CRITICAL MASS: THE WHO, HOW AND WHY OF INFORMING THE PUBLIC ABOUT CRYSTAL METHAMPHETAMINE IN PRINCE GEORGE

By

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BSW, University of Northern British Columbia, 2005

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF SCIENCE
IN
COMMUNITY HEALTH SCIENCE

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

November 2009

ABSTRACT

In 2000, crystal methamphetamine made an appearance in the Prince George hospital detox unit and drug busts; however, the first public warning via a provincially sponsored information forum did not occur until early 2006. This retrospective case study uses documentary evidence and interviews, to examine the who, how, and why of the information about crystal methamphetamine that is provided to the public in Prince George. A timeline of media accounts reveals an increase in language designed to stimulate public concern about crystal methamphetamine and increase public trust for the provincial government. Horizontal disconnection between community agencies in terms of role recognition (internal recognition of an agency mandate) and role perception (external perception of agency mandate) seems to increase difficulties in strategic planning and formulation of a shared vision for the community.

ACKNOWLEDGEMENTS

First and foremost, I wish to thank my children, Josh, Jeremy and Ange, without their support, strength and hugs this Masters would not have happened.

I would like to express my gratitude to my supervisor (Dr. Henry Harder) and my committee (Dr. Prkachin, Dr. Owen-Wilson and Dr. Schmidt) for their patience in guiding me through this learning process.

There is not enough room on the page to include my community of family, friends and supporters that were with me throughout this journey. My peers (Aaron, Anders, Brooke, Brian and Anke) as well as Dr Laurie Chan were invaluable both in support and insight. I would like to thank co-workers, staff and friends at UNBC for their help and support especially Eric Bayrd and Kathleen Olson. Of special mention is Bob Thomas who took the time to read every version of this tome from its inception, even the ones that did not make it to the supervisory committee. I would also like to acknowledge all my friends around the world through the wonders of Facebook.

Thank you for your support.

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FOREWORD

My introduction to crystal methamphetamine was a conversation with a friend about two young women. A young woman had been stealing from her parents in order to purchase crystal meth. It sounded like typical addiction behaviour until I heard the age of the young woman selling the drug. To this day, I cannot remember which role either young woman played but I do know one was addicted and one was dealing; one was 12 and the other 13. I remember feeling ill. In my mind, these were babies no different from my own sons and their friends. Parents were involved in the lives of both young women. The homes, while not flashy, provided beyond the daily necessities. Despite this, the girls still succumbed to the pull of crystal methamphetamine.

I was thinking about methamphetamine in this particular light when it became the topic of our group project in a social work research methods course. I realized the complexity of this drug. The cost to the communities, in terms of personal loss, potential, and resources appeared staggering. A wide network of peers, friends, and family that were aware of my, at times, all consuming interest in methamphetamine, helped to increase my knowledge of crystal methamphetamine and its effects. As my awareness grew, the effects of methamphetamine came increasingly closer to my own home. My sons had friends who were leaving Prince George to escape their addiction to methamphetamine. Others we watched helplessly as they lost ground daily. I know of adults now living with mental illness due to meth and watched young adults attempting to have functioning relationships while in the cycle of addiction and violence that meth inserted in their lives. Crystal methamphetamine affected my life and that of my sons without any of us actually touching it.

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GLOSSARY

community	A term to refer to belonging to a particular group through a common characteristic such as geographical area, service mandate, professional affiliation, providing or receiving specific services related to crystal methamphetamine use.
Community	With a capital C, this term refers to Prince George, British Columbia.
Crystal methamphetamine	A derivative of amphetamine that is used in a crystalline form. It is a central nervous system stimulant used illicitly as a recreational drug.
Methamphetamine	A derivative of amphetamine that is a central nervous system stimulant in the medical treatment such as obesity and illicitly as a recreational drug. This drug may be in powder, tablet, or capsule form as well as crystalline.
Ecstasy	A stimulant drug that is related in chemical composition to mescaline and amphetamine, and is used illicitly for its euphoric and hallucinogenic effects.
Methamphetamine lab	An area in which methamphetamine is made through a process of chemical reactions. A small operation usually only able to produce meth in crystalline or powder form.
Super lab	An area in which methamphetamine is made which has the resources to produce methamphetamine in pill and capsule as well as crystalline and powder forms.
Grow op (operation)	An area used to grow marijuana.
Minimum barrier services	Services that have few, if any restrictions, on providing health, shelter, addictions, or other necessities and services to marginalized populations. Often the only restriction on service provision is no drug or alcohol use on the property as well as no disrespectful or violent language or behaviour.

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INTRODUCTION

The premise of this research was that a single event involving crystal methamphetamine in Prince George made it necessary to inform the Community about crystal methamphetamine. While neither the documents regarding crystal methamphetamine incidents, nor the research participants of this study identified a single propelling incident, a definite catalyst appeared to emerge. Upon establishing a timeline of the information available, it seemed that the agenda of informing the Prince George public about crystal methamphetamine did not lie within the Community but with the Provincial Government.

The British Columbia provincial government sponsored the first Prince George crystal methamphetamine public information forum on February 2, 2006. The local MLAs and the BC Solicitor General who presented the forum focused on local responses and strategies for addressing the threat of crystal methamphetamine use (Ministry of Public Safety and Solicitor General, 2006). The province asserted that crystal methamphetamine is, "a serious and growing problem in British Columbia" (British Columbia Ministry of Health Services, 2004, p. 3). However, the Prince George Regional Hospital (PGRH) detoxification unit and the Royal Canadian Mounted Police (RCMP) identified crystal methamphetamine as a problem for the Community in 2000, six years before the public information forum.

Structure of Thesis

This retrospective case study examined media accounts and documents that were available to the Prince George public regarding crystal methamphetamine from January 12, 2000 to December 31, 2007. Interview participants range from executive administrators to frontline service providers; all participants frequently provided information to the public or specific populations within Prince George about crystal methamphetamine. Former crystal

methamphetamine users also participated in order to discern the "who, how and why" of informing the public about crystal methamphetamine in Prince George.

The purpose of this research was to:

1. Establish a timeline of public information about crystal methamphetamine in Prince George,
2. Determine if there was a comprehensive effort by Community agencies to inform the public in Prince George about crystal methamphetamine and its effects, and
3. Examine the agendas of the agencies involved regarding informing the public in Prince George about crystal methamphetamine and its effects.

Through these objectives, the "who, how, and why of informing the public" were explored, thereby enabling each facet of the research question to develop its own complexity and depth.

Chapter One provides an overview of the research objectives and theory regarding the provision of information to the public about crystal methamphetamine. The second chapter of this thesis examines relevant literature. Chapter Three presents the methods for the research and analysis. Chapter Four discusses the results, making reference to the relevant theories which are used to inform the public about crystal methamphetamine. Chapter five summarizes conclusions and recommendations.

Historical background

There was little interest to increase public awareness of crystal methamphetamine in Prince George in 2000. From 2000 until 2004, there were few media accounts of crystal methamphetamine (other than in connection with arrests in which crystal methamphetamine was present). In a letter to the editor of the Prince George Citizen in 2000 (Hessedenz, 2004)

stated that up to 40% of youth in a local high school were said to be using crystal methamphetamine. However, the first public forum on crystal methamphetamine in Prince George public was sponsored not by local service agencies but by the Provincial government.

There were two agencies who directed the information to the public about crystal methamphetamine in Prince George during this timeframe: the RCMP and the Northern Health Authority. Both the police force and the health authorities market prominent messages regarding the effects and consequences of crystal methamphetamine use to youth throughout Prince George. In fact, the RCMP actively campaigned against crystal methamphetamine, supporting initiatives at the federal (Peebles, 2005a), provincial (Peebles, 2004a), and municipal levels (the DARE program). In addition to the RCMP campaigns, the Northern Health Youth Drug and Alcohol Prevention program, and Street Spirits ("Street Spirits Theatre Company: Changing the world one performance at a time", 2008) promoted awareness of crystal methamphetamine's impact on health.

However, drug dealers were also active in informing the public about crystal methamphetamine. Often, drug dealers used marketing strategies that, at times, seemed to mimic campaigns by tobacco companies, such as negating possible health risks (Lovell, 2002). Frontline drug dealers worked through open markets (such as schools) and often determined the market by price or availability of illicit drugs (Kerr, Small, & Wood, 2005). Initiating new crystal methamphetamine users was relatively easy, either through friends (Harrison, Erickson, Korf, Brochu, & Benschop, 2007) or market manipulation (MacDonald, Zhou, & Breen, 2002). Research participants discussed marketing strategies in Prince George that were similar to those found in the literature.

In 2005, media accounts and other public documents began to increase the use of words such as "epidemic", "evil", and "devastating" to describe crystal methamphetamine (Jan, 2005; Peebles, 2005d). These words connoted a threat that must be prevented. Ultimately, these words raised crystal methamphetamine from the status of a non problem, or problem with no definitive beginning or end, to a symbolic crisis which compelled the public to act immediately to address the threat of crystal methamphetamine (Neuman, 1990).

During this timeframe, the provincial government needed to divert attention and increase public trust after unendorsed cuts to education, healthcare, and the sale of BC Rail. The Provincial government responded to the increasing panic about methamphetamine with resources in the form of one-time seed grants offered to each community in British Columbia. Goode and Ben-Yehuda (1994), in their theory of the social construction of a moral panic, described an elite model in which a panic was "fabricated over a nonexistent or trivial threat … in order to… divert attention from issues, that if addressed, would threaten their own private interests" (p. 160). Prince George, a riding with three provincial Members of the Legislative Assembly which included the deputy premier, not only received two seed grants, but was also chosen to host one of the Solicitor General's Methamphetamine forums.

LITERATURE REVIEW

Crystal Methamphetamine

Although crystal methamphetamine was generally regarded as a specific form of methamphetamine, the literature surrounding this compound was often unclear as to which specific form of methamphetamine was being discussed (Martin, Lampinen, & McGhee, 2006). In both academic and non-academic literature, methamphetamine was referred to as meth, crystal meth, methamphetamine, and crystal methamphetamine. Of the almost two hundred documents, books, and articles used in this paper, only ten contained the terms crystal methamphetamine or crystal meth. In addition, some publications referred to methamphetamine as a substance within the category amphetamine type stimulant (ATS) (Klee, 1992, 2001; World Health Organization, 2001). The remainder referred solely to methamphetamine. Therefore, throughout this paper, crystal methamphetamine is referred to as methamphetamine unless a specific name was used as a quote or reference title.

Methamphetamine Use: Past and Present

Amphetamine was first produced in the late 1800s in Japan (Lineberry & Bostwick, 2006). In 1932, amphetamine was promoted as a nasal spray to treat asthma, and by 1937, amphetamines were used in the treatment of narcolepsy and hyperactivity (Nordeste, 2004). Methamphetamine, a derivative of amphetamine that was a commonly used to treat depression and obesity in the 1950s and 1960s and reached a peak of 31 million prescriptions in the United States in 1967 (Anglin, Burke, Perrochet, Stamper, & Wud-Noursi, 2000). Soldiers from Germany, England, United States, and Japan used methamphetamine during

World War II to increase energy, alertness, and aggression (Anglin et al., 2000; Nordeste, 2004).

After WWII, stockpiles of amphetamine and methamphetamine that were "left over from licit production during the war period" (Nordeste, 2004, p.3) were available through both licit and illicit markets in Japan, the United States, and Sweden (Nordeste, 2004, p. 3). In February 2000, the United Nations General Assembly stated that the expanded use of amphetamine type stimulants (ATS), which included methamphetamine, had severe negative consequences for both individuals and the "national security and sovereignty of States" (Klee, 2001, p. 23). The World Health Organization considered world wide consumption of ATS to be greater than the number of people who consumed cocaine and opiates combined (World Health Organization, 2001, p. 7). However, Klee (2001) pointed out that reliable data on ATS use was rare, as most countries such as Sweden and Japan focused on "seizures, arrests and clinical studies of restricted samples" (Klee, 2001, p. 24). The most active research on ATSs came out of the US, Australia, and the United Kingdom (Klee, 2001).

Recently, the United States National Survey on Drug Use and Health, and the Monitoring the Future survey suggested that a decline in methamphetamine use among youth had occurred (NIDA, 2006). Yet the U.S. public health surveillance system, Drug Abuse Warning Network (DAWN), presented statistics which showed a 50 percent increase in emergency department visits related to methamphetamine use between 1995 and 2002.This number reached four percent of all drug-related visits in 2004 (NIDA, 2006). In addition, an increasing number of states in the US reported a rise in methamphetamine treatment admissions, as high as eight percent of all substance use treatment admissions by 2004

(NIDA, 2006). Clearly, these statistics appeared to present conflicting accounts of methamphetamine use in the United States.

To date, methamphetamine research in British Columbia has focused almost exclusively on street involved or marginalized youth in large urban centers (Collins et al., 2005; Lampinen, McGhee, & Martin, 2006; Miller, Strathdee, Kerr, Li, & Wood, 2006; Wood, Stoltz, Montaner, & Kerr, 2006). In Vancouver, from May 1996 to December 2004, while rates of methamphetamine use among injection drug users increased, the age of methamphetamine users decreased (Fairbairn et al., 2007). However, Nordeste (2004) asserted that methamphetamine trends in Canada were stable or decreasing.

While most people have not experienced injection drug use, current social trends which demand high achievement and performance (Nordeste, 2004) often receive comment. The effects of methamphetamine were perceived as beneficial by some mainstream populations such as workers on graveyard shifts (Nordeste, 2004; Rawson, Anglin, & Ling, 2002), students with heavy course loads (Lampinen et al., 2006; Quintela et al., 2000), and single mothers with multiple roles (British Columbia Ministry of Health Services, 2004; Covey, 2006).Young women often perceive methamphetamine use to be beneficial as an aid for weight loss (Covey, 2006; Jenkins, 1994; Jobe-Armstrong, 2005). For example, an Ontario Student Drug Survey reported that females had higher stimulant use and overall higher methamphetamine use than males in grades 10 to 12 (Adlaf & Ivis, 1998).

As recently as 1991, the US army used amphetamines to enhance wakefulness and attention in pilots who participated in late night manoeuvres (Emonson & Vanderbeek, 1995). Other studies detected methamphetamine use among active-duty US military personnel in 1996 (Kunsman et al., 1996) and from 2000 to 2005 (Lacy et al., 2008).

However, Lacy et al. (2008) suggested that methamphetamine use in the military was related to the regional drug scene. Some military drug policies seemed to discourage methamphetamine use among personnel, even in regions where civilian use was high. "These [psychostimulants] [fuelled] labor, [facilitated] longer hours of work, [enhanced] overall work intensity and focus, and [created] a kind of frenetic industriousness, embodying, therein, key American values" (Singer et al., 2006, p. 205). Some blue collar workers used methamphetamine to increase alertness and wakefulness, and to decrease the monotony of some job routines. Similarly, some truck drivers also perceived methamphetamine as beneficial when driving long distances (Jenkins, 1994; Klee, 2001; Nordeste, 2004; Rawson, Anglin, & Ling, 2002; R. Rawson, Gonzales, & Brethen, 2002).

In interviews with twenty five HIV positive men who had sex with men, Semple, Patterson, and Grant (2002) investigated the men's motivations for methamphetamine use. Most participants stated that friends introduced them to the drug, and the most commonly given reason for methamphetamine use was to enhance sexual pleasure (88%), followed closely by the desire to get high (84%). Participants stated that they were more likely to participate in unprotected anal sex while using methamphetamine, as well as seek out high risk partners or have sex with men they would not otherwise choose for a sex partner. Methamphetamine seemed to enable users to have longer lasting sex and multiple orgasms. In addition, participants who found anal sex painful used methamphetamine to relax and increase the pleasure of anal sex. In a study of 49 excerpts from a previous study on gay and bisexual men, similar motivations for methamphetamine use was shown, including increased sex drive with greater endurance, decreased sexual inhibition, and a higher pain tolerance (Green & Halkitis, 2006). Baskin-Sommers and Sommers (2006) recorded similar results in a

survey of 243 university students in Los Angeles, California. The students, 18 to 24, reported increased sexual risk taking (sex without condom use and sex with multiple partners) while using methamphetamine. Students also reported an increase in relationship violence with methamphetamine use. Studies of the effects of methamphetamine use in communities, especially regarding possible consequences such as HIV and other sexually transmitted infections through high risk sexual activity, (Gibson, Leamon, & Flynn, 2002; Semaan, Des Jarlais, & Malow, 2006; Semple, Grant, & Patterson, 2005) are increasingly prominent.

Methamphetamine Effects

Until the 1970s, the main sources of methamphetamine were black market products diverted (through theft or subterfuge) from pharmaceutical companies (Burton, 1991). While pharmaceutical methamphetamine was a legal, standardized medication, methamphetamine produced in home labs lacked oversight by the regulating bodies which ensure the safety of the community for users and non-users, and monitor the quality of the product. Methamphetamine produced in home labs, or large illicit manufacturing operations (super labs), was considered five times more potent than the legally made products of the 1970s (Rawson, Anglin, & Ling, 2002). Methamphetamine has also been produced in home laboratories from recipes available on the internet (Rawson, Anglin, & Ling, 2002; Strang, 2007).

As well as being cheaper and more accessible than other illicit drugs (Covey, 2006; Lineberry & Bostwick, 2006), methamphetamine has proven to be diverse in its consumption: it can be smoked, snorted, ingested, injected, and inserted vaginally or anally (Covey, 2006; Lineberry & Bostwick, 2006). Common characteristics of methamphetamine use, such as appetite suppression and sleep deprivation, with chronic use can lead to

cognitive and/or mood disorders such as anxiety, depression, and fatigue which, in turn, lead to poor coping abilities (Covey, 2006; Singer et al., 2006) and violence (Covey, 2006; Sekine et al., 2006; Singer et al., 2006). Long term effects of methamphetamine use include stroke, irregular heart beat, abdominal pain, trembling, anxiety, insomnia, (Anglin et al., 2000; Covey, 2006; NIDA, 2006) as well as structural changes to the brain (Volkow et al., 2001). Prolonged psychiatric symptoms seem to be caused by dopamine deficits from methamphetamine use (Chang, Alicata, Ernst, & Volkow, 2007; Sekine et al., 2001; Wang et al., 2004) and appear to correlate with the extent of methamphetamine use (Sekine et al., 2001). Some people who use methamphetamine exhibit methamphetamine-induced psychosis, amotivation, anhedonia (Wang et al., 2004), delusions, hallucinations (Srisurapanont et al., 2003), and incoherent speech (Ali et al., 2007; Callaghan, Brands, Taylor, & Lentz, 2007; Degenhardt, Roxburgh, & McKetin, 2007).

Following a study of 15 chronic methamphetamine users, Sekine et al. (2001) suggested that methamphetamine may contribute to prolonged psychosis. Marshall, Belcher, Feinstein, and O'Dell (2007) stated that there were long lasting deficits for object recognition memory in rats exposed to methamphetamine. Volkow et al. (2001) advocated for more research to determine if methamphetamine use increased "vulnerability to Parkinson's disease or other neurodegenerative diseases" (p. 381). In their study of brain images of chronic methamphetamine users, Baicy and London (2007) found cortical deficits in abstinent methamphetamine users that affected functions related to maintaining drug abstinence. The chemical changes in the brain were accompanied by impaired inhibitory control or the ability to monitor drug use behaviour. Ultimately, these findings suggest that

the changes to the brain from chronic methamphetamine use play a role in craving and relapse among people who cease to use methamphetamine.

Social impacts of methamphetamine use seem similar to other substance dependencies. Effects such as a decreased ability to parent effectively (Altshuler, 2005; Brecht, Anglin, & Dylan, 2005), relationship violence (Baskin-Sommers & Sommers, 2006; Morgan & Joe, 1996), and polydrug use (Austin, 2004; Reid, Elifson, & Sterk, 2007) have been documented. Although Baskin-Sommers and Sommers (2006) reported increased partner violence with methamphetamine use among university students, age 18 to 24, methamphetamine use did not play a significant role in carrying weapons such as a guns or knives, or as an instigating factor when fighting with strangers.

A major difference between methamphetamine and other drugs was found in the area of treatment, specifically regarding the length of time for inpatient treatment (Brecht & von Mayrhauser, 2002; Cretzmeyer, Sarrazin, Huber, Block, & Hall, 2003; Frawley & Smith, 1992; Hunt, Kuck, & Truitt, 2006; Obert et al., 2000; Rawson, Gonzales & Brethen, 2002; R Rawson et al., 2000; Strang, 2007). Standard treatment programs in the United States and Canada are based on the Minnesota Model, twenty eight days of inpatient rehabilitation followed by extended outpatient therapy and/or participation in 12-step groups such as Alcoholics Anonymous (Rawson, 1999). According to several studies, people who were addicted to methamphetamine seemed to require more than the 28 days allotted for inpatient rehabilitation (Brecht & von Mayrhauser, 2002; Cretzmeyer, Sarrazin, Huber, Block, & Hall, 2003; Frawley & Smith, 1992; Hunt, Kuck, & Truitt, 2006; Obert et al., 2000; R Rawson et al., 2000; Strang, 2007).

Cretzmeyer et al. (2003) argued that different treatment for methamphetamine addiction was unnecessary however, the alternative treatment models examined in this study provided at least 16 weeks of intervention. The lifestyle of a person who was addicted to methamphetamine often possesses elements of disorganization such as irregular sleeping patterns, inadequate nutrition, excessive sexual activity, and a social network of other methamphetamine users (Covey, 2006; R Rawson, 1999; R Rawson, Washton, Domier, & Reiber, 2002; Whitten, 2006) which may require longer periods to stabilize. While the standard 28 day treatment program appeared to be effective for some people recovering from methamphetamine use, others required a longer in-patient period to allow for lifestyle stabilization (Covey, 2006; Whitten, 2006). The literature is inconclusive on this aspect of methamphetamine use.

Making and Marketing Methamphetamine

Due to easy accessibility of chemical components and recipes for methamphetamine on the internet, a lab can be located locally, rather than solely in other countries or larger centres, which creates complex consequences for the community (Hall & Broderick, 1991). For example, a methamphetamine lab creates six pounds of toxic waste per pound of methamphetamine produced (Berguss, 1997; Blackwell & Colmenar, 2000; Lake & Huard, 2001). The resulting toxic waste is often flushed into the sewers or thrown on the ground, thereby contaminating the surrounding environment (Lineberry & Bostwick, 2006). A home which has been used as a methamphetamine lab is filled with airborne contaminants from the chemicals used to make methamphetamine (Martyny, Erb, Arbuckle, & VanDyke, 2005; Martyny, VanDyke, McCammon, Erb, & Arbuckle, 2005). Studies have illustrated that children, youth, and adults who live in a home where a lab is present, exhibit similar physical

and psychological effects as people who directly use methamphetamine (Ferguson, 2000; Lineberry & Bostwick, 2006; Sommers, Baskin, & Baskin-Sommers, 2006). At present, there is no information on the length of exposure time in a home methamphetamine lab necessary to produce these phenomena. However "detectable airborne concentrations of hydrochloric acid, iodine, and methamphetamine will remain within a structure for at least 24 hours" (Martyny, Erb, Arbuckle, & VanDyke, 2005, p. 15). Several months after a lab is dismantled there is evidence that methamphetamine contamination levels are still high on surfaces within the cook site (Covey, 2006; Martyny, VanDyke, McCammon, Erb, & Arbuckle, 2005).

Trained hazardous materials teams are required to safely dispose of any chemicals and waste, and to decontaminate people that lived or worked in a methamphetamine lab (Covey, 2006). First responders to labs such as police, fire fighters, ambulance attendants, social workers, and hospital personnel are at high risk for methamphetamine contamination from their exposure to toxic air borne chemicals (Martyny, Erb, Arbuckle, & VanDyke, 2005; Martyny, VanDyke, McCammon, Erb, & Arbuckle, 2005; McFadden, Kub, & Fitzgerald, 2006; Strang, 2007). A US study found that some first responders to methamphetamine-associated events required treatment for respiratory and eye irritation; most, however, did not require hospitalization (Centers for Disease Control and Prevention, 2000). In one case, three hospital employees experienced nausea and vomiting while treating a person involved in a methamphetamine lab explosion (Centers for Disease Control and Prevention, 2000).

Dealers in methamphetamine employ marketing techniques which are similar to mainstream business. Legitimate marketing strategies, such as giving free samples, are mimicked by people dealing methamphetamine (Harrison, Erickson, Korf, Brochu, &

Benschop, 2007). However, the dealer might not state whether the sample was methamphetamine. Some super labs (laboratories with the resources and equipment to manufacture meth in tablet and pill form) combine meth with other illicit substances in their manufacturing process (Nordeste, 2004; Strang, 2007) thereby increasing the opportunity to introduce drug users to methamphetamine and its effects. At rave dances in Vancouver and Montreal between October 2002 and April 2004, the RCMP seized and tested pills that were sold as Ecstasy. Analysis of the multiple samples revealed that only a small percentage of the illicit drugs contained pure Ecstasy. The remainder of the pills that were sold as Ecstasy, contained a variety of illicit drugs of which methamphetamine was the most common (Nordeste, 2004).

Changing the chemical compositions of illicit drugs in order to increase consumer exposure to methamphetamine (thereby increasing the consumer market via addiction) is a strategy reminiscent of those used by big tobacco companies (Lovell, 2002; Mitchell, 2006; Wigand, 1998). Big tobacco companies targeted children and youth (Ling & Glantz, 2002) through marketing strategies such as chew tobacco with cherry candy flavouring that was available in the United States, Canada, and the United Kingdom (Lovell, 2002). The taste of the flavouring was strong enough to last two or three minutes, allowing the child to adjust to the bitterness of tobacco (p. 38). Some communities in the US have reported strawberry flavoured methamphetamine, methamphetamine combined with powdered drink mix (Gambrell, 2007). Some police officers believed flavouring lessened the chemical taste of and possibly calmed fears of first time methamphetamine users (Gambrell, 2007).

Defining Community and Its Responses to Methamphetamine

The health of a community relies heavily on each member experiencing a sense of belonging to a given community. Studies have shown that social connection is necessary to the health and quality of an individual's life, while the absence of community is related to an increase of risk-taking behaviours (Israel, Checkoway, Schulz, & Zimmerman, 1994; McKnight, 1994; Saxe, Reber, Hallfors, Kadushin, & Jones, 1997; Schwartz, 2005; Semenza, March, & Bontempo, 2007; Storr, Arria, Workman, & Anthony, 2004). It is not surprising, then, that establishing community, both as a geographic area and as a service population, has a long history in Canada (Clark, 1962).

Academic literature contains numerous definitions of what a community is. Most people perceive community primarily as a geographical area, such as a neighbourhood or town (Caulkins, Larson, & Rich, 1993; Walter, 2006). However, community has horizontal and vertical frameworks that interact with other agencies or geographical areas. A horizontal framework refers to the interactions of people, groups, or organizations, while vertical frameworks refers to the relationship between the local community and those in the larger society and culture (Walter, 2006). The term community is further delineated through these frameworks by adding phrases such as 'the community to which we provide service,' or 'the community that was dealing with a specific issue' (Hummel, 1996; Walter, 2006). In her discussion of conceptual framework of community building practice, Walter (2006) discusses other influences used to define community, such as the agency mandate, the service provider's role, and the objectives of the funding bodies. The interactions among these various influences form a community consciousness, which is, essentially, a more fluid idea than the horizontal and vertical frameworks. The concept of consciousness defines

community as the "perceptions, cultural constructs, and frameworks through which interaction with one another and our environment are filtered and shared" (Walter, 2006, p. 70). Consciousness is visible in moral judgments of deservedness, political dominance, and personal biases. Oversimplifying the nature of community creates exclusionary definitions that were no longer functional for community building.

Once "community" is defined, the path of intervention for addressing substance use needs to be chosen. Since the beginning in Canada, communities have been addressing substance use issues at a local level (Caulkins, Larson, & Rich, 1993; Clark, 1962; Saxe, Reber, Hallfors, Kadushin, & Jones, 1997). In 1986, the Ottawa Charter for Health Promotion placed the communities' "ownership and control of their own endeavours" (Labonte, 2006, p. 82) at the centre of the health promotion strategy. Community development and community empowerment are two basic strategies for interventions in communities.

In a critical reflection on community and community development, Labonte (2006) describes community development as a combination of community organization and mobilization. Community development occurs when "both practitioner and agency are committed to broad changes in the structure of power relations in society through the support they give community groups" (p.82). Aguirre-Molina and Gorman (1996), in a review of community-based approaches for the prevention of substance use, stated that "community development should be the ultimate goal of prevention strategies because it enables individuals and communities to increase their control over the determinants of health by securing the tools (resources, skills, authority, etc) needed to change their environment" (p.341). Community development attempts to move the focus of substance use interventions

from the individual behaviour to environmental factors such as "social, political and economic systems" within a community (p.341). Aguirre-Molina and Gorman (1996) viewed community development as the initial step towards achieving personal and community empowerment, as well as the impetus for sustainable change.

While considering the relevance of empowerment to community interventions for women with HIV, Beeker, Guenther-Grey, and Raj (1998) defined community empowerment as "an intervention [that] [sought] to effect community-wide change in health-related behaviors by organizing communities to define their health problems, to identify the determinants of those problems, and to engage in effective individual and collective action to change those determinants" (p.833). The community empowerment paradigm posits that no behaviour is entirely under the sole, voluntary control of the individual person (Beeker, Guenther-Grey, & Raj, 1998). The community context, as well as concepts of consciousness, affects the manner in which behaviours are viewed. The empowerment principle is particularly apt in the study by Singer et al. (2006). Through drug monitoring and knowledge of methamphetamine trends, Singer et al, identified Hartford Connecticut as a possible site of increasing methamphetamine use. Researchers started to empower the community by creating awareness before methamphetamine use became problematic. Although the study is ongoing, methamphetamine use continued to increase in that community.

Engaging Community on Methamphetamine and Substance Use

Strategies for engaging community around substance abuse, specifically methamphetamine use, are complex and multi-levelled. Services and resources that are necessary for addressing methamphetamine use are often viewed as unrelated by service providers (Jobe-Armstrong, 2005). From a public health standpoint, there was a commitment

to respond to methamphetamine use from social and environmental perspectives in the community (Labonte, 2006). This method usually implies a top-down implementation of the public health model that has little resemblance to the community's contextual reality (Abelson, 2001; Libby, 2002; Nozick, 2007). The top down model refers to the imposition of solutions by decision makers (such as health administrators or policy makers) with little consideration for the individual context of communities. Many communities experience a top down method of inclusion through forums, focus groups, and interviews (Abelson, 2001; British Columbia Ministry of Health Services, 2004; Goldblatt, 2004; Parker & Gadbois, 2000; Waitzfelder, Engel, & Gilbert, 1998). However, this is often inclusionary in problem identification, not in solutions (British Columbia Ministry of Health Services, 2004; Green & Halkitis, 2006; Parker & Gadbois, 2000).

Fighting Back, a US case study of ten community programs with the mandate to "reduce the demand for alcohol and other drugs by developing a single unified system of prevention and treatment," (Lindholm, Ryan, Kadushin, Saxe, & Brodsky, 2004, p. 266) illustrated that the difference between national needs and community needs may be substantial. The funder's national mandate required demonstrable outcomes of decreasing substance abuse, while the *Fighting Back* campaign was built on establishing capacity for addressing substance use within the community (Hallfors, Cho, & Kadushin, 2001; Lindholm, Ryan, Kadushin, Saxe, & Brodsky, 2004). For example, street lights were not recognized as action to decrease substance use on a national level (Saxe et al., 2001), yet increasing perceptions of safety and empowerment encouraged the community to continue addressing difficult issues such as substance use (Bent, 2003; Caulkins, Larson, & Rich, 1993). The top down strategy of identifying key community leaders and organizations who

will deliver programs and initiatives meant little if the community was not actively engaged in creating and implementing a shared vision of substance use intervention (Nozick, 2007; Saxe, Reber, Hallfors, Kadushin, & Jones, 1997). As Chino and Debruyn (2006) point out, the top-down model of solution implementation is unlikely to create sustainable change within community.

Another difficulty with the top-down method of program implementation is the challenge of ensuring that information reaches its intended audience. For example, according to the British Columbia Ministry of Health (2004), methamphetamine use was decreasing among youth, yet education about methamphetamine continued to target youth in schools. Using retrospective drug use histories to examine drug use behaviour among young people in a large survey in Ontario, Dewit, Offord, and Wong (1997) reported that the high-risk period for youth drug initiation began around 12 years of age, with peak initiation for illicit drugs occurring between 15 -19 years. They further stated that high quit rates are seen within the first few years of use (DeWit, Offord, & Wong, 1997). In an editorial addressing the creation of programs for decreasing methamphetamine use, Ritter (2007) stated that "unfortunately the evidence does not support their effectiveness in preventing the uptake or reducing the use of illicit drugs" (p. 228). He further asserted that developing a strategic evidence-based approach "to reduce the production, distribution, use and harms associated with methamphetamine" was necessary (p. 227).

Creating a Methamphetamine Panic

For a community to develop a response to methamphetamine, there needs to be an awareness of a problem. Communities are often overwhelmed with social and health issues requiring recognition, funds, and action. Thus, in order for a community to be concerned

about methamphetamine, it must be perceived as a threat. The perception of a threat can be accomplished in a community by establishing concern and fear regarding methamphetamine, its use, and consequences within the community; in other words, constructing a panic (Jenkins, 1994).

Social panics generally follow similar patterns. With drugs, panics typically begin with policy makers and legislators demonstrating that a drug is "enjoying an explosive growth in popularity," or is so "extremely addictive" that "even occasional use can cause severe physical addiction," and is "encourage[ing] bizarre and violent behaviour" (Jenkins, 1994, p. 7). These claims are thus supported through visual representations of extreme examples of addiction, such as the faces of methamphetamine ("Faces of meth "; Jenkins, 1994). Words such as "epidemic" (conjuring visions of plagues and uncontrollable spread of disease) and "emerging crisis" (suggesting future consequences will be worse than current experience) further propel the panic (Jenkins, 1994, p. 15).

Social panics related to substance use were used by the Progressive Conservative party in Canada in an attempt to increase political popularity in 1984 (Jensen & Gerber, 1993). Jensen and Gerber (1993) outlined a four stage process of panic construction: incipiency, coalescence, creation and policy formation, and legitimation. This process was allegedly used during the 1984 federal election campaign to boost Progressive Conservative popularity. However, the evidence used to demonstrate an increase in drug use was often inconclusive. According to Jensen and Gerber (1993), at times "aggressive enforcement activities" (p. 457) were related more to the political climate than an actual increase in drug use or trafficking.

Goode and Ben-Yehuda (1994) discussed a moral panic as a condition, event, or group of people which had been declared by moral protectors, often media, religious leaders, "politicians and other right, thinking people" (p.155), to be a threat to society. By increasing the perception of a social threat, people who are presented as instigators of the threat are stereotyped and deviantized. Goode and Ben-Yehuda (1994) also identified three models for initiating a panic: elitist, grassroots, and interest groups. The grass roots model essentially states that an issue which has been dormant has managed to regain public attention. Once the issue has the public's interest, politicians, or media exacerbate the issue in such a way as to appeal to the public's concern of a moral threat. Elitist models create a panic over "a nonexistent or trivial threat…to gain something of value or divert attention from issues that, if addressed, would threaten their own private interests" (p. 160). Interest groups such as police, professional organizations, to a large degree, media, act independently from the elites to express their own ethics and morals. "Panics often entail populist sentiment which sees a threat as emanating from powerful, high-status strata. Their very power and status imparts an ominous, dreadful quality to their capacity to harm common, honest, hard-working folk"(Goode & Ben-Yehuda, 1994, p. 162). The public often disregarded evidence which states that the possibility of harm from the threat is minimal. Instead, the dread of an "involuntary, uncontrollable, unknowable, unfamiliar, catastrophic, certain to be fatal and delayed in their manifestation" event is embraced as reality (Goode & Ben-Yehuda, 1994, p. 163).

The role of the media in panic creation

Although media is "respond[ing] to real-world cues" (Neuman, 1990, p. 161) in the reporting of methamphetamine or other substance use, it is often blamed or credited with

instigating panics. The media does not invent events; however, it often influences public opinion through the presentation of the event or issue (Abelson, 2001; Neuman, 1990). Once an issue reaches the attention of the media, media then initiate awareness by saturating the public with comments on the issue (Neuman, 1990). A combination of interactions between the event, the public, the government, and the media is necessary to create the perception of a crisis for any sustained period. For governments, local agencies, and community groups, media (in its various forms) is the most common method of increasing methamphetamine awareness. Although there is little evidence to indicate that media campaigns are effective in preventing methamphetamine use (Ritter, 2007), it remains a popular strategy for informing and educating the public of the hazards associated with methamphetamine use (British Columbia Ministry of Health Services, 2004; Ritter, 2007; Waitzfelder, Engel, & Gilbert, 1998).

Neuman (1990) identifies four ways that media presents events to gain public attention: crisis, symbolic crisis, problems, and non-problems. A crisis simply means there is a beginning, middle, and end, during which time the media attempts to draw the public's attention to the event by examining it from many different angles (Neuman, 1990). Unlike substance use, which has no definitive end, wars fall under this category, as do court trials, and natural disasters. A symbolic crisis is unlikely to have resolution, yet through "a combination of events and the responses of the government, the public, and the media [led] to a public definition of the problem of crisis proposition for a limited period of time" (p. 169). To categorize methamphetamine as such would only work in the initial phase of awareness as substance use is an ongoing issue. Problems can experience periods of sudden change which are similar to crises (such as unemployment or inflation which are reported

with regularity without actually containing a storyline). There are repeated attempts to raise interest in problems through complex policy and economics theory but without a clear endpoint. The difficulty with methamphetamine, or any other substance abuse issue, is that it falls into the category of non-problem or a lasting social problem with little public interest (Neuman, 1990). Methamphetamine perhaps is a symbolic crisis; however, it rarely captures the public's attention for long, as there is no foreseeable resolution. Provincial strategies (British Columbia Ministry of Health Services, 2004), forums or funding announcements (Ministry of Public Safety and Solicitor General, 2006) which address methamphetamine use may hold public interest for a short time; however, they are not sustainable (Neuman, 1990).

Media Advocacy in Community Responses

Wallack (2006) suggested that the use of media for advocacy shifted the focus from individual behaviour to social and health policy. Effective media advocacy centered on the ability to articulate the goals for change (Stanton, 2004; Wallack, 2006). A community which was empowered with the ability to begin policy change had the potential for systematic transformation, which affected not only the individual but also environmental change such as methamphetamine precursor (chemical) legislation and sales (Aguirre-Molina & Gorman, 1996).

Vega and Roland (2005) and Cox and Cunningham (1998) demonstrated creative methods for working effectively with media that increased public awareness and involvement. Cox and Cunningham examined a media-led campaign which addressed substance use by increasing involvement and investment for community agencies. Community members paid a reduced price for advertising through sponsorship of drug and alcohol free events and the community coalition (Cox & Cunningham, 1998). These

initiatives increased attendance at events and investment in the community. Vega and Roland (2005) found that deferring costs and pooling resources, as well as presenting messages about HIV and condom use in a more positive and even humorous light, increased community involvement. Vega and Roland recommended that an evaluation component be included from the beginning of any initiative for two reasons: first, to provide evidence of change; and second, to establish a baseline of community knowledge regarding the issues before the campaign begins.

Assessing Community Need

Assessments of methamphetamine and other forms of substance abuse in a community commonly focus on what is lacking in the community (Kretzmann & McKnight, 2007). Drug dealing (and its accompanying environmental effects) is seen as demonstrating the visibility of need in a neighbourhood (Caulkins, Larson, & Rich, 1993; Goetz & Mitchell, 2003). Crime statistics (Caulkins, Larson, & Rich, 1993; Goetz & Mitchell, 2003), HIV/AIDS rates (Vega & Roland, 2005), and other indicators of methamphetamine addiction, such as child welfare reports (Covey, 2006) often provide assessments of the need for resources. Demonstrating need is necessary in order to acquire the funding needed to increase resources and opportunities for the community to address methamphetamine abuse (Saxe et al., 2001).

One challenge with assessments based on need (and the accompanying recommendations) is that the resources and time necessary to reach implementation and demonstrate effectiveness are often inadequate (Stimson, Fitch, Ball, & Rhodes, 1999). Assessments are often performed by academics whose proposals require more funds than are available, and require knowledge translation for the information to be useful at the grassroots

level (Stimson, Fitch, Ball, & Rhodes, 1999). In addition, rigorous investigation requires time that hinders the community in addressing the immediate issues (Stimson, Fitch, Ball, & Rhodes, 1999). Another criticism of needs assessments is this focus on proving helplessness. Funding awards often come to communities via proposal submission detailing the community's lack of ability (Kretzmann & McKnight, 2007). Not only is funding given for demonstrating the lack of ability to address community issues with current resources, but helplessness demonstrated via the proposal may actually increase the funding given to a community (Kegler, Twiss, & Look, 2000; Libby, 2002).

John McKnight (1994), co-director of Asset-Based Community Development Institute at Northwestern University in Illinois, stated that both the health system and community coalitions/associations are necessary for community health and wellness. There needs to be a recognition of the gifts of community (McKnight, 1994), in order to build sustainability into community efforts, an idea which Nozick suggested in *No Place Like Home* (2007). Many communities need to join together to address substance use by forming coalitions (Kretzmann & McKnight, 2007; Mayer, 2002). In some communities, the coalitions presented long term strategies for addressing service issues (Libby, 2002), or served as a visible presence advocating for change (Cox & Cunningham, 1998). In other communities, strategies were short term with little impetus to continue the coalition beyond current initiatives (Jobe-Armstrong, 2005; Weingart, Hartmann, & Osbourne, 1994). Foster-Fishman et al.(2006), in a study of the initiative, *Yes We Can!* (a mini-grant program with staff support to encourage collective action) asserted that coalition members required capacity building in order to access funding opportunities, as well as mentoring and support to feel included in the process, particularly in the initial phases (Lindholm, Ryan, Kadushin,

Saxe, & Brodsky, 2004). Bringing together diverse sectors of the community such as business, local government, and coalition members, created conflict which was difficult and in some cases impossible to overcome (Hallfors, Cho, & Kadushin, 2001; Libby, 2002; Lindholm, Ryan, Kadushin, Saxe, & Brodsky, 2004). Community inclusion is necessary for successful change at all levels; however, in some instances members need to see an initial change before they are willing to invest time and effort (Caulkins, Larson, & Rich, 1993)

RESEARCH DESIGN

This case study focused on understanding the context of individuals, service agencies and organizations with regards to information provided to the public about methamphetamine within a single setting, Prince George, British Columbia (Eisenhardt, 2002). The main characteristic of the case study method is the use of data from multiple sources (Stake, 1995; Yin, 1994); this permits triangulation thereby increasing the validity of the research.

The case itself is an examination of public information about methamphetamine in Prince George. From this point forth, the community of Prince George is differentiated from the conceptualization of community by a capital letter, as in Community. The research focus of this study is health, not as an outcome, but as a reflection of Community awareness of the potential risks of methamphetamine use before use reached a critical mass. This research focus had three components. First, the research sought, through a timeline of public information about methamphetamine, to determine if a specific event necessitated informing the public about methamphetamine use and any consequences within Prince George. Second, the research attempted to clarify whether there was a comprehensive effort by Community agencies to inform the public. Finally, the research investigated the agendas involved in informing the public.

Of the six sources of data identified by Yin (1994) as components of a case study, four were used in this study: documents, archival records, interviews and participant observation (p. 80). The other two sources of evidence, direct observation of behaviours (which was unattainable due to the historical nature of this case study, p.86-87) and physical artefacts such as tools, works of art, or other physical evidence (p.90), were not relevant to this research. Documents used include letters, agendas, meeting and forum minutes, media

articles, and press releases, as well as other documents that were pertinent to the research such as transcriptions of television video clips, and abstracts of books and videos. Archival documents that were reviewed contained lists of participants who attended methamphetamine information or action forums as well as funding disbursements from the province. Finally, interviews were conducted with Community members.

Participant observation notes were taken at two methamphetamine awareness events. Yin (1994) cautioned that participant-observer data collection may introduce bias in three ways: the researcher's participation in or advocacy of the issue; the researcher becoming a supporter of the group; and/or the researcher's insufficient note taking on the various perspectives due to time constraints (p. 89). However, the possibility of bias is typically balanced by media accounts and research participant interviews which also described the events, all of which are used to balance each other.

The study used purposive sampling in which participant selection was predetermined by criteria relevant to informing the public about methamphetamine in Prince George (Guest, Bunce, & Johnson, 2006). The goal was to interview as many people involved in informing the public about methamphetamine as possible (Guest, Bunce, & Johnson, 2006). Through repeated mentions in the documents on methamphetamine in Prince George as well as recommendations from other research participants, individuals involved in informing the Community and/or those who were knowledgeable about methamphetamine or substance use were asked to participate in an interview. The research participants ranged from executive administrators, to frontline service providers, to former methamphetamine users. Persons actively involved in methamphetamine use were also sought for an interview; however, no

volunteers came forward, and this idea was abandoned. Ethical approval was received for research involving human subjects prior to the interviews (see Appendix 1).

Relevant documents and interviews were analyzed separately. All information was then combined to reveal a timeline of methamphetamine awareness in Prince George. Documents were used to validate the information in the interviews (Yin, 1994) through the provision of concrete dates. Interviews added a depth to the information found in documented data and created a fuller understanding of methamphetamine trends in Prince George.

Documents were first grouped into their respective categories i.e. media reports. Then content analysis was employed to sort incidents into themes. Once those items were stabilized, the data was re-sorted to determine if themes were stable. During the thematic analysis of the documents, a predominance of concern provoking or panic words describing methamphetamine was noted. All documents were then examined for the use of panic words. These words such as evil, and epidemic were counted according to type of document. This analysis allowed the information to be sorted into the major method of information delivery; such as creating or communicating panic. In addition, the panic words occurring in media documents were counted by year of mention. Analysis further counted the mentions into yearly quarters to determine a timeline of panic words about methamphetamine.

Thematic analysis was determined to be more appropriate for analyzing the interview data. In addition to repeatedly listening to the recorded interviews, transcripts of the interviews were read and reread. The resulting themes represented an understanding of envisioned meaning, from sensing the importance of fragments of conversation, to the overall experience of the information about methamphetamine (Caelli, 2000; Willis, 2001). Analysis

of the interviews found multiple layers of information and decision making within Prince George which resonated in similar experiences throughout the Community.

RESULTS

Documents

Methodology

The preliminary inquiry focused on investigating when information on methamphetamine became available to the public. This search rapidly became an investigation of the overall information on methamphetamine use in Prince George, which was available to the public up to December 31, 2007. Initially, fourteen Community service organizations were contacted in order to request information on workshops, information sessions, pamphlets, etc. focusing on methamphetamine (see Appendix). Documents were received from one community agency.

Local databases, including the Prince George Public Library, Northern Health Resource Library, the College of New Caledonia Library, the University of Northern British Columbia Library, resource library for School District 57, *Prince George Free Press*, *Prince George This Week, Prince George Citizen, Vancouver Sun*, *The Province,* and Prince George City Hall, were searched using the following criteria: crystal methamphetamine, crystal meth, amphetamine, methamphetamine, and Prince George. Seventy-eight documents, archival records, interviews, and notes of direct observations were found. The earliest reference appeared in the *Prince George Citizen* in 2000 and the most recent one was found in the *Prince George Free Press* November 30, 2007.

The *Prince George Citizen* database yielded thirty-two articles fitting the criteria. Databases for both *Prince George Free Press* and *Prince George This Week* revealed no results. This return seemed highly unlikely; therefore, microfiche records were cross-referenced with the dates from the Citizen with no results. Personal reading resulted in two

articles from the *Free Press*. A second search added no further articles. Databases for the *Vancouver Sun* and *The Province* returned a single article that mentioned methamphetamine in Prince George.

Prince George Television (PGTV) video clips dating back to 1999 provided forty-eight possible video clips but only seven that fit the research criteria. Transcriptions of the clips were included in the analysis. A search of the Prince George City Hall database from 1997 to December 2007 resulted in four findings pertaining to methamphetamine. Due to internal policies regarding the release of previously aired programs at Canadian Broadcasting Corporation (CBC), neither transcripts nor abstracts of CBC Radio Prince George shows were available for this study.

Searching the Prince George Public Library, the Northern Health Resource Library, the College of New Caledonia Library, the University of Northern British Columbia Library, and the resource library for School District 57 databases resulted in one video from the Prince George Public Library and seven videos and one book from School District 57 Resource Centre. The CNC Library had thirteen resources which included reports, teaching guides, books, and videos.

Also included in the analysis were participant observation notes from the 2006 British Columbia Solicitor General's Methamphetamine Forum in Prince George and a Meth Busters presentation in 2007 ("Meth campaign launched", 2007). To be as thorough as possible, non-academic websites were scanned using the GOOGLE internet search engine. Of the 14,000 results only four fit the criteria.

Analysis

Media Topics

Prince George media produced thirty nine documents which fit the search parameters. Twenty eight appeared in the *Prince George Citizen*, six on Prince George Television, five in the *Prince George Free Press*, and one in the *Vancouver Sun*. Examination of these media documents produced four themes: policing, health, community, and provincial.

Policing

Articles that either originated with or had quoted the RCMP comprised the policing theme. There were four subthemes to the policing theme comprised of the strategies used to inform the Prince George public about methamphetamine: enforcement, prevention, legislation, and organized crime. The enforcement subtheme dealt with arrests and charges involving methamphetamine. Most items presented information from this point of view including the first large methamphetamine lab discovered in Northern BC (Peebles, 2007b). The prevention subtheme focused on role models, social causes of methamphetamine use, and harm reduction. One item specifically discussed marketing strategies by dealers and poly drug use which had not been previously mentioned in conjunction with methamphetamine (Peebles, 2006b). Although the RCMP believed "harm reduction should not be the first method of prevention" (Peebles, 2006b), police obviously saw harm reduction as part of their role.

The legislative subtheme was comprised of media articles about tougher sentences for drug dealing and bylaws for cost recovery. The bylaw changes were an attempt to hold landlords accountable for activities on their rental property, specifically grow ops and drub labs (Peebles, 2004a). While the Federal legislators were happy (Peebles, 2004a) with

stronger sentences and enforcement for methamphetamine involved crimes, the RCMP were concerned about the new legislation since they were given no additional resources to dealt with the changes (Peebles, 2007b).

The final subtheme was organized crime and the role it played in methamphetamine and other drug problems in Prince George:

> I don't think there is a single free lance drug dealer. The street dealer may not realize his or her connection but if you go up the ladder of where those drugs come from, it isn't long before you run into organized crime as the source (as stated by RCMP Superintendent B. Clark in Peebles, 2005c).

Health

The second theme of the media items was health, the public information provided by the Northern Health Authority and Alcohol and Drug Prevention. A Northern Health manager claimed methamphetamine use peaked in 2002 and was actually declining (Jan, 2004). Yet in 2005, Northern Health Youth Drug Prevention started an Anti-Meth campaign against the "danger-candy of choice" (Peebles, 2005d). In 2007, methamphetamine was described in the *Prince George Citizen* as an epidemic ("Meth campaign launched", 2007), while Northern Health Youth Drug Prevention stated that Prince George seemed to have reached a plateau in methamphetamine use (Peebles, 2007a). In 2004 (Jan, 2004), the Northern Health Authority stated they were "well ahead of the rest of the province" in addressing methamphetamine issues, yet it was not until 2005 that we saw "people shake methamphetamine addiction"(Peebles, 2005d). At a time when Northern Health management stated they were taking an overall systems approach to methamphetamine, there seemed to be a lack of cohesion within the system itself. Due to methamphetamine education, "dealers had

to work at selling [methamphetamine]" (Peebles, 2007a). At the same time, methamphetamine was still the drug of choice in schools and on the street (Peebles, 2007a). In 2005, initial discussions of methamphetamine effects occurred in relationship to individual populations (both mainstream and high risk), the labs, and organized crime (Peebles, 2005d). The information which was provided by Northern Health management and frontline staff appears, upon examination, to be disjointed and contradictory.

Community

The community theme revealed a shift that occurred in the presentation of methamphetamine information from 2004 to 2007. Until late 2007, descriptive language such as devastating, epidemic, the extreme examples of homelessness, and faces of methamphetamine were used. In November 2007, an advertisement presented methamphetamine awareness in an informational format ("Crystal meth ... it's in our community: be aware!" 2007). The "faces of meth" was replaced with a picture of two teenage girls leaning on each other. The focus on violence from methamphetamine use in previous years appeared more subtly through same page information on Phoenix Transition Society ("a resource for women and children who were in abusive situations"), and local Liberal MLAs ("please talk to your children today about the *dangers* of crystal meth"). Up until 2007, much of the methamphetamine awareness focused on prevalence.

Provincial

The provincial theme was made up of documents about the Solicitor General's methamphetamine forum, funding, and Ministry of Children And Families. Provincial methamphetamine forums supported Community and school based programs that address the "meth crisis" (Peebles, 2006a). Although the forum was to give the public "a clear sense of

what this drug is doing on local streets" (Peebles, 2006a), the experts who spoke at the forum on methamphetamine use and prevalence were from the Lower Mainland (Peebles, 2006a). At the forum, it was announced that several million dollars for methamphetamine initiatives was to be disbursed among all BC communities; however, when this funding was distributed it was considerably less – ten-thousand dollars per community (Coulik, 2005). Furthermore, the funding was a seed grant to start a program or an activity to target methamphetamine use, not sustained or long term change (Coulik, 2005). Increased funding allocation for health treatment and services budget was not discussed.

Abstracts, Agency and Government documents

Abstracts

Most resource document abstracts reviewed in Prince George libraries used panic words to inform the public about methamphetamine. For example, the official abstract for *Crystal Meth* (Harrow, 2007) stated that it provided "information about the drug crystal meth, explaining what it was, describing its effects on an addict's physical appearance, mind, and body, and discussing the consequences of crystal meth abuse." Yet, as a Prince George resource, the book's abstract description read: "[this pamphlet] discusse[d] the effects and dangers of crystal meth and its damaging physiological effects on the mind and body." Panic words such as danger, harsh reality, horror, epidemic, wrecked lives, and phrases like "sweeping across Canada at an alarming pace" (Davis, 2005) and "sensitive viewers may have trouble watching this program" ("Ruined lives: the dangers of methamphetamine", 2003) appear in some form in almost all abstracts.

Community Planning Council

Documents from the Prince George Community Planning Council (CPC) demonstrated a clear plan of engagement for methamphetamine awareness (Florey, 2005b). Meetings with key leaders, service providers, general public, and business were intended to result in a "solid plan of recommendations and/or actions" (Florey, 2005a). After an initial forum, the CPC was no longer involved in implementing the strategic plan or informing the Prince George public. Rather, the organisation, summaries, reports, and minutes from all discussions were now focused on youth, rather than the Community. The action planning notes showed that only in the criminal justice grouping were specific persons willing to enact the action items. Other action themes consistently listed "volunteers from the community" who acted upon the youth agenda. Both the Meth Watch pamphlet (NDMAC) and US Drug Enforcement Agency (DEA) Alert (Drug Enforcement Administration, 2003) were given to the people attending CPC meetings about methamphetamine. Both pamphlets sought to increase business cooperation by focusing on the dangers from methamphetamine production. While Meth Watch discussed increasing cooperation between law enforcement and business, the DEA Alert used panic language to link criminal activities to business losses.

Prince George City Council

Although there were five mentions of methamphetamine within the 2005 to 2006 Prince George City Council minutes and agendas, there was only one discussion about methamphetamine. A memo to council asked for assistance towards meeting space rental or printing cost "should the need arise" (Madden, May 23, 2006). Two Prince George agencies

(Native Friendship Centre and St. Patrick's House) had submitted applications for the provincial community grants for methamphetamine programs.

Northern Health Authority

All of the Northern Health Authority documents which discussed drug prevention and methamphetamine use incorporated the youth theatre company, Street Spirits. Both methamphetamine pamphlets (British Columbia Ministry of Health Services, 2004) and pregnancy pamphlets (Brouwer et al., 2006) avoided using panic words and judgments regarding methamphetamine use.

Regional Conference on Methamphetamine

The Regional Conference on Methamphetamine offered workshops for service providers ("Regional conference on methamphetamine", 2007), and youth ("Regional conference on methamphetamine: Youth program", 2007). Service provider information on methamphetamine included emergency responses to methamphetamine use, mental health effects, and recognition of a methamphetamine lab. Youth were engaged in unique workshops such as hip hop and multimedia; they also participated in a preparation workshop to "develop a collective voice" for discussions between youth and service providers, focusing on "ideas and insights as well as realistic solutions." Although there was a report written with recommendations from this conference as stated by research participants, a copy has not been located.

Government Documents

The provincial response to crystal methamphetamine contained some fear based language such as "crystal meth … is a dangerous choice" and a "horrible drug" ("Speaking notes for the Hon. Shirley Bond", 2006); however, the majority of information in the

speaking notes focused on the new BC health curriculum for schools. There was no discussion of provincial school closures during the methamphetamine forum, even though an expert from the lower mainland discussed the necessity of acceptance and safe schools to enhance the protective factors for students to resist drug use.

Methamphetamine awareness initiatives made it appear as if new money was available for addictions support. Yet addiction treatment did not receive new funding. Instead, presenters such as Shirley Bond and the Solicitor General reiterated that the government spent billions each year on mental health and additions. The methamphetamine initiative which was set up to provide ten thousand dollars to every community in British Columbia was managed through funding applications, not freely given to every community. Two Prince George agencies applied for and received grants.

Summary

The types of methods used to inform the community about methamphetamine were important in influencing the public's perception. A graph of the results revealed which agency documents used the most panic words when informing the public, thereby describing whether the majority of the information on methamphetamine use was panic creation or factual information (See Appendix 2). Initially, the *Prince George Citizen* seemed to have used the most panic words (1.29 words per document). However, the ratio of panic words was higher with PGTV (2.75 words per document), Provincial releases (2.2 per document), and School District 57 (2 per document).

Upon further examination of the number of panic words a major increase in 2005 was revealed (31 mentions). This analysis allowed the timeline of methamphetamine-related panic words about to be visible (see Appendix 3). In 2005, the number of panic word more

than tripled from 2004. This escalation seems to indicate that an agency or person was championing or speaking out about methamphetamine use.

Interviews

Methodology

Interviews were one of the most important sources of information for this case study. Semi-structured, open-ended questions were the most advantageous (Yin, 1994). Community members were not limited in length or breadth of their responses. Although questions and prompts were pre-designed, the prompts were not often used as every attempt was made to ensure active listening, and thorough note taking to maximize data collection (Mason, 2002).

Research participants received an information package prior to the interview which contained all forms that were pertinent to their participation (see Appendix 4). Preceding the interview, confidentiality and anonymity were discussed to ensure informed consent (Mason, 2002). Research participants had the option of having their transcripts returned to them for comments. Six of the sixteen research participants reviewed copies of their transcripts but no changes were requested. Interviews often occurred in the participant's office and the meetings ranged from ten to ninety minutes. Gifts were given following the interviews in recognition of the time and knowledge shared by the research participants. A short report of the findings was offered to all research participants.

For anonymity, the interviews, recorded on compact discs, were numbered with the key document containing the research participant's name and contact information in a separate database (*Tri-Council policy statement: Ethical conduct for research involving*

humans 2005). All transcribers signed confidentiality agreements. In addition, the peer collaborator who validated analysis categories signed a confidentiality agreement.

Research participants were initially coded by their roles within their organizations (see Appendix 5). These categories were still too revealing when quoted in conjunction with a specific agency. Therefore, research participants are cited as research participant (RP) using a code number.

Analysis

First, as described by Yin (1994), the initial scan used the interview questions as categories. Research participant data was separated into the five question responses and then compiled within the matched questions (Creswell, 2003).

1. When do you recall first becoming aware of crystal methamphetamine?
2. What do you recall of your organization's reaction to crystal methamphetamine?
3. When do you recall first discussing the possible implications of crystal methamphetamine for the municipality of Prince George?
4. What was the precipitating factor (s) that made you and/or your organization want to inform the public about crystal methamphetamine?
5. How did you and/or your organization choose to inform the public about crystal methamphetamine?

Grouped in this manner, a timeline of methamphetamine in Prince George was created. Second, the interview data was examined for overarching themes across the question categories. Third, research participant data was examined in relationship to the research

questions of who, how, and why the Prince George public was informed about methamphetamine.

Summary

Analysis of interview data revealed the following themes: disconnection and marketing. Within the theme of disconnection, there were subthemes of vertical and horizontal disconnection. Role identification was a substantial contributor to horizontal disconnection which was relevant to a discussion of the reasons for horizontal disconnection; yet on its own, it proved almost irrelevant. Marketing was a predominant theme throughout the interviews with subthemes of marketing methamphetamine and methamphetamine marketing effectiveness as well as marketing prevention and prevention marketing effectiveness. Last, was the timeline of methamphetamine in Prince George as revealed by the research participants.

Disconnection

Lack of continuity, or disconnection, of methamphetamine information was the first theme of the interviews. This disconnection appeared to have both vertical and horizontal subthemes. The vertical disconnection subtheme referred to the dissimilarity in knowledge within the hierarchy of Community service provision and the public in Prince George. The horizontal disconnection subtheme was the inconsistency of information from agency to agency. Differences between service agencies seemed to make sharing information secondary to meeting the needs of mandated populations.

Vertical Disconnection

The vertical disconnection subtheme, or the inconsistency of methamphetamine awareness, moved both up and down from those who were most informed, namely the

frontline service providers. Upward movement referred to executive and administrative service providers, while the downward movement referred to the Prince George public.

> [In 2000] the higher ups…at MCFD [Ministry of Children and Family Development] because we were MCFD at that time … we were told that *"if meth was really a problem she would have heard about it from Victoria by now"*, and the seven youth that were hardcore meth users that we had in the program did not seem to influence that opinion (RP001).

Vertically, service providers experienced methamphetamine in very different ways. Frontline workers considered methamphetamine a serious issue that needed immediate action; for executive administration, however, it appeared unrelated to their mandate of service (RP002). By 2003, the majority of participants were aware of methamphetamine. In 2005, Northern Health had "discussions with management table and planning table and conference tables" (RP015). At a higher executive level, there was little awareness as recently as 2007 (RP002). However, this may have been more reflective of rising need, rather than ignorance. Most participants stated or implied they were overwhelmed by the level of need within their mandated populations and agendas (RP005, RP007, RP010, RP012, RP014, RP015).

The final population that was engaged in discussions about methamphetamine on February 2, 2006 in Prince George was the public. Most research participants were not actively educating the public, preferring to devote energies and resources to their mandated service populations (RP005, RP007, RP010, RP013, RP014, RP015). Without information from service organizations, the public appeared limited in their knowledge and, thus, in their ability to take action.

Horizontal Disconnection

The horizontal disconnection subtheme was apparent in that there was not a consistent message about methamphetamine from the service providers. Methamphetamine was identified throughout the interviews as one issue among many that demanded a Community response. Other competing issues were homelessness, lack of health services, and overwhelming needs of the research participants' service populations. Although methamphetamine was considered problematic, it was unclear to what extent it affected the Community. Some administrative research participants believed that methamphetamine use had not affected Prince George in a major way; on the other hand, minimum barrier service providers discussed significant methamphetamine use among their populations.

Minimum barrier service providers expressed concern and confusion about the perception that methamphetamine was no longer a threat (RP007, RP012). Yet, the most common statement from minimum barrier service providers was that staff was not trained to deal with the increased violence (RP005, RP007, RP012, RP014). The sudden disconnection from long term methamphetamine-using clients created confusion, grief and, in some cases, fear among service providers. However, this reality was apparently not addressed through the local venues of knowledge dissemination such as forums, workshops, or conferences.

Role Perception

Although role perception did not meet the criteria of a subtheme, it was a substantial contributor to the horizontal disconnection subtheme, both by the service agency itself as well as by other agencies. Although there was a mandate for service provision for each research participant, there also seemed to be a role as perceived by other agencies. The role

perception of a service agency was difficult to identify, yet this aspect appeared instrumental in exacerbating horizontal disconnection.

An example of role perception was School District 57 in Prince George. For schools, the mandate was to educate children, and at times within that realm, to address issues such as methamphetamine use that hindered learning. "The school [did] have a role to play there; it [did] not have a role to play in isolation. It cannot be the fix it for everybody" (RP010). There was a perception of schools as the appropriate arena for educating children on a variety of community issues including substance use. However, school curriculum delivery was the mandated function not provision of information about substance use.

Even though frontline service providers had little free time or resources to devote to Community based prevention planning, some service providers perceived the role of an authority to be not only one who was responsible for presenting information to the Community, but also to provide or suggest solutions regarding methamphetamine and its consequences.

> There was concern from one agency that a frontline service agency [should be] the primary group heading this [event] … While they may have been experienced working with the client base, they weren't qualified really to do planning. What came out of it was not something anyone could really work with (RP006).

Service providers did not possess the expertise or resources which were necessary to move the agenda of methamphetamine awareness beyond specific focal populations, and reach the entire Community.

At times, the credibility of information surrounding methamphetamine use was related to role perception. One of the best examples of role perception by Community was the RCMP. Although their mandate of service was policing, there were many programs in schools and Community which were sponsored by the RCMP, such as DARE (Drug Abuse Resistance Education), a prevention program delivered by the RCMP in schools.

> When [the agenda was] driven by the community, it [became] more acceptable because it [was] not the "man" or the government saying you can't do this. It [was] coming from other informed sources that say, "if you do this, this is what will happen to you" (RP009).

The RCMP agenda of crime reduction through information provided to youth about substance use was regarded as credible and appropriate for children and youth. On the other hand, service providers regarded provincial initiatives with suspicion (RP015). Even though the Provincial initiatives targeted substance use education at children and youth (RP009), the government was perceived as having a hidden agenda (RP001, RP007), not as caring about the Community.

Conflict in role perception was visible in the use of outside expertise in preference to Community-based knowledge. Community providers were viewed as experts in Vancouver and other communities, and Prince George service agencies frequently sought expert information about methamphetamine use from outside northern British Columbia. Some providers (considered local experts) articulated, however, that their role was to inform their own mandated populations, not the public.

Marketing

The theme, marketing, was defined as "the process of planning and executing the conception, pricing, promotion, and distribution of ideas, goods, and services to create exchanges that satisfy individual and organizational goals" (Keefe, 2004). There were two subthemes of marketing; the marketing of drugs, and the marketing of a crisis regarding methamphetamine. Both the illicit drug and the prevention marketing campaigns had effects on the community.

Marketing Methamphetamine

The subtheme of marketing methamphetamine was drug dealing or trafficking. Marketing strategies created a desire for a product (in this case, methamphetamine) and, if they did their job correctly, strategies increased desire once that market was established. As with mainstream business, the goal of marketing was to maximize profits. For the most part, marketing was population-specific. One of the target markets was the youth in schools, often with other youth dealing methamphetamine and other drugs.

> "How many of you if you wanted to could get meth, could get crystal meth?" I think there were about two kids in the room that didn't put up their hands. Then I said "How many of you if you wanted to could get it in less that half an hour?" About half the kids still had their hands up … [that showed] they could buy it from somebody within the school right now (RP001).

The availability of methamphetamine in schools strongly suggested that the dealers were other youth. Selling methamphetamine within the schools also suggested a strong relationship to impulse buying. In addition, there seemed to be an investment in peer pressure or "fitting in" as a marketing tool (RP019).

Drug dealing also had to include the reduction of harmful perceptions of the product. As stated by one research participant, the best deterrent to methamphetamine use was seeing the effects of methamphetamine on some users (RP001). However, methamphetamine marketers negated harmful perception by showing other youth who did not exhibit signs of methamphetamine use; some marketers also referred to methamphetamine by another name (RP001). The peer to peer marketing was about relationships and trust. Some of the participants' comments about methamphetamine referred to the relationship between the clients and "their" dealer, which indicated a trust relationship similar to mainstream business (RP005, RP007, RP018, RP019).

> I'd be talking to people in my office[who were]using meth and I was hearing things like "oh it's no worse than smoking pot". You [would] have almost word for word the same comment from six different people and when you dive into that a little bit you find out that they're all from their source for their drugs (RP001).

Ultimately, the repetitions of specific phrases by clients to service providers indicated that trust was used to increase methamphetamine markets and thus profit.

Even when drug dealing marketing involved changing the name of the drug, for example from speed to crystal, or mixing methamphetamine with other drugs, the key to continued profit was the construction of a relationship between buyer and seller (RP001, RP005, RP018). As the trust was established (and, possibly, addiction was created), the methamphetamine user was more likely to be open to a relationship of exchanging drugs for profit or personal use. A promotion to dealer may be related to how connected the methamphetamine user was to possible markets (RP018, RP019).

The movement from methamphetamine use to addiction created a sense of indebtedness to the dealer. The indebted person was then exploited within the illicit drug market. Methamphetamine marketing had grown into organized crime that seemed to increase other criminal activities.

> One day this woman is IV using or addict [and] comes in badly beaten over a drug debt. Two weeks later, she might be the one beating on someone or intimidating someone else because she has [to pay] rent... it's not specific to crystal methamphetamine but it seemed like it was getting much worse at the same time. Its part of the strategy to have everyone indentured into that organized crime. You owe a twenty dollar drug debt; you're going to have to work that off in some way (RP007).

Many activities surpassed methamphetamine marketing to include the sale of other drugs or violent activities, yet, the trust relationship between dealer and user that was established during methamphetamine use seemed to still exist. Organized crime activities such as drug dealing, intimidation, and prostitution, used the dealer-user relationship to expand drug trafficking (RP001, Rp007, RP018, RP019).

Research participants became aware of some of the effects of methamphetamine marketing through either professional or personal experience. Methamphetamine effects were different from those of other illicit drugs in terms of behaviours presented.

> Some of the kids who hadn't ate in a number of days coming in and the food going literally right through them where they would soil themselves. They would not make it to the washroom ... we didn't understand that was part of

> them not eating for days… that was so impactful to our staff … and [youth] don't know what is going on and they are scared (RP012).

In addition, methamphetamine use changed the personality of the users. Service providers found client relationships significantly altered as violence became more prominent.

> If we had to draw any kinds of lines around their behaviour or their conduct, it was though we were talking to someone that we had no pre-existing relationship with … We had always been able to rely on having some sort of pre-existing history and working relationship… long standing clients that were just unplugged and violent (RP005).

For service providers, changes in their clients were often unexpected and unexplained.

A lack of information about methamphetamine effects, including violence, echoed throughout the interviews and left most service providers dependent on the internet or media for knowledge:

> We had one youth at the time that was an honour roll student then she started to slide. Then we also were concerned because there is not a lot of information out there, she was pregnant. So what were the implications to the fetus? And then other kids on it … we're not so much about informing the public as trying to get informed ourselves, and there wasn't a lot of information out there (RP014).

Lack of knowledge continued to stretch the abilities of service providers as methamphetamine effects on mental health increased.

> One of the things we had a really hard time with was this drug's effects. The behaviours they were having, were they drug effects or were they mental

health issues? That was huge because we had done some in house training but not to that level (RP012).

Symptoms of methamphetamine use brought psychological assessment to the forefront of service provision.

Methamphetamine Marketing Effectiveness

The subtheme of methamphetamine marketing effectiveness (as determined by evidence of increased drug use) was demonstrated through discussions of the impacts on service provision.

> They are sicker physically… in addition to mental health, substance use kind of means there is also lots of HIV/AIDS issues, hepatitis, all the things that goes along with drug use, abscesses, and all kinds of things. Incredibly poor dental health, with the crystal meth their teeth are just damn near gone. Lots of it is from the meth but lots of it is not have any … access to lots of services (RP007).

> When I started doing this work twelve years ago, we had …a sort of biker bar. These guys were doing what they were doing but they didn't come into my environment… [sometimes] they would come looking for some women then I'd go and say 'get the hell off the property'. It didn't bother me and I wasn't worried … I wouldn't do that now in the same way … there are several gangs in town that are obviously into the whole drug trade but its complicated our work immensely. The women that come to us used to be more easily identified as the victim (RP007).

> Sometimes the violence is aggression towards the staff. There's been a lot more of that. Like 'f—k you, you f'ing c' and getting disrespectful hardly happened before…it's about their drug uses, it's about organized crime, its about our backs are against the wall, we have nothing (RP007).

Consequences of methamphetamine use ranged from physical illness, to violent social interactions which were complicated by the context of the lives of people who used methamphetamine and other drugs. Methamphetamine effects created a very different reality for service provision than had been previously experienced.

Marketing Prevention

In the marketing prevention subtheme, media was a marketing tool as well as a business which sold information. Initially in 2000/2001, methamphetamine was briefly mentioned in media, typically as a drug that was prevalent in criminal activities or in difficulties with youth. Media marketing did not gain significant momentum until 2004 at which time "we did … our version of big expository pieces … that crystal meth was involved" (RP003). This was not to imply that media did not have an interest in Community wellness; however, its business agenda may have influenced the promotion of methamphetamine as an issue. Although media was a major contributor to increasing methamphetamine awareness, the first public information forum about methamphetamine in Prince George did not occur until February 2, 2006.

The BC Solicitor General's Methamphetamine Forum was part of a methamphetamine awareness and information gathering initiative sponsored by the provincial government. The forum resulted from an initial gathering of Community stakeholders in an effort to compel a cohesive response to methamphetamine (RP007). This

was an example of marketing methamphetamine prevention. As the provincial government brought methamphetamine to the forefront, the government's motivation was viewed with suspicion. As stated by one research participant, "when you're seen in the public as either government or service agency you're sort of labelled with an agenda" (RP006). Unlike the interdependent relationship between methamphetamine consumers and their dealers, there was little trust articulated for the government.

Prevention marketing created two divergent views: one in which methamphetamine was the chief evil in the substance hierarchy, and the other, where methamphetamine was just one of many substances. The "meth is evil" standpoint expressed by the provincial government seemed to cause a determined push by service agencies to broaden the agenda. Minimum barrier service agencies saw most of their populations using methamphetamine, yet service providers expressed the view that lack of services, not methamphetamine use, was the main issue (RP005, RP006, RP008). Although methamphetamine was a significant problem for minimum barrier service agencies, poly drug use made it impossible to target methamphetamine specifically in an intervention (RP001, RP005, RP008). The Provincial focus on methamphetamine use, constricted tools developed by the Ministry of Education as well as Prince George service agencies; a more general focus was needed. Marketing prevention was not as clear as drug trafficking. The provincial message was abstain from meth use; the community message seemed to be that meth was one issue among many, such as poly drug use and lack of health services for substance users, which all needed to be addressed in marketing prevention (RP010, RP001).

Research participants often commented that the prevalence of methamphetamine use was uncertain. Some service providers expressed their belief that methamphetamine use was

stabilizing or at least not as problematic as other community issues (RP001, RP009, RP011, RP013). Other providers described witnessing an increase in people using methamphetamine. Service providers viewed the level of hardship in Prince George, including methamphetamine use, as exacerbated by previous government cuts to frontline and health services (RP005, RP006, RP007, RP010). Many services providers were overwhelmed by the increasing health needs of their populations.

The information provided about methamphetamine and its effects did not seem consistent with Community concerns.

> There's a focus on crystal meth because meth is making itself a focus. The more it's in the community, the more the police have to face it, the more the health professionals have to face it and the more the teachers have to face it. The more it's going to be on everybody's radar screen (RP003).

The RCMP stated crack cocaine caused more policing issues. School District personnel said methamphetamine issues differed from school to school. Northern Health employees reported increasing mental health issues. Community service providers had differing views on the prevalence and severity of methamphetamine use in Prince George. For some, methamphetamine was no longer an issue (RP001, RP009, RP011); while for others, methamphetamine use and consequences were still a predominant issue for service provision (RP007, RP012, RP005).

A major tool for marketing prevention was funding. At the Solicitor General's Forum, seed funding (ten thousand dollars) was to be given to every BC community that implemented a program for methamphetamine use and awareness.

> I have been presented with memos from non-profit organizations in outlying areas saying what we presented to the most recent community consultation or addiction review is the same thing we asked for in 1974… there will be a realignment of resources to actually get on with some of the recommendations but I have some scepticism as this is not yet a political exercise that is backed up with resources (RP015).

There were no service enhancement announcements, such as an increase in the number of treatment beds or counsellors, at the forum. There were two significant difficulties with using funding initiatives as a method of addressing methamphetamine use. First, methamphetamine was not necessarily a difficulty in every community. Second, the one-time seed grant did not increase the sustainability of services to address methamphetamine; thus, the announcement seemed more political than supportive.

Funding with single issue focus, as with methamphetamine, necessitated that Community agencies continually redefine their services in order to meet requirements. Service providers were willing to adjust descriptions of events, programs, or services to ensure a component matched the funding conditions (RP001, PR007). Thus, determining the prevalence of methamphetamine use (or even efficacy of initiatives) was problematic. Provincial funding initiatives were unable to address issues caused by methamphetamine and substance use in a sustained manner. The Northern Health Authority seemed as hampered by funding issues as frontline service providers. They too, identified increasing health needs at a time when provincial health funds were being cut (RP005, RP015). The constraints on the Northern Health Authority were such that planning for additional funding did not exist (RP015). Northern Health Authority funds could not adequately address mental health and

addiction service provision to Prince George, let alone all of northern BC. The Community initiatives for methamphetamine prevention had not replaced the funds for service provision previously cut by the provincial government.

Prevention Marketing Effectiveness

The subtheme of prevention marketing effectiveness revealed that, in Prince George, provincial funds enabled service agencies to increase awareness of methamphetamine through conferences and public information sessions. However, it was difficult to measure the efficacy of prevention marketing for two reasons. First, a major difficulty was how to assess effectiveness; for example through health outcomes, crime statistics, or anecdotal information. Second, there were three main populations requiring assessment: the targeted group, the visible, and the invisible populations. Unlike drug trafficking in which the target population was all Community members and profit indicated successful marketing, prevention required complex definitions in order to assess effectiveness.

A convenient and popular approach for prevention marketing was to target school students for methamphetamine awareness and prevention initiatives. While youth may have experimented with methamphetamine, most did not end up on the street or living with addiction. Further, youth who had succumbed to methamphetamine addiction usually left school so if the intervention was not effective, that youth could not have reported this outcome. As a trend indicator, the decreased methamphetamine use among youth who attended school was misleading (RP001). Not all youth were in need of methamphetamine prevention (RP010). In fact, broader substance use agendas were more suitable as was indicated at provincial planning tables.

Prevention marketing to the visible population of people using methamphetamine involved subpopulations of those at high risk for complications of substance use, such as HIV/AIDS, mental and physical health issues; many users were street involved. When discussing marketing prevention effectiveness, some service providers found that methamphetamine use had significantly decreased (RP011, RP001, RP009). Yet, minimum barrier service providers were frustrated at the exclusion of their reality which included high rates of methamphetamine use among their populations (RP007, RP012). The need within their service populations was overwhelming. Many methamphetamine consumers did not access other services until they wanted to cut down, quit or were in extreme need of medical services. Additionally, the use of multiple minimum barrier services increased the probability that any intervention was delivered repeatedly, thus inflating the data collected.

Marketing prevention effectiveness was virtually impossible among the invisible population of mainstream methamphetamine users. For example, mainstream workers in natural resource industries used meth to increase their ability to work longer hours and thus increase their net wage. "He was doing meth and working as a logger in the bush… the idea of someone who is doing meth handling a chainsaw is just scary … he is working for bonus so he is going for more money" (RP001). Measuring intervention efficacy was impossible while this population remained invisible.

Some providers stated that methamphetamine use in Prince George seemed to stabilize, yet there appeared to be no documented evidence to support such a claim (RP012). Decreased methamphetamine use may have been entirely unrelated to prevention activity. Instead, witnessing the visible symptoms of chronic methamphetamine use, such as violence

or physical and mental health deterioration seemed to have deterred many people from trying meth or even encouraged cessation of methamphetamine use:

> The best aversion information that you get [is] from just talking to someone who uses it … there is an old saying that 'even junkies don't trust junkies' and junkies think meth heads are crazy… exactly what happened in the 70s (RP001).

An accurate picture of the prevention marketing effectiveness was not demonstrated through anecdotal evidence of decreased or stabilized methamphetamine use.

Methamphetamine marketing effectiveness could be measured via the strain on the community's response systems such as health, minimum barrier services, treatment, and policing. However, calculating prevention marketing effectiveness was complex. Effective methods for assessing total methamphetamine use or prevention efficacy among the separate and distinct populations (targeted, visible, and invisible) of Prince George did not seem to be available.

Timeline of Methamphetamine in Prince George

Most research participants identified awareness of methamphetamine as a problem in 2000/2001. During this period, many participants were working or involved with services in which few (if any) access restrictions existed (essentially, minimum barrier frontline services). Although some of the research participants who identified methamphetamine as a problem in 2000/2001 were in management or administrative positions, their roles did not ensure decision making autonomy. There were always other levels of consideration: Youth Drug and Alcohol Prevention was under the direction of Ministry of Children and Family Development, for example. Not until 2004 was there mention of youth early intervention

programming in the Northern Health Authority (*Health service redesign plan (Business Plan): 2005-06 to 2007-08*, 2005). Agencies and programs which serviced the methamphetamine using population were separate and distinct from each other. Thus, horizontal disconnection inhibited the recognition of the impact of methamphetamine throughout the Community.

Interestingly, in 2004 the majority of the dated documents (7 of 11) were concerned with policing issues such as arrests, laws, and bylaws. The bulk of policing issues were related to property holdings, such as theft, or buying a house formerly used as a methamphetamine lab. Few of the documents seemed concerned with methamphetamine use itself as a public harm. In addition, the escalation of panic words in 2005 validated research participants' views that the initial appearance of meth in Prince George in 2000/2001 was not perceived as cause for alarm.

Another visible trend which emerged through the timeline was a connection between methamphetamine and weapons. In the media reports, mentions of methamphetamine combined with other drugs and, more specifically, guns, became more common from 2003 up to the end of 2007. The documentary evidence corroborated research participant disclosures of gangs and gang related violence increasing in relationship to the drug trade in Prince George. Additionally, evidence of arrests for multiple drug possessions supported research participant statements: "it's so connected with all that poly drug use and people are using anything they can get their hands on" (RP007).

Evidence of Methamphetamine

Although establishing prevalence of methamphetamine was not a stated goal of this research, it was a major point of discussion throughout interviews and documents. To the province, methamphetamine was a significant problem as shown through both government documents and responses (community grants and school program development). However, documentary evidence, and research participant comments indicated that methamphetamine was not the epidemic proposed by the province.

In 2004, the BC Coroners Service stated that there were 174 illicit drug deaths in the province with 4 being in Prince George ("BC Coroners Service Annual Report 2006"). Although 3 out of 9 deaths in northern BC occurred with methamphetamine present, this did not indicate that methamphetamine was the cause of death nor that the deaths occurred in Prince George (BC Coroners Service, 2005). Interestingly, deaths by illicit drugs in BC ("BC Coroners Service Annual Report 2006") showed that the majority of deaths occurred between ages 31-50, not youth under 20.

In *British Columbia Youth Health Trends: A retrospective, from 1992-2003,* Tonkin (2005) stated that "folklore or myths surrounding some forms of substance misuse may outpace the actual behaviours" (p. 19). Tonkin also stated that methamphetamine use in BC was declining. The 2003 Adolescent Health Survey (Katzenstein & Liebel, 2004) revealed that 7% of Northern Interior students indicated having used amphetamines as compared to 4 percent in the rest of the province (p.16). However, "having used amphetamines" did not mean methamphetamine use or continual use. Other studies indicated a significantly higher use among street involved youth (Tonkin, 2005). However, this street involved research originated from urban communities in southern BC ("Between the Cracks: Homeless youth

in Vancouver", 2002) and was not useful to establish prevalence or trends in the northern BC or Prince George.

Even evidence regarding methamphetamine treatment (Callaghan, Taylor, Victor & Lentz, 2007; Callaghan et al., 2007) was inaccurate in stating northern trends related to methamphetamine. The treatment facilities discussed did not provide services solely to northern BC. Therefore, statistics included patients from other parts of BC. Additionally, detoxification and treatment records showed evidence of people accessing service which excluded mainstream and methamphetamine involved persons who had not reached a point of needing or wanting health services. The Northern Health Authority showed 232 community addiction services admissions for amphetamine misuse in 2003 (British Columbia Ministry of Health Services, 2004). However, the disclaimer stated that clients may have had more than one admission in 2003 and methamphetamine may not have been the primary drug used.

The overall evidence suggests that methamphetamine use was not a major problem in Prince George during the timeframe studied, 2000 to 2007. Yet, this did not diminish the reality of methamphetamine use and its consequences for minimum barrier service providers in Prince George. Instead, the available data demonstrated a significant gap between evidence and knowledge in the Community. BC Health officer Kendall cautioned, "if officials get 'too worked up,' there is a risk they will take methamphetamine "out of context of what works in terms of drug-abuse prevention and education" ("Don't overdramatize meth crisis, health officer warns", 2004).

DISCUSSION

The goal of this case study was to examine the agendas behind the information provided to the public about methamphetamine in Prince George: the who, how and why. Each of the who, how and why categories was separate and distinct from the others and contained its own complexities of who, how, and why. For example, the RCMP, Northern Health and local drug dealers were responsible for most of the information in Prince George or 'who' informed the public about methamphetamine. Community prevention information was, for the most part, factual and unrelated to increased panic words about methamphetamine. 'How' the Prince George public were informed about methamphetamine appeared to be through increased panic words in media reports in 2005. The increased panic words changed the Community's perception of methamphetamine. The 'why' of both increased panic words and information provided to the Community about methamphetamine and consequences of use, related to the larger Provincial government agenda of panic creation in order to increase public trust.

The Who of Informing the Public in Prince George

Two views were prominent in local methamphetamine awareness: prevention, and drug dealing. Policing and Northern Health marketed prevention messages mainly through Prince George School District 57. However, drug dealers also had an objective, to increase profits from methamphetamine sales. From prevention to drug dealing, strategic planning was utilized to garner larger markets for the product.

RCMP

The RCMP conducted a multilevel campaign against methamphetamine with initiatives at the federal (Peebles, 2005a), provincial (Peebles, 2004a) and municipal levels (the DARE program). The media actively engaged in methamphetamine awareness when they published articles on enforcement ("Drug bust", 2000) and on policing perspectives of the social factors in methamphetamine use (Peebles, 2006b). Police brought to Community presentations real life field experience of the consequences of methamphetamine use.

Enforcement's main premise was deterrence; an ideology that harsh and swift consequences hindered other Community members from committing the same action (Linden, 2000). From a policing perspective, the goal of harm reduction was achieved by:

> disrupting established markets and thereby reducing public disorder, as well as interrupting supply and thereby driving up drug prices and increasing the time drug users have to spend searching for drugs ... These approaches also aim to prompt drug users to refrain from drug use or enter treatment out of fear of adverse consequences (e.g., arrest, incarceration) or by making habits difficult to sustain due to rising price. (Kerr, Small, & Wood, 2005, p. 211)

This perspective was evident through the media accounts of arrests and drug busts in Prince George from 2003 to 2007.

Another method of marketing prevention which the RCMP used to inform the public was through Community policing presentations in Prince George, especially to elementary and secondary schools. Through a variety of community policing initiatives, the RCMP were active in informing the Community of their knowledge ("Meth campaign launched", 2007).

RCMP presentations increasingly acknowledged social factors (Peebles, 2006b) and presented information for "Just Say Know" approach (Beck, 1998).

Northern Health

The goal of the Northern Health Authority was increasing health within the Community with methamphetamine information focused on harm reduction. The health information was delivered, in large part, by Northern Health Youth Drug and Alcohol Prevention and Street Spirits ("Street Spirits Theatre Company: Changing the world one performance at a time", 2008). Street Spirits was a youth theatre company that performed interactive forum theatre. In addition, pamphlets and performances focused on increasing knowledge and awareness of the complexities of methamphetamine use.

Drug Dealers

Drug dealers had their goal too – increased profits. Their principle strategy to increase profits was the negation of prevention information (RP001). In many ways, methamphetamine marketing paralleled strategies of big tobacco companies. As Ling and Glantz (2002) demonstrated, tobacco advertisements subtly targeted youth. While not as complex as tobacco strategies, methamphetamine dealers suggested that consequences in anti-advertising presentations such as the "faces of meth"("Faces of meth ") were not the experience of all methamphetamine users (RP001). Dealers often gave free samples to introduce methamphetamine to new users in the hope of increased sales (Harrison, Erickson, Korf, Brochu, & Benschop, 2007).

The How of Informing the Public about Methamphetamine

In 2005, the Provincial government responded to the "methamphetamine panic" with resources in the form of one-time seed grants which were offered to each community in British Columbia that developed a methamphetamine intervention/prevention program. This response occurred at the same time that the provincial Liberals were dealing with issues of public trust related to school closures, health cuts, as well as the sale of BC Rail (Hatley, 2005; , "Premier put on defensive", 2005). In their theory of the social construction of a moral panic, Goode and Ben-Yehuda (1994) described an elite model in which "the elites fabricate a panic over a nonexistent or trivial threat … in order to gain something of value or divert attention from issues, that if addressed, would threaten their own private interests" (p. 160). Given their declining popularity, the provincial Liberals needed to demonstrate care and concern in order to regain public support.

Creation of a methamphetamine panic necessitated the movement of methamphetamine from a "non-problem" to a "symbolic crisis" (Neuman, 1990, p. 167). Media was essential in order to change public perception. Community awareness of methamphetamine up to 2005 often made the national and international news, such as the CBC Fifth Estate production, *Dark Crystal* (Davis, 2005). For the government to benefit from the creation of a "methamphetamine crisis" (Peebles, 2006a), the public needed to perceive a direct impact on Community. Even though methamphetamine was not an issue in 2004 for the Northern Health Authority (Jan, 2004), methamphetamine was deemed to be a crisis.

A popular process which created investment in a "symbolic crisis" (Neuman, 1990, p. 167) was to demonstrate a threat to children and youth. Statistics in British Columbia

(Tonkin, 2005) did not demonstrate high rates of methamphetamine use among mainstream youth. Therefore, to create moral panic, prior knowledge of methamphetamine needed to be extrapolated to show the possible consequences of long term methamphetamine use on the individual and the community (Beck, 1998). Creation of a threat increased the visibility of consequences of methamphetamine use through media images (Davis, 2005; Kwan, 2000; Neitzel, 2005; Peebles, 2004b, 2005d; , "Ruined lives: the dangers of methamphetamine", 2003) which reinforced perceptions of "dangerous choice" and "horrible drug" ("Speaking notes for the Hon. Shirley Bond", 2006) with "evil side effects" (Peebles, 2006a) to the public (Beck, 1998). The Prince George public was now aware of the "growing crisis" (Jan, 2006) "taking over the streets" (Jan, 2005) and that "treatment centres are more reluctant to take on crystal methamphetamine users as a result of their violent tendencies" (Jan, 2005).

According to Neuman (1990), abundant panic words throughout 2005 represented the discovery stage of an issue-attention cycle, that moved from non-problem to problem or "symbolic crisis" (p. 167). This stage was often accompanied by excitement in community to "do something effective" (p. 164) regarding the issue. Funding announcements during the election campaign emphasized the urgency of the crisis and the willingness of the government to help community deal with methamphetamine. As Neuman (1990) pointed out, public interest at this level of involvement was not sustainable as the complexity of the issue became increasingly prominent. In late 2006, perception broadened to polydrug use with complex contributing factors; this ultimately re-established methamphetamine as a non-problem with no foreseeable solution (Neuman, 1990).

The Why of Informing the Public about Methamphetamine.

There was a specific agenda behind informing the public about methamphetamine in Prince George related to the Provincial government. Service providers disclosed the presence of methamphetamine in Prince George to management as early as 2000, yet this reality was ignored. The first media account of methamphetamine in Prince George occured in 2003 ("Crack house raided", 2003). Panic words such as "danger", "evil", and "dirty filthy drug" that described methamphetamine were basically unheard before May 2004 (Hessedenz, 2004). There were three media accounts from the Northern Health Authority (Jan, 2004) and Northern Health Youth Drug and Alcohol Prevention (Peebles, 2004b, 2005d) in 2004 and early 2005 which discussed methamphetamine; however, the information was presented factually with only two panic words between the documents. Thus, the increased panic words in 2005 did not demonstrate the Northern Health Authority's view of methamphetamine. The number of panic words in 2004 more than tripled during 2005: from nine to thirty one.

From May 2001 to May 2005, the BC Liberals, led by Premier Gordon Campbell, broke many of the promises made during the 2001 provincial election campaign. The credibility and public trust in the government substantially declined, to the point where "the voters simply [do not] believe [Campbell]" (Strachan, 2006).With major credibility issues directly related to education and health cuts, as well as the opposition to the sale of BC Rail, the Premier needed an issue that improved his "cruel and uncaring" image and restored public trust (Strachan, 2006).

The issue of provincial public trust related directly to Prince George, a community with three Liberal MLAs. Even though there was considerable opposition to the sale of BC Rail, particularly in northern BC where Mayors and business leaders spoke out against the

sale, Prince George Mayor Kinsley publicly supported the sale (DeCiccio, 2005). Not only did Premier Campbell's credibility decline, but the Prince George Mayor was also affected through his involvement with the provincial Liberals.

As Goode and Ben-Yehuda (1994) discussed in their theory of panic construction, the provincial government needed a crisis which demonstrated ongoing care and concern of the health of its constituents. The issue ultimately needed education implications which demonstrated concern for youth and children. These efforts were to deflect attention from the sale of BC Rail, which was still a hot topic for many in BC, most noticeably in the north, and had to be achieved without spending large amounts of money. The chosen issue was methamphetamine. (See Appendix 2 for a more detailed account of the timeline and issues involved in the BC Liberals panic construction).

There was a lack of evidence regarding the prevalence of methamphetamine specific to Prince George both in government documents and provincial research (BC Coroners Service, 2005; Tonkin, 2005). Statements by research participants indicated that while methamphetamine was a significant problem for some agencies, the larger issue was the lack of funding that ensured sustainable programs, treatment beds, and other health services. Although the Methamphetamine Environmental Scan Summit was hosted in Vancouver in November 2002 (British Columbia Ministry of Health Services, 2004), provincially speaking, few changes regarding methamphetamine occurred until after the election in 2005.

In October 2005, the BC government created the Crystal Meth Secretariat in addition to the funds provided to community programs (Ministry of Public Safety and Solicitor General, 2007). The increase in panic words did not begin until 2004 with most occurring in 2005, the year of the provincial election. In fact, the majority of panic words occurred after

the election when Premier Campbell was experiencing a severe lack of public trust (Strachan, 2006). The first public information session in Prince George on methamphetamine and its effects was the BC Solicitor General's Methamphetamine Forum held on February 2, 2006. Although Prince George's inclusion appeared to be due to the influence of a local MLA, public trust and the liberal image may have been more of an incentive.

Summary

In 2005, while government directed its substantial resources toward methamphetamine awareness in an effort to increase public trust, the various service agencies in Prince George were not trying to increase awareness. Extreme need in service populations echoed throughout research participant interviews. From education to health to minimum barrier service, resources, both human and financial were overwhelmed. While this environment provided an ideal atmosphere in which to take comprehensive action that addressed the effects of methamphetamine in the Community, this was not the reality.

Jobe-Armstrong (2005) stated that service agencies often perceive themselves as unrelated to each other. Attempts to address methamphetamine as part of a plan of strategic action could have united most of the segmented resources within Prince George; yet, a single issue focus, methamphetamine, had the opposite effect (Singer et al., 2006). Youth quickly dominated concerns about methamphetamine in Prince George. A youth agenda, while appropriate, shifted attention from strategic planning for the Community to a youth agenda which stymied discussion about methamphetamine affects on other areas such as business (NDMAC), mainstream workers (British Columbia Ministry of Health Services, 2004; Klee, 2001; Singer et al., 2006), and post secondary students (Baskin-Sommers & Sommers, 2006;

Quintela et al., 2000). Saxe (2001) demonstrated that the visibility of illicit drugs does not necessarily indicate higher drug use and dependency. Even though high risk youth usage is visible throughout minimum barrier service agencies.

Labonte and Minkler (2006) stated that "cynicism [undermines] the efforts of health care workers to support" (p. 87) programs that are unique to the Community's differing populations and their needs.

> A common complaint was … too much time and money on talking, planning and researching local needs rather than doing something about problems that neighbourhood and minority organisations [find] immediate and obvious. They also believe that … overhead costs swallow resources that grassroots organizations could use more effectively (Lindholm, Ryan, Kadushin, Saxe, & Brodsky, 2004, p. 269).

Some frontline service providers express bitterness towards the process of inclusive and systematic action with resources that seem to be "wasted" on local and provincial meetings (Singer et al., 2006) while others embrace it as an opportunity to raise systemic issues at policy tables. The perception of addressing systemic issues through policy development is that it wastes valuable resources and opposes frontline service provision issues. This perception creates a confrontational environment regarding methamphetamine awareness in Prince George.

Labonte and Minkler (2006) identify three components for effective collaboration 1) "common definition of the problem", 2) "commitment to collaborate", and 3) "identification of the stakeholders" (p. 93). The three components are initially in place; yet, the shifts in organizing agency and focus on a youth agenda stall the proposed actions that arose from

discussions. For example, the only action item that includes Community members willing to volunteer efforts is in the area of policing ("Regional conference on methamphetamine: Youth program", 2007). There are two possible explanations for such an outcome: 1) persons who would normally volunteer are already working in the youth arena, and/or 2) the community is simply overwhelmed with need. Overwhelming need resonates most strongly with research participants. Organization difficulties, funding limitations, and appropriate disbursement of findings from the forums, refer to the need for specific skills and time to address Community issues in a timely manner. "Grassroot entities sometimes lacked formal organization or administrative capacity" (Lindholm, Ryan, Kadushin, Saxe, & Brodsky, 2004, p. 271) that are necessary to move an agenda forward.

Ideally, unifying the Community to address methamphetamine issues would gather "creativity, energy, resources and increase the impact" of strategic action (Lindholm, Ryan, Kadushin, Saxe, & Brodsky, 2004, p. 272). However, the ideal "contradicts the competition and segmentation that are the institutional context" of service provision at all levels (p. 272). Competition refers to "direct or indirect contests between sectors or organizations over resources … including clients, staff, grants, contracts, and public credit for local initiatives" (p. 272). Lobbying for community attention is another form of competition between agencies. Any interagency cooperation brings with it the mandates of each agency with the service providers' commitment to ensure that their specific focus or solution is at the forefront of any Community action. Grassroot contexts, funders contexts, political and business contexts also present barriers to comprehensive efforts to address methamphetamine use (Libby, 2002; Saxe, Reber, Hallfors, Kadushin, & Jones, 1997). Most research participants state that the main issues clients are facing is polydrug use and barriers to health

services, not methamphetamine. Saxe et al. (1997) assert that the difficulty "in convincing grass-roots and minority organizations to participate… [is] convincing them they have a say in the decision-making process" (p. 362). The competition is over not only resources but also a "shared vision" (Saxe, Reber, Hallfors, Kadushin, & Jones, 1997, p. 358).

The forums which initiated in Prince George lacked a formal process or defining body. The Community Planning Council started to inform Community members about methamphetamine while they developed a plan for comprehensive Community action (Florey, 2005b). This process stalled due to fragmentation in vision and lack of recognition of methamphetamine affects on Community as a whole. Vertical knowledge differed substantially from administration to frontline service providers; however, this disconnection did not affect comprehensive plans that addressed methamphetamine use. Horizontal disconnection created a "struggle within [the community] over which strategies were employed and who should control them" (Saxe, Reber, Hallfors, Kadushin, & Jones, 1997, p. 362). Although collaboration between agencies is achievable (Lindholm, Ryan, Kadushin, Saxe, & Brodsky, 2004), cooperation requires a clear definition of the issue, such as the prevention of methamphetamine use, as well as the role of each contributing agency and service provider, and the connection of that issue to various segments of the community.

CONCLUSION

Informing the public in Prince George is a difficult task. Differing perspectives on issues and solutions can create barriers to comprehensive movement toward Community wellness. Mandates for service provision and overwhelming need within the Community ensure that providing information to the public is largely "on the side of the desk." In addition, Community capacity to address problems diminishes without strategic planning to move forward in a comprehensive manner (Mayer, 2002).

Horizontal disconnection within Community indicates that most responses to methamphetamine, regardless of the agency involved, are regarded with cynicism and suspicion of a hidden agenda. Fragmentation provides an advantage for external agendas as with political lobbying. Inclusive knowledge sharing can be an early warning of a new drug trends as well as other issues that accompany methamphetamine such as the violence and mental health effects.

Hall and Broderick (1991) recommend that communities create strategies for monitoring such as local drug epidemiology networks. The network with "representatives from health, criminal justice, and other community agencies affected by drug abuse" (p. 113) tracking local data may reveal "emerging drug problem[s].... much sooner than it would be detected from national data or surveys" (p. 113). Thus, Prince George could reap the benefits of interagency cooperation rather than traditional independent action. "Networks of addiction treatment programs and health departments may anticipate and allocate therapy resources at the onset of a [drug] outbreak" (p. 118). "Local strategies may more rapidly identify, prevent, intervene in, and stop expansion of the problem" (p. 119).

Difficulties with role recognition demonstrate that local strategies require awareness of the diverse skill sets to advance the Community responses (Mayer, 2002). Agencies and service providers need to be aware of the differing skill sets at various stages of process such as long term policy change (Hall & Broderick, 1991) and short term frontline action (Stimson, Fitch, Ball, & Rhodes, 1999). Additionally service providers require knowledge of the relevance of specific actions such as forums, conferences, and provincial meetings in addressing methamphetamine use. Recognition of the abilities and skills within the Community would also allow partnerships which decrease barriers and increase capacity (Mayer, 2002), rather than the current competition of the most needy agency or program (Kretzmann & McKnight, 2007). Broader, creative partnerships, such as business owners mentoring youth, could encourage cohesive community, and knowledge sharing. There is little recognition of the capacity of Community resources such as people, agencies, institutions, and businesses.

Importing experts from the urban south is problematic. The northern experience is unique with difficulties that are related to both geography and resources as well, and the capacity for creative responses. Southern responses to methamphetamine are not contextualized to the northern reality; for example, the longer and colder winter conditions for street involved persons inevitably create different conditions. Conversely, the northern reality also includes the ability to implement unique programs such as Street Spirits and Meth Busters, "a local publicity package so people [could] learn about meth" ("Meth campaign launched", 2007). Recognition of successes and lessons learned by various agencies as with *Fighting Back* (Hallfors, Cho, & Kadushin, 2001; Lindholm, Ryan, Kadushin, Saxe, & Brodsky, 2004) increases feelings of empowerment to address difficult issues (Bent, 2003;

Caulkins, Larson, & Rich, 1993). However, the major difficulty in Prince George as seen through the agendas of informing the public and the disconnections within the Community is the lack of a shared vision. Without a vision that is embraced by the entire Community, not just segmented populations, any initiatives to create a more responsive system ultimately fail.

Recommendations

First, the creation of an epidemiological network would be necessary to monitor and investigate substance use in Prince George. Ideally, this entity would be distinct from the municipal government, lest it becomes a health and wellness committee guided by economic development rather than building community capacity. As a separate body, accepting members from local government and service agencies as well as Community members should minimize perceptions of bias or hidden agendas,

Inclusive knowledge sharing in the epidemiological network would act as an early warning of drug trends as well as other trends related to changes in local drug use such as increasing need in healthcare, policing, and minimum barrier service provision. This network would also decrease the time lag between awareness and intervention while providing an inclusive picture of the impact of a drug and the path through Community services and agencies. For example, RCMP could be the first to notice a change in drug trends and then health services or this could occur in reverse. Knowledge of trends in other communities, such as the Lower Mainland, would allow the network to inform the public of possible impacts to service provision and health outcomes while retaining the northern context.

Second, there would need to be recognition of the benefits of strategic planning to address substance use in a comprehensive manner. Not only would planning be necessary for increasing the capacity of Prince George to address the challenges of substance use, but this

will also demonstrate an acknowledgment of the resources and skills that different groups bring to new initiatives. Workshops to inform service providers and Community members of the skill sets necessary at various stages of a strategic process, such as frontline action in the short term and systemic policy change in the long term, could increase appreciation for the process. It would be essential for the Community to recognize that each action relating to substance use, whether it initiates within healthcare, policing and/or youth, can affect the Community as a whole. Therefore, the whole Community should respond to substance use trends that affect health in a strategic manner.

Third, the capacity of the Community should be encouraged, demonstrated, and initiated as a movement. Recognition of the abilities and skills within Prince George will allow partnerships which could decrease barriers and increase capacity. Broader and more creative partnerships such as partnering youth with seniors or business owners as mentors could encourage a cohesive Community and knowledge sharing as well as increasing empathy and compassion for different skills and abilities.

Finally, we must recognize and utilize the plethora of local expertise throughout Prince George. Developing a roster of presenters and their specific areas of expertise will allow an intervention or discussion, such as working with violent clients or recognizing specific mental health issues, to be congruent to the audience. This will also allow the service provider, agency or community member, the opportunity to highlight their abilities, challenges, and specialized knowledge to others in the community leading to decreasing disconnection between groups and thus resources for all populations.

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APPENDIX 1

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

RESEARCH ETHICS BOARD

MEMORANDUM

To: Judy Mitchell
CC: Henry Harder & Ken Prkachin

From: Greg Halseth, Chair
Research Ethics Board

Date: August 8, 2007

Re: **E2007.0723.074**
Critical Mass: A case study of the who's, the how's and the why's of informing the public about crystal methamphetamine in Prince George

Thank you for submitting the above-noted research proposal and requested amendments to the Research Ethics Board. Your proposal has been approved.

We are pleased to issue approval for the above named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review and renewal of REB approval. Any changes or amendments to the protocol or consent form must be approved by the Research Ethics Board.

Good luck with your research.

Sincerely,

Greg Halseth

APPENDIX 2

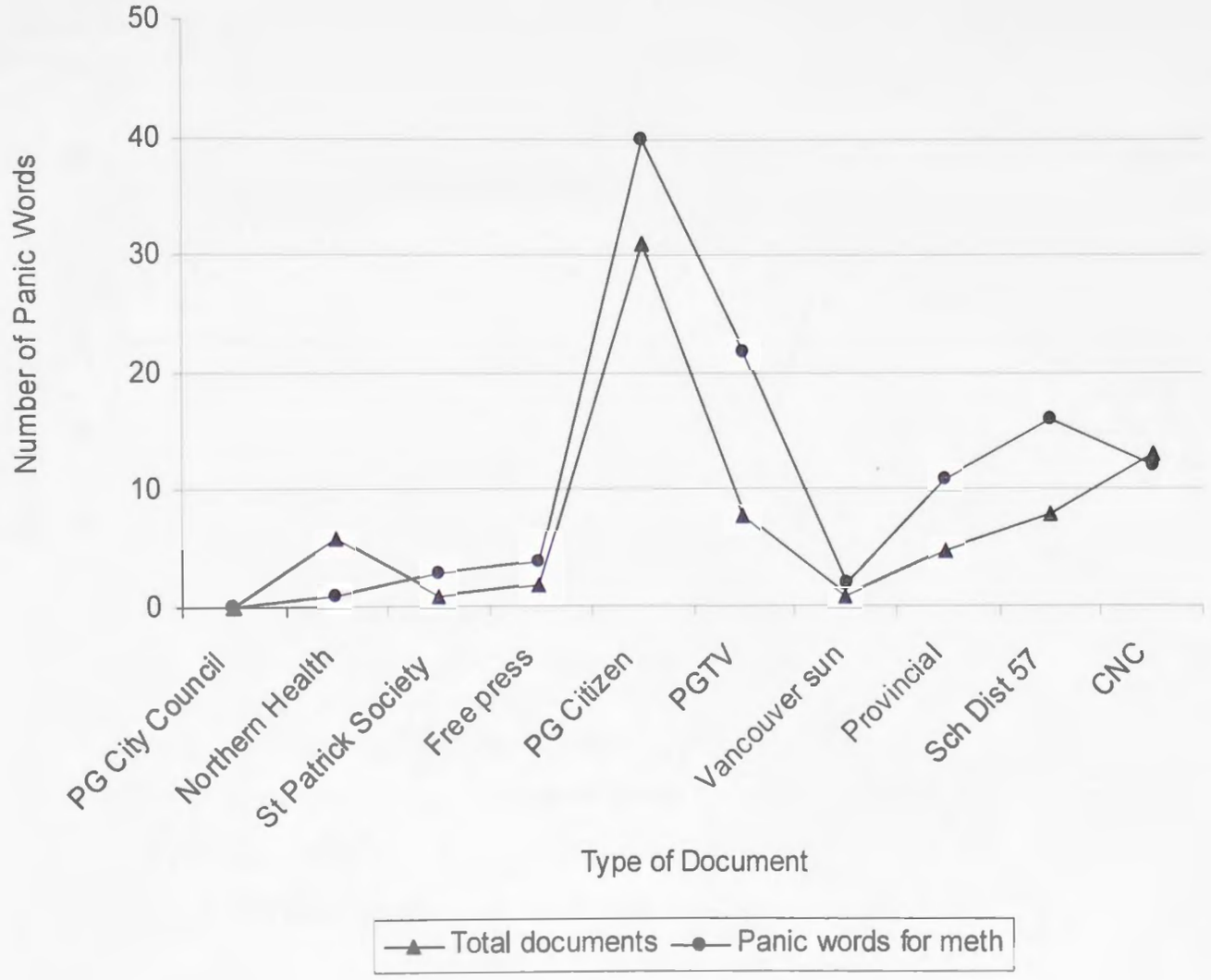

Figure 1. Type of Document by the Number of Panic words

APPENDIX 3

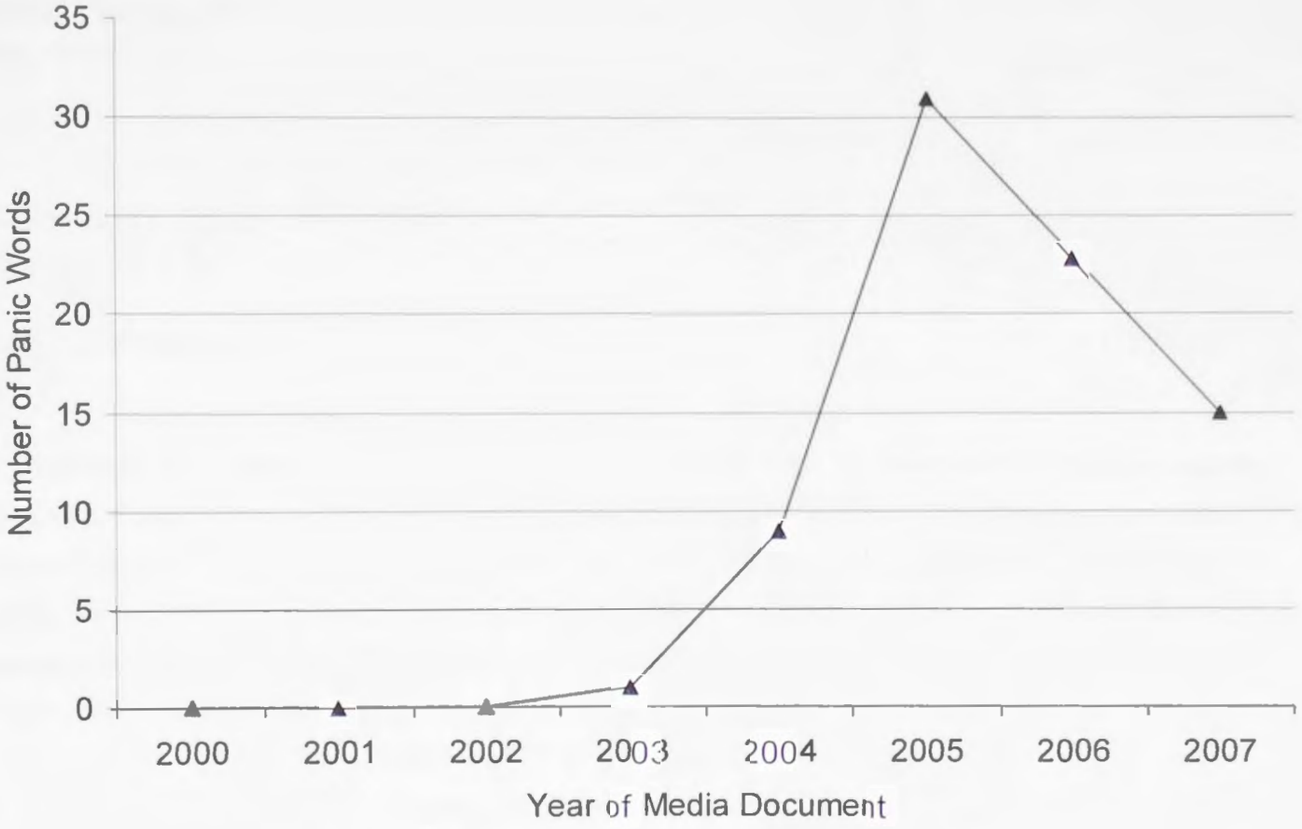

Figure 2. Number of Panic Words by Year of Mention in Media Documents.

APPENDIX 4

xxxxxxxxx
xxxx-xth Avenue
Prince George, BC
xxx xxxx

May 9, 2007

Good Afternoon,

My name is Judy Mitchell, Masters Candidate in the UNBC Community Health Sciences program. I am doing my thesis on public information about crystal methamphetamine in Prince George. Specifically around what the crisis point was that compelled informing the public about meth in our community. In order to do this I am creating a timeline of events throughout Prince George concerning meth such as workshops, presentations, or any other method of informing people.

If you are aware of any workshops, information sessions, pamphlets, or other literature on meth or have participated in any such events, I would appreciate any information that is available about when the event occurred, in what way the discussion related to meth and who the target audience was. If possible any copies of the information presented would be very much appreciated.

I am especially interested in the first event presented or that happened concerning meth within Prince George.

Thank you for your time.

Sincerely
Judy Mitchell

3333 University Way
Prince George, BC
V2N 4Z9

Ph: 250-562-7132
Email: tobinj@unbc.ca

XXXXXXXX
1350 5th Avenue
Prince George, BC
V2L 3L4

October 2, 2007

Dear XXXXX,

Re: LETTER OF INTENT FOR INTERVIEW PARTICIPANTS

This information package is to further our conversation regarding your participation in the research project, Critical Mass: A Case Study Of The Who's, The How's and The Why's of Informing the Public About Crystal Methamphetamine In Prince George.

Thank you for considering participating in this research project to establish a timeline of public knowledge of crystal methamphetamine in Prince George. I have asked for your participation in this research because of your involvement, either through your agency or through the media, in informing the public about crystal methamphetamine.

The **benefits** of participating in this research project include the opportunity to share your experiences in such as way that Prince George can better understand the impact of meth and possibly achieve positive change in Prince George. There are no anticipated **risks** associated with this study.

The interview will take about an hour of your time. Accompanying this letter is a copy of the questions I would like to ask. I would also like to make you aware of my preference for taping the interview. This is to preserve your information as stated rather than my interpretation of any notes taken. At any time, you may withdraw your consent for recording the interview, or withdraw your participation in the research.

The information that you give in the study will be kept confidential. Your information will be assigned a code number. The list connecting your name to this number will be kept in a separate computer file. When the study is completed and the data has been analyzed, this list will be destroyed. Your name will not be made public in any way without your consent. There is a consent agreement enclosed.

Your Rights As A Research Participant

- You have the right to withdraw from the interview at any time.
- You have the right to refuse to answer any question.
- If you choose to withdraw from the research project, your information will be withdrawn as well.
- You have the right to complete anonymity, meaning your name will not appear on any document in this project.

You may request a copy of your transcript. You also have the choice to receive a copy of a summary of findings upon completion of the research.

All documentation of this research will be kept in locked storage for five years and after that time, they will be shredded.

If you have any questions about this research study, please feel free to contact me.

Judy Mitchell,
Candidate for Masters in Community Health Science
3333 University Way,
Prince George, BC, V2N 4Z9
Phone: 960-5238 Email: tobinj@unbc.ca

Or my supervisor,

Dr. Henry Harder
3333 University Way,
Prince George, BC, V2N 4Z9
Phone: 960-6506 Email: harderh@unbc.ca

If you have any concerns about your rights as a participant in this study or your experience while participating in this research study, before, during or after your participation, please contact the University of Northern British Columbia Office of Research (960-5820) or by email: reb@unbc.ca.

Thank you for your time and I hope you have a very good day.

Sincerely,

Judy Mitchell

Attached:
Consent agreement
Interview questions

Consent Agreement for Interview Participants

I, _____, Give My Permission for the Following:

I agree to participate in this research project.	Yes	No
I agree to the audio-taping of this interview.	Yes	No
I agree to the use of my information in this research project as well as any publications resulting from this research.	Yes	No
I agree to the use of my name in this research project.	Yes	No
I would like to receive a copy of the transcription of this interview.	Yes	No
I would like to receive a summary of the findings upon completion.	Yes	No
I am aware that I can withdraw from this research process at any time.	Yes	No

***If You Choose To Withdraw, Any Information You Have Provided Will Be Destroyed; Audiotapes Will Be Broken, Printed Material Will Be Shredded And Any Information Stored Electronically Will Be Deleted.**

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Researcher **Date**

Sample Interview Questions for Key Community Members

1. When do you recall first becoming aware of crystal methamphetamine?

   Prompt: In what context do you first recall being aware of crystal meth?

2. What do you recall of your organization's reaction to crystal methamphetamine?

   Prompt: What was happening that your organisation was noticing crystal meth?

3. When do you recall first discussing the possible implications of crystal methamphetamine for the municipality of Prince George?

   Prompt: Was there a conversation with individual members of your organization or in a staff meeting or other gathering?

4. What was the precipitating factor (s) that made you and/or your organization to want to inform the public about crystal methamphetamine?

   Prompt: Was there any one situation, incident, or event that made you feel people need to know what is happening here?

5. How did you and/or your organization choose inform the public about crystal methamphetamine?

   Prompt: Was there a reason you and/or your agency chose a specific method of informing the public or a specific population within Prince George? (i.e. pamphlets versus presentations)

PARTICIPANT COPY

Information for Interview Participants Who Formerly Used Meth

Thank you for agreeing to be interviewed for the research project, *Critical Mass*. This research project is to try to make out a timeline of public knowledge and information available about crystal methamphetamine in Prince George. You have been asked to participate in this research because you have special knowledge as a person who has used meth in Prince George. I will be asking you about your experiences of crystal meth and the services for people using crystal meth in Prince George.

There are **benefits** to participating in interview such as:

a. Having the opportunity to share your story and your experience,
b. Sharing your knowledge so the Prince George community can better understand the effects of crystal methamphetamine, and
c. Sharing your knowledge can help effect positive change in Prince George.

There are also **risks** in participating in this interview:

a. Touchy subjects may come up and cause you some emotional distress. If you want to talk about these feelings after the interview, please ask me for help. I may ask if you need help if I feel you are having difficulty.

Your Rights As A Research Participant

- You have the right to withdraw from the interview at any time.
- You have the right to refuse to answer any question.
- If you choose to withdraw from the interview, your information will be withdrawn as well.
- You will have complete anonymity, **your name will not be on any papers or reports on this research project.**

Before we begin talking, I need to discuss the limitations of this interview.

1) **Anonymity**- The information you share will be recorded anonymously, meaning your name will not appear with that information. If this is a problem for you, you may choose to stop the interview. There will be no bad feelings if this is your decision.

2) **Confidentiality** – Your confidentiality will be respected. The list connecting your name to the information from this interview will be kept in a separate computer file. When the study is completed, this list will be destroyed. Your name will not be used in any report or made public in any way.

Another person may be typing out your information from this interview. They will not know your name because your interview will be given a number with no name. They will sign a confidentiality agreement saying that they will not repeat anything they heard while doing this job. All information collected from this interview will be kept locked storage for five years at the University of Northern British Columbia. After that time, it will be shredded.

3) I also need to inform you that I as well as

   a) **All citizens of British Columbia are required by law** to report to the Ministry of Children and Family Development if they have reason to believe that a youth under the age of 19 is being abused or harmed in any way. If you reveal this during the interview, I will work with you to make sure that any reporting is done with your full knowledge, and places your safety first. You need to keep this limitation to confidentiality in mind when you are answering the questions.
   b) **All citizens of British Columbia are required by legislation** to report anyone who expresses thoughts of harming themselves or others. If this is revealed during the interview, I will work with you to get immediate help and to help set up appropriate counselling services for you. If this is not enough to help you and the thoughts continue then I am compelled to report this to the appropriate authorities.

This interview will take about one hour of your time but it can take more or less time depending how much information you would like to share.

If you are interested in the findings of this project, I will mail you a summary of the findings or I can drop off a copy for you at a specific agency. Just fill in the address or agency name for where you would like the summary sent on the bottom of the consent agreement. This list of addresses and names will be kept in a separate file from any of the information collected today.

If you have any questions about this research study, please feel free to contact me.

Judy Mitchell,
Candidate for Masters in Community Health Science
3333 University Way,
Prince George, BC, V2N 4Z9
Phone: 960-5238 Email: tobinj@unbc.ca

Or my supervisor,

Dr. Henry Harder
3333 University Way,
Prince George, BC, V2N 4Z9
Phone: 960-6506 Email: harderh@unbc.ca

If you have any concerns about your rights as a participant in this study or your experience while participating in this research study, before, during or after your participation, please contact the University of Northern British Columbia Office of Research (960-5820) or by email: reb@unbc.ca.

Consent Agreement for Participants Formerly Using Meth

I, _____, Give My Permission for the Following:

I agree to participate in this interview.	Yes	No
I agree to have my information tape-recorded during this interview.	Yes	No
I agree to the use of that information for research purposes.	Yes	No
I am aware that I can leave this interview at any time.	Yes	No
I am aware that I can refuse to answer any questions.	Yes	No
I would like to receive a report of the project.	Yes	No

_____ _____

Signature of Participant **Date**

_____ _____

Signature of Researcher **Date**

Address to Receive a Copy of the Summary

Apartment/Street _____

City/Province_____

Zip Code_____

Name of the Agency to Receive a Copy of the Summary

_____

Sample Questions For Interview Participants Formerly Using Crystal Meth

1. Can you recall when you first heard about/used crystal meth?

   Prompt: What kind of situation were you in when you first heard about meth (ie a party, a friend, family member…….)?

2. Can you recall if there something specific happening in Prince George around that time?

   Prompt: What was happening around town at that time?

3. What kinds of services in Prince George do you access?

   Prompts: Did you go to the hospital, social services, college, or daycare?

4. Did those services show any knowledge about meth that you were aware of?

   Prompts: Did anyone ask you about your meth use? Were meth pamphlets on display at the service office?

5. Have you noticed any change in the way services in Prince George are provided to people using meth?

   Prompts: Are there specialized services for people using meth? If so, what kind? Are people using meth being directed towards certain people or services?

Transcriber Confidentiality Agreement

I, _____, agree to keep the confidentiality of all interviews I transcribe related to the Critical Mass research project. I will not reveal or discuss who is speaking, or what was said on the audio tapes I am transcribing other than with the researcher, Judy Mitchell.

_____ _____

Signature of Research Assistant Date

_____ _____

Signature of Researcher Date

APPENDIX 5

Organizational Role	Category (Identity Code)
A representative of television, radio, or print media.	Media (M)
A person holds some decision making and policy making authority within their agency. This person does not provide frontline service.	Executive Administration (EA)
A person with some autonomy and decision making abilities within their agency. This person does little or no frontline service provision.	Management Administration (MA)
A person who fulfils dual roles as frontline service provider while managing some other facet of their agency. For some participants this included a strong advocacy role.	Management Frontline Service Provider (MFSP)
A person providing frontline service to people experiencing difficulties with meth use and/or addiction.	Frontline Service Provider (FSP)
A person who has but is currently not using meth.	Former Meth User (FMU)

Figure 3. Coding of research participants.

APPENDIX 6

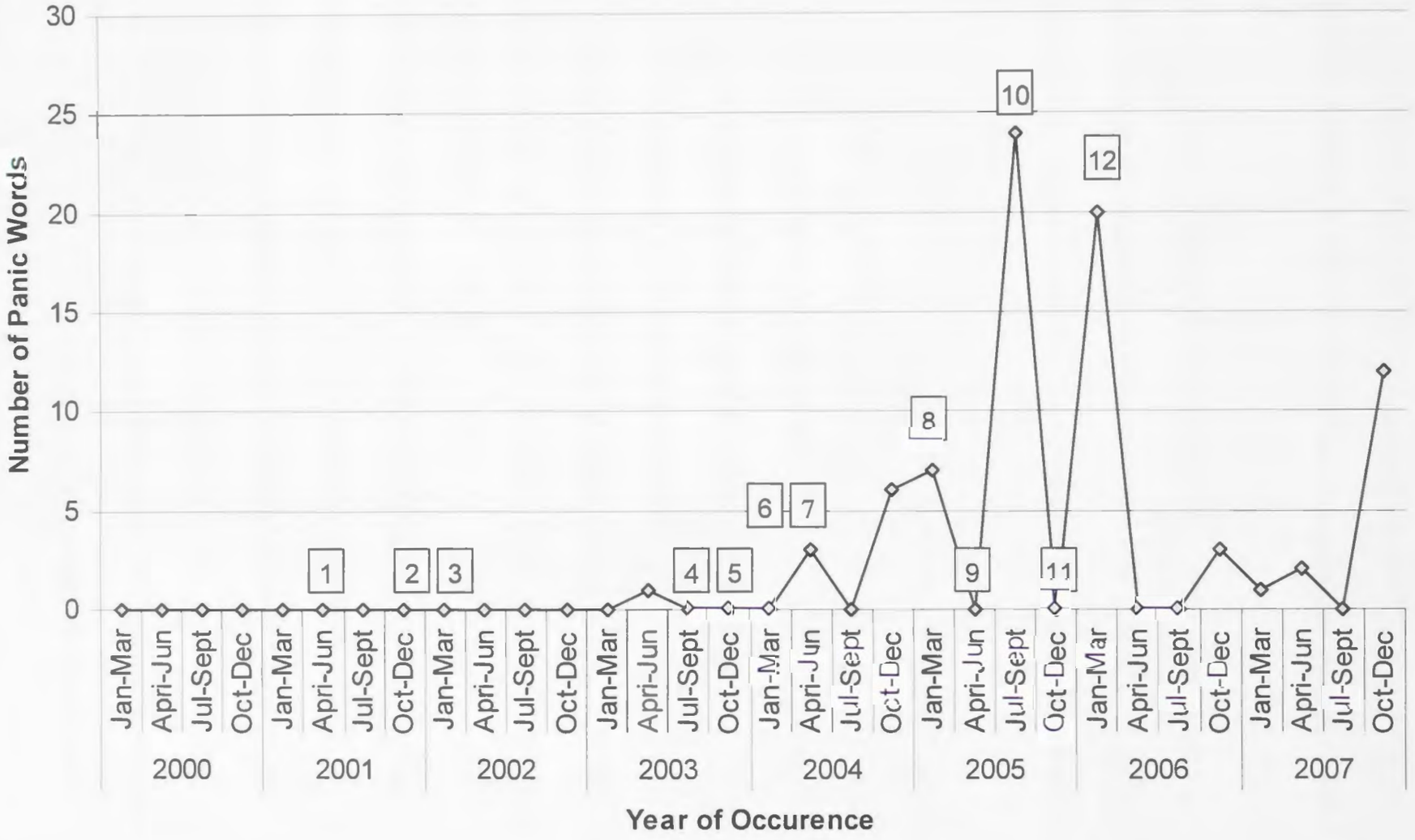

Figure 4. Time Line of Panic Words by Yearly Quarter Occurrence in conjunction with Provincial Government Events as Reported in Prince George Media.

1. BC Liberals win the provincial election with 76 of 79 seats. Campaign promises included: no cuts to healthcare, not to sell or privatize BC Rail, and to keep tuition frozen ("B.C. legislature could sit by summer, Campbell says", 2001; Hatley, 2005).
2. In "an Oct 19 bulletin to health ministry executives order[ed] the cutting of administration by $85 million over the next three years". The provincial government froze health and education funding over the next three years ("Gov't looks to slash health costs", 2001).
    a. The provincial government makes cuts to supplementary medical plan benefits, drug eligibility, and Medicare premium assistance ("B.C. cuts health services most other don't cover", 2001).
    b. An Ipsos-Reid poll shows Premier Gordon Campbell's approval rating is down from 70 to 51 per cent in three months; while his government's approval rating falls from 71 to 49 percent ("Campbell tumbles in approval rating: New poll shows half the voters still support premier's efforts to cut costs", 2001).
3. January 1, 2002, the Medical Service Plan cutbacks start. The government declares that it will only fund 'access to medically necessary' healthcare ("Campbell tumbles in approval rating: New poll shows half the voters still support premier's efforts to cut costs", 2001).
4. In a survey of 1500 Canadians by Leger Marketing, "BC showed up with the lowest level of satisfaction [with the educational system] of all provinces" ("Poll blasts gov't for education cuts", 2003).

5. The leader of the New Democratic Party receives a 25,580-name petition in Prince George that calls on the provincial government to keep BC Rail publicly owned (Nielsen, 2003).
    a. The petition with "more than 32,000 signatures of British Columbians opposed to the privatization of B.C. Rail services [is] presented in the legislature" (Rud, 2003).
    b. After seven schools closures helps to meet a $9.6-million shortfall in 2002, 2003 starts with a projection of a further $9.9-million shortfall in the 2003-04 budget (Strickland, 2003) .
6. In an open letter to Premier Gordon Campbell, "some northern BC City councillors, mayors, and business have signed up with labour to call on the BC government to halt the sale of BC Rail (Hoekstra, 2004).
7. BC Medical Association post graphs on a website that show increases in wait times across the province for various surgeries due to cuts to Medicare (Nielsen, 2004).
8. Opinion polls show that "over 75 per cent" of the Prince George population are against the sale of BC Rail ("BC Rail advocates still fighting", 2005).
9. At a BC Rail meeting people expressed the opinion that "Gordon Campbell and the BC Liberals should be voted out of office in the upcoming election for breaking his promise not to sell BC Rail" while one person challenges the Prince George Mayor to defend the sale ("BC Rail meeting draws packed house", 2005).

a. Former Liberal, Paul Nettleton states that recent increases in government spending are a ruse and that "Premier Gordon Campbell can't be trusted"(Hoekstra, 2005).

b. Issues brought up the day before the election includes "the sale of B.C. Rail [which] demonstrates complete betrayal of trust and lack of integrity on the part of [Gordon Campbell]'s Liberals…" Other broken promises include closures or cutbacks 71 hospitals and emergency rooms, wages cut for hospital workers, eliminates 2,500 post-secondary teachers and other staff, doubles college and university tuition fees, increases class sizes in every grade, and cuts training and apprenticeship programs ("Candidates tangle on economy, trust", 2005).

c. In the May 17, 2005 election, the Liberal government majority shrinks from 79 to 46 seats.

10. Prince George Mayor welcomes the provincial government announcement of 7 million dollars to help "battle the growing problem with crystal methamphetamine" (Nielsen, 2005).

11. A letter to the Editor describes the Prince George Mayor as being out of touch with regular folks. With business, many northern BC city councils and two separate Prince George polls showing the public is opposed to the sale of B.C. Rail, "Mr. Kinsley did everything he could to support what his community did not, and that is betrayal" (DeCiccio, 2005).

a. MLA Shirley Bond announces a provincial government plan to introduce, *MethWatch*, a program to monitor "bulk sales of cold medications that can be used to make crystal meth" (Peebles, 2005b).

b. The provincial government releases 2 million dollars to support community-based programming to fight "the use of crystal methamphetamine" ("Anti-meth fund seeking applications", 2005).

12. Feb 2, 2006, Solicitor General's Methamphetamine forum held in PG. While MLA Shirley Bond announces school initiatives to educate students about meth, there are no increases in funding for treatment beds.

a. One reporter notes that in September 2005, "Campbell was characterized as cruel and uncaring" however by March 2006 there was a perception that Campbell had mellowed in his leadership style (Strachan, 2006).