

## **Life with jib: A snapshot of street youth's use of crystal methamphetamine**

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### **Abstract**

Crystal methamphetamine (CM) is a psychoactive form of methamphetamine whose effects include euphoria, alertness, restlessness, feelings of endless energy, sleep deprivation, depression, paranoia, acute psychosis, and malnutrition. CM use among street-involved youth is high, yet little is known about their patterns of use, the side effects they experience, and the ways in which they manage their drug use and survive on the streets. We undertook a small qualitative study among inner-city, street-involved youth to explore the social context of their CM use. Semi-structured interviews were conducted with twelve youth. Data were analyzed using thematic analysis and four key themes were identified: Patterns of Jib Use, Reasons for Using Jib, Downside of Using, and Managing Jib Use. Each theme revealed interrelationships between drug use and street-involvement. The youth used CM to stay awake to protect belongings, to enhance social interaction, to cope with negative emotions, and as an alternative to psychiatric medications. The negative consequences of CM use included deteriorating physical and mental health, exploitation, isolation, and physical harm. These youth were knowledgeable about their drug use and capable of creatively adapting to many of the related consequences. Social service agencies and health care professionals were not identified as helpful in managing their drug use and its side effects. Although the

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sample size was small, this data gives insight for policy and program planning aimed at providing treatment and support for street-involved youth using CM.

**Keywords:** *Crystal methamphetamine, amphetamines, substance use, youth, adolescents, qualitative, street-involved, homeless*

## Introduction

Crystal methamphetamine (CM) use among youth is of growing concern to Canadians (The McCreary Centre Society, 2001; Centre for Addiction and Mental Health [CAMH], 1999). CM is a psychoactive form of methamphetamine that is inexpensive and easy to obtain. It is a powerful central nervous system stimulant whose effects include euphoria, alertness, restlessness, and a feeling of endless energy (Canadian Community Epidemiology Network on Drug Use [CCENDU] & Addictive Drug Information Council [ADIC], 2003). Youth who use CM have reported that it makes them feel confident, powerful, successful, sexy, and joyful and that it enhances sexual performance and contributes to weight loss (Anglin et al., 2000). CM use is also associated with a variety of potentially life threatening and life altering complications. It contributes to sleep deprivation, depression, paranoia, acute psychosis (Farrell et al., 2002), malnutrition, and increased risk of sexually transmitted infections including HIV (Farrell et al., 2002; Zule & Desmond, 1999). Violent incidents such as assault have also been reported among those using CM (Cohen et al., 2003; Harris, 2003).

The majority of research associated with youth using CM to date has described patterns and reasons for use among high school students (Oetting et al., 2000; Sattah et al., 1997). While not discounting the significance of this work, it is important to develop an understanding of CM use among street-involved youth<sup>1</sup> particularly as there appears to be an alarming increase of CM use in this population (Auerswald & Eyre, 2002). Furthermore, street-involved youth, particularly those who are homeless and involved in drug use, are at increased risk for many health and social problems compared to other youth including serious physical and mental illness, injury, assault, HIV and AIDS, and self harm (Commander, et al., 2002; Kidd, 2003). Although some programs exist for street-involved youth, these youth tend to have poor rates of health care and social service utilization (Auerswald & Eyre, 2002; Rew & Horner, 2003). These concerns precipitated the need and interest to gain insight through a qualitative subjective lens into the lives of street-involved youth who are regular users of CM. The purpose of this study was to describe the culture and experiences of street-involved youth, including their patterns of CM use, the side effects they experience, and the ways in which they manage their drug use and survive on the streets. By understanding the social context of street-involved youths' lives, better health and social service program planning for these youths can occur.

### Recent literature on CM use among street-involved youth

Current research that addresses CM use has focused largely on trends and patterns associated with CM use such as routes of administration (Matsumoto et al., 2002), presence of CM within the rave scene (Degenhardt & Topp, 2002), and epidemiological data such as surveys for the prevalence of use among specific populations based on age, gender, and ethnicity (Oetting et al., 2000). Other studies have focused on health associated risks such as cardiac illness (Yu, Larson, & Watson, 2003), HIV and AIDS (Yu, Larson, & Watson, 2003; Zule & Desmond, 1999), and the experience of acute psychosis (Farrell et al., 2002). Fewer studies have examined patterns of use, social and personal factors that might contribute to CM use, and methods of treatment (Brecht et al., 2003; Cohen et al., 2003). These studies tended to include participants involved in treatment for CM use and have focused on the adult *versus* youth populations.

Despite the dearth of in-depth research studies pertaining to the social and health contexts of CM use among youth, many health care and government agencies report that CM use among youth is on the rise and a growing health concern, particularly in Canada (CAMH, 1999; CCENDU & ADIC, 2003) and western USA (Rawson, Anglin, & Ling, 2002; Tartar, 1992). In a 1998 adolescent health survey in British Columbia (BC), BC high school students reported a lifetime prevalence rate of amphetamine use (including methamphetamines) of 5% (McCreary Centre Society, 1998). However, both Ontario (CAMH, 2003) and BC (McCreary Centre Society, 2003) reported a decline in CM use among youth over the past 5 years. A limitation of these surveys is that they are school-based and under represent high risk youth. Another BC survey conducted in 2002 that targeted a convenience sample of youth 'hanging out' in two downtown areas found a 19% lifetime usage rate for methamphetamine use among the youth surveyed (Pacific Community Resources, 2002). Further study with a diversity of youth is needed to obtain accurate results concerning the magnitude of CM use among youth including those who are street-involved.

The lack of research focused on CM use among street-involved youth is of grave concern as it has been well established in previous research that the incidence of drug use is much higher among this population (Adlaf, Zdanowicz, & Smart, 1996; Commander et al., 2002; Green, Ennett, & Ringwalt, 1997; McCreary Centre Society, 2001; Van Leeuwen et al., 2004). In a study designed to quantify substance use among homeless and runaway youth, Green and colleagues (1997) discovered that youth who were living on the street *versus* youth with a permanent or semi-permanent residence were significantly more likely to have used IV drugs, heroin, methamphetamine, and crack cocaine. The McCreary Centre Society (2001) found that drug and alcohol use were significantly higher with street-involved youth in comparison to the mainstream adolescent population. Fifty-three percent of the 523 street-involved youth surveyed, were self identified as of having a drug or alcohol addiction problem.

Other researchers have attempted to develop a more comprehensive understanding of the social context of the lives of street-involved youth. The aim of this work is to develop knowledge pertaining to the reasons youth become street-involved, the coping mechanisms used by street youth and the challenges street youth face with regard to their safety, health, and their opportunities to engage in mainstream activities that support a more traditional maturation into adulthood. While these studies have not been specific to CM use, common findings included that drugs were often used by street-involved youth to alleviate feelings of depression, escape from what the youth described as some of the circumstances of their lives, to allow them to remain awake for self protection, and to develop social relations with other street-involved youth (Adlaf, Paglia, & Ivis, 1999; Auerswald & Eyere, 2002; Higgitt, Wingert, & Ristock, 2003; McCreary Centre Society, 2001).

Recent preliminary research indicates increased incidents of acute psychosis as well as violent incidents among younger CM users. In 2002, a Vancouver inner city hospital reported that in one month 44 of their 215 psychiatric visits were for substance abuse. Of these 44 visits, 60% were documented as CM substance abuse (CCENDU & ADIC, 2003). In 2003, two Vancouver based service agencies serving homeless youth reported 28 incidents of violent aggression over the duration of one month as a result of CM psychosis (personal communication, Dr J. Buxton, June 30, 2004). Given the lack of available research pertaining to the social context of street youths' lives concerning CM use, we conducted a qualitative study with street-involved youth, to gain a snapshot of their patterns of use, the side effects they experience, and how they manage their drug use and survive on the street.

### **Methodology**

In November 2002, a methamphetamine environmental scan summit was hosted by the Canadian Community Epidemiology Network on drug use in Vancouver, Canada. The primary goals of this summit were to quantify the methamphetamine problems in BC and to develop strategies to address methamphetamine use (CCENDU & ADIC, 2003). A methamphetamine response committee (MARC) was established to respond to the recommendations made from the summit. Because MARC identified street-involved youth as an 'at risk' group, this study arose from the subcommittee's goal to develop a more realistic understanding of methamphetamine patterns of use among street-involved youth in Vancouver's Downtown South.

### *Sample*

It can be challenging to recruit participants from this study population as they are often transient and are rarely identified through traditional recording systems (Higgitt et al., 2003). A community outreach worker with experience working with street-involved youth was hired to recruit and interview participants.

Street-involved youth who were accessing health and social service agencies were invited to participate in the study. The method of snowball sampling was also used to recruit participants based on referrals made by other street youth. The sample of participants included 12 youths (ages 16–25). Five of the participants were male and seven were female. All participants were street involved to some degree and were accessing at least one of the health or social service agencies located in the downtown area.

### *The interviews*

Ethical approval for the study was received from the University of British Columbia Behavioural Research Ethics Board. Because of the sensitive nature of the topic and the possibility that many participants may be reluctant to reveal their identity, we received permission to obtain verbal informed consent. This practice has been used successfully in other studies aimed at ensuring confidentiality, safety, and anonymity for youth participating in research (Ensign, 2003). Once the participants provided informed consent, open-ended interviews were conducted. Each participant was reminded of confidentiality and their right to refuse to answer any question and to withdraw from the interview at any time.

Interviews took place at a drop in centre as well as in coffee shops or restaurants in the community. Each interview lasted approximately 20–45 min. Interview questions were open-ended and did not follow a specific structured template. Participants were encouraged to describe their experiences with CM and the relationship between CM use and living on the street. Several of the participants were high while the interviews were being conducted and as a result it was sometimes challenging for the researcher to maintain a focused interview. To facilitate discussions some specific questions were posed. These questions included such items as: ‘Are there benefits to using crystal meth?’; ‘Are there negative consequences?’; ‘Are you addicted?’ ‘Have you ever had to care for somebody who was flipping out in a psychotic state while they were on crystal methamphetamine?’ and ‘Did anything help dealing with that person?’ All participants were remunerated with a small meal (under \$10) and a bus ticket. Each interview was audio taped and then transcribed verbatim.

### *Analysis*

With the aid of NVivo software, interview data were coded and analysed using thematic analysis. Thematic analysis was chosen as a qualitative analytic approach as it allows the researcher to identify themes that are “. . . indicated by the data rather than concrete entities directly described by the participants” (Morse & Field, 1995, p. 139). The researchers worked through all 12 interviews, noting similarities and differences, and identified the dominant patterns and themes

throughout the data that best described the social context of CM use among the street youth interviewed.

## Results

The youth were very forthcoming regarding their experiences of using CM. They talked freely about their patterns of use, their reasons for using and the negative aspects of CM use. They gave detailed examples of how they managed their drug use and how they managed their day-to-day lives while living on the street. To ensure that we have represented the realities of these youths' experiences and the social context of their lives, we have presented many of these findings in the language used by the participants to describe their experiences with CM. The term *jib* was much more a common term used by the youth when referring to CM, and is the term used in our discussion of the study's findings. We have separated the findings into four key categories: *patterns of jib use, reasons for using jib, the downside of using, and managing jib use.*

### *Patterns of jib use*

All 12 participants had used jib at some point in their life and the majority reported that they were currently using on a daily basis. It was most common that initial use had occurred in their teens (e.g., age 15–16) and the duration of time in which participants had used jib ranged from 7 months to 8 years. The majority of the youth described that they had initially tried jib based on the suggestion from a friend or intimate partner. Some youth reported that they had initially used jib because they were seeking an alternative to their usual drug of choice such as marijuana or heroin. Many youth had not used jib until becoming street-involved. Of these youth, most had previous experience with other substances such as alcohol, marijuana, heroin, and cocaine prior to using jib.

Smoking jib appeared to be the most common and the preferred method of administering the drug. Four of the participants, however, reported injecting and smoking, and two reported only snorting the drug. The rationales for mode of use were varied. One respondent who reported injection as preferred mode of use stated "I like banging it better. It's good... cause I actually get high off the stuff. Seems like a waste when you smoke half a gram when you can... like you can smash two points" (Respondent 7). Reasons for snorting included a belief that snorting made the drug less harmful and that snorting the drug versus smoking or injecting provided a "better high." Of those who preferred smoking, they reported that smoking could provide a better high than snorting or injecting. The participants also reported polydrug use. For example, several participants reported that they used marijuana to help them "come down from jib". It was difficult to gain a sense of the actual amount of drug being consumed as the youth used several different terms to describe jib measurement such as "grams, points, bowls, and rock".

The most predominant pattern of use was bingeing. The youth reported that they would go on a run<sup>2</sup> using jib. This run entailed using jib several times in the course of a day or over several days consecutively until the supply of jib had been used up or they were no longer physically able to use. In this time, they would usually not eat, drink or sleep, often to increase the intensity of the high. The run typically ended with one of two outcomes; “crashing” or “freaking out”. Crashing referred to coming down from the high, taking the time to regroup and take care of themselves. The youth talked about self detoxifying by eating, sleeping, and drinking lots of water. “Freaking out” included auditory and visual hallucinations and erratic behaviours such as walking down the middle of the street unaware of traffic and removing clothing even though it was raining heavily, and losing sense of time, space, and belongings. Several youth mentioned incidents in which they had freaked out after being ‘sleep depped’ [sleep deprivation] for 2 days to over one month (36 days) while they were on a run. “Just before the last time I went to jail I stayed up for 36 days straight. Good old sleep-dep was in there... I think after a month or so of it [jib use]... you at least get a little bit of psychosis. You do some crazy stuff” (Respondent 8).

During the initial high, the youth often engaged in behaviours that required heavy concentration and focus (e.g., picking locks, making tools) or that required higher energy levels such as organizing and creating new projects. While on jib, users described the initial high as feeling energetic and engaged, but reported that the high eventually deteriorated into agitation, scattered thoughts and ritualistic or repetitive behaviours.

Some youth described how their pattern of use had changed over time. In several cases, youth reported that they had been very active users in the past but now had “calmed down” and used jib in what they considered to be moderation, including taking breaks to sleep and eat and using less jib each time. There were a variety of reasons for reducing the amount of jib used including not wanting to freak out, feelings of not needing as much of the drug or not needing the type of high associated with high doses. They also noted a decrease in their use due to the reduced quality of the jib available for them to use. For example, one youth described that moderation and “cutting back” on jib use meant that she didn’t “live for it”. Another youth had decreased her use because she felt that it was harmful to her body and that she was more content with her life as it currently was and therefore did not need to use as much anymore:

Now I’ll maybe do like a gram... and even that’s not really that much to me and I could be doing more but now it’s like I don’t do so much. I mean, it’s like I’m content with my life. I don’t need to do so much now that I am aware of reality. Now I’m content to enjoy reality while being high... it’s different. So like I’m not trying to get fucked out of my head, I’m just trying to get fucked (Respondent 10).

### *Reasons for using jib*

The youth were asked to describe why they use jib and if there were any positive aspects or benefits to jib use. The participants gave many reasons for use and the

reasons were often intertwined with being street-involved. Jib for example, helped them to stay awake for long periods of time to protect belongings, to be able to move quickly if necessary, and to not need to eat when food was difficult to find. As one youth described "...I know if I was high I like, wouldn't be hungry right now and sometimes it is easier to get drugs than food" (Respondent 2). Jib was described as an alternative to prescribed medications such as antidepressants or Ritalin<sup>®</sup> or an alternative to "harder" street drugs such as heroin or cocaine. Still others described it as helping with mental health issues such as attention deficit disorder and depression. The majority of youth discussed a sensation of liking the high associated with jib use and that it helped them focus and concentrate. Jib gave them energy, drive and motivation, increased their productivity, creativity, and improved their social skills. Other participants used jib because it increased their sexual satisfaction and one youth commented on his increased sexual stamina claiming, "everybody fucks like a porn star on meth" (Respondent 12). Other youth reported using jib because it was "something to do" and very social. As one youth stated, "...I do jib with people, you know and then I find some more people and I do more jib. It's a semi-social thing... jib is very interactive" (Respondent 10).

Many of the youth talked about doing jib because it was readily available to them and inexpensive. "It [jib use] developed gradually. It wasn't as common as pot at the time, but it became more popular and more used and more usable" (Respondent 5). Youth also cited jib's mind numbing qualities as a reason for using. Jib use was described as something that "stopped" these youth from experiencing their emotions of sadness or depression. For example one participant described how she found the drug "soothing" while at the same time acknowledging that it closed down her ability to express feelings or cry.

For many youth, there was a feeling of confidence, exhilaration, and carefreeness while using: "Because I am high I don't care what people think" (Respondent 1). As another youth described: "It made me feel powerful, like it made me feel like I could do anything. I liked that. I liked the feeling of being a badass or whatever and I liked being nocturnal" (Respondent 11). In addition to confidence, jib appeared to be associated with self identity for some of the youth.

When you're doing jib, it's like you're ok. Like when I do jib, I'm never at a loss. I'm always on top of my game and I've always got the right thing to say and it's like everywhere all at once and everything's cool and I'm fucking king shit. And fuck, you know, like it gives you a sense of being. You're managing to get 20 times what everybody else is doing done... You know you're pretty proud of yourself. It's just like a sense of being somebody. And you know that's the thing too, if you have like no life points or whatever, ok you can zip around so many places and invent so many things. To do that you can convince yourself that you're someone you know what I mean. So even the most insignificant person is somebody when they're doing jib (Respondent 10).

### *The downside of using jib*

All participants acknowledged that there were many negative aspects to using jib. Many recognized that their jib use was "changing them" in the short term,

both physically and emotionally but they did not talk about the long-term consequences of use.

All youth involved in this study reported a variety of physical side effects from their continuous jib use. The most commonly identified physical effects were loss of appetite and weight loss. The youth also described “jib sores” on their lips, tremors, shaking and itchiness. Many who smoked jib experienced chest congestion and acknowledged that “the mucousy fungus stuff that you hork up” or “lung butter” was a problem. Interestingly, this side effect led some to use alternative routes of administration such as intravenous or snorting.

The youth described excessive dirtiness and lack of personal hygiene and sanitation while using jib. They described having large pockets of puss all over their bodies which were referred to as “speed bumps”. Some explained that they believed that jib was leaking from their pores into these speed bumps and this was how jib was excreted from their bodies. The youth discussed that when they were using jib they were not aware of “being dirty” or of doing things that they later thought of as “gross”. For example one woman described an experience in which some users sat “...there in the bathroom for like 2 hours and pick[ed] their face with a screwdriver” trying to get rid of their speed bumps. She went on to say how she has engaged in this activity as well: “I’ve sat in the bathroom for 2 hours with one of my friends and we picked our faces together. It was really gross and when we left we were like ew, we just picked our faces for two hours...you do some gross things...when you’re high your judgment is really messed up” (Respondent 3).

Youth also discussed the cognitive effects of jib use and explained the paradox of the increased energy and motivational properties of jib. They described that at first “jib” would give them energy to create activities and organize aspects of their life but went on to explain that the projects would rarely get finished, organization would become increasingly scattered, and increased energy would inevitably backfire into agitation. They talked openly about the emotional downside of the drug. Emotional bouts of depression described as “black moods” were common. Other youth talked about feeling like their personalities had changed since they started using jib. They described being more irritable and cranky. Although jib use was identified by some youth as helping them not feel negative emotions, youth also alluded to the fact that CM use could magnify emotions that they were feeling at the time of taking the drug. As one respondent noted: “...being really depressed about some things and finding that the drug does nothing but make you focus more on that depression...if you’re feeling positive or having things going for you, you’ll seem more positive but if you’re you know, kinda bugged out or disappointed or upset, it makes that the focus” (Respondent 9).

Another downside of using jib was extreme paranoia. One participant relayed an experience in which she believed that police and other people on the street were chasing her. She spoke of “being gonged” and having paranoia induced by others who were aware that she was using. Jib-associated paranoia often culminated in what the youth termed “freaking out”. “Freaking out” was

described as a common and familiar response to jib use. Most of the youth described horrific situations in which they experienced terror and delusions. They described experiences in which they felt followed or spied on, they had visual and auditory hallucinations (e.g., police sirens chasing them), and experienced delusions that “everyone was after them” and that friends, strangers, and police were plotting against them. One participant talked about being in a psychotic state after a “minimum of 8 days of use”, describing the inability to articulate sentences but feeling as though his message was still being heard. Another stated that in the course of one summer, she had been hospitalized “188 times” for using jib. Most users discussed their episodes of freaking out as a consequence of the combination of jib use, lack of sleep, lack of food and water, and the additive effect of using jib and other hard street drugs such as heroin.

The risk of personal harm and loss of security and belongings were additional significant downsides associated with jib use. The youth in this study expressed a lack of trust and betrayal with other jib users and dealers. They reported having their drugs, personal belongings, and money stolen from them while they were high as evidenced in the comment from this particular youth: “. . . just the people, it’s just a sketchy, sketchy scene and everybody steals and it’s gross and you can’t find anyone to love” (Respondent 4). In addition, many of them talked about being so high from jib that they did things that they would not normally do such as lose their belongings (e.g., clothing, money), have sex with someone they normally would not have sex with, use injection drugs and engage in violent behaviour. One youth was barred from a youth group home due to his violent outbursts associated with jib use and discussed how he now had nowhere to go for food or shelter. In other instances the youth reported being exploited while they were high and in somewhat of a psychotic state. “I was up for . . . 9 days. And that was actually one of the nights where I was taken advantage of by one of my dealers. Yuck” (Respondent 4).

In response to being asked if they were addicted to jib, the youth’s answers were varied. Few youth identified themselves as being addicted while others acknowledged that they considered it a need in their lives, but one that they perceived they had control over. For example while some youth made comments such as: “Oh yeah, I’m quite addicted, emotionally and physically” (Respondent 5) or “I liked it [jib] and I was hooked on it” (Respondent 11), other youth commented: “I don’t use it if I’m not around it. I only use it cause it’s there” (Respondent 7) or “I don’t deny that I like wanna do it all the time, but I’m not like desperate for it” (Respondent 1). The youth discussed their use and need for jib in relation to how long they had been in Vancouver’s Downtown South. It appeared that many of the youth began using jib when they initially became street-involved. The youth also talked about how they resumed jib use if they returned to the street after not being street-involved for a period of time. This is particularly important considering that several youth reported that doing jib was something that kept them street entrenched, “That’s the thing

that jib does to me. It makes it seem so hard to get out of downtown, when it's actually not" (Respondent 2).

*"Managing" jib use*

Despite the harsh street life, the youth engaged in many strategies to "take care of themselves". Most of the youth talked about ways to stay "healthy" which included exercising (e.g., walking), eating nutritional food and drinking water, taking supplements, finding shelter and a quiet place to rest, and seeking out support from friends on the street. They recognized extreme physical deterioration in themselves and indicated that they could take time for what they described as "self-detox". This included engaging in behaviours that they had neglected such as eating, sleeping, and drinking fluids. As one youth described:

Sometimes, I don't do it for a couple of days to catch up on my sleep and get healthy. If detox doesn't have a bed, I self detox. Not having people around, having steady food and just being basically able to chill. I just sleep for two days and then I eat for a day and then I recognize myself in the mirror again (Respondent 1).

Some youth reported that they spent time in detox centres or group homes if they felt it was necessary to address some of the side effects of using jib. As one youth noted, "I go to detox all the time just to keep my weight on" (Respondent 2). The use of services however was not popular with all the youth. For example, one youth stated, "I had a counsellor but I don't go to her... she actually calls me... but I don't want help. It's easier to be crazy" (Respondent 4). Another youth commented that she had used detox services in the past, but preferred to self-detox. "I used their services [Detox], but I feel like I should detox myself. I'll go to my friend's tent in the bushes and I'll sleep for 3 days... He brings me food and... he won't bring dope around" (Respondent 3).

Many of the youth discussed how important it was to support people who were freaking out. Suggestions for activities to support people freaking out were to stay calm, provide them with a quiet place to rest, help them get food, and just "hang out" and "be with" the person who was "freaking out". Many youth also noted that it was beneficial for people to be with someone who had also had that experience as they understood what the person freaking out was going through and would therefore know how to help. Several youth reported that it was not helpful to have the police or ambulance attendants involved when someone was freaking out as this was perceived as exacerbating the problem. As one respondent explained: "the ambulance always came and they always locked me up and that... is never good ok... the last thing you want is to be locked up. You know that's gonna make you freak out twice as bad" (Respondent 10). This youth went further to discuss the importance of recognizing how hard freaking out is for a jib user:

You know I just think that people should try and have a little more understanding you know... I'll be walking down the street and people will laugh at me cause they see me sketchin' and I mean... I think man if I was you, I'd be in tears seeing somebody like that. It wouldn't

strike me as funny you know. It would strike me as tragic man that somebody that young was that fucked up you know? I just think the attitudes people have are really ignorant and they really need to be more fucking empathetic I guess (Respondent 10).

## **Discussion**

This study occurred as a response to a methamphetamine task force aimed at reducing CM use and drug related harms within the province of British Columbia and is the first qualitative study in Canada that has examined the social context of CM use among street-involved youth. Much of the existing research related to CM use has focused on adult populations, prevalence studies, and physiological and psychiatric health problems associated with CM use. By focusing on the context of the street-involved youths' day-to-day lives from their own perspectives, we offer insights into the role that CM plays in their lives, the reasons that they use, and the complex interrelationship between being street-involved and using CM. We argue that understanding the youth's perspectives on CM use is an essential first step for users, policy makers, health and social service providers, and law enforcement agencies to address the challenges and harms associated with CM use. This study also contributes to the growing body of research about the social context of street-involved youths' health behaviours and their ability to self-manage social and health related issues. This reinforces the significance of including street-involved youth in planning appropriate strategies aimed at enhancing their well being.

Overall, the findings highlight the adaptive or coping role that CM use plays in the lives of these street-involved youth even in the presence of the many negative consequences associated with use. Our results for example, lend support to other studies that have examined the role of drug use in "assisting" street-involved youth to deal with some of the challenges they face as a result of being street-involved including: suppressing their appetite when food is not available, staying awake so to avoid the need of shelter or sleep, and staying awake in order to protect themselves and their possessions (Adlaf et al., 1996; Higgitt et al., 2003; Rew, 2003). Contradictory findings were also presented about using CM to protect oneself and one's belongings. These findings are best explained in relation to the amount of sleep deprivation that the youth experienced. During periods of extended sleep deprivation they often had possessions and money stolen, engaged in violent behaviour or were victims of violence such as physical assault and rape. They also engaged in high risk behaviours such as sex with someone they would not usually have sex with and injecting as a mode of using. These behaviours place them at increased risk for Hepatitis C, HIV, and sexually transmitted infections. While it appears that CM may offer some self perceived benefits for the youth's survival, the length of a "run" with CM, the amount of sleep deprivation and being street-involved were of vital concern for these youths' overall well-being and survival.

The data also reflected opposing views among the youth about the mental health effects associated with CM use. This is an important finding that may

begin to shed some light on the role that perceptions about CM play in shaping street-involved youths' reasons for, and patterns of use. Youths who perceive CM as an alternative to psychiatric medications such as antidepressants or as self-medication for their mental health issues (e.g., "not wanting to experience feelings of sadness") may, for example, be less inclined to view their CM use as potentially harmful in their lives or consider the risks of CM use as acceptable given the perceived benefits. This may be worth exploring given the growing body of evidence that street-involved youth are using alcohol or illicit drugs as a means of coping with mental health issues (Adlaf et al., 1996; Higgitt et al., 2003; Rew, 2003) and that street-involved youth have higher incidences of depression, anxiety, and higher suicide rates than mainstream youth (McCreary Centre Society, 2001). Even more compelling is the recognition that the youth were not accessing mental health services to deal with these concerns, but instead they were self-managing in an approach that could have deleterious effects for their health and survival.

Similar to other research pertaining to the personal strengths, coping strategies, the ability to take care of one-self, and resiliency among street-involved youth (Higgitt et al., 2003; Kidd, 2003; Lindsey et al., 2000; Rew, 2003; Rew & Horner, 2003), these youths' narratives reflected that they were knowledgeable about their drug use and had many capacities that allowed them to creatively adapt to, and cope with, many of the consequences it had for them. They were able to recognize the need to take time off from using CM and engage in strategies to replenish food and water. They supported one another during episodes of "freaking out" and rarely relied on health and social service agencies or workers for support. These social networks of supporting one another are of particular interest in identifying the social context of street-involved youths' health behaviours. The lack of reliance on health and social service workers may be explained in part by the youth's perceptions that involvement of "professionals" lead to negative outcomes such as incarceration, hospitalization and a general lack of freedom. It may also be due to the perception that health and social service workers were unsympathetic and unfamiliar and as Rew (2003) noted, they may not have acknowledged that these youth have well-developed capacities that permit them to "stay alive with [such] limited resources" (p. 238). Peer support strategies may be better able to capitalize on the strengths of street-involved youths that emphasize personal resiliency.

It is important to position any discussion of CM within the broader discussions of substance use, substance abuse, and addiction. Although street-involved youth have higher rates of substance use than mainstream youth (Adlaf et al., 1996; Commander et al., 2002; Green et al., 1997; McCreary Centre Society, 2001; Van Leeuwen et al., 2004), these rates may not reflect youths' perceptions of their use. Very few of these youth identified themselves as being addicted to CM. In fact, the language of addiction only came into play when introduced by the interviewer. Some youth discussed that they needed CM in their life, but discounted the idea that they were addicted. They talked about only using CM when they were geographically located in Vancouver's Downtown South.

These findings are contrary to those found within the McCreary Centre Society (2001) Report and highlight that it may be reasonable to assume that these youth may not actively seek out addiction or drug treatment services. The stories of these youth also point to the importance of expanding our discussions of substance use to explore our conceptualizations of predisposing factors and reasons for use, and continue to move beyond the level of the individual in understanding the context of substance use.

The youth in this study described the patterns and consequences of CM use in the distinct context of being street-involved. Their stories provide unique insight into the needs of street-involved youth, supplying policy makers with the possibility of effective program planning to adequately support these individuals. Although the federal government has allocated millions of dollars to deal with issues related to youth homelessness and street involvement (Canada Mortgage and Housing, 2001), street-involved youth continue to report that affordable housing is not available and needs to be a top priority for community services (McCreary Centre Society, 2001). More specifically, housing options for youth must include housing for youth who continue to use substances such as CM. These youth require a safe place to seek services and consider options for the future.

It was evident that the youth in this study were still struggling with issues of hunger. Ideally, food services should provide youth with water, vitamins, and other necessary “survival tools” instead of the minimal nutritional content of free meals currently provided by only a few social service agencies. Health care providers should recognize that CM users’ lack of attention to personal hygiene in addition to the excessive dirtiness of street life may contribute to an increased risk of disease and therefore need to incorporate sensitive strategies for increasing personal hygiene and sanitation.

The additional traumas of street life in combination with CM use may have long-term psychological, emotional, and cognitive effects, and provision of services need to account for the nuanced context of CM use within youth and street culture to effectively respond to the needs emphasized by these youth. Stigma and lack of sensitivity by social service workers and health care professionals can adversely affect the likelihood of service use among youth (Ballon, Maritt, & Smith, 2004), and these themes were echoed by the youth in our study. Health care agencies should provide employees with proper harm reduction and sensitivity training so they can effectively convey a sense of empathy and a non-judgemental attitude when working with these youth.

### **Limitations**

The main intention of this study was to provide some insight into the day-to-day lives of street-involved youth and their CM use from the perspective of the youth themselves. Due to the qualitative nature of the work and budgetary constraints, the sample size was relatively small ( $N = 12$ ), which limits the generalizability of these findings. In addition, because the sample was drawn primarily from youth

who were accessing services, the experiences of more marginalized youth may not be represented. Obtaining a representative sample however, has appeared to be a consistent challenge for research with street-involved youth as these youth tend to be more transient, are rarely identified through more traditional recording systems and often wish to keep their identity unknown and may therefore be reluctant to participate in research (Ensign, 2003; Higgitt et al., 2003). Furthermore, some of the youth may have been high during the interviews which may have altered their responses to some of the questions.

As a result of the small sample, the gender differences among these experiences were not fully explored. Brecht et al. (2003) in their work with adults accessing treatment services for CM use, found significant gender differences among men and women concerning mode of initiation into CM use and length of time required for treatment. They found that women were more often introduced to CM by an intimate partner and required longer treatment periods. This raises important questions regarding the need to explore gender differences among street involved youth, particularly with regards to contributing factors for CM use and treatment programs. Despite these limitations, this research narrows the gap in the existing knowledge about the day-to-day lives of street involved youth who are using CM.

## **Conclusion**

We provided a snapshot of the wide variety of reasons street-involved youth use CM such as staying awake to protect belongings, enhanced social interaction, coping with negative emotions, and use as an alternative to psychiatric medications. The youths' stories reflect that CM use can function in an adaptive role that enables the youth to survive some of the challenges they face as a result of their street involvement. Our study also demonstrated however that there are many negative consequences of CM use for these youth such as deteriorating physical and mental health, exploitation, isolation, and physical harm. These youth are knowledgeable about their drug use and are capable of creatively adapting to, and coping with, many of the consequences it has for them. Interestingly, resources such as social service agencies and health care professionals were not identified as helpful to manage their drug use and its side effects. Although the study is limited by the small sample size, this data can provide some insight for policy and program planning aimed at providing treatment and support for street involved youth using CM.

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## Notes

- [1] For the purpose of this discussion, street-involved youth refer to youth between the ages of 12 and 25 years of age who may circulate between home and the street; have no connection to home; and/or have inadequate or insecure shelter (Caputo, Weiler, & Anderson, 1997; Peressini & McDonald, 2000). Street-involved youth may or may not have ties with mainstream society and may or may not be involved in activities such as drug use or criminal acts (Higgit, Wingert, & Ristok, 2003). The term street-involved youth is not meant to infer a homogenous population. Instead street-involved youth are recognized as having individual characteristics, histories, skills, and resources.
- [2] A run refers to using the drug until there is no more drug available or until the person is no longer physically able to use. This type of drug use is often referred to as bingeing. The youth did not necessarily use the terms run or bingeing. We applied this language based on previous research related to patterns of drug use and in an attempt to provide a descriptor for the scenarios that the youth reported.

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