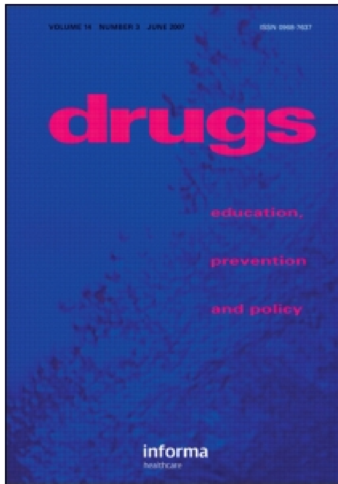
This article was downloaded by: *[Parker, Joanne]*
On: *16 April 2009*
Access details: *Access Details: [subscription number 910508720]*
Publisher *Informa Healthcare*
Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Drugs: education, prevention and policy
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t713412630

The power of relationships: Implications for safer and unsafe practices among injection drug users

Lois Jackson [a]; Joanne Parker [a]; Margaret Dykeman [b]; Jacqueline Gahagan [a]; Jeff Karabanow [c]
[a] Health & Human Performance, Dalhousie University, Halifax, Nova Scotia, Canada [b] School of Nursing, University of New Brunswick, Fredericton, New Brunswick, Canada [c] School of Social Work, Dalhousie University, Halifax, Nova Scotia, Canada

First Published on: 16 April 2009

To cite this Article Jackson, Lois, Parker, Joanne, Dykeman, Margaret, Gahagan, Jacqueline and Karabanow, Jeff(2009)'The power of relationships: Implications for safer and unsafe practices among injection drug users',Drugs: education, prevention and policy,
To link to this Article: DOI: 10.1080/09687630802378872
URL: http://dx.doi.org/10.1080/09687630802378872

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: http://www.informaworld.com/terms-and-conditions-of-access.pdf

This article may be used for research, teaching and private study purposes. Any substantial or systematic reproduction, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

Drugs: education, prevention and policy,
2009; 1–16, iFirst

informa
healthcare

The power of relationships: Implications for safer and unsafe practices among injection drug users

LOIS JACKSON[1], JOANNE PARKER[1], MARGARET DYKEMAN[2], JACQUELINE GAHAGAN[1], & JEFF KARABANOW[3]

[1]*Health & Human Performance, Dalhousie University, Halifax, Nova Scotia, Canada,* [2]*School of Nursing, University of New Brunswick, Fredericton, New Brunswick, Canada, and* [3]*School of Social Work, Dalhousie University, Halifax, Nova Scotia, Canada*

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

Abstract

Aims: To explore the influence of social relationships, at the interpersonal and community level, on safer and unsafe drug use practices among injection drug users (IDUs) in Nova Scotia, Canada.

Method: Thirty-eight current injection drug users were recruited through two needle exchange programs. Fifteen women and 23 men participated in semi-structured interviews about their daily lives, relationships and safer/unsafe drug use and sexual practices.

Findings: Most participants were well aware of the risks associated with injecting drugs and reported purposely engaging in numerous strategies to minimize those risks for themselves and others. However, several IDUs revealed that the dynamics of their relationships with other IDUs and with non-IDUs could and did lead to unsafe practices including needle sharing. Stigmatizing encounters with non-users and social exclusion from mainstream resources and structures appear to underlie and reproduce these unsafe practices.

Conclusions: Within the current Canadian political context, there is a move to shift drug policies away from harm reduction toward a more enforcement-based approach. This shift will likely only exacerbate the current discourse of blame and stigma directed at injection drug users. In addition, it may serve to increase the interdependency among IDUs, and social and economic exclusion from non-IDUs.

Correspondence: Lois Jackson, Dalhousie University, Health & Human Performance, 6230 South Street, Halifax, Nova Scotia, B3H 3J5, Canada. Tel: 902-494-7061. Fax: 902-494-5120. E-mail: lois.jackson@dal.ca

ISSN 0968–7637 print/ISSN 1465–3370 online © 2009 Informa UK Ltd.
DOI: 10.1080/09687630802378872

Copyright Informa Healthcare 2009
Not for Sale or Commercial Distribution
Unauthorized use prohibited.
Authorized users can download, display, view and print a single copy for personal use.

Introduction

In the 1980s, an escalating interest in harm reduction as a philosophy and practice developed in a number of countries around the world (Erickson, Riley, Cheung, & O'Hare, 1997). This interest was palpable and took hold because harm reduction provided an innovative response to injection drug use and the rising rates of the Human Immunodeficiency Syndrome (HIV) (Moore & Fraser, 2006). Unlike abstinence-based philosophies, which aim to have the drug user stop all drug use, harm reduction centers on minimizing the risk of infections regardless of whether or not abstinence is a personal goal (CCSA National Policy Working Group, 1996). Harm reduction presents the user as an active agent in the process of using drugs safely, and moral judgments are suspended in favor of immediate actions (Cooper, Moore, Gruskin, & Krieger, 2005).

Within parts of North America and much of Europe, community-based harm reduction programs for injection drug users (IDUs) have evolved since the 1980s. Today, harm reduction programs typically offer an array of pragmatic strategies for reducing harms particularly associated with HIV and hepatitis C. Programs vary from place to place but generally include some combination of education about risks of infection and safer injecting techniques, the provision of drug paraphernalia (e.g. clean needles), methadone treatment, supervised injection sites, and access to counseling and drug treatment (CCSA, 1996; Fraser, 2004; Gogineni, Stein, & Friedmann, 2001; Mateu-Gelabert et al., 2007).

Evaluations of harm reduction programs suggest that they are not only successful at reducing risks of infection, especially with HIV (Fischer et al., 2006; Côté et al., 2006; Smythe, Barry, & Keenan, 2001), but also contribute to a reduction in overdoses and mortality, and are cost-effective (Emmanuelli & Desenclos, 2005; Gogineni et al., 2001; Hwang, 2007; Lovell, 2002; Moore & Fraser, 2006; Wood, Tyndall, Montaner, & Kerr, 2006). However, despite harm reduction being heralded for stemming the tide of HIV/AIDS, critiques abound. In some instances the critiques centre on the philosophy itself or what we might call a critique *of* harm reduction, and can be heard from both conservative and radical forces. Conservative voices argue that drug policies should be oriented exclusively to primary prevention and abstinence, and that harm reduction encourages drug use (Mangham, 2001). The radical stance contends that over time harm reduction has become 'co-opted and medicalized', and as a result current programs serve to stabilize IDUs as a social problem thus obscuring the broader structural inequalities and the marginalization of illicit drug users (Roe, 2005).

In contrast to critiques of harm reduction, critiques *within* harm reduction suggest that this approach is 'preferable' to prohibitionist policies although it may be 'overly optimistic' (Miller, 2001). Many draw attention to the political, social and economic contexts that limit the application and success of harm reduction as a strategy (Keane, 2003). Within this school of thought harm reduction is an essential, humane and socially just response to drug use (Ball, 2007), but social, political and economic forces can and do limit the effective application of the key principles of harm reduction. Local and national political factors have, in

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

particular, been identified as thwarting harm reduction programs because they interfere with injection drug users' ability to actually practice harm reduction. One New York (US) study, for example, reported that a local police 'drug crackdown' resulted in IDUs using less safely because the fear of arrest resulted in a hesitation to carry syringes, and many were more likely to share injection drug equipment thus increasing their risks of HIV and hepatitis C (Cooper et al., 2005, p. 674). Within Canada, the recent threat of the closure of a supervised injection site by the national Conservative government is a further example of how political interests interfere with harm reduction initiatives (Hwang, 2007; Wood et al., 2006). Local public health policies, which dictate the number of syringes that can be distributed per user, also point to the intersection of political interests and harm reduction programs (Balian, 1998).

Additional critiques within harm reduction point to IDUs' 'vulnerabilities,' which affect their capacity to practice safely (Côté, Godin, Mercure, Nöel, & Alary, 2006). A study of IDUs in France noted that among economically disadvantaged IDUs many lacked the resources and the social competence to procure drugs, so they were dependent on others and this could translate into the sharing of syringes (Lovell, 2002). In some instances economic insecurity means IDUs receive 'tastes' of heroin or cocaine left over in someone's used syringe in return for services or for other drugs such as their own prescription medication. Mental illness and past histories of sexual abuse have also been shown to influence the capacity and/or desire to protect oneself from harm (Ezard, 2001, p. 213).

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

These recent critiques within harm reduction have emphasized how individual agencies operate within specific social, economic and historical contexts that shape and limit the practice of harm reduction (Ezard, 2001; Rhodes, 2002). Our research is likewise a critique 'within' harm reduction as we were concerned with understanding how social relationships shape and influence safer and unsafe practices. We accept that harm reduction is a critical element in ensuring the health and safety of IDUs, but we sought to understand how social relationships shape what IDUs do, both in terms of the practice of harm reduction as well as unsafe practices. Our main interest was the interpersonal (e.g. family, friends, other IDUs) and community level (e.g. needle exchange) relationships that are part of IDUs' day-to-day lives, recognizing that these relationships are in turn situated within wider societal relationships of class, gender, race and sexual orientation. Our research was based on the premise that gaining a deeper appreciation of how social relationships influence practices will assist in the further development of harm reduction policies and programs.

We conceptualized IDUs' relationships using a 'risk relationship' and 'social relationship' framework as outlined by Neaigus and colleagues (1993) as we were interested in articulating how different types of relationships influence practices given that current literature suggests that unsafe practices are more likely to occur among close friends, family members or intimate long-term partners (Costenbader, Astone, & Latkin, 2006; Jackson et al., 2002; Smythe et al., 2001). Within this framework, risk relationships are those where there is a direct risk of infection through drug use and or sexual contact, whereas social

relationships involve individuals who are part of IDUs' lives but do not directly lead to risks of HIV/hepatitis C. Although conceptually the two types of relationships are separate, in practice one may have both a risk and social relationship with the same individual, as may be the case when one shares needles with a colleague, and therefore has a drug-based and a work-based relationship with this person. For our research we explored both drug use and sexual practices, but here we are reporting only on drug use practices.

The research setting

This research was conducted in Nova Scotia, a province of just over 900,000 people on Canada's Atlantic coast. Approximately 41% (372,679) of Nova Scotians live in the capital city of Halifax, and approximately 44% live in rural areas or small towns (Statistics Canada, 2007). The number of individuals injecting drugs in Nova Scotia is unknown but the Public Health Agency of Canada (PHAC; 2006) provides an estimate based on the number of reported HCV diagnoses in which IDU is listed as a risk factor. Based on this figure, the minimum number of IDUs in the province in 2004 was estimated to be 1064 (PHAC, 2006).

In Nova Scotia, syringe distribution and other harm reduction services are provided by two key community-based organizations: Mainline Needle Exchange, which is in Halifax, and Sharp Advice Needle Exchange in Sydney, which is in the northern part of the province. Both organizations have a fixed service site in their respective downtown areas, and outreach workers provide support and mobile syringe distribution to clients including those in rural areas. Our study was carried out in partnership with these two organizations.

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

Methods

One-on-one, face-to-face interviews were conducted with 38 injection drug users who were at least 18 years of age at the time of the interview, and who reported injecting drugs in the previous year. All interviews were undertaken by trained outreach workers employed at one of the two partnering needle exchanges. Participants were recruited from within the network of clients utilizing the community-based services. A purposive sampling approach was utilized in order to obtain data from a diverse group of users in terms of gender, ethnicity, sexuality, employment, as well as IDUs from urban, rural and small-town localities. The interviewers were trained in interview techniques and research ethics. The study was approved by the Research Ethics Board at Dalhousie University (Nova Scotia, Canada).

All participants provided informed verbal consent, and no names were collected or recorded in order to protect confidentiality. The consent process sought participants' permission to be audio-recorded or alternatively for written notes to be taken, and for quotes from interviews to be used in publications and presentations. Only select demographic information was collected in an effort

to protect participants' identities. All interviews took place in a space that helped to ensure confidentiality. These locations included needle exchange offices, public libraries, and in some instances rural participants' homes.

Interviewers used a semi-structured interview guide, which was originally developed by the research team and subsequently refined based on feedback from the collaborating agencies, and a pilot interview with a recovering addict. After the first few interviews, some additional minor changes were made to the wording of the interviews to ensure clarity. The guide included questions about participants' daily lives; relationships with friends, family and partners; safer and unsafe practices related to injecting drugs and sexual relations; and use of community-based services. Participants were provided with a small honorarium to compensate them for their time and expenses related to participation.

All interviews were audio-recorded with the exception of five participants who did not wish to be recorded. In these five cases, the interviewer wrote near-verbatim notes. All other interviews were transcribed verbatim, and the transcripts were reviewed to ensure accuracy. Any identifying information was removed following transcription. Transcripts and written notes were entered into a qualitative data management software program, ATLAS.ti (ATLAS.ti GmbH, Berlin, Germany) in order to assist in data management. The principal investigator and research coordinator worked together to generate an initial coding scheme for the data based on a review of a number of transcripts and key concepts emerging from a review of these transcripts. These initial codes structured the data, and the coded data were read and re-read to identify common themes and sub-themes, which were compared and contrasted as per the process outlined by Strauss and Corbin (1998). New thematic areas were identified as data emerged that did not fit under the initial codes. This process was continued until conceptual integration of the themes and sub-themes was obtained.

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

Socio-demographic background of participants

Of the 38 interviews, 23 were conducted with men and 15 with women. Table I provides a summary of key sociodemographic characteristics of the participants. Briefly, participants were between 18 and 59 years of age. One participant identified as bi-sexual; the remainder (97%) identified as heterosexual. Two participants (5%) were of Aboriginal descent, one (3%) was Black, and the rest (92%) were Caucasian. In terms of education, 11 participants or 29% had completed a post-secondary program including university or trade school, 13 or 34% had completed high school or the equivalent, and 14 or 37% had less than high school education. At the time of the interview, none of the participants reported engaging in the formal employment sector. Twenty-eight participants or 74% reported relying upon some form of Income Assistance, four individuals or 10.5% reported financial support from a partner or their family, and eight or 21% reported informal economy practices such as panhandling, 'hustling' and/or sex-trade work as a major source of income. At the time of the interview, twelve participants (31%) resided in the provincial capital, Halifax, and the remainder

Table I. Demographic characteristics of participants.

Characteristic	Number (%)
Sex	
Male	23 (60.5)
Female	15 (39.5)
Age range	
18–29	11 (28.9)
30–39	11 (28.9)
40–49	12 (31.6)
50–59	3 (7.9)
No response	1 (2.6)
Highest level of education completed	
Less than Grade 10	4 (10.5)
Some high school*	10 (26.3)
Completed high school or equivalent	8 (21.1)
Some post-secondary	5 (13.2)
Completed post-secondary	11 (28.9)
Income sources**	
Income Assistance[†]	28 (73.7)
Family/partner support	4 (10.5)
Informal economy (panhandling, sex trade, etc.)	8 (21.1)

Notes: *Includes two students currently enrolled in high school. **Includes multiple responses. [†]Income Assistance includes social assistance, disability benefits and pension.

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

were living in various small cities, towns and rural areas. Efforts to recruit individuals with formal employment were unsuccessful, so the data are based on a sample of users who are not employed in the formal work environment.

Participants are either clients of one of the partnering needle exchange programs, or are known to clients of the programs. Therefore, participants may have stronger links to community-based services than many other IDUs in the province and results from this study should be interpreted with this in mind. As Watters and Biernacki (1989) noted early on in the HIV epidemic, there may be significant differences between IDUs who access services and those who do not both in terms of their rates of infection, socioeconomic backgrounds and safer/unsafe practices. Our initial analysis revealed a diverse picture of injection drug use in Nova Scotia. Although many users are entrenched in local drug-using scenes and are visible within their communities, others keep their use well hidden and report using their drugs and spending time alone or away from other users. Our recruitment strategy may have limited our ability to connect with these individuals and others who are not engaged with the illicit drug use scene and harm reduction services.

Findings

Safer injection drug use: Practicing harm reduction

When describing their day-to-day lives most of the participants we spoke to talked about the work and time that went into managing their addiction. Most indicated

that they organized their lives around procuring and using drugs in order to alleviate 'dope sickness', and they discussed how this work was a repetitive, time consuming, and all-encompassing part of their daily lives.

> Okay, a typical day is looking . . . basically looking for a fix every day. And it's not easy sometimes. When it's dry, it's a sickening day. I'm sore, I'm sick, until I get a fix. I have to go steal to get a fix. I would almost do just about anything for a fix. [32 Male]

Many that we spoke to described themselves as being personally responsible for protecting themselves from infectious diseases, and reported regularly engaging in practices to reduce risks of infection including having one's own equipment:

> Like my friends and that now, we don't have to talk about [risks from sharing] because it never happens. We always have our own [syringes]. Like if we were to sit down with a bag of dope or pills, everybody has got their own right away . . . it's just the way we are. And the minute they are used, they are capped and put away. [28 Male]

Access to clean injecting equipment is a critical element of IDUs' practice of harm reduction, and participants reported relying upon needle exchange sites and outreach services for a steady supply of clean injecting equipment. A few indicated that they regularly purchased syringes at pharmacies, but for most this was only a 'last resort' when they were not able to access the needle exchange.

Beyond the use of clean syringes, participants also described other harm reduction strategies, such as planning ahead to make certain one has enough clean 'gear' to last until the next needle exchange visit, and carrying clean equipment on their person to be prepared in case they were injecting away from their place of residence. Most participants indicated that they believed the responsibility to use safely rests first and foremost with the user. For many there was a sense of individual pride in using safely, and negative moral judgments were directed at 'dirty users' or those who failed to practice safely:

> I've seen so many fucking dirty addicts. And that is what I call them—dirty addicts—because they don't respect the drugs, they don't respect nobody else, they don't respect people's homes. They don't care. Like I said, they go out and spend $1000 on dope but they can't make sure they've got new needles. [28 Male]

Although many spoke of the individual's personal responsibility for practicing safely, importance was also attached to educating other IDUs about risks and even providing clean needles to encourage safer use. A number of participants reported keeping extra needles on-hand to give to other users who might not have clean ones. Several also spoke of educating other IDUs on the risks associated with injecting and techniques for using more safely, at the same time recognizing the limits to education, noting that in spite of good information sharing does occur. In these ways, participants were informally acting as what the needle exchanges refer to as 'peer helpers' or 'natural helpers'—in essence acting as an extension of the outreach services provided by Mainline and Sharp Advice.

> I have other people that come to the house to use and get gear. So I like having clean gear all the time in the house, in case people do drop by. [32 Male].

Several participants also pointed to practices in which they engage to ensure the safety of non-users. Such strategies included hiding injecting equipment from

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

children, not using during pregnancy, and disposing of both their own used equipment and the drug paraphernalia of other users.

> Participant: I usually break the tip and put it in the storm drain, in the gutters.
> Interviewer: I see. And do you think it's safe doing that?
> Participant: Well, it's safer than throwing it on the ground. I break the tip right off, and then put the cover back, and in a storm drain. Then you can't get pricked by it. A child can't find it there. To me, I feel that is the safest place I know where to dispose of it. [19 Female]

Risk relationships and safer/unsafe practices

Participants' emphasis on their own individual responsibility for safer use and the protection of others mirrors many of Fraser's (2004) findings from interviews with IDUs in Australia. However, many of the IDUs we spoke to also highlighted the ways in which interpersonal relationships with other users are critical in terms of their daily safety. Several stressed the importance of using with other IDUs in case there is an emergency and because one may need help with the injection process.

> [Sometimes other people inject me because] my arms sometimes don't co-operate so they'll get me, like, in other places. And it's hard for me to get them places. [15 Female]

For many, their daily lives are organized around their addiction, so it is not surprising that other IDUs are a significant part of their lives and play a role in their practice of harm reduction. Some participants were prescribed maintenance drugs but prescription drugs were frequently 'topped up' with drugs bought on the 'street.' Thus most participants were reliant on other users and dealers to procure drugs, and relationships with other IDUs continued to be part of their daily lives.

> When you have been using drugs for as long as I have, your social network has usually telescoped down to other drug users. So your conversation and your whole life goes around who's got, how to get, how to get money to get, et cetera. [17 Male]

Although there was a clear sense from speaking with many of the participants that IDUs help to shape and influence safer practices, discussions indicated that these relationships can also be barriers to personal safety. Being injected by another IDU could be interpreted as a safer practice since it facilitates access to the drug when in dire physical need and improves the likelihood of a successful injection. However, it also represents a potential context for unsafe practices given that it is sometimes unclear if clean equipment is being used, and because of the possibility of being administered an overdose.

> Interviewer: So when [these acquaintances] are injecting you, is that a clean needle or is it one that might have been used?
> Participant: It might have been used. [15 Female]

Several participants had a close relationship with one other user with whom they shared an additional bond, such as an intimate partner, a sibling or a very close friend. These were risk relationships as outlined by Neaigus and

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

colleagues (1993) but they were also social relationships given that these relationships involved interactions and roles outside of drug use. The overlapping nature of the relationships created for many a sense of 'trust' that clearly influenced safer practices. For at least two female participants, having an intimate relationship with an injection drug user meant that there would be a chance of 'sharing diseases' apart from the sharing of drug paraphernalia. In both instances the women's discussion indicated that they felt safer injection practices were not necessary with their partner, as this is only one route of transmission and they were already at risk through other means.

> Interviewer: And do you share works and rigs with this person?
> Participant: Yes.
> Interviewer: Do you think it is safe to do so?
> Participant: Yes . . . I've been with him all this time. And if I'm going to get anything, I'm going to get it anyway. [03 Female]

'Drug houses' or places for accessing and using drugs were also considered by many to be places where risk relationships meant potentially unsafe practices. These settings were described as often chaotic environments where people's drugs and equipment could become confused, and where people's ability to practice safely was often clouded by the effects of the drug.

> Everybody is either smoking crack or is whacking a needle or right out of it. You don't remember much in them places. [26 Male]

The need for a 'fix' in conjunction with a lack of economic resources to purchase drugs also created a context in which relationships between IDUs could translate into unsafe practices. Some participants indicated that when they lacked the economic resources to purchase drugs a form of 'drug dependency' on other users emerged that sometimes led to unsafe practices, as the following participants describe:

> You might share [paraphernalia] by doing a wash. You know, you're hard up for dope. You are hard up to get something into you, and someone is not going to give you some, but they'll let you play with their spoon where they cooked it up in. [17 Male]

> You might not get hit . . . You take what you can get and you don't be too picky. You are not going to insult someone, right? If they are giving you something, you are not going to be, you know . . .. [15 Female]

Given that interactions with other IDUs can be risky, some participants reported trying to avoid other users thereby eliminating the possibility of exposure to their blood or injecting equipment, as well as eliminating difficult situations where there might be pressure or temptation to share drugs or equipment. Some reported that they preferred to use at home—alone, with a partner, or in rare cases with a close friend—because they were well aware that being in a space with another drug injector presented significant challenges to safer use.

> . . . just no one around, and just no one there hounding you for it, and you're in the privacy of your own home. And by yourself, you do it at your own pace. You are not trying to get it into you as fast as you can before everyone else gets into it on you and starts taking it on you, and stuff like that. [30 Male]

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

Stigma and social relationships

For many of the IDUs that we spoke to, social relationships with people who are not drug users were almost non-existent or at least much less part of their lives than relationships with other IDUs. Even when relationships with non-IDUs or non-drug-users were evident, there was often a sense of unease and they were frequently fragile or tense relationships.

> Interviewer: Do you have contact with your family?
> Participant: Now I do but for the longest time they wouldn't have anything to do with me because of my drug use. Because my mother was always scared she was going to get a call in the middle of the night that I was dead . . . because I had so many over-doses. So she just put—she just stopped contact with me. The only one that would talk to me is my father. But when she was home, she would make him hang the phone up on me. [32 Female]

Non-drug-users were viewed by many as holding assumptions about IDUs, and having strong negative attitudes towards IDUs. Among both users and non-users of illicit drugs, injecting carries a certain stigma that often exceeds that associated with other routes of drug use. The act of injecting is even feared by some IDUs who have others assist with the injection process particularly when they first begin injecting (Eaves, 2004). A number of participants indicated that they felt this stigma. Interactions with non-IDUs were often painful, as expressed by one rural female who talked of using more drugs after feeling emotionally hurt by the non-IDU community.

> Interviewer: What is it like being an IV user in your community?
> Participant: People look at you. You know, they kind of suspect. It's a small place so everybody's got gab going from here to there. I don't know, it gets depressing once, you know, they all know that you're using and stuff like that. But what I do is go get high again and wait for it to pass again. When you are high, nothing really bothers you. You tune everybody out . . .. [41 Female]

A number of participants indicated that much of the non-IDU community assumes that addictions are 'chosen' and the individuals who are users have complete control over their drug use and receive great enjoyment from the drug. However, many spoke of their life as an addict as filled with the physical pain of withdrawal and often the absolute need to use drugs in order to function at all. Some responded to the felt stigma by attempting to hide their addiction and use of injection drugs or simply avoiding non-users altogether, because trying to educate non-IDUs to understand the real life of an addict was seemingly an impossible task:

> My family doesn't know or my social worker. My family would look down on me if they found out I was using again. I don't think it's any of my social worker's business—she would probably use it against me. My family doesn't associate with me anymore so it's not very hard to hide it from them. [38 Male]

Several participants reported negative or stigmatizing experiences when dealing with organizations such as social services, and in a few instances health-related institutions. A common response to the fears associated with being stigmatized and rejected or denied services was to avoid interactions or hide one's drug use when accessing such services:

> If I want to stay anywhere I have to say I'm clean. Or women's shelters, I can't have any syringes. I can't say I am on drugs or they will try to pawn me on Detox, or they will be trying to

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

> check on me every 4 or 5 hours to make sure I am not using. You can't tell people you have a drug problem because you can't get in there. [03 Female]

Hiding one's true social and health needs clearly presents a barrier to safer practices, and influences the quality of healthcare and health-related services. The process of hiding was not, however, necessary when accessing Needle Exchange programs, and when participants spoke of outreach workers in these settings they talked of being understood and acknowledged as having value. A few spoke of outreach workers as their 'friends' or 'family,' suggesting strong bonds and a sense of belongingness. At the same time, however, some participants described fear associated with accessing these sites because of how one is viewed by the public when entering these organizations as well as the potential for police surveillance.

> I would never ever go to the Needle Exchange or nothing like that just in case people lurking, the way they look at you—you know, a needle user. [30 Male]
> Interviewer: Do you feel safe there at these places [Needle Exchange and methadone programs].
>
> Participant: Not particularly. They can be singled out by the cops. I feel that they could be watched very easily by the police. [17 Male]

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

Conclusions and discussion

A key objective of our research was to understand how relationships among IDUs, and between IDUs and non-IDUs, shape both safer and unsafe drug practices. Findings indicate that for most of our participants, accessing and using injection drugs is a daily, often time-consuming process or a 'career' as suggested by researchers as early as the 1970s (Levy & Anderson, 2005). The IDUs we spoke to were recruited through Needle Exchange programs, and via individuals who access Needle Exchange programs, and most are aware of locally available services for IDUs. For this reason, it is not surprising that many spoke very easily and confidently about harm reduction practices and the importance of these practices for remaining safe. Participants indicated that they consciously and purposefully engage in numerous harm reduction practices to ensure not only their own physical safety but also that of other IDUs and non-IDUs, and they conveyed a sense of moral responsibility linked to safer injection drug use, which may be linked to the harm reduction education received through needle exchange services (Fraser, 2004).

Many also spoke negatively about IDUs who do not follow the current proscriptions on safer injection drug use, arguing that 'good' IDUs are those who use safely. Such findings point to what has recently been termed the 'staying safer practices' of IDUs, and highlight how the neo-liberal agenda of individual responsibility has been integrated into the daily lives of at least some IDUs (Fraser, 2004; Mateu-Gelabert et al., 2001; Moore & Fraser, 2006). Since the late 1980s, the safer-use messages of harm reduction have been increasingly disseminated to injection drug users, and the IDUs who participated in our study appear to have adopted and internalized these key messages.

Some IDUs indicated that they rely heavily upon other users to reduce risks through such strategies as assisting with the injection process, or remaining in close physical proximity in case of an emergency. There were also reports of supporting one another by recommending safer practices when in places where IDUs are sharing, and providing clean needles through informal 'peer helper' roles. These types of supports are consistent with an earlier study of IDUs in Halifax Nova Scotia (Jackson et al., 2002), and show promise for harm reduction's utility in controlling the spread of infectious diseases among IDUs. However, our findings also highlight the unsafe practices that occur within some 'risk relationships'. Safer injection drug use—like many health-related practices—is often inconsistent. To assume 'rational' unchanging practices (even when knowledge of safer practices is well entrenched), is unrealistic. The physical urgency for the drug and the particular convergence of other factors such as economic need and social isolation have the potential to thwart safer practices, as expressed by a number of our participants.

A sense of trust in other IDUs was also reported as affecting safer practices and appears to be strongest when the risk and social relationships overlap such as when one injects with a lover, close friend or family member. Small and colleagues' (2005) study of prisoners found a similar pattern of sharing among IDUs who had some form of social connection, and as they note the sharing of syringes within such a context is 'not random' (p. 836). In our research, most of the participants indicated that IDUs with whom they had only a drug-related relationship were simply 'acquaintances' not true friends, and they were not substantively trusted. However, when their social and risk relationships overlapped there was frequently a feeling of safety and trust that often translated into sharing practices. Earlier studies of IDUs in Halifax, Nova Scotia (Jackson et al., 2002) as well as Gogineni et al.'s (2001) study of injection drug users in methadone maintenance similarly report that in instances where users feel they can trust one another, harm reduction practices are often relaxed, and overlapping risk and social relationships represent a social space where trust clearly exists.

Weeks, Clair, Borgatti, Radda, and Schensul (2002) examined the personal networks and interactions among a group of drug users in Hartford, Connecticut, and found that 85% of the personal network members of the illicit drug users were also drug users (p. 198). The relative absence of kin in many IDUs' daily relationships, is according to Weeks and colleagues (2002), a 'condition of addiction' and this was confirmed by a number of our participants who indicated that 'no one wants to be around a junkie'. However, our research also suggests that IDUs often purposefully withdraw from many of these social relationships because of the stigma they experience, and that these negative experiences can have a significant impact on their emotional self. Risk relationships are often heavily relied upon because much of the non-IDU population operates in a way that socially excludes IDUs. Although drug use may be 'tolerated' by the non-IDU community, injection drug use is considered a highly objectionable form of drug ingestion even when the same drug is utilized (Eaves, 2004). Such fears and

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

rejection of IDUs by non-IDUs were commented on by most participants and were clearly hurtful to many.

The 'shaming' of IDUs by the non-IDU population may not only reduce IDUs' sense of self-efficacy and create a personal vulnerability to unsafe practices as suggested by other researchers such as Lovell (2002), but may also heighten IDUs' interdependency on one another. In instances where there is a heavy dependency on other IDUs, unsafe practices will be perpetuated especially in a context where withdrawal symptoms are severe and there is little access to drugs because of economic insecurity. The health consequences of concealment of one's addiction from needed services and supports (Day, Conroy, Lowe, Page, & Dolan, 2006) is also of serious concern because, as Burris (2006) noted, when individuals with stigmatized identities attempt to hide their health issue or disease, the health implications cannot be underestimated.

Over the past several years, critiques within harm reduction have argued that the individual agency of IDUs is often compromised because of personal vulnerabilities, as well as social, economic and political policies that impinge upon individual IDUs' efforts to practice safely. What has not been highlighted in these critiques, however, is the fact that many within the non-IDU community perpetuate the stigma, stereotypes and assumptions that are a key source—both directly and indirectly—of unsafe practices. Not only are IDUs often marginalized and excluded from structures and resources that are critical to safer practices (and that are readily available to others), but feelings and experiences of exclusion appear to result in a strong interdependency on other IDUs. The illegal nature of illicit drug use and the stigma and social and economic exclusion of IDUs from 'mainstream' resources and structures converges with the need to procure drugs to keep IDUs within a seemingly tight network of other IDUs. These risk relationships can, and do often, jeopardize safer practices, as participants in this study described.

The need to create safer 'micro environments' for IDUs to allow access to critical services has been recognized and discussed by other researchers and in particular Rhodes (2002) and Rhodes and colleagues (2006). However, attention continues to centre on injection drug users as the key locus of change. Our research indicates that there is a need to refocus on the non-IDU community. It is this sector of the population, we contend, that requires extensive education in order to understand addictions as a health—not a criminal—issue, and injection drug users as a population that requires varied and multiple forms of support in order to address their health concerns and related social and economic issues. As many have noted, harm reduction exists along a continuum and includes but does not require abstinence, because it is recognized that there are real physical and social challenges associated with addictions, and even when there is a strong desire to move to abstinence, relapse is a reality for many (Nelles, 2005).

Research in the United Kingdom suggests that some, although most certainly not all, sectors of the non-IDU population are supportive of harm reduction practices (Branigan & Wellings, 1999; Nelles, 2005) and it is probable that within other places, including Nova Scotia, there are many supporters of

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

harm reduction. Nevertheless, it is clear that societal level discourses about addictions as individual choice, and stereotypes and stigma linked to IDUs, are perpetuated by many within the non-IDU community, and are directly and indirectly affecting unsafe practices among IDUs creating a key barrier to moving harm reduction practices forward.

Currently, within the Canadian federal political context, there is a move to shift the focus away from harm reduction to one of enforcement and the criminalization of drug users. This shift will likely only exacerbate the current discourse of blame and stigma directed at injection drug users, and thus may serve to increase the interdependency among IDUs, potentially increasing unsafe practices. This potential trend is of serious concern and will require continuous and vigilant opposition if we are to ensure that the health and safety of IDUs remains a public health imperative.

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

Acknowledgments

The authors would like to thank all of the participants who gave of their time and contributed their thoughts and insights. We would also like to thank the collaborating agencies, Mainline Needle Exchange and Sharp Advice Needle Exchange, for their support. Special thanks go to the interviewers, Be Arsenault, Frances MacLeod and Angie Hiscock, for their commitment to this work. Finally we would like to thank the Canadian Institutes of Health Research for generously funding this study.

Declaration of interest: The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

References

Balian, R. (1998). Myth, truth and HIV, a user's perspective on the seroconversion rates, in Vancouver, Montreal and Ottawa. *International Journal of Drug Policy*, *9*, 359–364.

Ball, A. L. (2007). HIV, injecting drug use and harm reduction: A public health response. *Addiction*, *102*, 684–690.

Branigan, P., & Wellings, K. (1999). Acceptance of the harm minimization message in London clubs and underground system. *Drugs: Education, Prevention and Policy*, *6*(3), 389–398.

Burris, S. (2006). Stigma and the law. *The Lancet*, *367*, 529–531.

CCSA National Policy Working Group (1996). *Harm reduction: Concepts and practice*. Ottawa, ON: Canadian Centre on Substance Abuse.

Cooper, H., Moore, L., Gruskin, S., & Krieger, N. (2005). The impact of a police drug crackdown on drug injectors' ability to practice harm reduction: A qualitative study. *Social Science and Medicine*, *61*(3), 673–684.

Costenbader, E. C., Astone, N. M., & Latkin, C. A. (2006). The dynamics of injection drug users' personal networks and HIV risk behaviours. *Addiction*, *101*, 1003–1013.

Côté, F., Godin, G., Mercure, S. A., Nöel, L., & Alary, M. (2006). Preventing HIV transmission among marginalized injection drug users: New insights from a Québec City based research. *International Journal of Drug Policy*, *17*, 411–417.

Day, C., Conroy, E., Lowe, J., Page, J., & Dolan, K. (2006). Patterns of drug use and associated harms among rural injecting drug users: Comparisons with metropolitan injecting drug users. *Australian Journal of Rural Health*, *14*, 120–125.

Eaves, C. S. (2004). Heroin use among female adolescents: The role of partner influence in path of initiation and route of administration. *The American Journal of Drug and Alcohol Abuse*, *30*(1), 21–38.

Emmanuelli, J., & Desenclos, J. C. (2005). Harm reduction interventions, behaviours and associated health outcomes in France, 1996–2003. *Addiction*, *100*, 1690–1700.

Erickson, P. G., Riley, D. M., Cheung, Y. W., & O'Hare, P. A. (Eds.) (1997). *Harm Reduction: A New Direction for Drug Policies and Programs*. Toronto, ON: University of Toronto Press Incorporated.

Ezard, N. (2001). Public health, human rights and the harm reduction paradigm: From risk reduction to vulnerability reduction. *International Journal of Drug Policy*, *12*, 207–209.

Fischer, B., Kalousek, K., Rehm, J., Powis, J., Krajden, M., & Reimer, J. (2006). Hepatitis C, illicit drug use and public health: Does Canada really have a viable plan? *Canadian Journal of Public Health*, *97*(6), 485–488.

Fraser, S. (2004). 'It's your life!': Injecting drug users, individual responsibility and hepatitis C prevention. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *8*(2), 199–221.

Gogineni, A., Stein, M. D., & Friedmann, P. D. (2001). Social relationships and intravenous drug use among methadone maintenance patients. *Drug and Alcohol Dependence*, *64*(1), 47–53.

Hwang, S. (2007). Science and ideology. *Open Medicine*, *1*(2), E99–101.

Jackson, L., Bailey, D., Fraser, J., Johnson, K., Currie, A., & Babineau, D. (2002). Safer and unsafe injection drug use and sex practices among injection drug users in Halifax, Nova Scotia: An explanatory look at community and interpersonal influences. *Canadian Journal of Public Health*, *93*(3), 219–222.

Keane, H. (2003). Critiques of harm reduction, morality and the promise of human rights. *International Journal of Drug Policy*, *14*, 227–232.

Levy, J. A., & Anderson, T. (2005). The drug career of the older injector. *Addiction Research and Theory*, *13*(3), 245–258.

Lovell, A. M. (2002). Risking risk: The influence of types of capital and social networks on the injection practices of drug users. *Social Science & Medicine*, *55*(5), 803–821.

Mangham, C. (2001). Harm reduction and illegal drugs: The real debate. *Canadian Journal of Public Health*, *92*(3), 204–205.

Mateu-Gelabert, P., Treloar, C., Agulló Calatayud, V., Sandoval, M., Valderrama Zurián, J. C., Maher, L., et al. (2007). How can hepatitis C be prevented in the long term? *International Journal of Drug Policy*, *18*, 338–340.

Miller, P. G. (2001). A critical review of the harm minimization ideology in Australia. *Critical Public Health*, *11*(2), 167–178.

Moore, D., & Fraser, S. (2006). Putting at risk what we know: Reflecting on the drug-using subject in harm reduction and its political implications. *Social Science & Medicine*, *62*, 3035–3047.

Neaigus, A., Friedman, S., Curtis, R., DesJarlais, D., Gurst, R., Jose, B., et al. (1993). The relevance of drug injectors' social and risk networks for understanding and preventing HIV infection. *Social Science & Medicine*, *38*(1), 67–78.

Nelles, B. (2005). Comment on 'What are drug users looking for when they contact drug services: Abstinence or harm reduction?' by Neil McKeganey, Zoe Morris, Joanne Neal, & Michele Robertson. *Drugs: Education, Prevention and Policy*, *12*(4), 255–256.

Public Health Agency of Canada (PHAC) (2006). *Environmental scan of injection drug user, related infectious diseases, high-risk behaviours, and relevant programming in Atlantic Canada*. Halifax, NS: Public Health Agency of Canada.

Rhodes, T. (2002). The 'risk environment': A framework for understanding and reducing drug-related harm. *International Journal of Drug Policy*, *13*, 85–94.

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009

Rhodes, T., Kimber, J., Small, W., Fitzgerald, J., Kerr, T., Hickman, M., et al. (2006). For debate: Public injection and the need for 'safer environment interventions' in the reduction of drug-related harm. *Addiction*, *101*(10), 1384–1393.

Roe, G. (2005). Harm reduction as paradigm: Is better than bad good enough? The origins of harm reduction. *Critical Public Health*, *15*(3), 243–250.

Small, W., Kain, S., LaLiberte, N., Schechter, M., O'Shaughnessy, MV., & Spittal, P. M. (2005). Incarceration, addiction and harm reduction: Inmates experience injecting drugs in prison. *Substance Use & Misuse*, *40*, 831–843.

Smythe, B. P., Barry, J., & Keenan, E. (2001). Syringe borrowing persists in Dublin despite harm reduction interventions. *Addiction*, *96*, 717–727.

Statistics Canada. (2007). *Population and dwelling count highlight tables, 2006 census*. (Available from: http://www12.statcan.ca/english/census06/data/popdwell/Tables.cfm).

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. Thousand Oaks, CA: Sage.

Watters, J. K., & Biernacki, P. (1989). Targeted sampling: Options for the study of hidden populations. *Social Problems*, *36*(4), 416–430.

Weeks, M. R., Clair, S., Borgatti, S. P., Radda, K., & Schensul, J. J. (2002). Social networks of drug users in high-risk sites: Finding the connections. *AIDS and Behavior*, *6*(2), 193–206.

Wood, E., Tyndall, M., Montaner, J., & Kerr, T. (2006). Summary of findings from the evaluation of a pilot medically supervised safer injection facility. *Canadian Medical Association Journal*, *175*(11), 1399–1404.

Downloaded By: [Parker, Joanne] At: 19:49 16 April 2009