METHED UP:
HOW DO STREET YOUTH WITH METHAMPHETAMINE-INDUCED PSYCHOSIS
ACCESS MENTAL HEALTH SERVICES?

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

MASTER OF SOCIAL WORK

in

THE FACULTY OF GRADUATE STUDIES

THE UNIVERSITY OF BRITISH COLUMBIA

(Vancouver)

April 2008

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Abstract

This study explored the experiences of street-involved youth who have received mental health services for symptoms of methamphetamine-induced psychosis. Specifically, the study investigated what factors were perceived by participants to promote and hinder access to mental health services. The researcher interviewed nine street youth at Covenant House, a Vancouver agency serving street-involved youth. Interview data and the researcher’s field notes were coded and analyzed within a grounded theory paradigm. Youth discussed formal and informal sources of help and routes to both. Two distinct perspectives to treatment were identified: an addictions perspective and a concurrent disorders perspective. Respondents outlined the typical pathway into methamphetamine use and described barriers and supports for accessing services while undergoing drug-induced psychosis. Significant factors that encouraged access to services were positive relationships with helpers, strong peer supports, and the use of involuntary services when necessary. Identified barriers included fear of being stigmatized, lack of problem awareness, and systemic barriers. The current research proposed a model of access to mental health services that positions outreach and frontline workers as key figures to mediating street youth’s access to appropriate services.
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Acknowledgements

I owe a tremendous debt of gratitude to the youth who have so generously given me their time and shared their stories with me. I hope I have faithfully represented your thoughts and your words in these pages.

I would like to thank Dr. Grant Charles for his assistance and guidance in accomplishing this research. I would also like to thank Covenant House Vancouver for allowing me to carry out this research on their premises.

Finally, I want to express all my love and gratitude to my husband who has been an eternal source of moral support, help with transcription and proofreading, chai lattes, early morning drop-offs, and late night pick-ups. Without your support, I would still have accomplished this, but it would have been infinitely harder.
Chapter I  Introduction

Crystal methamphetamine is currently a high profile issue in Western Canada, and particularly in the regions surrounding Vancouver, British Columbia. The Canadian Community Epidemiology Network on Drug Use (CCENDU) hosted a Methamphetamine Environmental Scan Summit in Richmond, British Columbia in November 2002, largely in response to concerns raised by local social service agencies that were reporting a huge increase in the popularity of crystal methamphetamine (Nathoo, 2003). Delegates at the Summit reported a significant rise in the availability and use of crystal methamphetamine in Greater Vancouver, as well as unusually high rates of psychotic symptoms and violence among users. A second Western Canadian Summit (Vancouver Coastal Health, 2005) was held in November 2004 to develop further a regional understanding of associated health, enforcement, prevention, and treatment issues. Media coverage locally and from the United States maintains high awareness of these concerns among the general public (Leinwand, 2007, March 25; Pursaga, 2007, April 13; Ramsey, 2005, April 17-24). One of the key issues identified during these summits was the lack of services for young people who use crystal methamphetamine. Even where services exist there are access barriers particularly for youth who are concurrently experiencing mental health issues related to their drug use.

My desire to assist youth facing these barriers was originally kindled by my own personal experiences with homelessness and drug use. I have worked with street involved and at-risk youth for the last eleven years and seen first-hand the effects of methamphetamine use on their physical, emotional, and mental health. Over the last six years, at least four of my clients have died from reasons related to methamphetamine use.
I have seen many kids I care about descend into confusion, paranoia, and delusion. Even worse, many of them never completely recover their original mental status. Some have been as young as thirteen years old. My personal sadness and frustration over the inaccessibility of appropriate supports and these lonely deaths drives my interest in research that will result in more effective and accessible mental health services for street youth.

Both my first-hand experience and research evidence reveal a relationship between methamphetamine use and substance-induced psychosis (Srisurapanont, Jarusuraisin, & Kittirattanapaiboon, 2001). This research is intended to investigate how street youth access mental health services for symptoms of drug-induced psychosis, and what factors they perceive to promote and impede them from accessing these services.
Feminist Social Constructivism

Social constructivism as a theory of knowledge evolved from Berger and Luckmann's theory of social constructionism laid out in *The Social Construction of Reality* (1966). Social constructivism and related epistemologies like social constructionism (Franklin, 1995) and symbolic interactionism (Forte, 2004) are rooted in a post-modern understanding of pluralistic realities and multiple perspectives. Social constructivism does not deny the existence of an objective reality, but rather deems it to be unknowable as we all interpret and language events in individualistic and idiosyncratic ways (Furman, Jackson, Downey, & Shears, 2003). From this perspective, the stories that people tell — their social constructions of reality — are all that really matter, because for all intents and purposes, they *are* that person’s reality. This theoretical perspective positions the individual as the authority on him or herself and conveys respect for the individual’s expertise (Ungar, 2004). From this perspective, I consider one role of social workers to be helping people become conscious of how larger social, cultural, and economic influences act to shape and impact their reality, while simultaneously recognizing the individual’s unique and irreproducible lived experience.

I subscribe to a feminist perspective in both research and practice. In broad terms, feminist social work seeks to analyze, deconstruct, and redress power imbalances and oppression in all areas of people’s lives (Dominelli, 2002). For these reasons, a feminist perspective is especially useful when working with marginalized populations like street-involved youth and those with mental health issues. Feminist methodologies recognize the structural power differences inherent between researcher and participant. Common
strategies used in feminist research to minimize these inequities include locating the self within the research and self-reflexivity (Aranda, 2006). Questions of control and whose voice is being heard are central to the process of feminist and social constructivist research (Letherby, 2002).

A feminist constructivist critique reminds us to be aware of the power relations existing between different individuals and groups in society, between those who have and those who have not. Developing an understanding of homelessness, addiction, and mental illness requires recognition of the ways that street youth are stigmatized, marginalized and rendered invisible (Harter, Berquist, Titsworth, Novak, & Brokaw, 2005). As Furman et al. (2003) argue, “Social constructivism may be an especially useful perspective for working with disempowered, marginalized individuals since it gives primacy to the relationship between the social and cultural context and disempowered individuals (p. 273).” Incidentally, this awareness also demands a consideration of ethical ways of doing research with this population (a topic to which I will return in the Ethics chapter of this thesis).

Social constructivism provides an overarching framework that helps us to understand a person’s lived experience and process of change. This recognition of each person’s reality as individually constructed directs us to develop assessment, intervention, and other services that are flexible and individually responsive to the client’s reality. In other words, social work with a client or community should be developed collaboratively and driven by that particular client or community’s goals. This meta-theory can easily accommodate more specific models of aetiology and intervention. For example, systems-based theories, the biopsychosocial model, and complexity theory are congruent with
constructivist and post-modern constructions of meaning (Warren, Franklin, & Streeter, 1998). That is to say, people’s cognitions and behaviours are understood to act upon each other and their realities in multiple, complex, and recursive ways, and their relationships and realities are meaningfully constructed within that context.

A common criticism of social constructivism and other post-modern approaches is the problem of relativism (Ungar, 2004). If there is no way to determine which reality is more “real”, then how can social workers assert any position, ethic, or value without invalidating or denying someone else’s reality? Individuals who are psychotic (as well as those who are developmentally delayed, under the influence of substances, or otherwise limited in their ability to make sense of their surroundings) may construct realities that seem to lack any connection or shared foundations with “reality” as most others see it. Taken to its logical conclusion, it can be argued that social work within a social constructivist framework is obliged to respect that person’s reality and expert status and therefore cannot intervene “for his or her own good” regardless of the consequences.

Ungar (2004) points out that the key concept in social constructivism is not “everything goes”, but rather its emphasis on investigating and negotiating individual meanings as an alternative to assuming an objective and impersonal reality existing separate from ourselves. He argues that social constructivism’s relativism is not an absolute relativism, and social workers are able to assert consensually agreed upon ethics and principles for intervention. Consensual reality is still socially constructed and reflects assumptions agreed upon by the majority of participants. It is therefore unfixed and open to revision, rather than viewed as a permanent and transcendent truth existing independently of our senses. For example, there is general consensus in Canadian society
(as reflected in our provincial mental health acts and trusteeship legislation) that acutely psychotic people are unable to make reasonable decisions for themselves and therefore need another person to act on their behalf and in their best interests. I am in no way minimizing this extraordinarily complex decision-making process which would require volumes of text in which to enumerate the theoretical, practical, and ethical considerations involved. I merely assert that a social constructivist perspective does not preclude making such decisions.

There seems to exist a tension between two extremes of “modernist” and “post-modernist” social work. A modernist representation of social work positions the social worker as the authority and rests on assumptions of paternalism and the primacy of the “public good”. This approach to social work promotes universal ideals of human welfare and strives to eradicate injustice, poverty, marginalization, and oppression both locally and globally. In contrast, a post-modern version of social work extols individual autonomy and self-determination, and views local political, cultural, and social milieus as appropriate areas in which to seek change (Noble, 2004). I would argue that neither perspective is more valid than the other. It is possible, and indeed preferable, to integrate these perspectives into a more comprehensive and responsive model of social work and social action that offers the possibility of change on both the micro and macro levels. This is the approach I have taken with my research.
Chapter III  Crystal Methamphetamine

Methamphetamine is an amphetamine-type stimulant (World Health Organization [WHO], 1997) with similar neuropsychological effects. It was first synthesized in the 1880s from ephedrine, but not widely used until World War II when governments on both sides of the conflict provided methamphetamine to military personnel so they could remain awake and focused during missions (Anglin, Burke, Perrochet, Stamper, & Dawud-Noursi, 2000). Historically, the first “meth epidemic” occurred in Japan in the 1940’s and can be traced to the release of major amounts of surplus methamphetamine to the general public after WWII (WHO, 1997). Both amphetamine and methamphetamine were commonly used in the 1950s and 1960s to treat narcolepsy, depression, and obesity, and recreational use of methamphetamine or “speed” became popular along the West Coast of the United States during the 1960s (Anglin et al., 2000). Methamphetamine has made somewhat of a comeback since the synthesis of a smokeable form of crystallized methamphetamine (d-methamphetamine hydrochloride) or “crystal meth” in the 1980s (Nathoo, 2003).

Epidemiology

Other names for crystal methamphetamine include meth, crystal, tina, jib, gak, ice, speed, crank, and shards. Meth can be found in several different forms. It may appear as slightly transparent crystals, brownish granules, or beige, white, or pink powder. It is sold in paper flaps, plastic baggies, tablets, or capsules. Crystal meth is most commonly injected, snorted, or smoked in a pipe, but it can also be mixed into a beverage (often coffee or another caffeinated drink) (Meredith, Jaffe, Ang-Lee, & Saxon, 2005) or ingested in pill or capsule form (Murray, 1998). “Booty bumping”, or
dissolving crystal meth in water and then inserting it into the rectum, is used almost exclusively within the “party n’ play” (i.e., meth and sex) gay scene (Specter, 2005, May 23).

Amphetamines are the second most widely used class of illicit drugs in the world after cannabis. The most recent World Drug Report published by the United Nations (Chawla & le Pichon, 2006a) estimated that 0.6% of the global population used amphetamines during 2004 while 3.9% used cannabis during that same time period. Methamphetamine use is highest in South East Asia, Oceania, and North America. Historically, Thailand has reported the highest levels of use, but its recent crackdown on drug trafficking in 2003 has allowed the Philippines to take the lead (Chawla & le Pichon, 2006a). Most countries report stable or decreasing rates of amphetamine use since 2000, most noticeably in Thailand and Australia. Notable exceptions are China, South Africa, and New Zealand, all of which reported large increases between 2003 and 2004 (Chawla & le Pichon, 2006a). In 1998, Ireland reported the highest use of illicit amphetamines in Western Europe (Chawla et al., 2003), but by 2003, rates had fallen significantly (Chawla & le Pichon, 2006b). Currently, the United Kingdom is the largest consumer of amphetamines in Europe. Elsewhere in Europe, rates remain low. Meth use is negligible in South America and most of Latin America and Africa, although Costa Rica, the Dominican Republic, and some Western African countries report rates similar to those in North America (Chawla & le Pichon, 2006b).

Crystal methamphetamine is currently best-known for its association with the rave or club culture, but users also include a wide range of groups including students, professionals, blue-collar workers, men who have sex with men, and street youth
People use crystal methamphetamine for many different reasons. Some people use crystal meth recreationally at parties or clubs with friends. Others, especially young women, seek meth's anorectic effect as an aid to dieting. Students may use crystal meth to help them stay alert and focused on their studies (WHO, 1997). Some men use meth to enhance sexual sensation and stamina (Halkitis, Parsons, & Stirratt, 2001).

Perhaps the most common reason that people around the world use methamphetamine is as a tool to increase work productivity and performance (e.g., truck drivers, shift workers, labourers) (Chouvy, 2005; WHO, 1997). Researchers in Asia (Chouvy, 2005) and in the United Kingdom (Boys, Marsden, & Strang, 2001) report similar reasons for using meth as found in North America.

Recent Canadian indices of drug use among mainstream youth report a 2-5% lifetime prevalence rate of methamphetamine use (Adlaf & Paglia-Boak, 2005; Canadian Centre on Drug Abuse, 2004; McCreary Centre Society, 2004). These rates have not significantly increased over the last ten years. However, over the last decade, crystal methamphetamine use has skyrocketed among the marginalized populations of gay men and street youth (Nathoo, 2003; Lampinen et al., 2003 as cited in Rusch, Lampinen, Schilder, & Hogg, 2004). Local surveys of Vancouver street youth report lifetime use rates of crystal meth between 56% and 73% (Covenant House Vancouver, 2001; Martin, Lampinen, & McGhee, 2006; McCreary Centre Society, 2007). Methamphetamine is cheap, widely available, and virtually eliminates the need to eat or sleep. These factors make meth the preferred drug for many youth on the streets of Vancouver (Bungay et al., 2006). In Bungay et al.'s (2006) sample of meth-using street youth in Vancouver, many of them reported using methamphetamine in order to help them stay awake, maintain
vigilance, socialize, and bolster their self-confidence, thereby enabling them to cope with the chaos, disconnectedness, and dangers of street life.

A recent Canadian survey of primary methamphetamine-related admissions to youth residential treatment facilities found that approximately 20% of all admissions nation-wide were attributed to meth use, with the majority of these admissions occurring in British Columbia and Alberta (Callaghan, Tavares, Taylor, & Veldhuizen, 2007). Almost all treatment centres in British Columbia reported rates between 20-49%, and two centres reported primary methamphetamine admission rates higher than 50%. On a positive note, the most recent McCreary Centre survey of Vancouver street youth found that lifetime use rates have decreased in the last six years from 71% in 2001 (McCreary Centre Society, 2001) to 56% in 2007 (McCreary Centre Society, 2007), although these data do not include youth 19 or older.

**Physiological Effects**

Methamphetamine acts on several neurotransmitter systems in the brain. Without going into complex neurobiological details, methamphetamine acts to increase the amounts of the neurotransmitters dopamine, noradrenalin and serotonin in the central nervous system. It is these elevated dopamine levels in the brain that are mainly responsible for the feelings of euphoria and increased energy (Barr et al., 2006). As with other psychoactive drugs, the onset of effects is dependent on the route of ingestion. When smoked, users usually begin feeling the effects within 3-5 seconds, and the high may last 8-16 hours (Nathoo, 2003). Initially, the user experiences intense feelings of euphoria and feels energized, alert, talkative, happy, and self-confident (Hart, Ward, Haney, Foltin, & Fischman, 2001).
The short-term physiological effects of meth use include racing heartbeat, increase in blood pressure, dilated pupils, dry mouth, nausea, muscle spasms, and decreased interest in eating or sleeping (Meredith et al., 2005). A binge user on a “meth run” may use from two days to two weeks or even longer with minimal food or sleep, resulting in dehydration, extreme weight loss, and symptoms of psychosis (Bungay et al., 2006). Meth use decreases the production of saliva, which leads to increased bacteria in the mouth. In turn, higher bacteria levels lead to multiple caries and tooth loss, a phenomenon commonly referred to as “meth mouth”. Bruxism (tooth grinding) is commonly associated with stimulant use and exacerbates this tooth damage (Donaldson & Goodchild, 2006). High doses of methamphetamine can cause death from cardiac arrest, cerebral haemorrhage, or hyperpyrexia (high body temperature) (Ellinwood, King, & Lee, 2001; WHO, 1997). Meth use can also impact health indirectly when intoxication impairs a user’s ability to make good judgments about risky behaviours like unprotected sexual contact or injection drug use (Halkitis et al., 2001; Semple, Patterson, & Grant, 2004).

Effects on Mental Health

Long-term methamphetamine use has been shown to cause neurochemical changes to the brain’s dopamine system and structural alterations to the brain visible under magnetic resonance imaging (MRI) and proton magnetic resonance spectroscopy (MRS) (Barr et al., 2006). Regular use of methamphetamine has also been associated with memory loss and difficulty completing complex tasks (Simon et al., 2000), depressive symptoms (Meredith et al., 2005; Volkow et al., 2001), movement disorders (Harris & Batki, 2000), mood swings (Vincent, Shoobridge, Ask, Allsop, & Ali, 1998)
paranoia, and drug-induced psychosis (Harris & Batki, 2000; Srisurapanont et al., 2001; Zweben et al., 2004). Long-term use of crystal methamphetamine damages the brain's dopamine receptors, though preliminary research suggests they may recover with an extended period of abstinence (Volkow et al., 2001).

A significant body of international research confirms that long-term use and/or high dosages of methamphetamine can produce symptoms of acute psychosis (Barr et al., 2006; Curran, Byrappa, & McBride, 2004; Srisurapanont et al., 2001). An Australian study of 302 methamphetamine users in Sydney (McKetin, McLaren, Lubman, & Hides, 2006) found the prevalence of psychotic symptoms to be eleven times higher among regular meth users than in the general population. A large-scale study of methamphetamine users conducted in Taiwan found that more severe symptoms of meth-induced psychosis were correlated with earlier age at first use and higher doses of methamphetamine (Chen et al., 2003). This does not bode well for the mental health of street-involved youth who may start using meth as young as 12 or 13.

Most instances of methamphetamine-induced psychosis resolve within a few days of cessation of use (Ali et al., 2006; Baker & Dawe, 2005), although some users suffer psychosis for months or years (Sato, 1992), and some may never recover completely at all (Srisurapanont et al., 2001). Researchers have found evidence for a sensitization effect where individuals who have experienced one instance of meth-induced psychosis are more likely to experience subsequent breaks, even at reduced levels of meth use (Ellinwood et al., 2001; Sato, 1992). Yui, Goto, Ikemoto, Ishiguro, and Kamata (1999) found that former methamphetamine users were more vulnerable to psychotic breaks when subjected to elevated stress levels, even years after cessation of meth use.
Pharmacological treatments are symptomatic, with antipsychotics, antidepressants, and benzodiazepines for anxiety as needed (Barr et al., 2006).

The link between methamphetamine use and psychosis is not yet clear. Numerous studies confirm that large doses of amphetamine or methamphetamine will produce a brief psychotic state similar to schizophrenia (Barr et al., 2006; Curran et al., 2004; Harris & Batki, 2000; Meredith et al., 2005; Zweben et al., 2004). In their review of 43 studies on stimulant psychosis, Curran et al. (2004) found some evidence for a “kindling” effect in which repeated lower doses of meth increased the likelihood of a later psychotic break. Meth may act to precipitate a psychotic break by potentiating an underlying genetic vulnerability (Chen et al., 2003), although rates of psychosis have been found to be significantly higher even in individuals with no histories of psychotic disorders (Harris & Batki, 2000; McKetin et al., 2006). Other researchers have found that psychiatric symptoms may precede the onset of substance use (Curran et al., 2004), and some users report using methamphetamine to self-medicate pre-existing psychiatric conditions like depression or Attention Deficit Hyperactivity Disorder (Bungay et al., 2006, Lende, Leonard, Sterk & Elifson, 2007). Alternatively, methamphetamine abuse and a co-occurring disorder may be independent from one other but related to some other underlying genetic and/or environmental factor (Glantz & Leshner, 2000). Most street youth who use methamphetamine are also using other illicit and prescription drugs concurrently (Slesnick & Prestopnik, 2005; McCreary Centre Society, 2002), making it extremely difficult to tease out the effects of one particular substance on mental health. These issues and relationships are complex, transactional, and multifactorial in nature.
Treating Methamphetamine-Related Disorders

Extended use of crystal methamphetamine can result in dependence and methamphetamine abstinence syndrome upon cessation of use (McGregor et al., 2005; Newton, Kalechstein, Duran, Vansluis, & Ling, 2004). Typical withdrawal symptoms include fatigue, increased appetite, depression, anxiety, and intense cravings (McGregor et al., 2005; WHO, 2004). Withdrawal symptoms peak around 24 hours after last use and mostly subside after 7-10 days (McGregor et al., 2005; Newton et al., 2004). In some cases, depressive symptoms may persist for weeks or even longer (Volkow et al., 2001). Some users, particularly women (Kalechstein et al., 2000), may experience suicidal ideation in the first few days of withdrawal and warrant increased monitoring (Zweben et al., 2004).

Sensationalistic media reports have depicted crystal methamphetamine as the most addictive drug on the market with the highest relapse rate of any addiction (see for example CBC News, 2006, September 19). However, the research does not support these assertions. Rawson et al. (2000) did not find significant differences in treatment outcomes between meth and cocaine users. Several large-scale studies show minor if any differences in the treatment success rates between those who use crystal meth and those who use other substances (Bishop, 1999; Luchansky, Krupski, & Stark, 2007).

Cognitive behavioural therapy (CBT) and contingency management strategies have been shown to be most effective with methamphetamine users (Baker & Dawe, 2005; Rawson et al., 2006). CBT techniques focus on helping the client change his or her beliefs or cognitions and, by extension, his or her behaviours through teaching and coaching relapse prevention techniques, helping the client identify and avoid trigger
situations, and increasing the client’s capacity to cope with daily stressors. Contingency management strategies use operant conditioning principles to reinforce positive behaviours. These approaches can be tailored to help the client achieve his or her specific treatment goal, whether that be abstinence, moderation, or harm reduction. Traditional psychotherapy has not been shown to be useful (Baker & Lee, 2003), and most practitioners recommend motivational interviewing techniques as more effective tools for developing insight and motivation for change (Nathoo, 2003).

Many programs include a peer support group or twelve-step group as part of their treatment protocol. One example of an innovative peer support model is the Crystal Clear Peer Support Training Project (Sinclair, 2007), a street outreach initiative conceived by the Methamphetamine Response Committee in Vancouver. Street-involved youth who have experience with methamphetamine use are recruited to attend 12 weeks of paid training and receive ongoing consultation to enable them to support and educate their peers around harm reduction techniques, mental health issues, and resources for meth users in general. Unfortunately, this program has not yet been systematically evaluated for its efficacy in meeting its goals of reducing harms and connecting street youth with formal services. Successful peer support initiatives in other areas of health promotion (see Broadhead et al., 1998 for an example of a successful HIV prevention program) provide support for the anticipated effectiveness of this intervention.

In cases that involve methamphetamine-induced psychosis, current research indicates that the most effective treatments combine psychosocial and pharmacological interventions in order to treat substance abuse and mental illness in an integrated fashion (Mangrum, Spence, & Lopez, 2006). Psychosocial interventions ideally should begin
once acute psychotic symptoms have begun to wane (Barr et al., 2006). Antipsychotic medications are typically used to treat the acute symptoms of methamphetamine-induced psychosis with benzodiazepines as needed for anxiety (Barr et al., 2006). There is some experimental evidence that regular low doses of antipsychotic medications taken by an individual even while he or she is actively using crystal meth can have a protective effect on the brain by reducing the sensitization or priming effect of meth use for later psychosis (Curran et al., 2004). There have not been any controlled large-scale studies of the novel antipsychotics, but anecdotal reports in the literature and my experience working with youth presenting with meth-induced psychosis have shown them to be quite effective at treating the symptoms of psychosis. Risperidone (Misra & Kofoed, 1997), olanzapine (Misra, Kofoed, Oesterheld, & Richards, 2000), and quetiapine (Dore & Sweeting, 2006) have all shown success. Haloperidol, a conventional antipsychotic medication, has also been effective at treating the symptoms of methamphetamine-induced psychosis but its serious and potentially fatal side effects make it the least favoured option for treating meth-induced psychosis (Sato, Chen, Akiyama, & Otsuki, 1983 cited in Curran et al., 2004).
Chapter IV  Street-Involved Youth

For the purposes of this research, I have defined “street youth” as a young person less than 25 years of age who has no permanent or stable living address and who self-identifies as being involved in a street lifestyle. A street lifestyle involves intermittent homelessness or risk of homelessness, non-employment sources of income (e.g., welfare, panhandling, or “squeegeeing”), drug use, involvement in the criminal justice system, and/or primarily associating with other youth who are involved in these activities. This young person may be living outdoors, in a tent or car, in an abandoned building, in a single residency occupancy hotel room, in foster care, in a shelter, or temporarily living with friends/family. This definition is consistent with that used by street youth serving agencies (Yonge Street Mission, n.d.) and other Canadian researchers (DeMatteo et al., 1999; McCreary Centre Society, 2002). In this thesis, I will use the terms “street youth” and “street-involved youth” interchangeably. The most recent large-scale survey of street-involved youth in British Columbia found that street youth in Vancouver were fairly evenly gender distributed, but that Aboriginal youth and gay, lesbian, and bisexual youth were significantly overrepresented. Almost two thirds of the youth surveyed in Vancouver reported at least some Aboriginal heritage, and about one third of youth surveyed described themselves as gay, lesbian, bisexual, or unsure of their sexual orientation (McCreary Centre Society, 2007).

It is a truism to say that street-involved youth face limited life chances. These youth report significantly more barriers than do youth who have never been homeless, including histories in government care, family backgrounds of drug and alcohol abuse and poverty (Mallett, Rosenthal, & Keys, 2005), failure in school, a history of suicide
attempts, physical and sexual violence, poor health, and drug abuse and addiction (Commander, Davis, McCabe, & Stanyer, 2002; McCreary Centre Society, 2002). Some children run away and become street-involved after fleeing from abusive and neglectful caregivers; others are thrown out of their homes when their parents become overwhelmed by the pressures of parenting (McCreary Centre Society, 2002). These young people’s histories of abuse, neglect, discrimination, and institutionalization are likely to lead to insecure attachment and a generalized distrust of adults (Bacon & Richardson, 2001). I have been unable to unearth any research documenting adolescents’ narratives of homelessness and substance-induced psychosis, yet it seems self-evident that psychosis and its likely consequences of hospitalization, stigmatization, and interrupted employment or education will only compound the overwhelming challenges facing youth on the street and serve to further limit their chances for success.

These individual tragedies take place within a larger societal context. To view homelessness as an individual’s choice blames the victim and ignores the myriad of social, political, and economic inequities that underpin social exclusion. Social policies and social inequities lay the groundwork for many determinants of risk and homelessness, and likely account in part for the overrepresentation of Aboriginal and non-heterosexual youth on the street. By virtue of their limited access to safe housing, employment, and resulting social exclusion from safe places, street-involved youth report significantly more incidents of criminal and violent victimization (Gaetz, 2004). Laws targeted at the homeless that restrict panhandling, squeegeeing, and sleeping in public places push street youth into less public and more dangerous areas and communicate the lack of value with which they are regarded (Mitchell, 1997). Intergenerational poverty,
racism, cuts to social programs, substandard housing, and lack of economic opportunity are correlated to increased family stress, reduced parental supervision, and diminished coping skills (Miller, Donahue, Este, & Hofer, 2004). Children from these low-income and high-stress families are more likely to be involved in family conflict, delinquent behaviour, substance use, and running away (Commander et al., 2002). These factors have all been found to be associated with future homelessness (Mallett et al., 2005).

**Street Youth and Substance Use**

The literature consistently shows that street-involved youth are more likely to use illicit substances than mainstream youth (Baron, 1999; Ennett, Bailey, & Federman, 1999; Greene, Ennett, & Ringwalt, 1997). Drug use has been widely discussed as a coping strategy used by street youth to cope with the stresses of street life, (Tyler & Johnson, 2006), emotional distress (Boys et al., 2001), and other mental health concerns (Bungay et al., 2006). Street youth are more likely to report histories of physical and/or sexual abuse (Commander et al., 2002) which have consistently been shown to be correlated with increased drug and alcohol use (Harrison, Fulkerson, & Beebe, 1997; Perez, 2000). These youth may use drugs and alcohol at least in part to self-medicate feelings of worthlessness, guilt, and anger associated with childhood abuse (Harrison et al., 1997).

As discussed earlier, street-involved youth are also more likely to report histories of parental drug use, which have been shown to be positively correlated with increased risk of adolescent drug use (Mallett et al., 2005; Tyler & Johnson, 2006). Tyler and Johnson (2006) found that the street youth they interviewed were almost as likely to be introduced to drug use by a family member as they were to be introduced by friends.
Baron’s (1999) study of 200 male street youth found that youth who came from homes with drug-using parents or who associated with drug-using peers on the street were at substantially increased risk for drug use. Baron (1999) argued that youth on the street are more likely to be exposed to drug use before as well as after hitting the street, and as these youth become increasingly marginalized, they also become increasingly disconnected from mainstream expectations and sanctions on drug use. As these youth establish social networks with other street youth who are already using drugs and alcohol, they subscribe to new norms that are more favourable towards drug use (Ennett et al., 1999).

Consistent with rates of substance use among the general population (Adlaf & Paglia-Boak, 2005; Canadian Centre on Drug Abuse, 2004; Chawla & le Pichon, 2006b), research with street youth reports the most commonly used substances are tobacco, marijuana, and alcohol (Baron, 1999; McCreary Centre Society, 2007). Cocaine, hallucinogens, methamphetamine, and ecstasy remain popular choices among Vancouver street youth (McCreary Centre Society, 2007). Martin et al. (2006) surveyed a convenience sample of street-involved youth in Vancouver in 2003 and found that 67% of street youth reported using crystal meth at least once, and 43% reported having used in the last week.

Street Youth and Mental Health

The research literature reports that in comparison to mainstream youth, street youth consistently describe significantly more psychological distress and report a significantly higher prevalence of mental health symptoms that meet the Diagnostic and Statistical Manual- IV (American Psychiatric Association [APA], 1994) criteria for
mental illness (Cauce, 2000; Commander et al., 2002; McCaskill, Toro, & Wolfe, 1998; McCreary Centre Society, 2007). Slesnick and Prestopnik (2005) found that the majority of street-involved youth in their sample reported dual and multiple diagnoses of mental illness and substance abuse. Cauce (2000) reported that more than two thirds of the street youth she interviewed met DSM-IV (APA, 1994) criteria for a mental health diagnosis. Consistent with normative adolescent samples, the girls in Cauce’s (2000) study reported more internalizing disorders (e.g., depression, post-traumatic stress disorder) and boys reported more externalizing disorders (e.g., conduct disorder). Recent research suggests that mental health symptomology is both a contributing factor to homelessness as well as exacerbated by the stresses of homelessness (Martijn & Sharpe, 2006). Drug abuse, mental illness, associated stigma, and interrupted employment or education only compound the overwhelming challenges facing youth on the street and serve to further limit their chances for success (Martijn & Sharpe, 2006).
Chapter V  Seeking Mental Health Support

Mental health services in Vancouver include a whole range of services provided by hospital emergency rooms and psychiatric units, mental health teams, psychiatrists, psychologists, Mental Health Emergency Services, dual diagnosis clinics, Early Psychosis Intervention programs, counsellors, and any other professional services intended to provide intervention and/or treatment of mental health concerns.

Formal and Informal Help Seeking

Help seeking includes both formal routes through professionals like social workers, counsellors, and emergency personnel, and informal routes like family or friends. Adolescents in general tend to be resistant to seeking formal help (Ballon, Maritt, & Smith, 2004; Sheffield, Fiorenza, & Sofronoff, 2004) often due to concerns about confidentiality and trust (Wilson & Deane, 2001). Research indicates adolescents are most likely to access informal sources of help such as parents or friends initially (Boldero & Fallon, 1995). They may not see their problem as severe enough to require professional help (Wilson & Deane, 2001), and they are unlikely to have knowledge of services available or a pre-existing relationship with a formal helper (Boldero & Fallon, 1995). Boydell, Gladstone, and Volpe (2006) interviewed young people who had experienced prodromal symptoms of psychosis and found that the youth ignored or hid their symptoms until they became debilitating. They also found that while young people did not seek out formal mental health services on their own, access to services was usually facilitated and sometimes coerced by family members or other significant figures in their social support networks.
Commonly cited barriers for adolescents seeking formal help for mental health concerns are a lack of education about mental health and mental health services (Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003; Wilson & Deane, 2001), a preference for handling problems themselves (Sheffield et al., 2004), and a preference for relying on friends and family (Boldero & Fallon, 1995; Kuhl, Jarkon-Horlick, & Morrissey, 1997). Adolescents’ attitudes and general knowledge about mental health influence their perceptions of the stigma of mental illness and mental health services (Leong & Zachar, 1999; Sheffield et al., 2004). A history of successful mental health treatment may act to mitigate this negative perception, and thereby encourage future help seeking behaviour (Sheffield et al., 2004; Timlin-Scalera et al., 2003; Wilson & Deane, 2001).

Researchers have consistently found male (Boldero & Fallon, 1995; Timlin-Scalera et al., 2003) and non-Caucasian youth (Garland et al., 2005; Kim & Omizo, 2003; Neale, Worrell, & Randhawa, 2005) to be least likely to access formal sources of help. Reasons for these findings generally focus on socially constructed gender and cultural attitude towards help seeking behaviour. Timlin-Scalera et al. (2003) found that the white male high school students in their study felt strong pressure to maintain a strong, macho image that precluded asking for help in order to fit into their community. Kim and Omizo (2003) found that adherence to traditional Asian values like collectivism, avoidance of family shame, and emotional self-control was related to a reduced likelihood of seeking formal mental health support. Other researchers hypothesize that Aboriginal peoples may be reluctant to access mental health services due to cultural mistrust of “White Man’s” mainstream medical institutions (Johnson & Cameron, 2001).
Street Youth and Help Seeking

McCreary Centre Society researchers asked Vancouver street youth who they would be most likely to ask for help for a non-specific problem. Consistent with mainstream high school adolescent populations, respondents reported they would be most likely to seek informal help through friends and family, with outreach/youth workers and social workers the next likely source of help (McCreary Centre Society, 2007). I am particularly interested in how street youth seek help specifically for symptoms associated with meth-induced psychosis. As noted already, adolescents in general tend to be resistant to seeking formal mental health support (Ballon et al., 2004; Sheffield et al., 2004). As a subpopulation, street youth are even less likely to seek out formal help due to systemic barriers, stigma, and concerns about confidentiality (Ensign & Panke, 2002; Hagedorn & Ekegren, 2002; McFadyen & Fletcher, 2002).

Street youth are apt to wait until their health issues compromise their ability to manage day-to-day living before seeking out professional care (Barry, Ensign, & Lippek, 2002; Ensign & Panke, 2002; McFadyen & Fletcher, 2002). Street-involved youth, females in particular (Ensign & Panke, 2002), often experience care from medical professionals as discriminatory and condescending, and so may forgo needed care to avoid further stigmatization (Auerswald & Eyre, 2002; French, Reardon, & Smith, 2003; McFadyen & Fletcher, 2002). Mental health professionals may hold negative or moralistic attitudes towards substance users (Darbyshire, Muir-Cochrane, Fereday, Jureidini, & Drummond, 2006; Richmond & Foster, 2003), which can discourage meth users from seeking out mental health support. The delusions, hallucinations, and paranoia typical of meth-induced psychosis only serve to intensify the distrustful
individual’s avoidance of mental health services (Murray, 1998). Bungay et al. (2006) found that the youth they interviewed reported being reluctant to access formal mental health services during a psychotic episode, citing both the fear of involuntary hospitalization and the perception of service providers as unsympathetic.

A young person must be able to obtain information about available services as well as possess the financial resources needed to access them. For someone without an address or telephone, simply finding an appropriate service can be stymied by limited access to phones, the Internet, and resource manuals. Systemic and structural barriers like scheduled appointment times, waiting periods for service, expectations of sobriety, physical location, transportation requirements, and the cost of services can have a profound impact on whether a street youth will attempt to access health care (Barry et al., 2002; Hagedorn & Ekegren, 2002; Meade & Slesnick, 2002).

The literature in this area consistently and repeatedly highlights the critical nature of the relationship between the youth and the service provider (Darbyshire et al., 2006; Hagedorn & Ekegren, 2002; McFadyen & Fletcher, 2002; Wilson & Deane, 2001). Keys, Mallett, Edwards, and Rosenthal (2004) conducted an investigation of Project i, a large-scale longitudinal study with Australian street youth, and found that the quality of the youth’s relationship with a service provider was consistently more critical to the process of engagement than any other aspect of the service:

Services were largely, but not solely, judged on the way their workers treated clients. Young people stated clearly that the experience and knowledge of the service provider, and the model of care provided are less important than the quality of relationship developed between the service user and the service provider. The young people who participated in the Project i interviews consistently stated that ‘to be treated like a human being’ was the most important aspect of their relationship with services and service providers. (p. 28)
Dixon and Lloyd's (2005) sample of street-involved youth identified characteristics of the staff person, anonymity, and the provision of practical strategies as the most significant factors influencing their decision to access health care. French et al. (2003) investigated factors impacting clients' engagement with mental health services and identified "feeling understood" as the overarching theme in their interviews with street youth. Kurtz, Lindsey, Jarvis, and Nackerud (2000) report that the youth they interviewed valued relationships with professional helpers that were personal, involved multiple levels of support, and transcended traditional client-professional roles. Based on the literature, my own personal and professional experiences, and data collected from a pilot study of this research (Lambert, 2006), I anticipated that this emphasis on the critical nature of the relationship between the youth and worker would emerge from my own research as well.
Chapter VI  Grounded Theory

Grounded theory methodology is consistent with a constructivist epistemology (Charmaz, 2003). Data are collected in a particular space and time using particular methods, and the researcher analyzes the data and creates theory from within a particular theoretical orientation. Research findings are understood to be constructed rather than discovered “objective” truths. Here the researcher is not positioned as the expert. In contrast, the more common scientific method frequently used in quantitative research positions the researcher as an objective observer who begins with a preconceived hypothesis, and then collects and analyzes data in order to support or falsify the initial hypothesis (Sawin, 2005). Researchers using a grounded theory approach are expected to begin their investigations with minimal preconceptions, and researchers who already have significant experience or knowledge of the phenomenon being researched are expected to “bracket” their knowledge and preconceived beliefs in order to remain open to new ideas and conceptualizations (Backman & Kyngas, 1999). Researchers inductively work from the raw data to a framework focused on a particular social process (McCann & Clark, 2003) or to a more general formal theory (Strauss & Corbin, 1990), depending on the scale of the study. Small-scale studies like the research conducted in this thesis are useful to “describe and explain some underlying social processes shaping interaction and behaviour” (McCallin, 2003, p. 205) upon which further research can elaborate and build formal theory.

Researchers using this paradigm often initially use a purposeful sampling strategy in order to capture as much data as possible (Fassinger, 2005). This initial data is organized into substantive or open codes (Strauss & Corbin, 1990). Significant themes
and theoretical constructs gradually emerge through the strategies of ongoing and recursive coding and analysis, field notes, and self-reflective memos (Fassinger, 2005). Initial substantive codes are linked with each other and developed into higher-order categories via the process of axial coding (Strauss & Corbin, 1990). It is crucial that data collection and analysis occur simultaneously, with each process informing the other (Strauss & Corbin, 1990). Once the initial data has been collected and coded into conceptual categories, grounded theory researchers use theoretical sampling to select specific individuals or groups with the goal of developing, extending, and refining that theory (Fassinger, 2005). In turn, the new data is used to further refine and develop the researcher’s theory until no new information is being discovered, a state known as theoretical saturation (Strauss & Corbin, 1990).

I chose to use a grounded theory approach as a way of making meaning of the youths’ stories and understanding their pathways to mental health services. Other research in this area has been mainly quantitative and/or descriptive, without offering much by way of an explanation for the process by which these events occur. Grounded theory takes raw data and goes beneath the surface by seeking out connections and commonalities that construct a theory or story of how or why a particular phenomenon occurs. What appeals to me most about this approach is its positioning of research participants as collaborators rather than passive subjects to be studied. There is no denying that it is the researcher who codes and analyzes the data, but participants can play a significant role in checking, challenging, and validating the researcher’s interpretations and theories (Fassinger, 2005). This seems to me to be a more ethical and respectful way of learning street youth’s stories.
Chapter VII  Ethical Issues

Dual Roles

It is crucial to note that I worked full-time at Covenant House for seven years from 1997-2004. I had previously met four of the research participants in my capacity as a case manager at Covenant House. On the one hand, I anticipated that a previous relationship could be an advantage in the recruitment and interview process by helping participants feel safe and comfortable talking to me. On the other hand, I was also highly aware that youth could feel pressured to help me by participating in my research either because of their prior relationship with me, or from a sense of obligation because I have provided assistance to them in the past. I clearly communicated to the youth involved that there were absolutely no negative consequences to their decision to participate or not to participate.

I was aware that these dual roles of researcher and service provider could create role confusion on the part of both the researcher and of the participant (Ensign, 2003). I attempted to maintain awareness of my role as researcher and refrained from providing counselling or assessment, and through procedural consent, I ensured that participants maintained their own awareness that they were participating in research, not counselling.

Offering Remuneration

I believe that to be properly respectful of a participant’s time and contribution, researchers must recognize that contribution in some way. I initially considered offering a monetary honorarium, but when interviewing drug users, giving money creates the risk of contributing to their drug use (Ensign, 2003). However, the decision not to give money compromises the principle of self-determination and reduces self-efficacy by
denying participants a choice around how they will use such an honorarium. Having worked with substance-using youth for as long as I have, I considered it a greater harm to possibly contribute to their drug use than to limit their choice of how to spend the honorarium.

Another issue to consider was the potential for coercion in offering remuneration for research participation. Hutz and Koller (1999) argue that one should not offer payment as it is always coercive due to street youths’ economic deprivation, while Ensign (2003) urges researchers to consult with the local community to determine what is appropriate in a particular research setting. For these reasons, I decided to provide a $10.00 gift card to Subway Restaurants. From seven years of working with this population in the South Granville community, I am aware that street-involved youth appreciate gift cards to Subway, as the restaurants are readily accessible and often open 24 hours a day. $10.00 to $20.00 is a typical amount to provide to street-involved youth in this community who volunteer as research participants, and it is not likely to be so large a sum as to be coercive or to unduly influence youth into participating.

**Risk of Emotional Distress**

This study dealt with a sensitive topic and had the potential to be emotionally distressing to the participant. Ensign (2003) points out that:

Homeless youths are an especially vulnerable group because of their age, socio-economic disadvantage and stigmatized status. As most homeless youths have had a series of harmful past and present experiences with various adults and institutions in their young lives, they are highly distrustful of adults and institutions. (p. 46)

In order to minimize these risks, I regularly checked in with the participant throughout the interview to assess their emotional state. Each youth was provided with a list of free
mental health, detox, and crisis resources prior to the interview. Additionally, I had made prior arrangements that should a participant become distressed during the interview, immediate counselling and assistance would be available from Covenant House workers. Consistent with other studies’ findings, I hoped that participants would experience the interview process as an empowering encounter that validates the expertise the participant brings to this area of inquiry (Hutz & Koller, 1999; Murray, 2003). Unfortunately, none of the participants chose to follow up their experience of the interview process with me.
Chapter VIII  Methods

Research Questions

My research questions concerning how street youth access mental health care arose from my years of working with high-risk youth with mental illnesses and witnessing their unwillingness and/or inability to access mental health services. As a professional currently employed in a mental health facility for youth, I wanted to know what factors promote help seeking in this vulnerable population in order to tailor programming to be more effective and responsive to youths’ needs.

1) How do street youth with symptoms of methamphetamine-induced psychosis access mental health services?

2) Specifically, what factors do these youth identify as promoting or hindering access to mental health services?

Selection & Recruitment

For ethical and informed consent purposes, all participants had to be 19 years or older. Of the nine total youth I interviewed, five were male, three were female, and one was male-to-female transgendered. Their ages ranged from 19 to 24 years old. Four participants self-identified as Caucasian, one was Indo-Canadian, one was Middle Eastern, two were Aboriginal (Haida and Nisga’a nations), and the last youth was of mixed Caucasian and Aboriginal descent. They self-identified as street-involved and reported at least one instance of crystal methamphetamine use and consequent symptoms of drug-induced psychosis. They reported having received some kind of professional mental health services as a result of these symptoms, whether on a voluntary or involuntary basis.
Table 1
Demographic Breakdown of Participants

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Ethnic Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>21</td>
<td>Aboriginal</td>
</tr>
<tr>
<td>M to F</td>
<td>24</td>
<td>Aboriginal</td>
</tr>
<tr>
<td>M</td>
<td>22</td>
<td>½ Aboriginal, ½ Caucasian</td>
</tr>
<tr>
<td>F</td>
<td>20</td>
<td>Indo-Canadian</td>
</tr>
<tr>
<td>F</td>
<td>19</td>
<td>Middle Eastern</td>
</tr>
<tr>
<td>M</td>
<td>21</td>
<td>Caucasian</td>
</tr>
<tr>
<td>M</td>
<td>23</td>
<td>Caucasian</td>
</tr>
<tr>
<td>M</td>
<td>23</td>
<td>Caucasian (pilot study participant)</td>
</tr>
<tr>
<td>F</td>
<td>20</td>
<td>Caucasian (pilot study participant)</td>
</tr>
</tbody>
</table>

I anticipated that some youth would not have received a formal diagnosis from a physician, so I used the youth’s self-report of symptoms consistent with the DSM-IV-TR (APA, 2000) definition of substance-induced psychotic disorder as a criterion for selection instead. This manual, published by the American Psychiatric Association (APA), is the most commonly used diagnostic classification system in North America. The DSM-IV-TR’s (APA, 2000) criteria for substance-induced psychotic disorder consist of prominent hallucinations or delusions associated with substance intoxication or withdrawal, not better accounted for by another diagnosis. A hallucination is defined as “a sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ (APA, 2000, p. 823)”.
A delusion is “a false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary (APA, 2000, p. 821)".
I posted recruitment posters at Covenant House Vancouver, an agency located in downtown Vancouver that provides shelter, crisis intervention, and transitional living services to street-involved youth between 13 and 24 years old. I used a third party reputational case selection recruitment strategy in which workers at Covenant House approached youth they knew who fit the selection criteria and informed them of the research opportunity. The workers then provided an introductory letter to interested youth. This letter described the study and provided my contact information. Workers did not ask the youth to participate or to reveal whether they would be participating. I met with the workers prior to the recruitment phase to explain the process and to ensure that the workers were vigilant in taking care that the process of recruitment was not coercive.

As one of the selection criteria for the participants in this study was that they did not have stable living arrangements, I anticipated it would be difficult to make contact with prospective participants who might not have an address or phone number. In my experience working with this population, the best way to connect with these youth is at a drop-in centre. Covenant House serves a hot meal every Monday evening and a lunch every Friday afternoon for women and their children, so I attempted to schedule meetings with youth for a time when they would already be in attendance for a meal. Additionally, I was aware that a well-fed youth is more able to attend to interview questions and give thoughtful answers than a hungry one.

On pre-arranged dates, staff announced my presence at the drop-in centre and in the shelter, and potential participants were free to approach me to participate or not. Covenant House staff were not informed whether potential participants decided to participate or not. Once the youth agreed to participate, I reviewed the study procedures
described in the introductory letter and went over the consent form with the potential participants to ensure that they understood the protections inherent in the informed consent process.

**Data Collection**

Interviews ran anywhere from twenty minutes to an hour and a half, with the average interview approximately forty-five minutes in length. Each interview consisted of open-ended questions regarding the participant's experiences of drug-induced psychosis, perceptions of the mental health services provided for these symptoms, and the factors perceived as promoting and impeding the youth from accessing these services. Prompts were minimal and process-driven in order to encourage as much detail as possible from the participant and minimize the imposition of my own expectations and assumptions (Fassinger, 2005).

**Pilot study.** During the pilot testing phase, I made contact with two youth who met the selection criteria provided above and interviewed them in a private office at Covenant House. The research methods were virtually identical to those used in the main study and discussed below (Lambert, 2006). In order to broaden my data set and explore the concept of accessibility from a service provider’s perspective, I also interviewed an outreach worker with three years experience working with methamphetamine-using street youth. Unfortunately, due to technical difficulties with my tape recorder, I failed to record the majority of my first pilot study interview. This participant was initially willing to meet with me again, but she subsequently lost her accommodation and I was unable to reach her. I did my best to reconstruct the interview through the recording I did have and
from memory, but I am painfully aware that a great deal of the power of this young woman’s voice was lost.

I had also initially planned to meet a second time with each youth to review, clarify, and edit their own transcripts, but I was unable to reach either of them, a not unexpected outcome with this population. The outreach worker did review her transcript and debriefed the interview experience. The youth gave written consent at the time of their interviews to allow their data to be used again for the main thesis research.

**Main study.** Subsequent to analyzing the data gathered from the pilot interviews and refining the interview process, I met with seven youth, five of whom were residing in the Covenant House crisis shelter at the time of the interview. Prior to the interview, I informed participants they could stop the interview at any time to take a break or to end the interview entirely. I asked participants to read over and sign a consent form prior to continuing with the study. I ensured that participants were aware they could refuse to answer any questions with which they felt uncomfortable. It was clearly communicated there would be no repercussions for any answers they gave or for ending their participation at any time. I explained confidentiality and consent. As suggested by Ensign (2003), in order to counter the possible concern of participants “forgetting” they were participating in research and disclosing more than they intended, I ensured participants were aware that they had “veto rights” over information they didn’t want included. Throughout the interviews, I checked the validity of my interpretations of the data through an ongoing process of respondent validation informally during the interview and through interviews with subsequent participants. These “checks” also allowed opportunities for the youth to stop the interviews easily if they had been so inclined.
I interviewed six of the participants in a private office at Covenant House. One participant was interviewed in a public food court near her apartment. The Covenant House location was preferred as it was a safe and known place for the youth. An additional benefit was that if any participant had become distressed during or after the interview, a counsellor was immediately available. Workers did observe youth meeting with me, but I believed in this case the benefits outweighed the risks. From my professional experience with this organization, I am aware of many research studies conducted here. I have never seen or heard of a youth's access or service at this agency being restricted due to his or her decision to participate or not to participate in any research study. Upon completion of the interviews, I provided a $10.00 Subway gift card. One participant requested a $10.00 gift card to Starbuck’s Coffee instead.

**Grounded Theory Data Analysis**

I started my analysis of the interview transcripts by coding each interview line by line and then organizing and incorporating these codes into categories. This line by line coding ensured that all the data was considered in my analysis. As a researcher working within a grounded theory perspective, I immersed myself in the data and used inductive reasoning to identify which codes and concepts were important, and which ones did not add to the analysis. Generally, the more frequently the codes appeared and the more transcripts in which they were found, the more significant I considered them to be. I used a visual mapping technique to assist in the organization of codes and identification of linkages. Visually mapping the codes using reusable sticky notes on a large piece of paper allowed me to integrate and move codes and categories around as my analysis developed. Significant themes and theoretical concepts gradually emerged through the
grounded theory strategies of ongoing and recursive coding and analysis of interview data, organizing and linking of categories, and researcher self-reflective memos (Fassinger, 2005). As part of my grounded theory analysis, I wrote memos to myself regarding each interview as well as recording my thoughts throughout the analytic process. These memos explored similarities, contradictions, and questions within the data and recorded the progression of my analysis. They constituted part of the data set and, as such, they were also included in my inductive analysis.

I continued to interview youth until I felt I had reached theoretical saturation at which point no new data was emerging (Strauss & Corbin, 1990) and the concepts of access to mental health services, promoting access, barriers to access, and the linkages between these concepts were well-developed. During the pilot study process, I quickly came to realize the impracticality of planning for multiple interviews with transient and homeless youth, so I subsequently planned to meet once only with each youth, with the option for a second meeting if the youth wished. Four youth provided a valid email address to which I emailed a copy of their transcripts for their review and feedback, but I did not receive a response from any of them. I do not know whether this was because the youth felt the transcripts were a true representation of their interviews, they did not have the time or inclination to respond, or if they simply did not have access to their email account. Despite the lack of feedback and secondary interviews, I was still able to use the grounded theory strategies of constant comparative analysis and participant feedback.
Chapter IX  Results

Getting Into Meth

Eight of the nine youth interviewed were already involved in drug use and a street lifestyle prior to their first use of methamphetamine. Youth typically used marijuana first, then ecstasy, cocaine, and crack before beginning to snort or smoke crystal methamphetamine. Almost all of the youth reported their preferred route of ingestion was smoking at the time of their psychotic breaks, a finding in line with evidence that smoking meth is more likely to lead to symptoms of psychosis than any other non-intravenous route of administration (Matsumoto et al., 2002). They described a pattern of increasing binge use culminating in extended meth runs lasting between three and thirteen days. One youth reported being on a run for three months, grabbing a few minutes of sleep wherever she could. Consistent with other researchers’ findings (Bousman et al., 2005; Greene et al., 1997; Martin et al., 2006), youth reported using multiple substances, making it difficult to say definitively whether an episode of drug-induced psychosis was directly attributable to meth use. The majority of the youth I spoke with reported mixing methamphetamine with cannabis, ecstasy, cocaine, and alcohol, all substances associated with inducing or exacerbating psychotic symptoms (Harris & Batki, 2000; Landabaso et al., 2002; Sato, 1992; Semple, McIntosh, & Lawrie, 2005).

One youth, Nathan, described a different route into meth use and psychosis in which he initially took meth as a performance-enhancing substance to perform better at work. He was able to maintain his employment while using meth for several months and even received a promotion. Nathan reports it was only after trying to quit and then losing
all motivation to attend work while detoxing that he became homeless. Nathan was the only youth who did not report paranoia about police involvement and actually called the police for assistance during a psychotic episode. He was also the only youth who independently sought out formal community psychiatric services, albeit post-meth use. Johnny was living at home and selling drugs at the time of his first and only use. He reported he never used crystal meth again due to the psychotic symptoms he experienced after his first time.

All but one of the youth in this study reported they were first introduced to methamphetamine by a more experienced street-involved peer. They described feeling like everybody around them was using crystal meth, and they wanted to fit in. Some belonged to social networks that revolved around methamphetamine use.

I started meeting a lot of people who also smoked it, like it just became this big circle of people who loved to smoke crystal meth. I was surrounded by these people, and I don’t ever remember not being surrounded by anybody who smoked it or used it. (Elaine, 24-year-old female)

Living on the streets and everything, and hanging out with all those kids, you know? I’m just trying to fit in when I was 16... Seeing everybody doing it, and they seem like they’re having a good time, didn’t seem as stressed out as I was. So I just tried it. (Mark, 22-year-old male)

Honestly, I just was hanging out with the wrong people. I just got caught up. Hang around people that are using, that’s obviously not a good thing. (Johnny, 21-year-old male)

Five youth – more than half of the sample – disclosed that they had thought about committing suicide while using methamphetamine or experiencing delusional thoughts. This figure is consistent with the inordinately high rates of suicidal ideation (Kalechstein et al., 2000) and suicide attempts (Zweben et al., 2004) found in other studies of methamphetamine users. These high numbers should be of significant concern to service providers working with this population.
Every single day, in the middle of the day, that’s all I could think about. Because I was convinced that the whole world was going to either kill me or unless I killed myself, right? (Ruby, 19-year-old female)

I was really depressed. ...Drugs I guess mess up your brain so you’re totally delusional. You start adding things together in your brain and it’s like, it never ends till you have negative thoughts going through your brain constantly and you’re stuck with this drug, and it’s tearing you to pieces. And you can’t fight it, you don’t know how, you get very depressed. And your self-esteem goes way down really quick till you don’t care anymore. You’ll do anything. That’s when it becomes dangerous. That’s when you become a danger to society and to yourself. (Devon, 23-year-old male)

Another youth shared that suicide was a not uncommon occurrence among the youth in her peer group.

We just had two deaths in the community just two months ago. Two youth that were fine the week before, had a really bad psychosis trip and as a result – they didn’t get help – they’re dead now. (Sunni, 20-year-old female)

The “Enough Moment”

After varying periods of active use, participants described a particular moment at which they felt that they had had “enough” and decided they needed to make a change. I chose to label this the “enough moment” rather than the more traditional “hitting bottom”, because I think the concept is more reflective of the experiences of young people who are already homeless and on the street than the older term that is associated with adult alcoholic men who have lost their jobs and/or families. These youth have already lost their homes and families. They have already “hit bottom” as the term in commonly understood. “Enough moments” are epiphanic and signal a change in priority. They motivate a youth to seek or accept help. The particulars of these moments were different for each youth, but they shared a common sense of sudden realization that things could not continue as they had. Several youth had had enough when they
experienced a serious enough episode of psychosis and others when they became too physically ill to function normally.

Yeah, I was sick of it. As I am now. Sick of it. ...All these holes in my memory, it bothered me. That I didn’t know why I was so sick, and I had physical cuts and burns and I didn’t know where those came from... I really just wanted to change that about myself. (Sunni)

One youth identified a key moment with her father, and another identified losing his girlfriend as his “enough moment”.

Then one day my dad comes downtown... and he grabs me and throws me against the wall. And he’s like, “I’m going to stick a dirty rig in your arm, kill you, and at least I’ll know where you are.” That’s what made me go, click, “I need to get help.” (Kat, 20-year-old female)

I loved my ex, and I fucked it up. I always had this thing, “Fuck it, the world screwed me up and foster care, this and that. I never got a chance at anything.” And then I had everything, and I threw it all away for dope. (Greg, 21-year-old male)

Four of the youth reported they left Vancouver and went to live with their parents temporarily. All of them found this time out of the city helpful in staying away from crystal meth and stabilizing their mental health.

Experiences of Mental Health Services

As would reasonably be expected, respondents reported mixed experiences with mental health providers. Most youth were surprisingly positive about their relationships with service providers. Four youth reported consistently positive contacts with all their mental health providers.

I didn’t really feel judged. Like she [the drug and alcohol counsellor] didn’t look at me weird or anything like that, like the way I thought it was going to be. She just made me feel really comfortable and made me feel relaxed when I was talking to her. (Mark)
One youth who approached Covenant House outreach workers for assistance commented favourably on the speed with which they made referrals to detox and to a doctor. Elaine said, “There was very good help and it was quick. Everything happened so quick. I guess I was fortunate.” The other five youth reported mixed experiences. As expected, the quality of the youth’s relationship with the service provider was a good predictor of the youth’s satisfaction with the service being offered, although this was not necessarily always the case.

Supports to Accessing Services

**Quality of the youth-professional relationship.** Seven participants made reference to the importance of genuine relationships, consistent with the literature’s emphasis on the importance of relationship to engage youth in treatment (Hagedorn & Ekegren, 2002; McFadyen & Fletcher, 2002). These youth identified a particular worker or a group of workers at a particular agency with whom they had established a positive relationship, and who had played a key role to their receiving mental health services.

When asked what advice he would give a friend who was experiencing symptoms of drug-induced psychosis, one youth reported he would send his friend to the same outreach worker who had helped him when he was psychotic.

Yeah, it seems sometimes like the same workers will have all the same connections. It’s just how that worker’s day is going. And other workers it’s like they’re totally committed twenty-four seven. They’ll drop everything in the world to make sure you’re okay. (Devon)

If they have a favourite youth worker or something, maybe getting them on board. ‘Cause I always listened to my favourite youth worker. (Sunni)

They knew me for years, for like 7 or 8 years, ‘cause my sister used to go there, and I always used to follow her there. I just went there, talked to my counsellor, and he told me if I needed anything. He was just trying to help me out. (Johnny)
A related theme was a preference for counsellors with a personal history of drug use or street involvement. The four youth who discussed this issue said they felt more understood and could connect better with counsellors who had had similar experiences.

If they just read stuff from books I don’t really think they know what they’re talking about. ‘Cause they haven’t done them, so of course they don’t know what it’s like. (Mark)

They’re book psychiatrists. You know, I don’t like book people; I don’t like book outreach workers. (Kat)

Because, the way I’ve always looked at it is, just ‘cause you’re reading stuff like it in the textbook, doesn’t mean that you know how to get over the problem unless you actually went through it yourself... ‘Cause I’ve been to a lot of counsellors, and the ones that I have are the ones that have basically been through it themselves. And I realized I can tell them anything... because they know what it’s like. (Ruby)

**Peer support.** Four of the youth interviewed emphasized the key role of trustworthy friends in maintaining their mental health while using crystal methamphetamine. Two youth explicitly attributed the minimization of their symptomology to the presence of a trusted friend or others. Another youth felt he would not have become so paranoid if he hadn’t been alone at the time.

I was doing it with my friend George. I grew up with the guy in Kenora, and we both came out here together. I knew he was my best friend. He wasn’t going to fuck me over or anything like that. I don’t know, I just found it comforting. And I knew if I was by myself or with somebody I didn’t know, it would be a lot worse. (Mark)

I don’t remember having friends. They were just people I got high with. They’re not friends. Now my boyfriend tells me if I’m going crazy. Now I have a couple of good friends that tell me, “Hey, you know you’re not looking so good.” (Sunni)

That was the biggest thing. I would not have been like that if I wasn’t alone. (Nathan, 23-year-old male)
Five of the youth interviewed felt that peers could be helpful in identifying mental health problems.

Sometimes that’s all it takes, is a peer telling another person, “You know, you look like shit.” ...That’s how people did it for me, and I got the message slowly. People that I care about or people that I try to impress, peers I look up to – them telling me, “Yeah, you don’t look so good.” (Sunni)

I told my friend everything that happened, and how I used to see things and stuff, and she told one of the counsellors at the safe house. ...[Now] I think it was good, ‘cause if she didn’t do it, I probably would never have gotten help. (Ruby)

These results provide additional support for peer support initiatives like the Crystal Clear Peer Support Project (Sinclair, 2007) discussed earlier. Three youth used mutual peer support groups like Narcotics Anonymous or a relapse prevention group for street youth provided through Covenant House as adjuncts to more formal services. These were generally seen as helpful, and both youth who attended the Covenant House support group reported strong relationships with the worker who led the group.

**Coerced services.** Two youth reported having been committed under the BC Mental Health Act (Province of British Columbia, 1996a) and hospitalized against their will. While they were involuntarily admitted at the time, both indicated during their interviews that being locked up was the only way they could have received the help they needed.

In the end, eventually I got to where I really appreciated them [hospital psychiatrists] a lot, for all the work they did. (Devon)

Sunni experienced multiple hospitalizations and indicated that each occasion was necessary to force her to stop using crystal meth long enough to treat her mental and physical health and keep her alive.

Because the reality is if I didn’t get the psychiatric help I needed, I would have committed suicide. (Sunni)
Three youth reported feeling pressured to seek treatment for their mental health and drug issues or face losing access to a program that was particularly significant to them. One program provided shelter, one provided employment training, and the third program provided income, so the youth felt coerced to do as they were asked. At the time of the interview, all three felt it had been a necessary step to getting help.

I talked to them about, you know, how I was doing meth and stuff. And they told me about the counsellor, and I said, “Okay.” And I knew if I didn’t do it I would have got kicked out. But I wanted to do it in a way, but in a way I didn’t. Like I probably wouldn’t have done it myself at that time. Probably not until later on. I felt I was forced a little bit, but I kind of wanted to do it a little bit. (Mark)

Well it was both of them. The safe house and this program. But it was mostly the program that was like, “You can’t come back here, if you don’t go there [detox].” And I was like, “I need to be in this program.” So I was like, “Okay, fine.” (Ruby)

**Barriers to Accessing Services**

**Unaware of psychotic state.** Consistent with the nature of psychotic episodes, seven youth reported they were unaware they were experiencing psychosis at the time.

That’s the thing about even an ex-crystal meth addict. For him to admit that he’s seen things that weren’t there is almost impossible. ‘Cause in his mind he firmly believes that they are there. (Devon)

Before that, you would not be able to convince me. I’d be like, “No, the world is actually changing.” I was so convinced. I was in my own world. A literally dark world. (Ruby)

I’ve gone through psychosis, and I don’t know how long I’ve been going through it, and I don’t know where I’ve been getting treatment, and I don’t know what the hell else. It’s like a coma patient. You just wake up. (Sunni)

The other two youth reported experiencing intermittent awareness of their symptoms.

It was weird ‘cause I thought I was out of it, and for like a month long period I’d think I was out of it, and kind of go back into it but be aware that I was in psychosis. And they say that you’re not supposed to because when you’re insane
you don’t know you’re insane kind of thing. But I was aware that like, “Yeah I’m
fucked and that’s not actually happening”, but then I’d start believing it again.
And then I’d realize, “Oh no, that’s not real.” (Greg)

This lack of awareness made it extremely unlikely that youth would voluntarily seek
help. The outreach worker I interviewed during the pilot phase of this research estimated
that of the seven recent hospitalizations for meth-induced psychosis of which she was
aware, five were forcibly brought to the hospital and involuntarily committed. Only one
of the nine youth who participated in this research voluntarily sought out mental heath
services during a psychotic episode. Six youth suggested that outreach workers or peers
would be useful in helping someone recognize his or her mental state and thereby
facilitate access to mental health services.

Stigma. Six youth discussed the stigma associated with drug use and mental
illness, as well as the stigma associated with help seeking itself, as barriers to accessing
services.

I was always too paranoid people would think I was a drug addict. ...I’ve got this
thing about me where I’ll do drugs, I’ll do lots of them, and I’ll be a complete
crack head and fucking drug fiend. But God forbid anybody knows. (Greg)

[I was worried] that I would be shut out. Get pushed away because I was a drug
user, a person who didn’t know their own limits. I didn’t want to be shamed.
(Elaine)

Overcoming the idea that you’re broken [makes it harder to ask for help]. The
idea that there’s something very, very wrong with you... I don’t like asking for
help. I don’t like asking for handouts, end of discussion. ...My dad always
brought me up with it, specifically psychological problems. (Nathan)

Nathan experienced the stigma of being a drug user first-hand when his psychiatrist
insisted on regular urine drug screens before agreeing to treat him.
A lot of times I’ve found, specifically with doctors as I mentioned, they will shoot you down as soon as they find anything drug-related in there... I don’t know exactly why, because I figure normally psychiatrists are there to help people. But no, he became very one-sided and negatively opinionated as soon as I brought it up. (Nathan)

Two youth also discussed the need for a broader cultural change in attitude from regarding substance abuse as a criminal problem to treating it as a health issue.

So, other countries like Holland, drugs are considered a medical problem, so you can actually go into a clinic anywhere and say, “Oh, this is what I got.” It’s a lot more socially accepted. More understood. (Devon)

**Systemic barriers.** Systemic or structural barriers such as transportation requirements or program policies were the least cited barrier to accessing mental health services. Only one youth had made any attempt to seek out psychiatric help while in a psychotic state. Greg came to the local emergency room in psychosis and with a broken wrist, and he was asked to take a number and wait to be seen. Not surprisingly, he left. On another occasion at the same hospital, he was evicted from the emergency room when he became frightened and verbally threatened a nurse who wanted to give him an injection of antipsychotic medication.

And then they were going to give me some antipsychotic, and my eyes still weren’t open. I was still laying, I was still drooling, but I can hear them talking about it, and I remember yelling at her, “Poke me with the needle, I’m gonna fucking poke you back with it.” And then them asking me politely to leave which I thought was insane. Like, I should have been in the fucking psych ward at that point. Me getting up, getting my bag, and going back to my hotel room. (Greg)

I have personally witnessed this lack of understanding on the part of medical personnel when I escorted an acutely psychotic youth to the emergency room and observed the youth being told to leave because of his agitated behaviour.
Two youth said that they did not know about services available to them, and this lack of knowledge got in the way of seeking out appropriate help.

Probably not knowing where to get help [makes it harder to get help]. ‘Cause I was new to BC, and even when I asked my friends, even when I asked some people on the street, they didn’t know. Nobody knew ‘cause I guess it’s not made that open except for places like this where they have those bulletins, right? (Ruby)

One youth cited police involvement as another systems barrier to seeking help. His experience was that he was more likely to be arrested than provided with mental health services, especially if he was on probation.

**Youth Recommendations**

**Improving access.** Five youth spoke about the need for increased accessibility of mental health support services. They felt that the current mental health system did not sufficiently accommodate the unique characteristics of street-involved youth who were already resistant to asking for help and unlikely to go voluntarily to an office or hospital or to keep the same hours as most typical office-based counsellors.

You get mental health [services] in the day and then at nighttime you’re still stuck. I could go to a counsellor in the day… but I’m still gonna be around 10 dealers and 500 addicts at least that night. (Devon)

Outreach workers [to] find them on the street, ‘cause a lot of people won’t come in. ...If somebody would have come up to me, I probably could have used some help, but there was no way I was going anywhere, or been like, “Hey, I need help.” (Greg)

One youth suggested a telephone crisis line for youth in psychosis so that youth would not have to leave their rooms. Two youth who had travelled to Vancouver from Ontario recommended publicizing information about services so that youth, especially out-of-towners, would know where to get help.
I think maybe advertisements. You know those ones that are Psychosis Sucks, and it gives all the symptoms? I’m pretty sure that’s the first time I ever heard about psychosis, when I came out here. They don’t have anything like that in Ottawa. They don’t have all this information about jib like you guys do out here. (Ruby)

Two participants noted that taking a harm reduction perspective would increase accessibility by engaging youth and keeping them connected until they decide to quit using drugs.

Harm reduction will keep you alive until you can get clean... I know guys who get clean when they’re 65. And some people die at 35 because they don’t know what they’re doing, or they’re using dirty rigs, or fucking diseases. Harm reduction works until you can get clean. (Greg)

**Specialized services.** Two participants suggested specialized methamphetamine-specific services. One of the youth strongly recommended the separation of youth with drug-induced psychosis from the general psychiatric population. He described his two month stay in an adult general psychiatric ward housed with much older chronic psychiatric patients as a constant struggle to manage his paranoia and urge to elope.

I think they need to make a [ward] that’s more devoted towards this kind of psychosis ‘cause it’s different than the other. Street youth need more counselling than they need drugs to get off of it. And they need a place to stay to get off of it. (Devon)

The other youth suggested residential treatment services specifically for youth suffering from methamphetamine-psychosis. Her concern was to maintain confidentiality for youth accessing these services due to the stigma of drug use and mental illness.

Well, there should be a clinic out there to deal with psychosis. And it should be private… Because if people clean up, they wouldn’t want everybody to know about them. (Elaine)
Pathways to Mental Health Services

Most youth did not begin using methamphetamine until after they had become homeless and involved with a street lifestyle. National drug surveys consistently report that relatively few mainstream high school youth are using meth (Adlaf & Paglia-Boak, 2005; Canadian Centre on Drug Abuse, 2004; McCreary Centre Society, 2004), which is consistent with the pathway to meth use conceptualized in this research. The youth in this study were not introduced to crystal meth until after they had left home and were already living in a drug-saturated environment whose norms supported this activity. After a period of increasing binge use, sleep deprivation, and consequent symptoms of drug-induced psychosis, each participant identified a moment at which he or she had had enough. This “enough moment” served to motivate the youth to seek or accept help. This was also the moment in which the youth’s relationship with an outreach or other frontline worker was paramount to connect the youth with services.

Research on early psychosis intervention programs has gathered evidence that the longer the duration of untreated psychosis, the poorer the prognosis and the lower the likelihood of symptomatic recovery (McGorry & Yung, 2003). Outreach or other frontline workers are most likely to make first contact with youth who are just hitting the street. They are ideally situated to catch psychotic symptoms early in their course and encourage immediate access to mental health services, thereby promoting the best chances for recovery. The high rates of suicidality found among the youth in this sample make it even more urgent for workers to establish relationships with these youth.

Most youth reported they were completely unaware that they were psychotic at the time of their illness. Given the nature of psychosis, paranoia and lack of insight is to
be expected, hence the improbability of these youth voluntarily seeking out mental health services. Two of the nine youth interviewed indicated they had been forced to submit to treatment via certification. Another was brought by police to a hospital overnight, but he did not receive any treatment and was released in the morning. The other participants did not come to the attention of the authorities while they were actively psychotic, likely because their feelings of intense paranoia caused them to isolate themselves and avoid contact with others, especially the police. Most youth did not come into contact with service providers until their acute psychotic symptoms had resolved, leaving outreach services and frontline agencies in the critical role of connecting with these youth and facilitating their access to mental health services.

Figure 1 is a model that represents how street-involved youth access mental health services for symptoms of methamphetamine-induced psychosis. The outer circle includes outreach workers, shelter or safe house staff, other frontline workers, and peers. These individuals are most likely to make first contact and to notice mental health issues first. Workers or a youth’s peers may communicate with other frontline service providers who have a relationship with a particular youth in order to notify them about mental health symptoms, consult, or arrange referrals and support. When workers have positive therapeutic relationships with youth who are beginning to experience psychotic symptoms, they are key figures in supporting the youth to access appropriate mental health services. They provide referrals to mental health services as well as ongoing support. They may refer directly to community mental health services or contact emergency services if the youth is so ill as to be in need of involuntary hospitalization. The broken lines in Figure 1 represent an indirect referral to hospitalization through contact with police or other emergency services.
Access to mental health services is almost always mediated by a frontline or outreach worker with whom the youth already has a relationship. Youth in this study reported that internal factors like the fear of being stigmatized and lack of knowledge were the most significant barriers to accessing service. Frontline workers can ameliorate these barriers through education and support, and the strength of their relationship is vital to convincing a paranoid youth to trust his or her worker and follow through on the referral. Peers and other sources of informal help were also viewed as key to encouraging, supporting, and educating their friends. This emphasis on peers as a source of informal help is normative among adolescents in general (Boldero & Fallon, 1995), and has been found to be even more true among marginalized youth (Slesnick & Prestopnik, 2005) who may have had limited experiences of help from trustworthy adults (Ensign, 2003).
The shaded second tier represents voluntary community mental health services and supports including counsellors, therapists, social workers, community psychiatrists, and family doctors. They provide mental health treatment, support, and follow-up services. In most cases, this is the preferred layer of services for youth with meth-induced psychosis to be accessing. These service providers may also contact the police to transport the youth to a hospital emergency room should the youth’s mental health deteriorate and require involuntary hospitalization. Psychiatrists or other physicians may directly commit a youth to the hospital for 48 hours pending another physician’s examination.

The inner circle represents involuntary hospitalization. At this point, the young person is so ill that at least one physician has signed a medical certificate determining that the youth requires involuntary treatment to prevent his or her deterioration or for the safety of the youth or others. Upon release from hospital, the youth is typically referred for outpatient treatment, support, and follow-up mental health services in the shaded layer of services. The findings from the current research suggest that compliance with follow-up care is likely to be significantly influenced by the youth’s relationship with the referring agent and the commitment and ability of important support figures from the outer circle to support ongoing mental health care.

Taking a Concurrent Disorders or Addictions Perspective

During the analysis, there arose a clear division between youth who had received treatment from a concurrent disorders perspective, and those for whom addiction issues were viewed as the primary concern (see Table 2). Three of the youth interviewed were served solely via addiction services. These services included detox, residential drug and
alcohol treatment, mutual support groups, and drug and alcohol counsellors. The other six received mental health services such as psychiatric hospitalization, antipsychotic medications, community psychiatric support, and mental health counselling in addition to the addictions services noted above. There was an obvious gender breakdown to these avenues of support. Of the three youth who received only addictions services, all were male. In contrast, all four females interviewed were treated from a concurrent disorders perspective. This finding is consistent with other research that shows women hold more positive attitudes towards help seeking and are more likely than men to access formal mental health services (Boldero & Fallon, 1995; Leong & Zachar, 1999; Timlin-Scalera et al., 2003).

Table 2
Gender and Type of Services Received

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Males</th>
<th>Females&lt;sup&gt;a&lt;/sup&gt;</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addictions services only</td>
<td>3</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Concurrent disorders services</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

<sup>a</sup> includes one male-to-female transgendered youth

There did not appear to be any difference in outcomes as eight of the nine participants in this study reported they were not currently using crystal meth, but the sample size was likely too small to show any differences between the two approaches. The literature suggests that the best outcomes follow from concurrent and integrated mental health and addiction services (Mangrum et al., 2006). Given the high proportion of street youth suffering from concurrent disorders (Slesnick & Prestopnik, 2005) it makes sense to offer services from this perspective whenever possible.
Increasing Accessibility of Mental Health Services

The results of this study suggest several avenues for increasing the accessibility of services to street-involved youth experiencing methamphetamine-induced psychosis. In terms of the model of access presented in this research (see Figure 1 on page 53), these recommendations are aimed at improving the accessibility of frontline services in the outer circle and mental health services in the second circle. Participants in the pilot study all endorsed a need to extend the hours of mental health services. Later interviews did not express this theme, presumably due to the recent establishment of a 24-hour full-service youth centre in the downtown area that addressed many of the needs early participants had raised.

The youth in this study identified internal factors (i.e., lack of awareness of the problem, fear of being stigmatized, or lack of knowledge of available services) as barriers to accessing services far more often than external factors (i.e., transportation problems or program expectations). Interestingly, the three participants who explicitly discussed the issue of stigma associated with help seeking were all male, consistent with research on gender differences in attitudes toward help seeking (Timlin-Scalera et al., 2003). These findings suggest that local service providers need to adopt strategies that address these internal barriers through education, outreach, and advertisement of available services where high-risk youth are likely to gather. One participant spoke highly of the *Psychosis Sucks* campaign (Fraser Health Authority, 2006) sponsored by the Fraser South Early Psychosis Intervention program. She reported that reading these advertisements on public transit helped her recognize her own symptoms of psychosis and led her to speak with her physician about them. Educating youth about these matters will hopefully also
enable them to act as educators and supports should their peers be experiencing symptoms of psychosis.

As discussed earlier, most youth were unaware they were psychotic and in need of assistance. Outreach and other frontline youth workers play a necessary role in finding these youth and facilitating access to mental health support. Building in outreach and low-barrier service components will help youth agencies expand their service population and assist those youth to connect with needed supports. Consistent with other studies investigating adolescents’ help seeking behaviour (Hagedorn & Ekegren, 2002; McFadyen & Fletcher, 2002), participants identified the quality of the relationship between the young person and the worker or mental health professional as key to accessing mental health treatment. Research consistently shows that one of the most robust determinants of continued engagement and positive treatment outcomes is a positive alliance between the client and the worker (Meier, Barrowclough, & Donmall, 2005). It is clear that youth workers and mental health professionals would do well to prioritize relationship-building, especially in the initial stages of engagement and treatment.

The current research emphasized the role of peers as significant support figures for many street-involved youth. A related theme was the stated preference by some of the informants for counsellors who had previous first-hand experience with drug use. They indicated they felt more understood by these workers (Wilson & Deane, 2001) and less stigmatized when seeking help. Mental health agencies interested in enhancing accessibility should recruit youth with personal histories of mental illness or substance use and establish peer outreach and/or mutual support components to their programs.
Limitations of the Current Study

The current research asked youth to talk about their past experiences of drug use and mental illness. Any research that relies on retrospective interviewing is open to the inaccuracies and errors inherent in the complex processes of memory processing and retrieval, as well as the reconstructive nature of autobiographical memory (Gardner, 2001). This was a particular concern in the current study as it examined experiences relating to methamphetamine use and drug-induced psychosis, both of which have been found to be associated with deficits in memory and recall (Fitzgerald et al., 2004; Simon et al., 2000). Three participants explicitly noted they had trouble remembering events surrounding their psychotic episodes as well as current problems with their memory.

By virtue of accessing Covenant House services, the youth I interviewed had already demonstrated their willingness to access some sort of community service. I was therefore unable to interview the most service-resistant youth who would logically be the population least likely to access mental health services. I also chose only to interview youth who had already received some sort of mental health service in order to focus on the experience of accessing services. The experiences of youth who refused or were denied mental health services is not represented in this research.

The generalizability of these findings is limited by the small number of youth interviewed in one small area of a particular city over a short period of time. Longitudinal research undertaken at multiple Canadian sites would provide stronger evidence for the suggested model of access arising from the current study, as well as address the problem of retrospective memory. North American studies have found that high-risk youth of Caucasian descent are more likely to access mental health treatment.
and support than other ethnic groups (Garland et al., 2005). However, as one of the selection criteria of this study was that the youth all had to have previously accessed mental health services, the data did not allow for an examination of ethnic differences in access. These questions will need to be explored in future research.

Ethical issues around informed consent and reporting requirements (Meade & Slesnick, 2002) prevented me from interviewing minor children under nineteen years of age, but I suspect these youth’s experiences may be quite different. Formal services often require a guardian’s consent or notification to the Ministry of Children and Family Development. Since many street youth want to avoid contact with their parents or with the Ministry, these requirements may decrease the likelihood that a youth will access services. Further investigation of these issues would be helpful to determine how underage youth access mental health services.
Chapter X  Implications for Social Work Practice and Future Research

Social Work Practice with Street Youth

The research presented here certainly has implications for social work practice with street-involved youth. It offers a beginning point from which to examine issues of access and barriers to services. This research focused on the specific topic of mental health services for meth-induced psychosis in street-involved youth, but of course in the real world this issue is wound around and entwined with issues of homelessness, trauma, stigma, poverty, and social disenfranchisement. The stories of the youth interviewed here may be focused on their experiences with meth and psychosis, but many of them begin with themes of isolation, abandonment, and homelessness. Social workers must be aware of these issues when working with street youth, yet also seek out and highlight the strengths and resilience that these youth bring with them as well. Any approach to this issue must be multi-faceted and integrated. Mental health services without responsive health care, housing, addictions treatment, and educational and vocational opportunities are unlikely to amount to much in the end.

Crisis services must be followed by integrated aftercare services in order to maintain the stability of a young person’s mental health. In a recent meta-analysis of interventions with dually diagnosed clients, aftercare incorporating intensive case management was found to have a significant positive impact on long-term treatment effectiveness (Dumaine, 2003). Once the initial crisis is over, should these youth return to their former lifestyles of homelessness and association with drug users, it seems exceedingly unlikely that they will be able to maintain their mental health. Conversely, as shown in this research and from my own personal experience working with street
youth, they may be most receptive to making changes in their lives and accepting of assistance to do so immediately after a “wake-up call” or “enough moment” like a psychotic break or hospitalization. We are limited in our ability to foster “enough moments”, but by being available and accessible to these youth we can act immediately to facilitate their access to help when the “enough moment” happens.

I located social workers within the second tier of the model of access to mental health services presented in this research (see Figure 1 on page 53) as, for the most part, we are a specialized service working with clients referred from other sources. I do believe that social workers have the knowledge, skills, and credibility to bridge the first and second tiers of access and facilitate the transition between the two. I see that social workers are sometimes caught between the drive to professionalize and the desire to remain available and accessible to our clients, but I do not think it will diminish our professional identities to leave our offices, abandon traditional office hours and scheduled appointments, and walk the same streets as the youth we seek to help. The Canadian Association of Social Work’s Code of Ethics (2005) states:

Social workers promote social fairness and the equitable distribution of resources, and act to reduce barriers and expand choice for all persons, with special regard for those who are marginalized, disadvantaged, vulnerable, and/or have exceptional needs. (p. 5)

One way that social workers can act to reduce barriers to marginalized and vulnerable youth is by actively cultivating the critical relationships needed to hook youth in to mental health services with ourselves or with other mental health professionals via outreach work on the street and in drop-in youth centres.
Social Work Practice with Underage Street Youth

Research is needed to examine how underage street youth experience mental health services and access to services. Requiring parental or guardian consent for treatment is likely to be perceived as a significant barrier to service and may reduce the likelihood that a young person needing help will come for assistance. When working with minor street-involved youth, social workers are in the position of walking an ethical tightrope with reporting requirements and child protection legislation on the one side, and the desire to lower barriers to youth seeking help on the other (Meade & Slesnick, 2002).

Section 13 of the Child, Family, and Community Service Act states:

A child needs protection in the following circumstances... (i) if the child is or has been absent from home in circumstances that endanger the child’s safety or well-being. (Province of British Columbia, 1996b, 13(1)(i))

Thus, by definition, street youth under nineteen years of age are children in need of protection and must be reported to a director or designate. Nevertheless, we recognize that there are degrees of risk or endangerment. There is a vast difference between a twelve-year-old runaway being commercially sexually exploited on Franklin Street and an eighteen-year-old homeless youth sleeping in shelters and panhandling on Granville Street. How do we reconcile these legal requirements with the reality that resources are limited, cases must be prioritized, and it is highly unlikely any intervention will occur if the youth refuses to cooperate?

These are ethical questions facing every social worker who works with street-involved youth. Perhaps the principles of harm reduction can be applied in these situations. It seems to me that youth are more likely to come to harm if they are unwilling to approach service providers out of a real or imagined fear that they will be
reported to the Ministry of Children and Family Development, than if they are positively connected to social workers who can monitor risky behaviour, provide support and counselling, and to whom youth can turn for help when they have had “enough”.

**Directions for Future Research**

Larger-scale longitudinal studies are required to further examine the relationship between how street youth access mental health services and associated future outcomes, but researchers will have to find ways to work around the transient nature of this population and what will almost certainly be a higher than usual drop-out rate. In order to focus on investigating the experience of accessing mental health services, the current study only interviewed youth who had already received service. There may be significant differences between these youth and those who refused or who were denied access to services. Future research could test the validity of the model of access presented in this research by investigating the experiences of street-involved youth who did not receive mental health services and the barriers that they faced. Do the groups differ in terms of access to outreach or frontline services? Is there a difference in the quality of their relationships with outreach or frontline workers? Do they differ in their willingness to accept help, and if so, what are the underlying factors that promote or hinder willingness to accept help in this specific population?

Most research with street-involved youth has been with convenience samples, usually recruited from homeless shelters, safe houses, youth centres, and other youth-serving agencies. Very few researchers are willing or able to look for and find the most street-entrenched, hidden, or service-resistant youth. Since these youth are least likely to have contact with service providers, they are logically also the least likely to participate
in research studies. What is their perspective? How do we hear their voices? How do we as practitioners offer services that are relevant to this population?

Youth who have been assaultive towards a staff member or who have behaved aggressively at a particular agency may be barred from accessing that specific service. In the urban core of a major city like Vancouver, there are many other agencies available to provide support. This is often not the case in suburban or rural areas outside of Vancouver or in smaller cities, and some youth may find themselves without access to the sorts of frontline services identified in the outer tier of services in the proposed model of access to services. What mechanisms are available then to support access to mental health services? What other differences might we find among street-involved youth living outside of major urban centres like Vancouver?

The research presented in this thesis has suggested several ways of improving accessibility: increased outreach presence, peer support programs, increased advertisement of services, and education around methamphetamine use, psychosis, and mental health issues in general. Future research in this area would do well to investigate what other aspects of traditional mental health services could be altered, enhanced, or done away with entirely in order to better fit the unique needs of this population.
Chapter XI Conclusion

This thesis presents the results from interviews with nine street-involved youth who have experienced symptoms of methamphetamine-induced psychosis. The main constructs identified to promote access to mental health were the quality of the youth’s relationship with the professional, peer supports, and the use of involuntary services. Youth identified the fact that they were unaware of their psychotic state as the chief barrier to seeking mental health services. They also named systemic barriers and stigma associated with substance use, mental illness, and help seeking itself.

The overarching objective of this line of research was to generate strategies for developing effective programming and increasing the accessibility of mental health services to methamphetamine-using street youth. The Four Pillars Drug Strategy in Vancouver recognizes the marginalized and vulnerable status of street-involved youth and makes several recommendations aimed at improving and increasing treatment options for youth (MacPherson, 2001). A comprehensive investigation of these issues is vital to understanding the “methamphetamine epidemic” among Vancouver street youth. New policy and programming designed to reach this specific population can only be responsive when guided by the needs identified by the youth themselves.

While “empowerment” and “self-determination” are concepts to which most service providers readily subscribe, substance users and mentally ill clients are still largely viewed in a paternalistic manner and as individuals requiring protection from themselves (Timms & Borrell, 2001), thus perpetuating the idea of “the professional knows best”. It is hoped that the growing trend towards client-driven service as evidenced by increasing acceptance of harm reduction strategies (MacPherson, 2001),
consumer activist groups, and research exploring clients’ voices (e.g., Dixon & Lloyd, 2005; Wilson & Deane, 2001), signals a paradigm shift towards framing drug addiction as a medical and social problem rather than a criminal problem, thereby reducing the stigma of drug use, associated mental health concerns, and accessing treatment. I hope that the current investigation will add to this literature.

My intent in doing this research was to do more than simply complete a graduate degree. This research needed to have a real impact in terms of how services to street youth are offered. This work has personal meaning to me. I will use what I have learned throughout this process in my work in the future. I can only hope that this research will offer something of value to others’ practice as well. Finally, I trust that participation in this research will yield some benefits for the youth themselves. My hope is that the experience of speaking about the impact and influence of their peers and of their own influence on their peers will rouse a sense of efficacy and faith in their own abilities to influence and care for each other.
References


British Journal of Psychiatry, 185, 196-204.

Engagement with health and social care services: Perceptions of homeless young 
people with mental health problems. Health and Social Care in the Community, 14, 553-562.


American Journal of Health-System Pharmacy, 63, 2078-2082.


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Appendix I Interview Prompts

Demographics
Gender, age, ethnicity?
Where were you born? How long have you been in Vancouver?

Street Involvement
When did you first become involved in street life? How did it happen?

Meth Use
Tell me about your meth use. Why did you start? Who introduced you to meth?
How old were you when you started? Did you start before or after street involvement?

How long have you used? Pattern of use? Why do you use now?

Tell me about a time you used crystal meth and then experienced hallucinations, paranoia, confused thinking, voices in your head, irrational fears or beliefs, or any other similar symptoms. What happened? Why do you think you experienced these symptoms?

How many times has this happened to you? What happened on those occasions?

Help Seeking
When you had this experience, what did you do? Did you look for help? Where did you go? Include formal and informal help. What kind of help did you want? What kind of help did you get? Crisis or long-term?

Walk me through how you came to the decision that you wanted or didn’t want help. What made it easier to ask for help? What made it harder?

Did someone else make you get help? What happened? What did you think of that at the time? What do you think now?

What did you think of the helper at the time? What do you think now?

How did you first access formal mental health services? How did you feel about using this service? Was it helpful? What made it easier to access that mental health service? What made it harder?

If you had a similar experience now, what would you do? If you had a friend who was going through a similar experience, what advice would you give him/her?

Is there anything else you think people should know about this topic?
Appendix II  UBC Behavioural Research Ethics Board Certificate of Approval

The University of British Columbia
Office of Research Services
Behavioural Research Ethics Board
Suite 102, 6190 Agronomy Road,
Vancouver, B.C. V6T 1Z3

CERTIFICATE OF APPROVAL - FULL BOARD

<table>
<thead>
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<th>INSTITUTION / DEPARTMENT:</th>
<th>UBC BREC NUMBER:</th>
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<td>UBC/Arts/Social Work &amp; Family Studies</td>
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INSTITUTION(S) WHERE RESEARCH WILL BE CARRIED OUT:

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Other locations where the research will be conducted:
Covenant House Vancouver, 575 Drake St., Vancouver, BC V6B 4K8. Letter of support from Covenant House Vancouver is attached to this application form at 7.1.B

CO-INVESTIGATOR(S):
Olivia Lee Lambert

SPONSORING AGENCIES:
N/A

PROJECT TITLE:
Methed Up: How do Street-Involved Youth with Methamphetamine-Induced Psychosis Access Mental Health Services?

REB MEETING DATE: CERTIFICATE EXPIRY DATE:
April 12, 2007 April 12, 2008

DOCUMENTS INCLUDED IN THIS APPROVAL: DATE APPROVED:

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The application for ethical review and the document(s) listed above have been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval is issued on behalf of the Behavioural Research Ethics Board and signed electronically by one of the following:

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