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Fluorescent blue lights, injecting drug use and related health risk in public conveniences: Findings from a qualitative study of micro-injecting environments

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ABSTRACT

This paper presents findings relating to injecting drug users' experiences and opinions of public toilets illuminated with fluorescent blue lights and presents an empirical assessment of the intended deterrent effect of such installations.

Data analysis identified that blue lights deterred less than half the sample interviewed. Furthermore over half (18/31) of the sample were prepared to inject in conditions specifically designed to deter injecting practice. Of these, 11 respondents were completely undeterred and 7 individuals were only partially deterred by blue light environments.

These findings are discussed within the interpretative frameworks of Pierre Bourdieu's theory of habitus and symbolic violence. The authors conclude that fluorescent blue lights contribute towards the development of situated resistance by injecting drug users within a public injecting habitus; a resistance that produces and reproduces drug-related harm and is a behaviour that opposes the symbolic violence of harm reduction intervention. The paper concludes with suggestions for theory-driven practical intervention that may seek to disrupt the harmful elements of the public injecting habitus.

1. Introduction

The injecting use of illicit drugs in public settings has prompted a number of official, formal responses on an international basis. Apart from those relating to law enforcement, these responses range from the introduction (or piloting) of services with a harm reduction remit to those with a more preventative agenda. Examples of those seeking to reduce harm may include the installation of street-based syringe vending machines and roving mobile van outlets in areas known to contain public injecting (Islam and Conigrave, 2007). Similarly, the introduction of Safer Injecting Facilities (or Drug Consumption Rooms) throughout continental Europe (Hedrich, 2004) appears to have mainly been a response to street-based drug injecting and/or open drug markets. Although the latter facilities do not currently exist in the UK, they have been adopted in nations beyond Europe in attempts to reduce drug-related harm in community settings. Namely, they currently exist as medical and scientific trials, respectively, in Australia and Canada. In contrast with these interventions with a specific harm reduction concern are those that seek to disperse and/or displace public injecting. Such preventative strategies may include increased policing of drug markets in so-called 'crackdowns' (Cooper et al., 2005; Fitzgerald et al., 2004; Maher and Dixon, 2001); the physical removal of public injecting sites (PIS) by legitimate force (Parkin and Coomber, 2009) or displacement strategies such as blocking, improved fencing, increased surveillance or the installation of motion detector alarm systems (Parkin and Coomber, 2009; Rhodes et al., 2006). A further mode of drug prevention by dispersal, and the major theme of this paper, concerns the installation of fluorescent blue lights (FBL) within public conveniences (Hamilton, 2000; Flemen, 2003; Parkin and Coomber, 2009).

Although very different approaches in attempts to address public injecting issues, the dichotomous strategies of harm reduction and drug prevention outlined above, somewhat ironically, appear to have some shared common goals. That is, the core concerns are the reduction of street-based injecting, the protection of public health and the maintenance of community safety. However, harm reduction approaches typically prioritise the development of 'enabling environments' (Moore and Dietze, 2005; Rhodes, 2002) in attempts to alleviate the situational and structural environments of risk-taking in specific drug-using settings (Rhodes, 2009, p. 91). More succinctly, the focus of such schema is on challenging *environments* (and not *behaviours*) towards reducing drug-related harm. In contrast with the

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'enabling environment' concept is that of 'risk environment'. This model, developed and advocated by Rhodes (2002, 2009), contends that drug-related risk and harm are constructed by an interplay of four types of environment (physical, social, economic and policy) at two environmental levels (micro and macro). Accordingly, an analytical synthesis of the subsequent overlap of these constituent structures seeks to provide an understanding of the production and reduction of drug-related harm. Furthermore, Rhodes (2009) contends that the central tenets of the theoretical model aim to re-prioritise the sociality of drug use within public health intervention, in which responsibility for harm shifts focus from individuals towards social and political institutions. This model is further concretised in a demonstration of the 'risk environment' concerning the social and structural production of HIV risk on a global scale (Rhodes et al., 2005). Indeed, 'risk environment' appears to have gained considerable ground and is advocated with increasing regularity within drug-research literature as an explanatory mechanism for drug-related harm (for example, Burris et al., 2004; Duff, 2009; Fitzgerald, 2009; Moore, 2004; Moore and Dietze, 2005; Strathdee and Bastos, 2002). Similarly, the authors previously demonstrated that the displacement and dispersal of public injecting in an urban setting both establish and perpetuate particular risk environments. Furthermore, such practice may serve as a precursor to 'micro-spatial structural violence' (Parkin and Coomber, 2009, p. 403) due to the potential for injecting drug users (IDU) to experience *actual* harm as a consequence of the structural modification of public injecting sites (PIS).

2. Defining 'public'

Throughout this paper we refer to toilet facilities that are located and managed within the public and private sectors and, as such, should be jointly considered 'public' conveniences. In this respect, we follow the definition of Kitchin and Law (2001) of 'public' to describe places of citizenship that are socially shared and socially private despite the operational differences that exist within the two sectors. That is, toilets made available by the local authority were typically open access, free of charge and available to all for periods of up to 12 h per day. Those operated within the private sector were also free of charge and available during the hours of business within the premises concerned. However, those within the latter category were typically exclusive to cash-paying patrons accessing the relevant settings (such as fast food restaurants) and there was the expectation that non-patrons would not casually access these toilets in a manner similar to those within 'high-street' locations (i.e. public sector facilities). This was made apparent with various signs noted during fieldwork that declared, 'These toilets are for customers only'.

In this paper we further develop the themes of risk environment, micro-spatial structural violence and drug-related harm in an analysis of IDU experiences of injecting practice associated with public settings illuminated with fluorescent blue lights (FBL). However, prior to this account it is perhaps necessary to elaborate further on the function and wider concerns of FBL.

3. The fluorescent blue light phenomenon

The installation of fluorescent blue lights in public conveniences is perhaps a distinctly visible phenomenon in many UK cities, towns and villages. Such lights may be noted typically within public conveniences in a wide variety of amenities, such as travel termini, shopping centres, fast-food restaurants, cinemas and 'high street' toilets. As such, FBL may be installed in facilities that are located within the private and public sectors and premised solely on relevant stakeholder decisions (Parkin and Coomber, 2009).

Fig. 1. Illustration of public conveniences equipped with FBL provided by agencies from the public sector within the city of Plymouth (UK).

The function and purpose of such lighting has previously been described (Hamilton, 2000; Flemen, 2003) as an attempt to deter IDU from accessing the semi-protective and needful amenity afforded by public toilets for the purpose of drug injecting. This deterrent effect is premised on the decreased and distorted lighting that serves to problematise the visibility of veins (*corporeal* injecting sites) that render injecting episodes 'more arduous' (Hamilton, 2000, p. 12). This is achieved by an intense, electric-blue ambience created by FBL that may also establish wider, minor visual disorientation amongst individuals entering affected environments—regardless of intent. However, from a harm reduction perspective, such lighting may establish particular risk environments for IDU and has been condemned as initiatives that are 'ill-informed and ill-advised' (Flemen, 2003, p. 3) due to their potential for increasing opportunities for the production of risk behaviour and related hazard.

Figs. 1 and 2 provide visual data gathered during ethnographic fieldwork that attempt to portray environments lit by such 'manufactured' illumination. (However, the impact of these images may be reduced by monochrome printing, which significantly understates the full 'blue' effect).[1]

Flemen (2003) further explains that although such environments may make superficial veins (e.g. those in the forearm) less visible they equally have *no* deterrent effect on the body's deeper veins (such as the femoral vein located in the groin). Accordingly, Flemen contends that 'groin injectors' may not necessarily be deterred, or discouraged, by the presence of FBL as such corporeal sites can be located by touch rather than vision. This perhaps raises immediate concerns for advocates of harm reduction who actively discourage groin injecting amongst IDU *regardless of setting*. For example, a national (UK) drugs information agency stresses that groin injecting *per se* 'should only ever be a last resort' (Lifeline, n.d., p. 15). Similarly, Preston and Derricot (2006)

[1] However, readers interested in viewing colour copies of these images should contact the corresponding author.