membership, education or knowledge." Critical discourse analysis needs to focus on the discursive strategies used to mark the control of the dominant powers. vanDijk suggests that dominance might be reproduced in such a way that the forms of text appear natural and legitimate. Because elites have access to discourse, "They literally are the ones who have the most to say" (van, 1993:255). He uses the example of Board Chairs and CEOs. People in these positions can exercise power by controlling the time, place, setting and the presence or absence of participants. He suggests that because of this, the freedom of choice might be limited or restricted by those in the position of dominance.

I have discussed the theoretical and methodological issues raised by Foucault, Phillips and Hardy and vanDijk I use to examine the provincial government documents from British Columbia, Alberta and Saskatchewan. I also examine the limitations of these documents and their implications.

2.4 Methodology and Data Used

In this section, I review the themes of the discourse on crystal meth and its users. I apply the theoretical analyses of discourse by Foucault (2002), Phillips and Hardy (2002) and vanDijk (1993). I use the same definition by Parker, 1992, (cited in Phillips and Hardy, 2002:3) presented previously in my theoretical section, of discourse as "an interrelated set of texts, and the practices of their

production, dissemination, and reception, that brings an object into being…social reality is produced and made real through discourses, and social interactions cannot be fully understood without reference to the discourses that give them meaning." My task is to explore the relationship between the discourse on crystal meth and its reality, by examining government documents from British Columbia, Alberta and Saskatchewan. In other words, is the reality of the crystal meth problem identified by the users of crystal meth the same as the reality of the crystal meth problem identified by the government officials? I intend to learn how crystal meth is constructed in these documents. Discourses are embodied in a variety of different texts, which are called 'discursive units'. Sherzer (1987) and vanDjik (1997) state, "Discursive activity does not occur in a vacuum, however, and discourses do not "possess" meaning. Instead, discourses are shared and social, emanating out of interactions between social groups and the complex societal structures in which the discourse is embedded." To understand the discourses of these government documents I examine the context in which they arise, which historically has been very punitive. Fairclough (1992) suggests that discourse analysis is three-dimensional. Discourse "connects texts to discourses, locating them in a historical and social context, by which we refer to the particular actors, relationships, and practices that characterize the situation under study" (Phillips and Hardy, 2002:5). I use this three-dimensional analysis, based on the constructivist approach to discourse, as well as the critical discourse analysis of vanDjik and Foucault. vanDijk (1993:250) indicates that "critical discourse analysis wants to know what structures, strategies or other

properties of text, talk, verbal interaction or community events plays a role in these modes of reproduction." He examines how power is exhibited in discourse and the discursive strategies to influence others. He indicates that discursive action may be restricted because of institutional power resources like the use of professional expertise.

Foucault (2002) indicates that in discourse analysis there are primary, secondary and discursive relations. Foucault saw the problem with discourse analysis as trying to analyze these discursive relations and the interplay between the primary, secondary and the discursive. In other words, who is speaking, who is being spoken to and what is the context or the discursive of what is being said? What are the institutional sites offering discourse on crystal meth? In this case, most sites are provincial health departments. What about the subject of the discourse? In the case of crystal meth, the subjects are marginalized people and would occupy 'secondary relations' in the discourse process. I explore Foucault's notion of power. I examine the characteristics of power relations through the language of the government documents. In each government document I examine, I use the methodology of these theorists.

Discourse analysis is a form of qualitative analysis and it does present some limitations in the research process. Unless research is grounded in the historical process, which I have attempted to do, it is difficult to understand the way in which, in this case, crystal meth has been framed as a problem and how crystal meth and other illicit drugs have been dealt with in the past. When examining the texts of the documents, it is important to examine all voices, even

though some of them remain invisible. Phillips and Hardy (2002:84) state “ some voices will remain privileged over others by the way in which the research is conducted…”

In each chapter I examine the written texts represented within each document, examining who the authors of these documents have defined to be at risk in the use of crystal meth and what solutions have been offered. I look at who the authors are in relation to the users of crystal meth. I look at how these authors have socially constructed the use of crystal meth. I look at the interconnectedness of these texts and ask how they are made meaningful. How do these documents and their discursive actions create the social reality of crystal meth? I examine the common themes of these discourses and attempt to look at the similarities and differences they present. I present these documents in each chapter, addressing my thesis questions, followed by my analysis.

Summary

In this chapter I have presented a literature review and the theoretical and methodological framework that inform this thesis. I presented my methodology and theoretical basis of discourse analysis to conduct my analysis of these documents. I intend to interpret the themes of these documents. I am guided by the concepts I have investigated such as Foucault’s (2002) analysis of discourse and power; Phillips and Hardy’s investigation of how a social problem is constructed and how social reality is produced and made real. As well, I am guided by vanDijk’s analysis of the relations between discourse, power and dominance. I examine the limitations and implications of these documents. In

the next three chapters I undertake a detailed analysis of these official documents produced by British Columbia, Alberta and Saskatchewan, respectively Appendix one lists all of the documents.

In the next three chapters, I critically examine government and health agency documents created on crystal meth from British Columbia, Alberta and Saskatchewan. By examining these documents, I address the central questions of the thesis outlined earlier: (i) who are the voices of these documents? (ii) who are the social groups identified as being at risk? (iii) how is crystal meth framed as a problem and what solutions to the problem are proposed and implemented? In doing so, I investigate the content of the documents; their omissions and silences on particular relevant issues, such as the marginality of those who are identified at risk, the lack of resources available to them in terms of basic needs such as food, shelter and affordable housing, treatment issues, and funding. I also look at the agencies that produced the documents and the circumstances under which they produced them; the intended audience of documents; the sources of information used for writing the documents and the accessibility of such information to the public; the suggested recommendations and the extent of what has been realized.

CHAPTER 3: THE CASE OF BRITISH COLUMBIA

3.1 British Columbia Documents on Crystal Meth

British Columbia was the first province to produce a series of documents on crystal meth. In January, 2003, The Canadian Community Epidemiology Network on Drug Use (CCENDU) from Vancouver and the Addictive Drug Information Council (ADIC) produced a report entitled *Methamphetamine Environmental Scan: Final Report.* CCENDU is an organization, established in 1995, to facilitate and coordinate the collection, organization and dissemination of both qualitative and quantitative data on drug use across Canada. It examines Canadian populations at the local, provincial and national levels (CCENDU, 2008:1). The Addictive Drug Information Council of British Columbia, (ADIC), involves members from medicine, health, education, law, science, government and non-government agencies, business and community leaders (ADIC, 2007:1). In May, 2004, the British Columbia Ministry of Health Services produced a second document entitled *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance and Addiction.* In August, 2004, the British Columbia Ministry of Health Services produced a document on crystal meth, *Crystal Meth and Other Amphetamines: An Integrated BC Strategy.* In April, 2005, a Six Month Progress report was completed, examining recommendations produced in *Crystal Meth and Other Amphetamines;* Vancouver Coastal Health produced a document entitled

Methamphetamine, based on meetings held in Vancouver, November 15-17, 2004, which "brought together a diverse group of 250 delegates to share their knowledge of methamphetamine" (Vancouver Coastal Health, 2005:1).

In the analysis that follows, I address my main research questions by asking: who are the voices of these documents? Who is identified as being at risk? How is crystal meth framed as a problem? What are the solutions offered?

3.1.1 Who are the Voices of These Documents?

The first document on methamphetamine or crystal meth in British Columbia, *Methamphetamine Environmental Scan: Final Report* (CCENDU and ADIC, January, 2003), was the outcome of a summit that took place in Vancouver in November 2002. The need for a summit on methamphetamine was first identified at a Vancouver CCENDU meeting in September 2002. The participants at this conference were from a variety of different levels of government agencies across British Columbia including the Ministry of Children and Family Development, Vancouver Coastal Health Authority, Ministry of Public Safety and the Solicitor General, Vancouver Network of Drug Users, and the New Westminster Police Service. The second document produced was *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction* in May 2004 by the BC Ministry of Health Services, (BCMHS). The authors of this document were academics and professionals. The individuals were listed as advisors, and authors would be considered to be experts in their fields as they were listed as 'Director,' 'Senior Scientist,' 'Executive Director,' and 'Vice President,' as examples. There were

members of a variety of high profile organizations such as the Mental Health Evaluation and Community Consultation Unit at the University of British Columbia, the British Columbia Centre of Excellence for Women's Health, Addiction Medicine, and the Vancouver Health Authority. The third document I examined was *Crystal Meth and Other Amphetamines: An* Integrated *BC Strategy* (BCMHS, August, 2004). The British Columbia Ministry of Health Services was the author of this document. The executive summary stated, "Methamphetamine use is a serious and growing problem in British Columbia" (BCMHS, 2004:3). The specific contributors of this document were not identified. In her message at the beginning of the report, The Minister of State for Mental Health and Addiction Services, the Honourable Susan Brice stated, "there has been an increase in awareness and concern about the illicit drug crystal meth, and its impact on its users, particularly youth and the community" (BCMHS, 2004:1). Six months later, a Progress Report was produced entitled *Crystal Meth and Other Amphetamines: An Integrated Strategy: Six Month Progress Report* (BCMHS, April, 2005). This document was prepared by "a wide variety of provincial and community-based partners including municipalities, local social service agencies, health authorities and the ministries of Children and family Development, Community, Aboriginal and women's services, education, Human Resources, Public Safety and solicitor General, and Health Services" (BC Health Services, April, 2005:iii). The last document, *Methamphetamine*, completed in April 2005, reported the findings of a conference organized by Vancouver Coastal Health entitled *The Western Canadian Summit on Methamphetamine,*

held in November 2004. Key experts from Canada, the United States, the United Kingdom and Australia were invited to attend this conference, as well as a variety of people from the Western Canadian provinces, including former users and families of users.

3.1.2 Who is Identified as Being at Risk:

In the first document, *Methamphetamine Environmental Scan: Final Report* (CCENDU and ADIC, January, 2003), medical and police evidence was examined, pointing to an increasing problem of methamphetamine use among youth. In order to determine the extent of crystal meth use, the 2002 summit participants looked at existing survey data, referrals of youth to detoxification centres; youth outreach programs and admissions to hospital. Participants at the summit noted an increase in the number of referrals of youth addicted to crystal meth to detoxification centres.

The second British Columbia document I examined, *Every Door is the Right Door: A British Columbia Planning Framework to address Problematic Substance Abuse and Addiction* (BCMHS, May, 2004), looked at substance abuse on a broader spectrum and did not focus solely on methamphetamine. Different groups were identified to be at risk for substance abuse in general: adolescence, which is the primary period of substance initiation, individuals with mental illness such as depression, the differential impacts of sex and gender in peoples' lives, concurrent disorders or multiple diagnoses in individuals, Aboriginal people and especially those living in remote and rural areas as they may face barriers accessing appropriate services, and vulnerable populations

such as lesbian, gay, bisexual and transgendered (LGBT) people and lastly, people incarcerated.

In the third document I examined, *Crystal Meth and Other Amphetamines: an Integrated BC Strategy* (BCMHS, August, 2004), street youth, youth involved in the rave dance scene and gay men were the most prevalent users of meth (BCMHS, 2004:5). It is not very clear where the authors of this document obtained their information on youth involved in the rave dance scene. Weir (2000:1843) stated, "raves are all night dance parties sometimes attended by as many as 20 000 youths who dance vigorously and continuously to repetitive electronic music played by celebrated disc jockeys (DJs)." Weir (2000: 1843) indicated that very little has been published on this subject and there is nothing specific to British Columbia in Weir's document.

A document entitled "No Place to Call Home: A Profile of Street Youth in British Columbia" by The McCreary Centre Society, 2001, and referenced in this third document on crystal meth specifically did examine who the street youth are. The McCreary Centre Society is a non-government, non-profit organization committed to improving the health of British Columbia youth through research, education and community-based participation projects. This document stated, "British Columbia appears to be absorbing a large number of youth who migrate west from other provinces. Nearly two-thirds (61%) of the street youth in Vancouver and a third (33%) of those in Victoria were from elsewhere in Canada" (The McCreary Centre Society, 2001:14).

The fifth document, *Methamphetamine* (Vancouver Coastal Health, April, 2005), suggested anecdotal evidence provided key information in the prevalence of MA use "reflected in a significant and steady expansion in hospital admissions, police contacts and in the number of clients seeking treatment in community treatment centres" (Vancouver Coastal Health, 2005:11). Individuals at highest risk appeared to be "street-involved youth, gay men and young adults involved in the party scene" (Vancouver Coastal Health, 2005:9). The common denominator in these findings is youth.

3.1.3 How is Crystal Meth Framed as a Problem and What Solutions are Recommended?

In the first document, *Methamphetamine Environmental Scan Summit: Final Report* (CCENDU and ADIC, 2003:9), recommendations were provided in the areas of prevention, education and awareness, treatment, the need for an integrated and coordinated response, resource allocation, law enforcement and justice and research monitoring. Taking into account the age of the users and the fact that users are becoming younger and younger, the participants recommended starting educating youth about drugs at a much earlier age. The summit participants recognized the need to educate parents, families and professionals and they acknowledged that increased consideration must be given to issues of diversity, including culture, gender and sexuality. A need for more emphasis on the social roots of addiction was emphasized. Much of the discussion centred on the need for more employment, low-income housing and supporting strategies facilitating integration into the community, and

consideration for diversity, including culture, gender and sexuality needs to be addressed.

The summit participants acknowledged the need for more treatment facilities and more treatment. Given the scarce resources available, the possibility of re-allocating proceeds of drug and crime seizures was discussed as well as trying to secure federal funding and sharing current resources. Consistent medical protocols for treatment needed to be developed as well as alternative models of care such as alternate therapies like "acupuncture, longer term treatment involving former users in the treatment process, family treatment and outreach, different detoxification models such as "residential, mobile, home, secure treatment" (CCENDU and ADIC, 2003:16) and provision of services specific to needs of MA users like twelve step crystal meth programs. An integrated and coordinated response to address MA use was addressed, suggesting better communication between service providers and the need for a provincial approach. Overall, a holistic approach was suggested, addressing MA use within a larger addictions framework and considering mental health and addictions concurrently. The participants "described the importance of finding a balance between medicalization of the issues and still holding users accountable for their criminal actions" (CCENDU and ADIC, 2003:17). The development of effective penalties to reduce MA use and changes in the *Criminal Code*, which reflected "the harm of MA use on the community… the need for realistic dealer sentencing, harder penalties and financial consequences for organized crime…" (CCENDU and ADIC, 2003:17) were explored by the summit participants. This harm of MA

use in the community was identified earlier in this document, “at the levels of the family, children of MA users are at higher risk of neglect and use can lead to family breakdown, use by pregnant women can result in growth retardation, premature birth…parents who are using cannot be a resource for their children and MA use can lead to family breakdown” (CCENDU and ADIC, 2002:13). Furthermore, an emphasis was placed on the development of protocols for MA users and a better method of information sharing between police, social workers and healthcare providers and the identification and dismantlement of clandestine labs. The summit participants also argued for the establishment of protocols concerning children in drug-endangered environments and the extension of existing federal regulations regarding licensing of production, importation and exportation of ephedrine and pseudoephedrine to domestic sales.

Finally, the document suggested ongoing data collection and monitoring the efficacy of different treatment models for purposes of evaluation. Most significantly, the summit participants recommended the involvement of users in processes of research and monitoring.

In the second document, *Every Door is the Right Door: A British Columbia Planning Framework to Address Problematic Substance Use and Addiction* (BCMHS, May, 2004), four concepts fundamental to prevention were discussed. Population health was the first concept addressed, which encompasses adequate income, employment, housing, and social support, which are just as important in keeping people healthy as access to health care itself. These are all social determinants of health. Health promotion was the second concept and

referred to building healthy public policy, creating supportive environments, strengthening community action, developing personal health and coping skills and re-orienting health services beyond the scope of treatment. These concepts were borrowed from Health Canada (1999). The third concept was harm reduction, defined as" a public health philosophy that makes the reduction of potential harm from substance use the highest priority" (BCMHS, 2004:80). This concept was borrowed from the World Health Organization (2003). Further, British Columbia Health Services intended to provide practical solutions to the problem of substance abuse as well as providing housing, nutrition and hygiene. There was no indication of how they will do this. The fourth concept was community capacity-building and referred to the development of networks and partnership among community assets such as churches, community centres, schools, and citizens groups, which may assist with dealing with substance abuse. This document did not indicate how or who will initiate this.

The third document, *Crystal Meth and Other Amphetamines: An Integrated BC Strategy* (BCMHS, August, 2004) indicated that in order to address this problem; an integrated strategy should be adopted. It listed five objectives: "prevent individuals from ever starting methamphetamine use, reduce methamphetamine use by current users, reduce harm and overdose deaths, and reduce the supply of methamphetamine and improve community strategy" (BCMHS, 2004:12). This same document listed five priority actions: "inform the public, build safer communities, identify key groups at risk, increase skills of service providers, and reduce individual harm" (BCMHS, 2004:12). The first action

of informing the public stressed how resources must be used in an efficient manner. It was recommended that information should be spread across a wide variety of different educational institutions and social service and justice agencies. The second action outlined building safer communities. This was envisaged by a collaboration of different partners and different sectors in the community spanning across the federal government, the British Columbia College of Pharmacists, the police, municipalities, provincial ministries such as corrections, justice, health care, social services, local businesses, community organizations and individuals who have used methamphetamine and their families. The third action identified the key groups at risk: women of child-bearing age using methamphetamine, children at risk in homes where parents or other family members engage in methamphetamine use or production, youth and young adults such as street youth, youth attending rave dance scenes, youth using methamphetamine to control weight and 'super achievers', gay men and other vulnerable populations engaged in methamphetamine use, sex trade workers who use methamphetamine and persons in rural and remote communities using methamphetamine as the primary illicit drug of choice (BCMHS, 2004:23). There was no indication as to how these groups were identified other than the information The McCreary Centre Society offered. The McCreary Centre Society's document profiled street youth in British Columbia and looked at street youth in six British Columbia communities. Because definitions of street youth and homeless youth vary, The McCreary Centre Society chose the term street youth "to describe adolescents under the age of 19 years who are living on the street or are involved with street life to a significant extent"

(The McCreary Centre Society, 2001:8). The key findings of The McCreary Centre Society suggest "about half of street youth see themselves as having an addiction problem" (The McCreary Centre Society, 2001:1). This same document found that many are involved in the sex trade and also found a "disproportionate number of gay, lesbian, bisexual and transgender youth among the street youth" (The McCreary Centre Society, 2001:40). The McCreary Centre Society document also found that "street youth are not exclusively an urban concern" (The McCreary Centre Society, 2001:9). This document stated that youth from smaller centres tend to migrate to the cities. It offered no reasons as to why, but it can be speculated that there would be more to do in bigger cities than in small towns. The McCreary Centre Society (2001:30) also stated "Thirty-three percent of youth in Vancouver, 35% in Victoria, and 24% in the suburban/coastal communities said they had been pregnant or had caused a pregnancy." The McCreary Centre Society (2001:19) also stated "most street youth who do attend school are behind the grade level that would be expected for their age." The fourth priority action was to build the skills of service providers "to support and respond effectively to the needs of individuals, families and communities" (BCMHS, August, 2004:17). The last priority action was to reduce individual harm.

The last document I examined, *Methamphetamine* (Vancouver Coastal Health, April, 2005), looked at prevention and treatment. Prevention needs to be broad-based, focusing on individuals, families and communities. The need to look at risk factors was identified as well as applicability to both general and targeted populations such as street youth. In terms of treatment intervention, the document

acknowledged, “the empirical research for best practise intervention is limited at best” (Vancouver Coastal Health, 2005:20). It was suggested that more information is required to understand the characteristics of the user in order to provide the appropriate treatment. This document further stated, “It is also important to understand the impact of the social determinants of health such as poverty, homelessness, education and employment” (Vancouver Coastal Health, 2005:20). This document did refer to peer support groups, which are showing some promising results. The Crystal Clear Peer Support Training Project, an initiative of British Columbia’s Methamphetamine Response Committee (MARC) seemed to be an example of some positive results. This program works with street youth in Vancouver’s South Downtown. The consensus panel committee lastly addressed policies, programs and research and stressed the urgent need for the allocation of resources to address the MA issue. It also stressed the need for programs at all levels of government using a collaborative approach. Overall, it appears that British Columbia Health Services has constructed crystal meth as a health and educational problem.

3.2 Analysis of BC Documents

I have presented a synopsis of five documents produced in British Columbia to look at the problem of crystal meth. In these synopses, I have examined who the voices of these documents are. Secondly, I have examined who the agents of this problem are. Lastly I examine how the authors of these documents frame the problem and what solutions are offered. Phillips and Hardy

(2002), Foucault (2002) and vanDijk (1993) guide my analysis of these documents. I begin my analysis by discussing the voices of these documents.

(i) Professional people have written all of the British Columbia documents, which indicate a ‘top down’ approach to this problem. It is interesting to note that the third document, *Crystal Meth and Other Amphetamines…*(BCMHS, August, 2004), did not indicate who wrote this document. These authors are the individuals who frame or construct the problem of crystal meth. They are drawn from all levels of government and from provincial ministries such as health, education, social service, community agencies, justice and corrections. They hope to develop a collaborative approach to develop resources through prevention, education, awareness, treatment, resource allocation, law enforcement and justice, and research and monitoring. All of the individuals identified as being at risk are marginal. They do not have a voice. These British Columbia documents attempt to assist them by defining the problem and then offering what they felt were the appropriate solutions. The users and families of users were invited to the table in one document, *Methamphetamine*, (April 2005), but did not participate in making the recommendations on the issues discussed. In the first document, *Methamphetamine environmental Scan Summit: Final Report*, (January 2003), the recommendations suggest involving users in their educational strategies and research process. They did not, however, elaborate on how this would be done. It appears only to be a recommendation.

(ii) After reading these documents, I examine which social groups are defined as being at risk. First and foremost through anecdotal evidence, the

documents identify crystal meth as a problem across different groups of individuals, depending upon which document you read. For example in the first document, a physician noted, “He and his colleagues were seeing an increasing number of patients with methamphetamine-related problems” (CCENDU and ADIC, 2003:5). This first document, *Methamphetamine: Environmental Scan…*(CCENDU and ADIC, January, 2003), also indicated that the RCMP was also seeing an increase in the use of methamphetamines and they had no official data collection process other than anecdotal evidence (CCENDU and ADIC, 2003:5). The last document, *Methamphetamine* (Vancouver Coastal Health, April, 2005), indicated that individuals at highest risk appeared to be “street-involved youth, gay men and young adults involved in the party scene” (Vancouver Coastal Health, 2005:11). This same document stated that the scope of the problem presented a challenge, “Because few studies have been conducted specifically on MA” (Vancouver Coastal Health, 2005:9).

Among all of the individuals identified being at risk, youth is the common denominator. Most of the youth identified are street youth. CCENDU and ADIC, (2003:3) states, “Summit participants reported methamphetamine use to be of particular concern for youth.” The only study which focuses on street youth is the one completed by The McCreary Centre Society (2001). This study involved surveying street youth and speaking to them directly about issues such as family, education and work, physical and emotional health, substance use, sexual behaviour, safety and violence and social supports. This study does not appear to be reflected in the official documents I examined, especially in terms of offering

positive solutions for these street youth such as providing them with job opportunities and affordable housing. This provides serious negative implications for street youth. Two other vulnerable populations identified as being at risk are lesbian, gay, bisexual and transgendered (LGBT) people and people incarcerated in provincial and federal institutions. McFarlane, (2003) indicates that currently there is no queer-specific treatment and additionally, there is no funding for these people. McFarlane (2003) also found that the broad determinants of health such as education, housing and shelter, and access to programs such as life skills were barriers for LBGT individuals. According to the six-month progress report, (BCMHS, April 2005), on crystal meth, two treatment programs have been implemented in two correctional facilities for females in British Columbia. The Report does not specify if these institutions are provincial or federal. The official discourse of these documents does not discuss other solutions for these individuals. These documents again, appear to ignore the material presented, leaving the social reality of the individuals described above as significantly unchanged. With the lack of comprehensive research and data, it is difficult to know exactly how many individuals are at risk.

Foucault (2002) indicates there are primary, secondary and discursive relations in discourse analysis. In this case, the primary relations are those of the experts who framed these documents. The secondary relations are the individuals identified as being at risk. There appears to have been little interplay between the primary and secondary relations. In other words, there is little communication between the individuals at risk and the authors of these

documents. VanDijk (1993:250) states, “dominance is the exercise of social power by elites, institutions, or groups that result in social inequality, including political, cultural, class, ethnic, racial, and gender inequality.” In this case, the discursive unit of each document created the social reality for the individuals identified at risk, but in the terms the authors of these documents understand, which is not necessarily the same terms the people at risk understand. The authors of these documents are middle or upper class people while the individuals at risk are poor and marginal. Foucault indicates that, “Truth is linked to a circular relation with systems of power that produce and sustain it, and to effects of power which it induces and which extend it-a “regime” of truth” This regime of truth “is to be understood as a system of ordered procedures for the production, regulation, distribution, circulation, and operations of statements” (Rabinow and Rose, 1994:317). This regime of truth (BC documents) concerning crystal meth excludes the marginalized people identified as part of the problem.

Using the three-dimensional approach of Phillips and Hardy (2002), I examine how the texts of these documents are connected to the discourse they use. This approach connects texts to discourses, locating them in a historical and social context. Historically, illicit drugs like crystal meth and their users have been dealt with by the criminal justice system. These British Columbia documents represent a shift away from the criminal justice system, at least in terms of who is presenting the discourse on crystal meth. I ask if these documents construct a social reality that is meaningful to users of crystal meth.

(iii) In my discussion below on major themes or solutions identified, it is clear to see in what follows that British Columbia has socially constructed crystal meth as a health and educational problem with a minor emphasis on treatment and regulation. Prevention is a major theme, and solutions, which are described through the use of technical health terms, like 'health promotion,' 'population health,' 'harm reduction,' and 'community capacity building'. These technical terms with the exception of harm reduction have been adopted from Health Canada (1999). Harm reduction was adopted from the World Health Organization (2003). Health is broadly defined as the well being of individuals, families and communities. The solutions point to a holistic approach, which necessitates the engagement of concerted efforts of a variety of institutions. Most importantly, by constructing crystal meth as a public health issue, the problem is identified as rooted in social inequality such as unemployment, poverty, and lack of housing. If individuals are in a position where they lack access to resources such as employment, food, clothing and shelter, this can adversely affect their health.

These issues seem to be pushed aside. The discussion on health promotion suggests healthy alternatives, family resiliency, and decreasing stigma, and yet there are no concrete solutions offered to assist the individuals at risk. Family resiliency suggests that those at risk have families to live with. Decreasing stigma suggests that if you live within a family and practice good nutrition and hygiene that the stigma will go away. The authors of these documents remain silent on public policy issues suggesting social support systems like adequate housing, education, poverty, and homelessness.

Another major theme or solution is prevention through education. The document *Crystal Meth and Other Amphetamines…*(BCMHS, 2004:14) indicates, "BC will use resources efficiently across ministries, health authorities and communities to create evidence-based, shared information initiatives." Certainly education on a broad base is very important but it is only part of the crystal meth problem. Different educational packages will need to be prepared, depending upon the audience and this takes time and money. While the theme of prevention addresses education and partially constructs the crystal meth problem as an educational problem, none of these documents address the cost of providing education. These documents also suggest that street youth attend school. While some do, a significant proportion of them don't, especially on a regular basis. Because this discursive activity is coming 'from above', there is an assumption made that all youth attend school.

The theme of 'harm reduction' recognizes the importance of educating the public about methamphetamine use and keeping people safe by providing safe paraphernalia like needle exchange programs. The *Crystal Meth and Other Amphetamines* document states, "We will provide information to the public about methamphetamine use and its harmful health, social and economic impacts (BCMHS, 2004:18). The second part of harm reduction was to provide safe paraphernalia, which contributes to the health and safety of the individuals who engage in using needles. There is part of the theme of prevention called 'community capacity building', which suggests people need to come together to address the problem of crystal meth. The first document refers to an integrated

and coordinated response, which is somewhat similar, however, the focus is on better communication between service providers and professional groups to "decrease the fragmentation and lack of coordination between existing services…" (CCENDU and ADIC, 2003:13). No suggestions or recommendations are made as to how this will be accomplished and no suggestions are made about how to communicate with the individuals identified as being at risk. Community capacity building appears to be a neo-liberal concept where the onus of responsibility to resolve these serious issues is placed on the communities without researching how this can be accomplished. Treatment is prevalent as a minor theme. Although these documents address treatment, they tend to point out what doesn't exist, like more treatment beds and a lack of a consistent treatment protocol for the province. In the first document, *Methamphetamine Environmental Scan: Final Report* (January, 2003), "participants stressed the severe shortage of treatment capacity and options…barriers to treatment including waiting periods, discrimination, lack of attention to issues of culture, problematic location of treatment centres and the need to allocate more beds to specific populations (e.g., LBGT)" (CCENDU and ADIC, 2003:15). The second document, *Every Door is the Right Door…* (BCMHS, May, 2004), describes their current model of response for treatment issues, but falls short of suggesting what more needs to be done. The third document, *Crystal Meth and Other Amphetamines…(*BCMHS, August 2004), makes reference to this same model, but makes no attempt to suggest that it does not work (BCMHS, 2004:36-7). This model is divided into three sections: universal and selective prevention, secondary prevention and tertiary prevention.

Universal prevention would include activities like school programs, drug awareness services, and videos about crystal meth. Secondary prevention would be targeted to high-risk individuals "showing minimal signs and symptoms of a disorder or whose biological markers indicate a predisposition" (BCMHS, 2004:36). An example of this would be outreach and support services geared to s specific population such as parents and/or their children. Tertiary prevention would involve intensive treatment offered through a specific program such as mental health services. This treatment model falls short of reaching its goals according to the information provided in these documents. This discursive activity does not match the reality of the situation crystal meth users and other individuals addicted to other substances are experiencing. The second document (*Every Door is the Right Door…*(BCMHS, May, 2004), indicates that, "Different groups may need tailored care to better address specific needs and improve the quality of life" (BCMHS, 2004:9), and yet nothing has been put in place to address this issue. Treatment is one of the most important aspects of assisting crystal meth users and yet these documents downplay this and offer little in the form of solutions.

The legal dimensions of the crystal meth problem are a minor theme as is research and monitoring. In terms of legal dimensions, there was more concern expressed about dismantling clandestine labs in particular. A Meth Watch Program has been established to "curtail the theft of over-the-counter cold remedies and other household products…" (BCMHS, 2005:3). In terms of research and monitoring, the first document *Methamphetamine Environmental*

Scan: Final Report (January, 2003), discussion centred upon "Establishing mechanisms for ongoing data collection in individual communities and later amalgamation by a central group" (2003:17). In the last document, *Methamphetamine,* (CCENDU AND ADIC, April, 2005:28), research gaps were identified such as assessing MA use on parenting, identifying patterns of use among street-involved youth and gay men, developing a means of assessing cognitive impairment and identifying the long-term health and social impacts related to MA use.

In conclusion, after analyzing these documents I found that first and foremost government personnel and academics are making decisions for crystal meth users. As vanDijk (1993) and Foucault (2002) observe in their analyses, this is a 'top-down' approach. While some of the users and their families have been brought to the table to engage in discussions about their problems and issues related to crystal meth, they do not participate in presenting the findings and recommendations (*Methamphetamine,* 2005*).* The people at risk do not have a voice. They remain 'secondary' in the discourse process. Nowhere is it documented that identified precursors to poverty such as affordable housing and job training will be provided. This was a dominant theme addressed in these documents. These are structural problems and yet it would appear that the burden of solving these problems falls back on the individuals at risk and their communities. The state and their experts are very efficient at identifying the problems but they fall short of offering realistic solutions. There appears to be a gap between the actual plan and its realization. These documents certainly

make it look like something important is being done by giving legitimacy to their own actions such as providing workshops and conferences and by writing and publishing their documents. The social reality of improving the health of the individuals identified at risk and providing education to them, in particular, costs money, and the last BC document, *Methamphetamine* indicates this by stating "the main limitation of interventions…is cost" (Vancouver Coastal Health, 2005:22).

Historically illicit drug use has been constructed as a criminal problem. I have identified in the various documents a shift away from treating crystal meth as a criminal problem, or so it would appear. In the period of 2003 to 2005, it is important to also look at what type of provincial British Columbia government was in place. Like the other provincial governments I examined, this provincial government was more focused on fiscal restraint than social programming, which is part of the neo-liberal mantra. Finkel, (2006:285) stated, "most provincial regimes elected after 1980 subscribed to some version of neo-liberal ideology." It also appears that the federal government heavily influenced British Columbia, at least in terms of the health solutions offered for this serious problem. 'Population health' and 'health promotion' are part of the federal government's discourse on health issues and the British Columbia government has adopted this discourse. These findings are unrealistic in terms of the individuals identified as being at risk. Until the people at risk are brought to the table and engage in attempting to solve the problems they encounter with the professionals and academics together, the problems encountered will continue. Until accurate

research and statistical data is gathered from the individuals described as being at risk, no one will know the actual extent of the problem. Even though it appears that there has been a shift to viewing crystal meth as a health issue and educational issue, the implications of these documents suggest that while an effort is made to address the crystal meth problem, it has come ‘from above’ and the social reality of the people at risk remains ignored.

CHAPTER 4: THE CASE OF ALBERTA

4.1 Alberta Documents on Crystal Meth

In this chapter I examine four written documents; two are prepared by AADAC, one by a private consultant, and one by the Premier's Task Force. The first document is entitled *A Community Stakeholder View of Crystal Meth in Edmonton: Trends, Strategies, Challenges and Needs* (Goldblatt, February 2004). The second and third documents, entitled *Coordinated Alberta Response to Methamphetamine*, and *Methamphetamine: What we know about it, What we're doing about it*, were produced by AADAC, in April and June of 2006. AADAC (Alberta Alcohol and Drug Abuse Commission) until 2009 was an agency of the Government of Alberta reporting to the Minister of Health and Wellness. It is "mandated by the Alcohol and Drug Abuse Act to operate and fund programs and services and to conduct research" (Alberta Alcohol and Drug Abuse Commission, ND: 1). The last document I examine is a document produced by the Alberta government entitled the *Premier's Task Force on Crystal Meth: Fighting Back (*Government of Alberta, September, 2006).

4.1.1 Who Are the Voices of These Documents?

The first document, *A Community Stakeholder View of Crystal Meth in Edmonton: Trends,* Strategies*, Challenges and Needs* (Goldblatt, February, 2004), was prepared for the City of Edmonton by the Social Development Working Group of Safer Cities Advisory Committee of the City of Edmonton. Seventy-one stakeholders in the Edmonton area were interviewed as well as members from ten municipalities where responses to the issue of crystal meth have already been initiated. The stakeholders included a variety of different government (provincial and municipal) groups involved with youth specifically, education agencies, youth-focused community agencies and community agencies. Other organizations, involved with youth and adults, were classified under health organizations, addictions, prostitution and justice and law enforcement.

The second document, *Stronger Together: Coordinated Alberta Response to Methamphetamine* (AADAC, 2006), is part of the Alberta Drug Strategy, "which lays the groundwork for a coordinated and community-based approach to alcohol and other drug issues in the province…at the core of the Alberta Drug Strategy is a commitment to collective action to reduce the harms associated with alcohol and other drug use" (AADAC, 2005). The working group of effective responses were all experts from various government departments such as the Solicitor General, Aboriginal Affairs and Northern Development, Children's Services, the co-chair of AADAC and the RCMP.

The third document, *Stronger Together: A Provincial Framework for Action on Alcohol and Other Drug Use, (*AADAC, 2005), was produced by AADAC. The authors were a collaboration of different provincial ministries, Alberta's health regions, the business sector, industry and organizations as well as different communities in the province and individuals and families. The last document, *Premier's Task Force on Crystal Meth: Fighting Back* (Government of Alberta, September, 2006), was produced by a task force to study the crystal meth problem including people from the community, private sector individuals and members of different departments of the provincial government.

4.1.2 Who is Identified as Being at Risk?

In the first document, *A Community Stakeholder View of Crystal Meth in Edmonton: Trends, Strategies, Challenges and Needs (*Goldblatt, February, 2004), Goldblatt (2004:iv) stated that this study found "young people are the primary users of crystal meth in Edmonton…in particular those 15 to 25 years of age". The second document, *Stronger Together: Coordinated Alberta Response to Methamphetamine* (April, 2006) discussed a survey conducted on Alberta high school students entitled "The Alberta Youth Experience Survey" (TAYES). In 2002, this survey indicated, "5.3% (about 21,000 students) had used "club drugs" (including ecstasy and methamphetamine)" (AADAC, April 2006:5). The third document, *Methamphetamine: What we know about it, What we're doing about it* (AADAC, June, 2006), referred to a Canadian Addiction Survey conducted in 2004 where it was reported that, "6.1% of Albertans aged 15 or older reported

having used “speed” (amphetamines) at some point in their lifetime. Amphetamines include but are not limited to methamphetamine” (AADAC, June 2006:21). Like the previous report, this report made reference to the Alberta Youth Experience Survey (TAYES). “According to preliminary results from TAYES 2005 1.2% of Alberta students in grades 7 to 12 (aged 11 to 19) reported using crystal methamphetamine in the year prior to the survey…1.8% of Alberta students surveyed reported using other forms of methamphetamine in the year prior to the survey” (AADAC, 2006:22). AADAC also uses a software program to track statistical information about their clients, especially in terms of what services they were providing. This program is called ASIST. “ASIST youth client statistics for September 2005 to March 2006 indicate that 7% of AADAC clients under the age of 18 reported crystal methamphetamine use in the 12 months prior to seeking treatment, and 3% reported having concerns about their use” (AADAC, 2006:23). The executive summary of the last document, *Premier’s Task Force on Crystal Meth: Fighting Back* (Government of Alberta, September, 2006), identifies the following at risk groups: “street-involved youth, specific groups within the gay male community and young adults in the party scene” (Government of Alberta, 2006:7). Once again, youth appear to be the main group of individuals who are at risk.

4.1.3 How is Crystal Meth Framed as a Problem and What Solutions are offered?

In the first document, (Goldblatt, 2004), after making contact with ten different municipalities, found that many community strategies were underway even

though very few of them had any funding for this type of activity. Such strategies included educational sessions, counselling and support groups. The value of collaboration was highlighted. Goldblatt, (2004:54-55) stated, "Collaboration emerges as a strategy that is not an end in itself. It can be an intentional strategy to achieve results in other areas: staff and public education, legislative change to limit access to the precursors for making meth and more timely access to treatment that is sufficient in length and tailored for youth"

Goldblatt (2004:58) recommended four strategic directions: "establish links with existing collaborative groups already addressing crystal meth…sponsor or co-sponsor an event with another collaborative group(s) to bring together stakeholders for dialogue and debate…use the findings…to inform and raise awareness and…develop an advocacy plan to take forward positions on issues affecting the safety, health and well-being of people in Edmonton in relation to crystal meth." This study also identified five consistent gaps that need to be addressed: staff and public education, investigating legislative changes to disallow the availability of ingredients used to make crystal meth, the more timely access for treatment, especially for youth, protective factors that reduce the likelihood of substance abuse, such as communities coming together to address the problem of crystal meth, and lastly and possibly the most important gap, addressed the need for social policy changes "affecting access to affordable housing and high income, research on the long term effects of meth and effective treatment, expanded outreach services and better enforcement laws" (Goldblatt, 2004:vi).

The second document, *Stronger Together: Coordinated Alberta Response to Methamphetamine* (AADAC, April, 2006), identified prevention, treatment, harm reduction and policing and enforcement as the main issues concerning addiction and other drug use. Prevention and treatment stressed the importance of Albertans working together. The authors of this AADAC document (2006:4) stated, "Support is being provided to 51 community drug coalitions in Alberta." The working group wanted to provide support in the form of awareness campaigns and prevention programs, which targets strategies to deal with substance abuse. As an example, the document described some of the activities already set in motion such as AADAC hosting a forum once a year for these communities to come together and share ideas and information on what has worked in their communities. Other activities included working with First Nations groups to develop a crystal meth strategy for their people, planning a conference on crystal meth for healthcare professionals, and working with the Edmonton City Police to develop a system to monitor individuals arrested who have been under the influence of drugs and/or alcohol, including crystal methamphetamine.

This document identified gaps in treatment for youth. The authors indicated "a recent increase in funding has allowed AADAC to expand its system of youth services, with the opening of 24 detoxification and treatment beds in Calgary and Edmonton" (AADAC, 2005:21). Harm reduction was addressed by listing a number of strategies: "delay the onset of alcohol and other drug use, decrease alcohol and other drug-related problems in at-risk groups, reduce alcohol and other drug-related morbidity, reduces the harms associated with alcohol and

other drug use, decrease the availability of illicit drugs and decrease health and economic costs" (AADAC, 2005:9-10).

Legislative action was also being taken by the Alberta Government and The Alberta College of Pharmacists to restrict the access of products containing ephedrine and pseudoephdrine. These two drugs are ingredients used to make methamphetamine. A drug treatment court was opened in December of 2005, posed as offering "an alternative to incarceration for non-violent offenders, who participate in a specialized addiction treatment program provided through AADAC" (AADAC, 2006:7). Other initiatives included training for front-line workers responding to drug-endangered children. The *Drug-Endangered Children Act* was proclaimed in November 2006. This Act "intended to protect children from serious drug activity. This Act gives police the authority to charge parents who expose their children (under 18 years old) to illegal drug manufacturing or drug trafficking activities" (AADAC, 2006:7). Another piece of legislation, which came into force on July 1, 2006, is *The Protection of Children Abusing Drugs Act*. "This Act gives parents the authority to place their children into a mandatory drug detoxification program" (AADAC, 2006:7). Parents or guardians must ask the court for an apprehension and confinement order, complete the order and then attend court before a judge with evidence written down as to why their youth should be allowed to be sent to a protective safe house for a period of five days to manage withdrawal and make other treatment plans.

Shortly after AADAC released the above noted document, they released this second document, *Methamphetamine: What we know about it, What we're doing about it* (AADAC, June, 2006), because Alberta communities were expressing concern about drug use and, in particular, the use and production of methamphetamine, which was still receiving considerable media attention. The main purpose of this document was to highlight what is known about methamphetamine and to provide a list of different resources available on methamphetamine such as services provided by AADAC and information resources and how to access them.

In the last document, *Premier's Task Force on Crystal Meth: Fighting Back* (Government of Alberta, September, 2006), three themes emerged: prevention, healing and treatment, and getting tough. In the first theme of prevention, the task force defined what prevention is to them, drawing from a definition from Loxley et al. (2004:27) that prevention is "measures that prevent or delay the onset of drug use as well as the measures that protect against risk and reduce harm associated with drug supply and use" (Government of Alberta, 2006:19).

The second theme was healing and treatment and this document indicated, "immediate action was needed to help people who are suffering from drug addiction" (Government of Alberta, 2006:23). For example, this document acknowledged that more detoxification time is required for crystal meth users. There is a chronic lack of beds across the province for detoxification, healing and treatment with the most acute need in rural and remote areas (Government of Alberta, 2006:23). Because of this chronic bed shortage, those who wait,

continue to use and do not make it to their next appointment. Another problem identified the “nine to five” mentality the current treatment system has. People in crisis need around the clock assistance. Once detoxification is completed, there is yet another wait to get into a treatment bed. The wait time is usually too long and the individual falls prey to his/her habit once again. Rural and remote areas have little access to treatment and healing facilities. If someone from one of these areas accesses treatment, they are removed from their families and support systems, not allowing them to participate in the treatment process. In addition to providing treatment, aftercare support, mental health issues and integrating services for children, youth and families were addressed.

The last theme was getting tough, which implies punitive actions. The getting tough section of this document is divided into two main areas: supporting police, law enforcement and first responders and protecting the environment. It was felt that drug producers and dealers needed stiffer sentences. Attempts should also be made to address environmental concerns, as meth labs can produce toxic waste that is harmful to human health and the environment.

The end of this section on getting tough included a discussion of working with Aboriginal communities. There was not any indication of which Aboriginal communities the task force spoke to. These communities indicated that they “were vulnerable to the devastating effects of crystal meth and other drugs because of geographical and social isolation, lack of economic opportunities, the loss of culture, identity and language that resulted from historic policies of

assimilation and federal laws that fail to adequately protect First Nations lands and communities" (Government of Alberta, 2006:29).

This document outlined eighty-three recommendations grouped under five different headings: taking a province-wide approach, prevention, healing and treatment, getting tough, supporting Aboriginal communities and improving services and assessing results. Twenty-six recommendations were under the first category of taking a province-wide approach. All twenty-six of these recommendations were under the first overall theme of prevention, with the authors highlighting that, "The emphasis on prevention is at the core of our recommendations" (Government of Alberta, 2006:35). It was first and foremost suggested that a fund be created to pool resources and develop programs "that reduce and eliminate the use and abuse of crystal meth" (Government of Alberta, 2006:34). The task force wanted to develop an implementation team, which would provide "advice, direction and control of the fund" (Government of Alberta, 2006:34). There should be a system put in place to look at the accountability for action of recommendations made by different government departments and agencies. Drug education programs need to be developed for all urban and rural communities. It was suggested that more funding be given to Regional Health Authorities "to increase walk-in capacity for prevention, support, addiction services, and mental health counselling and ensure that it is more accessible to youth and young adults" (Government of Alberta, 2006:35).

Only nine recommendations dealt with healing and treatment. Of these, three suggested funding for more detoxification beds, treatment beds and

residential treatment programs for youth. There are not sufficient resources in the area of healing and treatment. This document indicated that there is a shortage of detoxification beds and further, it was suggested that more beds are required for rural and urban communities for both detoxification and treatment. Residential treatment programs need to be established. Young people may require education upgrading, life skills and career planning as part of their treatment. Health care professionals should be trained to identify meth users, especially as they have access to a large percentage of the population in their work. It was suggested that a protocol be developed in the school system to deal with youth caught with drugs in school. Currently students caught with drugs are suspended the first time and expelled the second time. This document acknowledged that this must change. Counselling services for students and parents should be provided. The last recommendation in this section was to "enhance the Health Link to provide 24-hour drug information and support to those in need" (Government of Alberta, 2006:42).

The third set of recommendations dealt with 'getting tough'. It had the largest number of recommendations, which was thirty-three. These recommendations suggested a drug undercover street team be established "to address the impact of methamphetamine and drugs in urban, rural and Aboriginal communities" (Government of Alberta, 2006:44). Drug prohibition teams should be expanded at bus depots, train stations and on the provincial highways. Canine teams need to be expanded as they have a good record of searching and locating drugs. It was further suggested that drug dogs be used in the educational system, as they

have “proven useful in breaking down barriers between children and the police” (Government of Alberta, 2006:44). An increase in support for analytical resources to drug intelligence teams needs to be put in place. There should be a greater effort to focus on outstanding warrants, especially those related to organized crime and gangs. Smaller communities need more police officers to assist them in their fight against meth. The document suggested using full-time Emergency Response Teams/Tactical Teams in Edmonton, Red Deer and Calgary. Businesses that sell drug paraphernalia should not be permitted to do so. Drug products containing ephedrine and pseudoephedrine should only be sold in pharmacies and should be kept behind the counter. These are active ingredients used in the production of crystal meth. Ranchers should be educated about how to securely store chemicals on their property.

The province has enacted *The Protection of Children Abusing Drugs Act,* (July 1, 2006) to provide children under the age of eighteen up to five days in a protective safe house. Community-based drug courts should be developed. These courts “would provide an opportunity for communities to be more actively involved in developing solutions that match the needs of the individuals involved” (Government of Alberta, 2006:47). This document suggested further amendments to the *Criminal Code* so that young persons convicted of drug offences are not diverted to alternative measures, stating that, “Diversion methods do not require a young person to receive addictions and mental health counselling, and that allows the cycle of drug abuse and criminal behaviour to continue” (Government of Alberta, 2006:47). Another recommendation was to

change legislation to “make the manufacture, possession, trafficking and use of crystal meth or any other dangerous drug a serious violent offence that warrants incarceration before trial and upon conviction” (Government of Alberta, 2006:47). Information sharing is another part of these recommendations. Key to these recommendations were those looking at information sharing for the protection of children at risk. It was suggested that police have a common information management system so they can share information and data. Information sessions should be conducted for judges and prosecutors to keep them up to date on the latest issues involving drug crimes. This document suggested that legislation should be amended to place a reverse onus on the accused "…requiring them to prove that the possession of precursors was for a purpose other than meth production” (Government of Alberta, 2006:49).

The last set of recommendations in this document dealt with improving services and assessing results. Funding needs to be looked at for the implementation of the many programs this document outlined. More support systems are required for distant or remote communities. Consistent protocols need to be put in place for meth users. There needs to be performance evaluation, measurement and accreditation measures established. This document was released on September 12, 2006. After all of this work and examination of the crystal meth problem in Alberta, nothing has been done. Since the writing of this document, a new Alberta government has been formed and this government has decided that not only crystal meth presents as a problem, but other substances as well; therefore, more investigating needs to be

done. After reviewing these documents it appears that Alberta has socially constructed crystal meth as an education problem and a criminal problem.

4.2 Analysis of Alberta Documents

I have examined four Alberta documents and in keeping with my thesis questions, I examine who the voices of these documents are, who is identified as the agent of this problem? how is the problem of crystal meth framed? and what solutions are proposed?   Again, Foucault, vanDijk and Phillips and Hardy guide my analysis.

(i) Two documents were prepared by AADAC, a government agency reporting to the department of health. Goldblatt (2004), an independent consultant, prepared the first document, which involved stakeholders from the city of Edmonton as well as from the province of Alberta. This was the only document prepared for a municipality. The Premier's Task Force on Crystal Meth (Government of Alberta, 2006) completed the last document. Once again, experts have produced all of these documents. The first document by Goldblatt (2004), the second document by AADAC, (April, 2006) and the last document, by the Premier's Task Force, (2006) does include reports of consultation with the community. By involving the community, at least an attempt is made to acknowledge the 'secondary' relations in the discursive activity. Goldblatt's document was more detailed in terms of outlining community concerns, which again refer to 'secondary relations' in the discourse. This is especially so in the section of her document where representatives of ten different municipalities are interviewed. She provides a section entitled "Experience from Other

Municipalities in Alberta" (Goldblatt, 2004:44), which includes a series of tables outlining what these different communities are doing to address drug-related problems. For example, the town of Drayton Valley was experiencing reports of increased use of crystal meth in 1999. The town council and mayor decided to do something about this. Goldblatt (2004:47) indicates that in 2000, they hired a community mobilizer to work with a police officer to address "crime in the community in general and crystal meth within this mandate." An educational approach is employed, focusing on youth and their parents. While the amount of funding is not indicated for this undertaking, five groups both nationally and locally are named who assist with funding for this. This is a very positive step and empowers this community to take control of managing this serious problem of crystal meth. A section of the table on each municipality is entitled "Lessons Learned to Date." In Drayton Valley they include: "Learned not to use addicts to give talks to their own community because it results in stigma. Youth willing to partner, seniors were not. Be mindful of information given regarding drugs and anticipate its potential impacts. Try to get the community to think differently about addictions" (Goldblatt, 2004:48). There are important insights to be learned from Goldblatt's "Lessons Learned," such as there is much stigma surrounding drug users, senior citizens are not willing to become involved and possibly for a number of reasons such as fear and lack of trust. This is mere speculation as no reasons were given for them not to partner. The last observation indicates that knowing your audience when you are giving

information about drugs is very important as well as anticipating its impact. Once again this is all the information given.

(ii) Goldblatt's (2004), document identifies young people ages 15 to 25 being at greatest risk. The AADAC documents confirm crystal meth as being a problem. AADAC identifies youth as being the main group at risk, however, through the use of "The Alberta Youth Experience Survey" (TAYES); they find a drop in the use of methamphetamine. The surveys provided on high school students offer valuable data but the data misses important groups like street youth, the homeless, and Aboriginals; there was no breakdown in ethnicity or gender. While these individuals are identified as being at risk, the text of this discourse or the discursive unit, which possesses meaning, in this instance, exists only for these students, who are from the mainstream. In other words, these surveys are not inclusive to the individuals identified as being at risk.

The Premier's Task Force document identifies youth as being at risk but gives no reference to where this information came from. This document identifies street-involved youth, specific groups in the gay male community and young adults in the party scene (Government of Alberta, 2006:13). It is difficult to create a social reality without proof of where it came from. Goldblatt's document is the only one to find that crystal meth reaches across socio-economic lines. This could be as the result of using 'secondary' discourse such as involving the community in her study. The first three documents provide a very different picture of how the crystal meth problem is socially constructed than the Premier's Task Force. These three documents socially construct crystal meth as a multi-faceted

problem with a major emphasis on prevention through education, regulatory measures, collaboration, and a minor emphasis on treatment. Goldblatt's study is the only document recommending social policy changes, suggesting affordable housing, higher incomes, and research on the long-term effects of crystal meth and subsequent treatment. The *Premier's Task Force on Crystal Meth: Fighting Back* (Government of Alberta, September, 2006), socially constructs crystal meth as a criminal problem first as thirty-three out of eighty-three recommendations (equivalent to 40%) are based on 'getting tough'.

(iii) In these four documents, there are themes or solutions relating to treatment and education, but the major theme emulating from the last document focuses on 'getting tough', suggesting many regulatory actions. The first AADAC report, *Stronger Together: Coordinated Alberta Response to Methamphetamine* (AADAC, April, 2006), addresses the need for more youth detoxification and residential treatment programs, especially for northern and southern Alberta. The second AADAC document, *Methamphetamine: What we know about it, What we're doing about it* (AADAC, *June,* 2006), provides an extensive list of services and educational resources available related to methamphetamine. This discursive unit makes no mention of a lack of resources like the above documents. There appears to be a discrepancy in terms of this entire issue of resources. The text of the discourse from AADAC indicates there are resources and, as an example, after reviewing the two documents from AADAC, it appears that many initiatives directed towards the crystal meth problem are underway and have funding, however, the text of the Premier's Task Force suggests that

nothing has happened. While the issue of cost was not addressed, it appears from the second AADAC document that a great deal of money has been invested in a variety of prevention programs. This same document lists thirteen strategic priorities to be put in place between 2005 and 2010. All of these priorities already appear to be in place at the time this document was prepared.

Both AADAC documents review legislative and regulatory changes, however, the Premier's Task Force outlines the largest number of changes in relation to this and calls it 'getting tough.' Recommendation forty-six suggests that the *Criminal Code* be amended to recognize 'child drug endangerment' as a *Criminal Code* offence. "Recognizing child drug endangerment as a *Criminal Code* offence would mean tougher sentences for persons responsible for the child's care" (Government of Alberta, 2006:46). Presumably, the police would apprehend the children and have them placed foster care, if no other family members are available. This could be for a long period of time as possession of methamphetamine could mean up to seven years of imprisonment and trafficking of methamphetamine could lead to life imprisonment (Government of Canada, 2009:1). The Alberta government has already implemented the *Protection of Children Abusing Drugs Act* (July 1, 2006). This Act "provides children under the age of eighteen with up to five days in a protective safe house" (Government of Alberta, 2006:46). While this Act suggests that this will be of great assistance to youth taking drugs and their parents or guardians, I suggest that most parents of youth on drugs would not even know how to initiate this process. An application has to be made to a provincial court judge by the parents or guardian, stating the

reasons why the youth needs this kind of treatment. If the judge agrees, then the youth is taken to a protective safe house for a period of five days. Since this document was released, an amendment to this legislation, *Protection of Children Abusing Drugs Amendment Act*, has been made, increasing the time from five days to ten days, with the consideration for another five days (Government of Alberta, 2009:1). It is already stated that detoxification from methamphetamine requires much more time than five days. There is no indication made as to where these youth go after this time period. Many of the individuals identified are estranged from their parents and do not have a guardian, which insinuates that this Act only works for those privileged enough to have this is in place. Recommendation sixty-one states, "The Government of Canada should enact and/or amend the legislation that places the reverse onus on the accused requiring them to prove that possession of precursors was for other than meth production" (Government of Alberta, 2006:49). Canadian citizens value their justice system, which upholds that one is innocent until proven guilty. To suggest that an individual is guilty and must prove his/her innocence would be a drastic step to take and one which most would argue against. The Canadian Charter of Rights and Freedoms guarantees each and every citizen the right to "be presumed innocent until proven guilty according to law in a fair and public hearing by an independent tribunal" (Department of Justice, 1982: Section 11(d)). Recommendation forty-eight states young offenders who are convicted of drug-related charges are incarcerated so they can receive treatment. Currently, "diversion methods do not require a young person to receive addictions and

mental health counselling, and that allows criminal behaviour to continue" (Government of Alberta, 2006:47). It would be more appropriate to allow young people to receive treatment in the community because diversion programs are community-based allowing young people to remain in the community and this keeps them with their families and support systems.

Six recommendations were made to support Aboriginal communities. Two pages of this sixty-one-page document are devoted to Aboriginal communities. The wording of these recommendations suggests that currently there is no prevention, no education strategies, no community mobilizations, no detoxification and treatment facilities and aftercare for Aboriginal people. This observation is very distressing and suggests that Aboriginal people have little or no power to address crystal meth issues in their communities. Recommendation seventy-one does suggest that the "government of Canada should rescind its policy requiring Aboriginal people to return to their home reserve for treatment services" (Government of Alberta, 2006:52). The current arrangement reflects the federal government's funding support, which is such that Aboriginal people have to live on a reserve to obtain services. Today, more and more Aboriginal people have moved from their reserves, into towns and cities. This situation suggests an urgent need for the federal government and the province of Alberta to meet and discuss addiction and treatment issues to provide support to Aboriginal people. There is no indication that this will happen any time soon.

The last set of recommendations, which dealt with improving services and assessing results, have not been implemented. Once again the text in the documents does not match the suggested recommendations.

In conclusion, after reviewing these Alberta documents on crystal meth, it is clear to see that crystal meth presents as a problem. Overall the social construction of the problem is much more punitive, especially in terms of the last document, the *Premier's Task Force on Crystal Meth: Fighting Back* (Government of Alberta, September, 2006). Historically, the context of this discourse remains much the same, as punitive measures have been the mainstay of treating those using illicit drugs such as methamphetamine. Between 2004, when the first document was written and 2006, when the last document was written, Klein's conservative government was in power. As early as 1994, he slashed spending on health by 20% and as well, he significantly reduced welfare payments (Finkel, 2006:293). While the community was consulted on crystal meth in the first and last documents, experts such as medical doctors, school superintendents, the CEO of AADAC, the Dean of Pharmacy from the University of Alberta, the RCMP, and the Chair of the Palliser Public Health Region have produced these documents. Similar groups at risk were identified in these documents, especially youth, but there was a range in the data presented from some to none and little to no reference stating where this information came from. The need for prevention through education was addressed in all of these documents. According to the two AADAC documents, much is being accomplished; however, the discursive activity in these documents and in the

Premier's Task Force on Crystal Meth: Fighting Back (Government of Alberta, September, 2006), contradicts one another. The AADAC documents state education is being provided on drug addiction in the school system while the Premier's report states that it should be provided. All of these documents address the need for more detoxification and treatment beds especially in the northern and southern areas of the province and they suggest that detoxification will occur within five to ten days when research on detoxification from methamphetamine indicates that this process can take much longer. Very little was stated about Aboriginal issues other than there are very few resources available to them. Funding was alluded to in the *Premier's Task Force on Crystal Meth: Fighting Back* (Government of Alberta, September, 2006), but in a futuristic manner. It appeared that many communities had to do their own fund-raising to support the different initiatives they have created to battle drug problems. This was a positive initiative, which reached out to all members of communities involved, even though these communities had to be creative in looking to how to solve these problems and obtain funding. Drug education programs need to be developed for many different people including ordinary citizens, health and educational professionals and the workforce. No price tag was attached. The Premier's Task Force talked of a social marketing campaign, focusing on youth, which would be very costly to operate. Once again, this was a positive suggestion, however, no action was indicated for this recommendation. The largest sets of recommendations put forward by the Premier's Task Force were in the section entitled 'getting tough'. Many of the recommendations in this

section would be very costly such as undercover drug teams, drug prohibition teams, the use of dogs and creating full-time tactical teams. This sounds like the creation of a police state. No one but Goldblatt addressed the underlying problem of affordable housing and income security, which needs to be addressed through social policy changes. Her focus on this issue is not stressed in the other documents. The two AADAC documents and the Premier's document focused on regulatory changes and prevention through education and punitive measures. The overall implications of these documents do not appear to be positive. The government of Alberta does not appear to be interested in the welfare of crystal meth users. This has serious implications for those who are still using. With no actions being taken, the individuals who are identified as marginalized will continue to be marginalized. The power remains 'top-down.' Once again, while these documents were produced to address the crystal meth issue, they fell short of providing viable solutions.

CHAPTER 5: THE CASE OF SASKATCHEWAN

5.1 Saskatchewan Documents on Crystal Meth

In 2005, a series of documents was provided and published by the government of Saskatchewan and its agencies. There appeared to be pressure placed upon the Premier after a Saskatchewan Party MLA's daughter was addicted to crystal meth and he went public about this (CBC News, June 20, 2007). Premier Calvert was urged by the opposition party (The Saskatchewan Party) to address the problem of crystal meth. On June 10, 2005, Premier Calvert hosted a Western Ministers conference in Regina to address the crystal meth problem. These events appear to have set the stage for the writing of these Saskatchewan documents.

In February 2005, the province of Saskatchewan's Health ministry produced a document on crystal meth entitled: *A Strategic Plan for Crystal Meth and Other Amphetamines in Saskatchewan.* In June 2005, the Legislative Secretary on Substance Abuse, Prevention and Treatment, Graham Addley, produced a second document entitled: *Healthy Choices in a Healthy Community: A Report on Substance Abuse, Prevention and Treatment Services in Saskatchewan.* In August 2005, the *Premier's Project Hope: Saskatchewan's Action Plan for Substance Abuse* was released (Saskatchewan Health, 2005). In August 2006, a one-year update was provided to this action plan (Saskatchewan Health, 2006).

5.1.1 Who are the Voices of These Documents?

The first document, *A Strategic Plan for Crystal Meth and Other Amphetamines in Saskatchewan* (Saskatchewan Health, February 2005), acknowledged the BC document, *Crystal Meth and Other Amphetamines: An Integrated Strategy,* (BCMHS, August, 2004) and thanked the BC government for allowing them to "use and adapt portions of the document" they prepared (Saskatchewan Health, 2005; ii). Saskatchewan Health professionals prepared this document. In June, 2005, the Legislative Secretary on Substance Abuse, Prevention and Treatment released a document entitled *Healthy Choices in a Healthy Community: A Report on Substance Abuse, Prevention and Treatment Services in Saskatchewan* (Addley, June, 2005). Premier Lorne Calvert appointed this legislative secretary in December of 2004, after pressure from his opposition party to investigate the crystal meth problem. The mandate of this document was to review current "services, identifying gaps in services, identifying best practices, consulting stakeholders, and developing recommendations to improve the services available to the people of Saskatchewan" (Addley, 2005:1). Stakeholders included a range of different provincial government ministries such as Justice, Education, Health, Corrections, Community Resources and Employment, First Nations and Metis Relations and the Children's Advocate Office. Mayors and councillors of a number of rural and urban cities were involved. Service clubs like the Elks Service Club from Saskatoon were involved. Other provincial agencies were consulted like AADAC from Alberta, the Manitoba government and national agencies like the Canadian Centre on Substance

Abuse.

In August 2005, Lorne Calvert, the Premier of Saskatchewan, released the *Premier's Project Hope* document. A year after this document was released, a one-year update was provided. The specific authors of these two documents were not indicated, but it would be assumed they were individuals hired by Saskatchewan Health.

5.1.2 Who are the Individuals Identified as being at Risk?

In the first document, *A Strategic Plan for Crystal Meth and Other Amphetamines in Saskatchewan* (*February* 2005), target populations were identified: youth, Aboriginal peoples, 'street involved' individuals and northern residents. According to this document, "Forty per cent of the northern population is under the age of 15" (Saskatchewan Health, 2005:30). This has a tremendous implication for what will be done to assist this northern population when the target populations are Aboriginals, northern residents and youth. This document provided limited statistics on the extent of the problem in Saskatchewan, relying on data from "Saskatchewan police who reported 58 arrests or seizures related to crystal meth in 2003, compared to none in 2000" (Saskatchewan Health, 2005:3), or about "clients admitted to provincially funded alcohol and drug treatment programs, among whom "the proportion reporting problematic stimulant use, including crystal meth, increased from 7.9% in 2001/02 to 9% in 2002/03 to 10% in the first nine months of 2003/04" (Saskatchewan Health, 2005:4). For additional data this document relied on a study entitled "Youth on the Brink of Success" (MacDermott et al., October 2004) "which was developed

by Saskatoon Communities for Children, specifically the Working Group to Stop the Sexual Exploitation of Children and Youth with staff support from Addiction Services-Outpatient and the Saskatoon Tribal Council to assess the substance abuse support needs of children and youth in our community" (MacDermott et al., 2004:10). Crime Prevention, Community Mobilization and The Community University Institute funded this project for social research. This study used surveys and interview questions "to gather data from youth (552), parents (1300 and service providers (30)" (MacDermott et al., 2004:3). The study revealed that out of 10% of these youth who used illicit drugs, crystal meth use averaged 19% (Saskatchewan Health, 2005:3). The study also found that "youth appear to be getting involved with alcohol and drugs at an earlier age. Seventy-five percent of youth aged 12-14 at the time of this study were drinking alcohol, and 72% were using drugs" (MacDermott et al., 2004:3).

In the second document, *Healthy Choices in a Healthy Community* (June 2005), which targeted all addictions; several trends in addiction were identified. Other studies were examined such as *Best Practices: Treatment and Rehabilitation for Youth and Substance Use Problems* (Health Canada, 2001), where it was found that substance abuse involving youth was increasing.

5.1.3 How is Crystal Meth Framed as a Problem and What Solutions are Recommended?

In the first document, *A Strategic Plan for Crystal* Meth *and Other Amphetamines in Saskatchewan* (Saskatchewan Health, February, 2005), Saskatchewan Health, identified four strategic areas for action: prevention,

treatment, education and reducing drug availability. Under prevention, two goals were identified: to allow children and parents to make healthy choices about their health and to establish collaborative relationships among all players with an emphasis on education, treatment and health promotion.

This document reviewed the existing range of services for treatment and identified areas for improvement such as providing funding for inpatient and outpatient services and for the care of high-risk children and youth; offering programs integrating mental health and drug abuse, developing detoxification and treatment protocols appropriate for crystal meth; increasing the skills of service providers, research and development identifying and evaluating the best practices for prevention and treatment, developing a database of addictions services for workers to use across the province, and offering outreach centres to assist families of children with substance abuse issues (Saskatchewan Health, 2005:13-14). While youth were targeted as the highest at risk group, it appeared that most services currently developed did not cater to this group, with the exception of two. The Saskatoon Community Addictions Services (CAS) established a crystal meth group. "The group was prompted by requests from clients who needed information specific to crystal meth. The group has been attended sporadically by 8 clients or less, with 29 clients having accessed this service in the past year" (Saskatchewan Health, 2005:14). The age of the individuals who attended this group was not specified. A second treatment initiative involved high-risk children and youth: "The Department of Community Resources and Employment and Saskatchewan Health continue to nurture a

partnership with the Ranch Ehrlo society to serve high risk children and youth who are in need of protection and require specialized treatment services for addictions and other problems" (Saskatchewan Health, 2005:14). Ranch Ehrlo "is a non-profit, registered charitable organization dedicated to provide a range of quality assessment, treatment, education and support services that improves the social and emotional functioning of children and youth" (Ranch Ehrlo Society, March 22, 2009:1).

Out of nine new treatment initiatives recommended, three addressed youth. It was suggested that a new youth stabilization service be created "to provide a safe, substance free place in which a youth may safely withdraw from alcohol and drugs and/or stabilize physically, emotionally and socially" (Saskatchewan Health, 2005:15). *The Youth Drug Detoxification and Stabilization Act* (YDDSA) was proclaimed on April 1, 2006. The Act provides parents, guardians, police, and other officials with operations for accessing services on behalf of youth, who are unwilling or unable to engage in services for severe substance abuse or substance dependence" (Saskatchewan Health, nd: 1). A second new treatment initiative recommended "implementing a mobile treatment model to provide services in a non-traditional way to northern communities" (Saskatchewan Health, 2005:16). The third new treatment initiative recommended offering "outreach centres that are accessible and community-based, designed to meet the needs of "street youth" and families with children and youth who have serious disruptive behaviour problems, including addictions issues" (Saskatchewan Health, 2005:16).

The third strategic area was education. The authors want to educate the public to understand the harm caused by crystal meth and then empower them to do something about it. The first action was preparing and distributing factual information about crystal meth. Many initiatives were mentioned covering a wide range of different groups from schools to First Nations groups, to police, corrections, justice, health care and social services. Web sites were created through Saskatchewan Health to provide information on crystal meth. New initiatives yet to be completed included a community resource guide and the development of a media campaign.

The fourth strategic area was reduction of drug availability. The priority was the prevention of the production and distribution of the drug. A number of actions were suggested such as using the existing legislation to target meth labs for criminal and legal action. A fifth action was lobbying the federal government to consider legislation concerning the movement and access of materials used to make crystal meth. The last action, a call for stiffer penalties, and did not stipulate what this meant.

The second document, *Healthy Choices in a Healthy Community* (Addley, June, 2005), addressed recommendations in four core areas: prevention, treatment, coordination, and central support, and supply reduction. The entire range of substance abuse, not just crystal meth and other amphetamines was addressed. While this document stated, “the lifetime use of most illicit drugs is below the national average,” those who did use illicit drugs in the past year “…indicated their use had caused them personal, social, physical or financial

harm. This was above the national average for drug-related harm to self" (Addley, 2005:7). This information was taken from the Canadian Addiction Survey (November, 2004), though the actual national average for harm related to self was not indicated for Saskatchewan. The rates in British Columbia and Alberta were17.5% and 16%, respectively, for harm related to self. Recommendations concerning prevention were to target the high-risk populations identified such as youth and parents were viewed as being critically involved in delivering an anti-drug message. The document further stated, "There are also issues with respect to providing good information to all Saskatchewan communities, especially those in remote northern locations. Some face resource challenges in providing factual and timely substance abuse awareness programs that build drug and alcohol resistance" (Addley, 2005:15). Part of prevention is education and the other part is the promotion of population health. Addley (2005:16) stated, "Prevention health promotion planning must go beyond changing individual attitudes and behaviour to include initiatives aimed at addressing other factors that determine our health such as poverty, homelessness, income, education and literacy." Two major recommendations were made under the umbrella of prevention. The first was to "create a new alcohol and drug prevention directorate within the department of health and secondly, to "de-normalize current attitudes about alcohol abuse and reduce the opportunity for abuse" (Addley, 2005:17). This document did not specify whose attitudes they referred to, however, it did suggest that restriction of alcohol for minors and surcharges on harmful products would help to change attitudes about

alcohol abuse. The new directorate was viewed as an opportunity to centralize resources to allow for a coordinated approach to substance abuse prevention and education throughout the province.

The second core area identified treatment: "The hallmark of substance abuse services is treatment, and while most individuals who seek treatment in Saskatchewan are able to access the services they need, there are some who are having difficulty" (Addley, 2005:18) These individuals were not clearly identified; however, Addley stated, "This integrated approach recognizes that the functions of addictions and mental health services need to be integrated to better treat patients with co-occurring conditions. This is especially true for those addicted to crystal methamphetamine" (Addley, 2005:18-19). This document addressed the shortcomings of the current treatment model called the Saskatchewan Model for Recovery Services (SMRS), which is not suitable for the treatment of young people and especially those detoxifying from crystal meth. A treatment model providing "community-centred outpatient approaches" is recommended (Addley, 2005:19). Secure care for youth needing substance abuse treatment, but who refuse this treatment was addressed insofar as it was identified as a problem. The percentage of youth admitted for any addiction service has remained steady at 17 per cent of total admissions. However, there are only 12 inpatient beds, less than 5 per cent of total beds, specifically dedicated to treating young people. Treatment services need to be flexible and responsive. Once an individual has completed their portion of inpatient treatment and moves on to outpatient treatment they are met quite often with having to

return to an unsafe environment and then the likelihood of returning to using again is very high. This document identified the need for inpatient services for those with dependent children, especially women. Currently there are no such facilities in Saskatchewan.

The last issue under treatment addressed the links between substance abuse and criminal activity, which are significant. "Canadian studies estimate that 38 to 68 per cent of offender populations are alcohol or drug dependent" (Addley, 2005:20). This document did not break this down to offender populations in Saskatchewan. Drug treatment courts are being piloted in Canadian cities across Canada by the federal government and one is running in Regina for adult offenders. Addley (2005:23) suggested three treatment recommendations: developing a new and more flexible model which is sensitive to the culture of the First Nations and Metis communities, reviewing methods of assisting youth who resist treatment, and Introducing new, more flexible supports for individuals and families." Some youth and adults need transitional housing when moving from inpatient to outpatient services. Housing that is based on the mental health model of certified approved homes should be considered" (Addley, 2005:23). Further, it was suggested that some form of mobile treatment be developed to meet the needs of people living in remote communities in northern Saskatchewan.

The third core area this document looked at was coordination and central support. While substance abuse services are centrally coordinated, a number of issues of concern were identified. Up-to-date information on the availability of

treatment beds for counsellors needs to be made available through a central resource. The document noted inconsistencies in treatment across the province, which was attributed to “variations in the training and qualification of addiction workers” (Addley, 2005:24). Seven recommendations were made to resolve these issues: complete a community development framework reflecting Canada’s Drug Strategy, centralizing access to treatment information, providing more support to communities dealing with substance abuse issues, developing province-wide training for addiction workers and publicly funded programs should go through an accreditation process, providing a new substance abuse chair at the University of Saskatchewan providing an evaluation process for treatment and prevention programs, providing greater integration of services, and lastly, this document recommended that the attention to drug and alcohol addictions must be ongoing.

The last core area identified supply reduction. This document specifically referred to crystal methamphetamine. Addley stated, (2005:29) “At the present time, most of the crystal methamphetamine (and other substances) that is available at the street level in Saskatchewan is imported from elsewhere.” In June 2005, Saskatchewan’s Premier hosted a conference of Western Canadian Ministers of Health, Justice and Public Safety entitled “Building Partnerships to Address Addictions-Responding to Crystal Meth.” The main themes of this conference were supply reduction and treatment. The participants of this conference noted that maximum penalties for the possession and trafficking of opiates were much harsher than those for the possession and trafficking of

crystal meth. As a result, the participants decided to urge the federal government to strengthen penalties for drug possession and trafficking of crystal meth. It was suggested that new offences be created for possession of key ingredients and equipment used in the making of crystal meth.

A second recommendation suggested building on the Meth Watch program. This is a partnership of retailers and manufacturers to prevent the sale of common household products used to produce crystal meth. Over-the-counter cold remedies such as ephedrine and pseudo-ephedrine are used to make crystal meth. The last recommendation was "to enhance supports to implement the *Safer Communities and Neighbourhoods Act*" (Addley, 2005:31). This legislation was enacted in October of 2004. Its goal was to shut down illicit drug or alcohol manufacturing laboratories by inviting community members to call into a toll free hotline to report suspected drug operations in their communities.

In August 2005, Lorne Calvert, the Premier of Saskatchewan, released the *Premier's Project Hope* document. This document was prepared in response to the two previous documents and presented Saskatchewan's action plan for substance abuse, targeted over three years. It addressed the four core areas identified in Addley's document, *Healthy Choices in a Healthy Community.* Under the first core area of prevention, the document stated it would provide "Education and a change in attitude" (Saskatchewan Health, 2005:5). A new Alcohol and Drug Prevention and Education Directorate would be created in Saskatchewan. In addition, information about substance abuse across Saskatchewan would be provided, using a province-wide media campaign and by educating "youth and all

Saskatchewan residents," as well as educating all professional staff involved in dealing with abuse. A price tag of $1.9 million was being invested over the next three years. Work would begin "to change attitudes about the use and abuse of alcohol in our province" (Saskatchewan Health, 2005:5).

The second core area of treatment was addressed, listing ten new initiatives involving developing more treatment beds, especially for youth. The price tag attached to this was $3.8 million in capital costs and $5.7 million in annual operational costs. Providing training, hiring program consultants and hosting an annual clinical conference, would develop a new treatment approach. The price tag for this initiative was $400,000 per year (Saskatchewan Health, 2005:2).

The third core area addressed coordination. Five new initiatives were addressed which include developing a community development framework, creating a treatment data base, empowering communities to address substance abuse on the streets and in their homes by providing them with community tool kits, an inventory of speakers and experts on substance abuse, a centralized accreditation process for substance abuse programs so that "clients and their families can be assured of quality and trustworthy experience" (Saskatchewan Health, 2005:4).

Lastly, a new research chair at the University of Saskatchewan would be created to improve the evaluation of substance abuse programs and to provide data collection. The price tag attached to this was $723,000 (Saskatchewan Health, 2005:4). The last core area addressed supply reduction. The idea was to make communities safer. This was envisaged by placing two additional

officers to enforce *The Safer Communities and Neighbourhoods Act* and by hiring four additional drug enforcement officers. A price tag of $700,000 over the next three years was attached. In addition, a price tag of $50,000 over the next two years was attached to inform Saskatchewan residents about these new initiatives (Saskatchewan Health, 2005:3).

A year after this document was released, a one-year update was provided. The action plan was presented as a three-year plan and the progress at this point was presented. A new *Youth Drug Detoxification and Stabilization Act* came into effect on April 1, 2006 with provisions for involuntary stabilization of addicted youth who are considered at high risk to harm themselves or others. A new research chair position has been created at the University of Saskatchewan to oversee the evaluation of substance abuse programs and data collection. Additional police officers have been hired to enforce the *Safer Communities and Neighbourhoods Act*, one in Regina and one in Saskatoon. Four additional drug enforcement officers have been hired. A new Alcohol and Drug Prevention and Education Directorate within Saskatchewan Health has been created and began its work in November of 2005. Its role is to "work with regional health authorities, schools, and other agencies to enhance prevention and education efforts" (Saskatchewan Health, 2006:6). *Project Hope* focused much of its attention and the largest amount of money on treatment and within one year, it was impressive to see what they have accomplished. Examples of new treatment facilities for youth, in particular, are mentioned such as a new 12-bed stabilization unit in Saskatoon, and another 15-bed inpatient residential youth treatment facility in

Prince Albert. There are still many other works-in-progress, such providing more detoxification centres and improving mobile treatment service for the north of the province. Saskatchewan has constructed crystal meth as first and foremost a health and specifically, a treatment problem, as well as an educational problem with some emphasis on regulation.

5.2 Analysis of Saskatchewan Documents

I have presented a synopsis of four documents produced in Saskatchewan to look at the problem of crystal meth. In a short space of time in 2005, these documents were drafted when Premier Calvert was urged by his opposition party (The Saskatchewan Party) to address the construction of the problem of crystal meth after a Saskatchewan Party MLA had gone public with his daughter's struggles with crystal meth. The Saskatchewan Premier also hosted a Western Ministers Meeting of Health, Justice and Public Safety to respond to the crystal meth problem on June 10, 2005. As a result of this meeting, the ministers were committed to "restrict the sale of products containing ephedrine, pseudoephdrine, hold a Western Canadian clinical conference to discuss best practices in prevention and treatment and build all existing treatment programs on best practices" (Canadian Intergovernmental Conference Secretariat, June 10, 2005). They also urged the federal government to become involved especially in terms of regulatory practices like implementing harsher penalties for crystal meth possession and trafficking.

In my analysis, I examine these government documents from Saskatchewan using discourse analysis informed by Phillips and Hardy, Foucault and vanDijk. I

examine the voices of the discourse, how the problem of crystal meth is framed and who is identified as the agents of this discourse. Lastly, I identify key themes or solutions that these documents produce.

(i) In the case of this province, only the first document addresses crystal meth specifically (Saskatchewan Health, 2005). The other three documents address substance abuse on a much broader scale. Graham Addley, the Legislative Secretary on Substance Abuse, Prevention and Treatment, produced one document, *Healthy Choices for a Healthy Community* (June, 1995); Saskatchewan Health produced the remaining documents. These documents were produced 'from above', when you examine who is involved. The second document indicated that "extensive consultations with more than 50 diverse groups including addictions and mental health professionals, community action groups, police, and government representatives as well as individuals, parents and parent groups throughout Saskatchewan were involved" (Addley, 2005:1). This again does involve some of the 'secondary' relations in the discursive process. The Saskatchewan documents targeted some of the same strategic areas as British Columbia; however, treatment and legal regulations were given far more emphasis. Saskatchewan acknowledged the British Columbia documents and thanked the authors of *Crystal Meth and Other Amphetamines* (BCMHS, August, 2004) for allowing them to use portions of their document. In this case, the discursive activity was transferred from one province to the next.

(ii)The individuals identified at highest risk were Aboriginals, street-involved youth and northern residents. Anecdotal evidence provided this information,

however, it was somewhat sketchy. While the police, treatment programs and a study conducted in Saskatoon, presented some statistics (MacDermott et al., October, 2004), it is unclear how these groups at risk were identified. These groups of individuals have what Foucault defines as 'secondary' relations in the discursive activity. Because of their positioning, they have no voice. It was encouraging to see consultation expand beyond the professional community. Reference was made to the Northern Health Strategy, Saskatchewan Health, 2002. Northern Saskatchewan has the fastest growing population in the province and this population is mainly Aboriginal youth (Saskatchewan Health, 2002).

(iii) In the first document and the only document that looked exclusively at crystal meth, the idea of prevention was to provide 'trusted' information to parents and youth about crystal meth. It was not clear what this document meant by 'trusted' information. This insinuates that only certain individuals are capable of providing this information. Moreover, the emphasis on 'trusted' information implies, or raises the question of non-trusted information. Similarly, the dissemination of trusted information or knowledge through websites did not take into account unequal access to computers among groups at risk. This discourse assumes that everyone has equal access. The authors of these documents wanted to provide drug education in the school system but will this information reach those individuals at highest risk? These primary agents of this discourse did not focus on the individuals at highest risk.

Addley's document addressed prevention programs by targeting high-risk groups through the education of parents and youth and by "providing good

information to all Saskatchewan communities especially those in remote northern locations" (Addley, 2005:15). It was not made clear what 'good information' is. Again, this discourse insinuates that firstly, not all information is good and secondly, people living in remote northern communities especially need this good information, because they have the greatest need for prevention programs.

Population health was addressed as part of prevention, but was not a repetitive theme like in the British Columbia documents. It was referred to in the Addley document which states that, "Prevention and health promotion programming must go beyond changing individual attitudes and behaviour to include initiatives aimed at addressing other factors that determine our health such as poverty, homelessness, income, education and literacy" (Addley, 2005:16). This is the social reality of the individuals at risk; many live in poverty or are homeless, do not have an adequate income, and are uneducated and illiterate.

The second common theme or solution arising from the Saskatchewan documents was treatment. More emphasis was placed on treatment; especially acknowledging that much more needs to be put in place for youth. Current problems were identified such as youth resisting treatment, accessibility to treatment and the lack of treatment resources. Youth are admitted to adult facilities but "this approach does not provide an optimal approach to meeting the specific needs of young people" (Addley, 2005:19). An action plan (three years) has been put in place and progress is being made. This was the only province to take action. British Columbia, on the other hand offered more general solutions,

indicating a continuum of care, but they did not offer any specifics or follow-up like Saskatchewan.

The third common theme or solution in these documents was education, and to use it as a preventative measure. Other recommendations included province-wide training for addictions counsellors, accreditation for publicly funded programs, providing a substance abuse chair through the University of Saskatchewan, and providing a tool kit for communities experiencing problems, giving them a list of resources. One of the main goals was to educate the public so they can understand the harm caused by crystal meth and then be empowered to do something about it. The first Saskatchewan document on crystal meth, *A Strategic Plan for Crystal Meth and Other Amphetamines in Saskatchewan* (Saskatchewan Health, February, 2005), also suggested new initiatives addressing education such as a community resource guide; a media campaign. The Premier's *Project Hope* (Saskatchewan Health, August, 2005), indicated it would spend $1.9 million dollars towards improving prevention through education (Saskatchewan Health, 2005:5). Saskatchewan also described what the provincial government needed to do to make information and services pertaining to crystal meth and addictions overall more efficient and more readily available.

Lastly, the issue of supply reduction or reducing drug availability was addressed. Saskatchewan offers many regulatory solutions, some of which are already in place like the *Youth Drug Detoxification and Stabilization Act*, proclaimed on April 1, 2006.The process which must be undertaken to allow this

Act to work properly is extremely cumbersome. A parent or guardian must obtain a document from the court and complete it, indicating why their youth needs to be placed in a secure treatment facility. They then must appear before a provincial court judge to have him/her review this document and if the judge agrees that there is sufficient evidence to have the youth committed, he will ask two doctors to carry out separate assessments. If the doctors both agree and only then, the youth can be transported to the only secure facility in Regina, which is the Paul Dojack Centre, for five days. If five days is not enough, then the staff of the facility have to go back to court to have five more days approved. This can occur for three periods of five days. Most youth who have serious drug problems do not have parents or guardians to walk through this complicated process. The Paul Dojack Centre in Regina has five beds for the entire province of Saskatchewan.

Saskatchewan established a Meth Watch program and the *Safer Communities and Neighbourhoods Act*. British Columbia has established The Meth Watch Coalition, similar to the Saskatchewan Meth Watch program. British Columbia was also interested in tightening up "the Controlled Drug and Substances Act regulations on precursors in the production of methamphetamine" (British Columbia Health Services, 2005:3). They were more interested in the environmental effects of meth labs such as hazardous waste.

Saskatchewan like British Columbia has socially constructed crystal meth as a problem of health and education. Saskatchewan placed more specific emphasis on health, especially in terms of treatment issues, and especially those

that concern youth. Unlike British Columbia, Saskatchewan actually attached a very large amount of money (almost 20 million dollars over 3 years) to deal with the different problems crystal meth and other addictions presents. Saskatchewan also places more emphasis on regulation than British Columbia does.

In conclusion, while there are some similarities between the Saskatchewan and British Columbia documents, Saskatchewan actually put some of their plans into action and provided funding for these plans. The players are the same: the state, in this case, the province, the community and the individual. Saskatchewan does commit money over a period of three years while British Columbia does not. While both provinces thoroughly review where the problems lie in terms of education, treatment, prevention and supply reduction, Saskatchewan is more specific and outlines new solutions, especially for the treatment of youth. Saskatchewan also provides new regulatory changes such as the Meth Watch Program and the *Safer and Communities and Neighbourhood Act*. The individuals identified at risk in Saskatchewan are marginal people like those in British Columbia. They do not have a voice and have not been given a voice. Programs and positions established through Project Hope remain, however no new funding has been established as a new government, the Saskatchewan Party, has replaced the New Democratic Party.

CHAPTER 6: CONCLUSIONS AND RECOMMENDATIONS

This thesis started by posing the following questions about crystal meth: who are the voices in the discourse on crystal meth, who are the social groups defined as being at risk? how it is constructed by some groups as a problem and what, if any, impact, has this construction had on formal responses to crystal meth use? I have critically examined government documents from British Columbia, Alberta and Saskatchewan to answer these questions. I summarize what I have found, focusing on key questions: What is similar? What is different? What do these documents remain silent on? Lastly, I provide my conclusions and recommendations for what I believe needs to be done to address this problem and my own personal reflections from my work experience.

All three provinces indicate that crystal meth is a problem. British Columbia was the first province to address the problem, followed by Saskatchewan and then Alberta. Experts such as academics, health professionals, enforcement professionals, social service professionals, and educational professionals produce the documents I examine from each province. Documents of these provinces (British Columbia, Alberta and Saskatchewan) were produced between January 2003 and September 2006. Interestingly, there appears to be a shift in who defines drug-related 'problems', from experts in the legal field to experts in the health field.

To answer my questions I used discourse analysis informed by Foucault, Phillips and Hardy and vanDijk to analyze these official documents. I did this by examining the themes of these government documents to learn how they are interrelated to each other. Phillips and Hardy (2002:5) stated, “Social reality is produced and made real through discourses.” I used a three-dimensional approach to discourse, looking at how the texts are connected to discourse and locating them as I have done, in a historical context and the discourse they create. I examined who has written these documents, and who is identified as being at risk to using crystal meth, and what solutions are presented. The documents present several common themes, including recommendations to promote health, provide education about crystal meth, provide more treatment to those affected and conduct more research and monitoring of this drug, and to introduce regulatory controls like the Meth Watch program in Saskatchewan and British Columbia, the *Youth Drug Detoxification and Stabilization Act* in Saskatchewan and Alberta and the *Protection of Children Abusing Drugs Act* in Alberta. I examined these government documents from British Columbia, Alberta and Saskatchewan to determine how the ‘object’ (crystal meth and its users) of this discourse was identified. Some documents obtained information from statistical data, which clearly did not involve all of the groups identified as being at risk. This statistical data came from a variety of sources: CCSA, Health Canada, in BC, The McCreary Centre Society, AADAC, and Goldblatt in Alberta, and in Saskatchewan, Saskatchewan Health, and a project developed in Saskatoon Communities for Children published by MacDermott et al. Most of the

information is anecdotal derived from a variety of sources such as detoxification centres, the police and hospitals. In British Columbia, the highest at risk group identified is street youth. Other groups identified were individuals with substance abuse issues and concurrent mental disorders, Aboriginals, gay, bisexual, transgender groups, criminals, single mothers and immigrants.

The Alberta documents also identify street youth, gays and young adults involved in the party scene. The Goldblatt study conducted in February 2004 in Edmonton, found crystal meth use high among young people, girls who want to lose weight and amongst the gay population. This study also found that crystal meth use seems to cross socio-economic lines. This is a different finding than those in the other reports where users appear to be poor and marginalized. This study found that crystal meth seemed more prevalent in northern Alberta, but appeared to be spreading south. The other statistical information in Alberta is from the Alberta Youth Experience Survey or TAYES, which conducted interviews on school students. AADAC uses a tracking system called ASIST (The AADAC System for Information and Service Tracking). While this tracking system provides information about meth use of youth, it does not indicate any other information about these youth, It does state they are under the age of eighteen, however, it gives no information about their sex, cultural backgrounds, if they are from the street, or whether they are from rural or urban settings. The *Premier's Task Force on Crystal Meth* (Government of Alberta, September, 2006) identifies street youth, specific groups within the gay male community and youth involved in the party scene as being at risk. Nowhere in this document are

there references to support this conclusion. Aboriginal issues were discussed in two pages. The authors of this document state, "The Government of Alberta should direct its departments that work with Aboriginal communities to build and implement drug prevention and 3educations strategies for Aboriginal youth and young adults " (Government of Alberta, September, 2006:51). This statement suggests that nothing yet has been done.

The province of Saskatchewan identifies groups at risk as being youth, Aboriginal people, 'street –involved individuals' and northern residents. Some statistics are obtained from the police and provincially funded alcohol and treatment programs as well as a study completed in Saskatoon called "Youth on the Brink of Success," which found that youth are using drugs and alcohol at an earlier age. I could not find any specific references other than these to identify these at risk populations.

Overall, I find the statistics in all three provinces are not very reliable and other than The McCreary Centre Society 's work on street youth, it appears that many marginal people have been identified, like Aboriginal people across the provinces, but very little investigating or research has been completed on this particular group. In fact British Columbia and Saskatchewan remain silent on this issue. While Alberta acknowledges the crystal meth problem in the Aboriginal community, there are no concrete solutions offered.

My third thesis question asks how these provinces socially constructed crystal meth as a problem. From examining the recommendations produced in the documents from British Columbia and Saskatchewan, I conclude that they have

socially constructed crystal meth both as a problem of health and education. Two terms used in the British Columbia documents are 'population health' and 'health promotion.' Population health defines the social determinants of health such as adequate income, employment, housing and social support. The first British Columbia document I examined, *Methamphetamine Environmental Scan: Final Report* (CCENDU and ADIC, January, 2003), the authors state, "For street youth, MA is one way to deal with the problem of staying awake, coping with lack of shelter and food" (CCENDU and ADIC, 2003:10). In The McCreary Centre Society's report, one of the key findings stated, "Street youth named affordable housing, job training and work experience as top priorities for community services" (The McCreary Centre Society 2001:10). Saskatchewan also addresses 'health promotion' in Addley's document where he stated "prevention health promotion planning must go beyond changing individual attitudes and behaviour to include initiatives aimed at addressing other factors that determine health such as poverty, homelessness, income, education and literacy" (Addley, 2005:16). Nowhere in these British Columbia or Saskatchewan documents are these issues addressed.

Phillips and Hardy refer to how "language constructs reality rather than revealing it" (2002:83). The language of these documents constructs this reality, but does nothing to reveal it, other than write about it. No direction to change policy to address these issues is made. These documents produced by 'experts' appear to avoid the real issues, which I have noted above and make it appear as if something very important is being done, with the exception of Saskatchewan. It

would be interesting to see what the cost involved in producing these documents, hosting conferences and running various workshops was.

'Health promotion' suggests an advocacy process and suggests that individuals and communities take control over factors affecting their health. All of the individuals defined to be at risk are marginal people with no resources at their disposal to organize themselves and take control. 'Community capacity building' is another concept used across these British Columbia reports. Saskatchewan calls this 'coordination and central support' but approaches this more from the position of what the government can do to help the communities in Saskatchewan. The idea is to bring people together "to provide an integrated and coordinated response" (CCENDU and ADIC, 2003:16). The authors, however, do not say how this is to happen.

The very first document, *Methamphetamine Environmental Scan: Final Report* (CCENDU and ADIC, January, 2003), talks of harm reduction and seeking practical solutions to the harm of substance abuse. The authors make a disturbing statement related to this theme, stating that harm reduction "will reduce risk and impose safety by increasing acceptance and intolerance" (CCENDU and ADIC, 2003:21). Indirectly this suggests that people using meth are not accepted or tolerated in society. Addley's document from Saskatchewan (Addley, 2005), talks of 'de-normalizing' current attitudes about drugs and addictions. How do you 'de-normalize' current attitudes? What are the current attitudes? Both in Addley's document and in the Saskatchewan Premier's *Project Hope* document (Saskatchewan Health, 2005), it is suggested that

attitudes can be changed by "restricting access to alcohol by minors and reviewing minimum pricing standards …on harmful products" (Saskatchewan Health, 2005:6). On the surface, this sounds good, however, attitudes towards addiction problems are much more deep-rooted and will require much more than this to 'de-normalize' or change them. All of the authors of these documents write about the need for harm reduction.

These documents emphasize the importance of education about substance use and abuse is in this process, offering education as a solution. The cost of implementing educational programs is neglected by two of the provinces, while Saskatchewan commits a substantial amount of money through *Project Hope* (Saskatchewan Health, August, 2005). Different educational packages will need to be prepared, depending upon the audience. Saskatchewan and Alberta also feel that education on substance use and abuse is very important. In fact, the Alberta government contradicts itself in one part of the Premier's Task Force (September, 2006), where it states that substance use and abuse education should be made part of the high school curriculum when AADAC states that it is already in place. In the AADAC document, *Stronger Together: Coordinated Response to Methamphetamine* (AADAC, April, 2006), it appears that Alberta, through AADAC, which is provincially funded, has done a lot a lot more than the Premier's Task Force (2006) gives them credit for. British Columbia and Saskatchewan identify many treatment issues. The difference between the two, however, is that Saskatchewan does come up with an action plan and a significant amount of money ($23 million dollars over three years), while British

Columbia does not. A need for consistent medical protocols is recognized throughout all of the provinces. All provinces have implemented new regulatory actions. British Columbia and Saskatchewan implemented Meth watch programs, for example, though Saskatchewan and Alberta go furthest. Saskatchewan implemented the *Youth Drug Detoxification and Stabilization Act*, and Alberta enacted a piece of legislation entitled the *Protection of Children Abusing Drugs Act*. Saskatchewan also implemented the *Safer Communities and Neighbourhoods Act*. The *Youth Detoxification and Stabilization Act* and the *Protection of Children Abusing Drugs Act* appears to be a positive step, but when you examine the process that needs to occur to allow a youth to enter into a secure facility to become detoxified and then begin treatment, it quickly becomes apparent that this is a very cumbersome process. The *Safer Communities and Neighbourhoods Act* allows community involvement. A hotline has been established to report suspected drug houses, alcohol manufacturing and illicit grow operations. Saskatchewan and British Columbia are more concerned with the drug traffickers and the safety issues that meth labs bring to their environments than Alberta.

While Alberta addresses some of these same issues in their province, one document in particular, *The Premier's Task Force on Crystal Meth* (Government of Alberta, September, 2006), socially constructs crystal meth as a criminal problem. In eighty-three recommendations made in this document, thirty-three of them (almost 40%) are punitive. The section of this document is entitled 'Getting Tough'. While this document addresses prevention and treatment, the overall

emphasis is punitive. Many of the recommendations in the ‘getting tough’ section of this document, would be very costly. These recommendations sound more like the creation of a police state. Probably the most encouraging document prepared in Alberta was that of Goldblatt in February 2004. While this study is conducted over a one-month period and mainly looks at the crystal meth situation in Edmonton, ten communities were also involved from around the province of Alberta. This study outlines some of the different community concerns and outlines “lessons learned” from these various communities. In Drayton Valley, one of the communities included in this study, the ‘lessons learned’ are very interesting. An example of this was that drug addicts should not be involved in the education of substance use and addiction in their own communities because of the stigma involved. Goldblatt’s study was the only document indicating the need for social policy changes, pointing to affordable housing and income security (Goldblatt, 2004).

In conclusion, while all three provinces that I have researched have gone to considerable trouble to provide documents on crystal meth, they really only produce what Foucault would call fragments of reality. Foucault states, “A particular discourse can figure at one time as the programme of the institution, and at another it can function as a means of justifying or masking a practise which itself remains silent” (Foucault, 2002:194). While all of these documents outline what the experts or authors feel need to be done, they do not address the underlying issues of poverty, homelessness, lack of employment the people identified as at risk are encountering. British Columbia and Alberta remain silent

on the cost of their recommendations. While Saskatchewan provides funding for their recommendations, this government has now changed hands from a NDP party to the Saskatchewan party, which has a conservative orientation. Alberta also has a new premier, but from the same Conservative party. All of these governments define the problem of crystal meth, but then pass over their solutions to the individual and their communities. This is in keeping with the new neo-liberal ideology, which these governments embrace. These governments are more concerned with fiscal restraint than assisting individuals and their communities in their respective provinces. Alberta and British Columbia offer no funding for their solutions. While these documents allude to addiction problems with Aboriginal people, they also remain silent on their issues. All of these documents write about the social determinants of health, which most of the people at risk are missing; they offer no solutions to these problems. There appears to be significant gaps between the offered solutions and the realization of these solutions. These gaps include inadequate research and monitoring, inadequate access to treatment of sufficient length and specifically tailored to meet the needs of the individual involved, like youth, LGBT, and Aboriginals, as well as better regulatory mechanisms, allowing parents and guardians more assistance in assisting their youth to obtain help with their addiction. These gaps exist because individuals who are not from the same social environment as the individuals in need are making all of the decisions for them. This reveals how official discourse is tied "in a circular relation with systems of power that produce and sustain it…" (Rabinow and Rose, 1994:317).

Earlier in this thesis, I addressed the possibility that the problem of crystal meth has been presented as a moral panic. Between 2002 and 2006, crystal meth received heightened media attention and these provincial governments wrote all of these documents to address this problem, however, since then, we do not hear much more about the problem, suggesting that crystal meth is not as big a problem as earlier thought. I suggest that crystal meth is still presenting as a problem and because these documents do not provide accurate statistics or consult the people at risk, all they do is appease the public and provide rhetoric to make people believe something has been done. Part of discourse analysis is to look at the historical perspective of the discourse and while I have traced the history of the criminalization of illicit drugs, it is important to also look at the more recent history of these three provincial governments. Finkel (2006:285) states that neo-liberal ideas have taken hold in all of Canada's major political parties by the 1980s. British Columbia has a Liberal government, just recently re-elected, Alberta has a Conservative government and Saskatchewan in the past three years has elected the Saskatchewan Party. All of these governments have cut social programming and their focus, in keeping with neo-liberalism, has been fiscal restraint in some areas.

In November of 2008, the Saskatoon Health Region released a report entitled "Health Disparity in Saskatoon; Analysis to Intervention," produced by epidemiologist Mark Lemstra and Dr. Cory Neudorf, Chief Medical Health officer for the Saskatoon Health Region (French, J., November 14, 2008: A: 1). It is interesting to note that "the authors of this report have divided their

recommendations into five topics: Income, education, employment, housing and health initiatives" (French, J. November 14, 2008:A: 6). These are the social determinants of health repeated over and over again in the provincial reports I examined. *The Globe and Mail* published an article by J. Lehmann (February 14, 2009) entitled "The Money Pit," which discusses the Downtown Eastside in Vancouver. This article states, "It has been nearly a decade since three levels of government signed a landmark agreement to transform Vancouver's notorious Downtown Eastside, but the neighbourhood remains a vortex that sucks junkies, the mentally ill and other desperate souls from across the country." Further in this article NDP MP Jenny Kwan is quoted," I can honestly say, politics aside, I have never seen such desperation on the streets, I walk down there in the early hours, I go down to the community and I am literally stepping over bodies." The author of this article states that "More than $1.4 billion" has been spent on this area alone" (Lehmann, J. February 14, 2009:F: 7). The author asks where did all of this money go and finds that no one seemed to be keeping track. Donald MacPherson, Vancouver's drug policy coordinator, recalls the tragic rash of overdose deaths in the 1990s. "Around 200 people died in 1993, and another 200 in 1998," he said "People were also dying of HIV at an incredible rate. There was a sense of despair on the street" (Lehmann, J., February 14, 2009:F: 7). Lehmann goes on to say "At least $300-million has been spent since 2000 by the health authorities in the Downtown Eastside. More than half of the funds have gone to services and housing supports for addicts and the mentally ill (Lehmann, J. February 14, and 2009:F: 7). I have just looked at two examples, one in

Saskatoon where poverty is a serious problem and so far it would appear no new money has been spent on the issues identified and then Vancouver, where a large amount of money has been spent, with very little progress. It was pointed out by Lehmann that there appeared to be no accountability in place between the three levels of government in British Columbia. In my thesis analysis, the Saskatchewan example clearly indicates that the social determinants of health have not been addressed, which indicates that no significant difference is being made. The example of this article from British Columbia indicates that while money has been spent, problems still exist and without any accountability for the money spent, the people at risk remain at risk.

When I reflect on my past experiences over the past forty years as a nurse and criminologist, there were many programs in place to address adolescent needs in a psychiatric setting both inside and out of the hospital setting. As well, there were educational and addictions programs offered to adult and young offenders in the prison settings that I worked in. Today there appears to be a lack of infrastructures to deal with these same issues and no money available to fund them.

In light of this experience, I would like to make some recommendations from studying these government documents. First, the people at risk need to be brought to the discussion table. The governments and people involved in addressing the crystal meth problem needs to know first-handed what needs to be done. Future research needs to include the people at risk to be able to tell these different experts what their needs are. Secondly, a more extensive

undertaking of obtaining accurate statistics about the people defined as at risk is required. If new programs are developed, they need to be evaluated on an ongoing basis. More qualitative research is also required to discover the reality of individuals who do not live in the mainstream. We need to hear their stories. If a holistic approach continues, which I would recommend, then these statistics need to be seamless. Everyone needs to know who is at risk. This would include authorities from health, education, social services, the legal system and anyone else who deals with issues surrounding crystal meth. Thirdly, education on crystal meth and other addictive substances needs to continue on many levels, such as with children, young adults, adults, parents, in the school system, health system, law enforcement, EMS, work environments, rural and urban communities, and for children and street youth who don't attend school. Not everyone has access to computers. This is assumed in some of the documents I examined. I suggest that the departments of health and/or education hire teaching teams to go to the different communities to educate citizens on crystal meth, especially those communities identified as being at greatest risk. Fourthly, throughout all of these provinces, a consistent medical protocol needs to be established and this should be a priority. Detoxification for individuals on crystal meth should be increased from twenty-eight days and should be a flexible time period geared to the individual involved. There should be more facilities for youth. Aftercare should be examined more closely, so recovery continues and these individuals do not end up back in the vicious cycle of abuse. Treatment should be seamless from detoxification to aftercare and recovery. Fifthly, these

provinces need to develop social policy around the social determinants of health or 'population health' as the documents call it. Interestingly, these are the same determinants that Lemstra and Neudorf (2009) refer to in their new study on poverty in Saskatoon, (November 2009). They chose what they felt were the ones the public would support, suggesting the need to:

> Develop a multi-year plan with measurable targets to reduce child poverty, double the shelter, food, clothing allowances for parents on social assistance to raise them above the poverty line…remove social assistance claw backs when recipients earn some money, to help ease the transition to employment…more support for community schools…universally funded child care for low income parents…redirect funding from administration-heavy programs to effective ones, like better skills training and free college tuition for some…expand affordable housing (French, J., and November 14, 2008: A; 6).

The last recommendation I would like to make is that if these provincial governments choose to address these problems in a way that is realistic for crystal meth users, they need to be held accountable for their spending.

While we do not hear as much about crystal meth through the governments and the media, it remains a serious problem. I would like to think that work is still being done to attempt to help the people at risk and hopefully what I have gleaned from these documents can help future studies in this area, which will provide more than just 'words'.

This thesis highlighted the problem of crystal meth in British Columbia, Alberta and Saskatchewan. One of the limitations of this study was that Manitoba was not included in this study. This was done for pragmatic reasons. However, the inclusion of Manitoba in a future study is very important for a

complete understanding of the crystal meth problem in Western Canada, especially when we consider the demographic similarities between Manitoba and Saskatchewan. Moreover, future research needs to include Central Northern, and Atlantic Canada. In addition, comparative studies need to be conducted to look at the crystal meth problem on a broader scale, comparing and contrasting data from the United states and from an international perspective.

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APPENDIX 1: LIST OF PROVINCIAL DOCUMENTS

British Columbia:

i. Methamphetamine Environmental Scan: Final Report (CCENDU and ADIC, January 2003)
ii. Every Door is the Right Door: A British Columbia Planning Framework To Address Problematic Substance Use and Addiction (BCMHS, May 2004)
iii. Crystal Meth and Other Amphetamines: An Integrated BC Strategy (BCMHS, August 2004)
iv. Crystal Meth and Other Amphetamines: An Integrated BC Strategy: Six Month Progress Report (BCMHS, April 2005)
v. Methamphetamine (Vancouver Coastal Health Authority, April 2005)

Alberta:

i. A Community Stakeholder View of Crystal Meth in Edmonton: Trends, Strategies, Challenges and Needs (Goldblatt, February 2004)
ii. Stronger Together: Coordinated Alberta Response to Methamphetamine (AADAC, April 2006)
iii. Methamphetamine: What we know about it, What we're doing about it (AADAC, June 2006)
iv. Premier's Task Force on Crystal Meth: Fighting Back (Government of Alberta, September 2006)

Saskatchewan:

i. A Strategic Plan for Crystal Meth and Other Amphetamines in Saskatchewan (Saskatchewan Health, February 2005)
ii. Healthy Choices in a Healthy Community (Addley, June 2005)
iii. Premier's Project Hope (Saskatchewan Health, August 2005)
iv. Project Hope: One Year Update (Saskatchewan Health, August 2006)

APPENDIX II: ACRONYM LIST OF TERMS AND GOVERNMENT AGENCIES AND SERVICES

Terms

ASIST AADAC System For Information and Services Tracking

CBC Canadian Broadcasting Corporation

CCF Cooperative Commonwealth Federation

CEO Chief executive Officer

LGBT Lesbian, gay, bisexual, transgender

MA Methamphetamine

MARC Methamphetamine Response Committee

MLA Member of Legislative Assembly

NDP New Democratic Party

RCMP Royal Canadian Mounted Police

SP Saskatchewan Party

TAYES The Alberta Youth Experience Survey

Government Agencies and Services

AADAC Alberta Addictions and Drug Abuse Centre

ADIC Addictive Drug Information Council

BCMHS British Columbia Ministry of Health Services

CAS Canadian Addictions Survey

CCSA Canadian Centre of Substance Abuse

CCENDU Canadian Community Epidemiology Network on Drug Use

YDDSA Youth Drug Detoxification and Stabilization Act

List of Illicit Drugs

1911 Opiates and Cocaine

1923 Cannabis

1969 Methamphetamine and amphetamine control drugs

APPENDIX III: TIMELINE FOR DRUG ACTS IN CANADA

1908	OPIUM ACT
1911	OPIUM AND DRUG ACT (REPLACED WITH)
1920	OPIUM AND NARCOTIC DRUG ACT (RENAMED)
1929	OPIUM AND NARCOTIC DRUG ACT
1969	NARCOTIC AND CONTROL ACT (RENAMED)
1997	CONTROLLED DRUGS AND SUBSTANCE ACT

2004 (OCT)	SAFER COMMUNITIES ANDNEIGHBORHOODS ACT [SK]
2006 (APRIL)	YOUTH DRUG DETOXIFICATION AND STABILIZATION ACT [SK]
2006(JULY)	THE PROTECTION OF CHILDREN ABUSING DRUGS ACT [AB]
2006 (NOV)	THE DRUG-ENDANGERED CHILDREN ACT [AB]

APPRENDIX IV: TABLE OF FINDINGS

	BC	AB	SK
Who Are The Voices?	Experts	Experts	Experts
Who Is Identified As Being At Risk?	Street Youth, Mentally Ill, Aboriginal People, Rural And Remote, LGBT	Street Youth, Gay Males, Young Adults in the Party Scene	Aboriginal Youth, Marginal Population like BC
How constructed? 2003-2006	Health, Education	Criminal, Education	Health, Treatment Problem, Education, Regulation
Political Party?	Liberal	Conservative	NDP, 2002-2006, Now SP
Acts		The Drug Endangered Children Act (2006, March). The Protection of Children Abusing Drugs Act (2006, July).	Safer Communities and Neighbourhoods Act (2004, October). SK Youth Drug Detoxification and Stabilization Act (2006, April).
Resources	Meth Watch Coalition Crystal Clear Peer Support	Toll-Free 24-hour help line Comprehensive School Strategy Protocol for First Responders	Meth Watch Program, 12 Bed Stabilization Unit Saskatoon, 5 Bed Stabilization Unit Regina, 15 Bed Inpt Residential PA, Ranch Ehrlo Society Regina
Economics			23 Million between August 2005 and October 2006