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Research paper

Moral ambivalence and the decision to initiate others into injection drug use: A qualitative study in two California cities

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ABSTRACT

Background: Research has shown that people often need assistance from an established person who injects drugs (PWID) in order to initiate their own injection drug use. Yet, there is scant research on the injection initiation process from the perspective of established PWID who assists with initiation. In this paper, we examine the injection initiation process from the perspective of established PWID.
Methods: From 2011 to 2013, we conducted qualitative life history interviews with 113 PWID in San Francisco and Los Angeles, California. Qualitative data were coded using an inductive analysis approach. Emergent themes are presented in a series of emblematic case studies that elucidate the injection initiation process from the point of view of the PWID who help people with their first injection.
Results: Most participants (70%) said that they had never initiated another person into drug injection, citing negative health and social consequences of drug injection as their primary reasons. Among those PWID who had ever facilitated initiation (30%), most expressed moral ambivalence about the behaviour. Using case studies, we show how PWID engage in a complicated calculation that weighs the pros and cons of assisting someone with their first injection. Concerns about long term harms associated with injection drug use sometimes give way to short-term altruistic concerns related to self-initiation or instrumental needs on the part of the established PWID.
Conclusions: Objections to facilitating initiation of injection naïve persons appear to be common among established PWID but are sometimes overridden by a need to reduce harms that can be associated with self-initiation and one's structural vulnerability. For established PWID, helping to initiate another person becomes a complex moral question with nuanced motivations. While further substantiation of this observation will require more research, it is worth considering how existing disinclination to initiating injection naïve persons can be integrated into new or existing approaches to preventing injection initiation.

Introduction

Injection of illicit drugs is a significant source of morbidity and mortality worldwide. People who inject drugs (PWID) are at high risk for HIV, hepatitis C virus (HCV), skin and soft tissue infections as well as fatal and non-fatal drug overdose (CDC, 2012; Centers for Disease Control and Prevention, 2013; Hagan, Pouget, Des Jarlais, & Lelutiu-Weinberger, 2008; Kerr et al., 2005; Lloyd-Smith et al., 2005; Mathers et al., 2013; Palepu et al., 2001). Other complications from injection drug use result in costly hospitalizations and include conditions such as endocarditis, osteomyelitis, gangrene, sepsis and, at times, death (Haverkos & Lange, 1990; Heinzerling et al., 2006; Stein, 1990; Takahashi, Maciejewski, & Bradley, 2010). Indeed, mortality rates have been found to be higher among PWID compared to the general population (Evans et al., 2012; Goedert, Fung, Felton, Battjes, & Engels, 2001; Vlahov et al., 2008, 2004). Despite the health risks associated with injecting drugs, people continue to transition from non-injection drug use to injection drug use.

Initiation to injection drug use from the perspective of the initiate has been well studied (Bryant & Treloar, 2008; Crofts, Louie, Rosenthal, & Jolley, 1996; Feng et al., 2013; Goldsamt, Harocopos, Kobrak, Jost, & Clatts, 2010; Hadland et al., 2012; Harocopos, Goldsamt, Kobrak, Jost, & Clatts, 2009; Kermode, Longleng, Singh, Bowen, & Rintoul, 2009; Neaigus et al., 2006; Swift, Maher, & Sunjic, 1999; Witteveen, Van Ameijden, & Schippers, 2006). Factors

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which influence initiation to injection drug use include: opioid dependence and experience with withdrawal symptoms, increased drug tolerance, the desire for a more intense effect or "high" that is associated with injecting, the economics of a more efficient route of administration, and the influence of an individual's social networks such as peer groups, individual friends, lovers or family members as role models (Crofts et al., 1996; Goldsamt et al., 2010; Kermode et al., 2009; Mars, Bourgois, Karandinos, Montero, & Ciccarone, 2014; Swift et al., 1999; Witteveen et al., 2006). Those who experience poverty, homelessness, childhood sexual abuse, recent physical abuse, or had greater exposure to PWID have been shown to have a greater risk of initiating injection drug use (Crofts et al., 1996; Feng et al., 2013; Hadland et al., 2012; Neaigus et al., 2006).

Although possible, learning to inject oneself without the help of established PWID is uncommon (Crofts et al., 1996; Rotondi et al., 2014). In a study investigating transitions in drug route of administration from non-injection heroin use to injection heroin use, only 14% of participants reported self-initiation (Stillwell, Hunt, & Preston, 2005). This study found that when PWID self-initiate, the injection practices are often learned by downloading information from the internet, observing others in their social environment, or by being taught by an experienced injector. Self-initiation can result in repeated and painful injections, missed veins, and abscesses. Being injected by an established PWID is common among new initiates: 68–88% of PWID report being injected by established PWID the first time they inject. (Crofts et al., 1996; Rotondi et al., 2014)

It is important to distinguish injection initiation episodes from the more common practice of peer-to-peer injection that has been extensively studied. Assisting with initiation, the subject of this manuscript, is a distinct subset of behaviours within the larger concept of peer-to-peer injection in its epidemiological profile (e.g. prevalence and risk factors) and from the perspective of PWID. Peer-to-peer injection has been found to occur 2–4 times as often as injection initiation episodes (Bluthenthal et al., 2014; Fairbairn et al., 2006; Kral, Bluthenthal, Erringer, Lorvick, & Edlin, 1999; Lee et al., 2013). In addition, risk factors for injection initiation include recent non-injection cocaine use, describing injection to non-injectors, self-reported likelihood of initiating someone in the future, and providing injection assistance to another PWID (Bluthenthal et al., 2014). By contrast, peer to peer injection is associated with distributive syringe sharing, frequent heroin injection, cocaine injection, and crack cocaine use, binge drug use, and unstable housing; characteristics that are different from injection initiation (Fairbairn et al., 2006). Furthermore, qualitative research on peer to peer injection (Bourgois, 1998a; Carlson, 2000; Fairbairn, Small, Van Borek, Wood, & Kerr, 2010; Parkin & Coomber, 2009; Tompkins, Sheard, Wright, Jones, & Howes, 2006) indicate that the meaning associated with this practice (mostly for money or in exchange for drugs) differs significantly from what has been reported by PWID who assisted an injection initiation episodes in the few studies that have examined this practice (Kolla et al., 2015; Simmons, Rajan, & McMahon, 2012). Finally, just because a behaviour mimics another (initiation as compared to peer-to-peer injection) does not mean that the experience of them is the same. The most obvious example of this is seen in the literature related to sexual risk behaviours. The intention of the partners, their own history and emotional investment greatly changes the meaning of the activity for the participants and the risk they are willing to engage in. Indeed, the greatest successes in improving condom use is with casual partners where expectations of intimacy and partnership are lowest. The results of this meaning difference are easily observable in most samples of sexually active people. (Cuervo & Whyte, 2015; Hicks, Kogan, Cho, & Oshri, 2016; Lachowsky et al., 2015; Lu et al., 2013; Rosenberger, Herbenick, Novak, & Reece, 2014) The differences in sex risk with a casual partner versus a steady partner matter and can inform prevention intervention similar to the differences between initiating someone into injection differs from helping an established PWID inject (Cuervo & Whyte, 2015; Hicks et al., 2016; Lachowsky et al., 2015; Lu et al., 2013; Rosenberger et al., 2014).

The distinctive practice of initiating others into drug injection requires more research. Qualitative studies from Toronto and New York on injection initiation from the perspective of the initiator have described a complex interplay of individual circumstances and social contexts which include: conceding to pressure from non-injectors for assistance, wanting to reduce perceived risk or harm that can occur when an inexperienced person attempts to inject themselves, assisting because it provides a sense of pride, and assisting to obtain drugs to stave off their own withdrawal symptoms (Kolla et al., 2015; Simmons et al., 2012). In addition, recent published studies indicate that PWID who are willing to initiate people into injection drug use play a pivotal role in facilitating growth in the number of PWID (Bryant & Treloar, 2008; Rotondi et al., 2014). For instance, in Bluthenthal et al. (2014); it was found that 44 PWID initiated 431 people into injection drug use in the 12 months prior to their interview (Bluthenthal et al., 2014). PWID willing to initiate non-injectors into drug injection are a key population that has been understudied to date.

Examining injection initiation for the perspective of the PWID initiating people can be challenging. Prior qualitative and ethnographic studies indicate that a social norm exists in most subcultures of PWID against introducing drug injection to non-injectors (Bourgois, 1998b; Faupel, 1987; Small et al., 2013). The limited quantitative data on this topic indicates that the vast majority (greater than 70%) of PWID report being asked and refusing to initiate others into drug injection at some point in their lives (Bluthenthal et al., 2014).

That most PWID report refusing to initiate someone into injection drug use at some point in their life is likely explained in part by existing social norms among communities of PWID. There is a body of literature suggesting that PWID maintain a distinct code of ethics or participate in a moral economy in the social world in which they function (Rosenbaum, 1981; Small et al., 2013; Waldorf, 1973; Zinberg, 1984). The term moral economy was originally employed by E.P Thompson to examine how certain groups establish consensus about what are legitimate and illegitimate practices (Thompson, 1971). In recent years, the notion of a moral economy among inner-city drug users has been used to understand how minimal resources and a social expectation of sharing drugs can lead to risk-taking by sharing of injection paraphernalia such as syringes, cookers, and cottons (Bourgois, 1998b, 2002; Bourgois, Prince, & Moss, 2004; Zule, 1992). Understanding the nuances of the moral economy elucidates the ways that social norms and acceptable practices are established among street-based PWID. Although these subcultural norms exist, PWID occasionally violate those norms in certain contexts (Bourgois, 1998b; Faupel, 1987; Small et al., 2013) In order to survive, PWID are often forced to assess the risks, costs and benefits of their actions and at times they perceive the immediate benefits to be greater than long term harms (Zule, 1992).

The term moral ambivalence has been used to describe behaviours that are heavily stigmatized and implicitly tolerated in certain socio-cultural contexts (Boyce, 2006). Moral ambivalence also includes reference to the ways that people negotiate the fine lines between what is socially prescribed and the agency they activate within their social environment (Gokariksel & Secor, 2012). In this paper, we describe the moral ambivalence of experienced PWID as they navigate the ethics of injection initiation, a stigmatized behaviour that is often denounced by PWID, yet still practiced by a small number of experienced PWID.