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Research paper

The phenomenon of low-frequency heroin injection among street-based urban poor: Drug user strategies and contexts of use

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ABSTRACT

Background: Dominant public health and medical discourse has relied on a pharmacocentric conception of heroin use—that is, the notion that heroin users inject compulsively to stave off physical and psychological withdrawal. Previous research disputes this claim suggesting that other patterns of heroin use, such as occasional, recreational, or controlled use are possible. In our previous cross-sectional epidemiological research, we identified the phenomenon of low frequency heroin injection (low-FHI), among street-based drug users. The goal of the current study was to qualitatively assess and contextualise this phenomenon over time among a sample of street-based low-FHI.
Methods: 29 low-FHI and 25 high frequency heroin injectors (high-FHI) were followed for 2 years, during which they participated in a series of in-depth interviews. Qualitative data were coded using an inductive analysis approach. As similarities and differences between participants were discovered, transcripts were queried for supportive quotations as well as negative cases.
Results: We found the social context among low-FHI and high-FHI to be similar with the exception of their patterns of heroin use. Thus, we focused this analysis on understanding motivations for and management of low-FHI. Two major categories of low-FHI emerged from the data: maintenance and transitioning low-FHI. Maintenance low-FHI sustained low-FHI over time. Some of these heroin users were circumstantial low-FHI, who maintained low-FHI as a result of their social networks or life events, and others maintained low-FHI purposefully. Transitioning low-FHI did not sustain low use throughout the study. We found that heroin use patterns frequently shift over time and these categories help identify factors impacting drug use within particular moments in an individual's life.
Conclusions: Given the various patterns of heroin use that were identified in this study, when working with IDUs, one must assess the specifics of heroin use patterns including drug preferences, desire for substance abuse treatment, as well as basic physical and mental health care needs.

Background

The idea that heroin is so severely addictive that users must inject compulsively to stave off physical and psychological withdrawal is firmly entrenched in the dominant public health and medical discourse. The U.S Department of Health and Human Services Research Report on heroin, asserts: "... heroin abusers' primary purpose in life becomes seeking and using drugs. The drugs literally change [addicts'] brains and their behavior." ("Heroin Abuse and Addiction," [1997] 2005) This paradigm suggests that any heroin use is inevitably compulsive and that users' everyday existence is consumed by the pursuit of heroin, since the physical aspects of addiction overwhelm other life concerns.

There has been some research in the last four decades, that has challenged the focus of heroin use as a pharmacocentric phenomenon (Decorte, 2001). This research suggested that other patterns of heroin use are possible, ranging from occasional or recreational use to purposively controlled patterns of use (Harding & Zinberg, 1977; Zinberg & Jacobson, 1976). Harding surveyed numerous studies and noted that there remains difficulty in defining those potential patterns of heroin use, but that controlled use has been attributed to social norms within specific social networks and individuals' personal motivations related to financial concerns

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and physical and mental health (Harding, 1988). More recent research supports these claims of controlled use by proposing a typology of heroin users classifying people as ranging from "controlled occasional user" to "problem addict" (Boeri, 2004) and theorizing that controlled use is not necessarily associated with negative health or social outcomes (Shewan & Dalgarno, 2005). This research provides an alternative to dominant conceptions of heroin use as always compulsive, but the studies largely draw from populations who report stable employment and housing. The results of these previous studies leave questions about the possibility of controlled use of heroin among the street-based urban poor.

Zinberg reports findings about controlled use from a sample in which 77% of participants were classified as "middle to upper class" (Zinberg, 1984); Dean, Saunders, and Bell (2011) draw data from a sample of which approximately 50% of participants were employed as professionals, tradespeople, administrative workers, and manual labourers; Shewan and Delgarno report findings from a population that was nearly 90% housed and 74% employed (Shewan & Dalgarno, 2005); Decorte excluded certain categories of people from the sample, including street drug users and sex workers (Decorte, 2001); and Warburton, Turbull, & Hough, 2005 conducted research using an online survey advertised in magazines and at universities, which would exclude people without access to computers or computer literacy. Despite prior studies regarding controlled use, there remains a dearth of research on patterns of controlled heroin use among street-recruited injection drug users who experience extreme poverty, frequent incarceration, homelessness and marginalisation from social institutions.

Our team found in a previous cross-sectional epidemiological study ($N = 2410$) of street-recruited injection drug users (IDUs) that 15% of heroin users who reported (1) injecting heroin in the past 30 days, (2) having injected drugs for at least 5 years, and (3) not being in methadone treatment (or any other substitution therapy), also reported that they had injected heroin fewer than 10 times in the 30 days prior to the interview (Harris et al., 2012). To further explore this finding, we designated two analytic categories of heroin injectors, *low frequency heroin injector*, or "low-FHI", who injected fewer than 10 times within the previous 30 days and *high frequency heroin injector*, or "high-FHI," who injected at least 30 times in the last 30 days. To address ambiguity, we utilized the numerical cut off for frequency of use put forth by the United States Office of National Drug Control Policy, which defines "hardcore" use as more than 10 days of heroin use per month (Rhodes, Scheiman, Pittayathikhun, Collins, & Tsarfaty, 1995). We found in our epidemiological study that self-reported African American race, men who have sex with men, and injection and non-injection methamphetamine use were independently associated with low frequency injection 30 days prior to the interview (Harris et al., 2012).

The cross-sectional epidemiological data alerted us that, potentially, a phenomenon of low frequency heroin use existed in this population. In order to explore this phenomenon further, we designed a 2-year longitudinal study to examine street-based IDU's heroin use patterns qualitatively. Using a longitudinal study design was of particular importance because we wanted to assess whether it is possible to maintain low-FHI over time and to examine the aspects of their lives that facilitate controlled use.

Methods

We recruited 602 IDUs to participate in an anonymous quantitative screening interview using targeted sampling methods (Bluthenthal & Watters, 1995; Watters & Biernacki, 1989) in San Francisco, California in 2008. Eligibility criteria for the screening interview were: (1) injection of illicit drugs within the past 30 days, verified by checking for signs of recent venipuncture; (2) age 18 years or older; and (3) ability to provide informed consent. Participants were interviewed by a trained interviewer, who read questions and entered responses into a computer-assisted personal interviewing program on a lap-top computer, programmed using Blaise 4.0. (Westat, 2009) Participants were remunerated $15 for completing the screener interview.

During the screening interview, we assessed eligibility for the qualitative study, the topic of this manuscript. We utilized the epidemiological categories of low-FHI and high-FHI as our qualitative sampling frame. Eligibility criteria for low-FHI included (a) having injected heroin (alone or in combination with other drugs) 1–10 times in the past 30 days, (b) having first injected illicit drugs at least 5 years ago, and (c) not having been in methadone or buprenorphine treatment in the past 30 days. Eligibility criteria for high-FHI were the same as for low-FHI, with the exception that participants needed to have injected heroin (alone or in combination with other drugs) at least 30 times in the past 30 days. We were interested in studying established heroin users using at low frequency and not new initiates into injection, therefore, excluded individuals who began injecting fewer than 5 years prior to their screening interview. Additionally, the phenomenon of using drugs occasionally while enrolled in substance abuse treatment has been well documented (Gogineni, Stein, & Friedmann, 2001; Longshore, Hsieh, Danila, & Anglin, 1993; McNeely, Arnsten, & Gourevitch, 2006) and was not of interest in this study, leading us to exclude individuals who reported methadone or buprenorphine treatment in the 30 days prior to their screening interview. Questions related to eligibility criteria were embedded among other questions in the 20 min screening survey including: demographic characteristics, drug use, syringe access and disposal, and HIV risk behaviour. Analysis of the quantitative data has been published elsewhere (Kral et al., 2010; Wenger et al., 2011).

Eligible participants were invited to enrol in a 2-year qualitative cohort study. There were two informed consent processes, one for the screening interview and one for the qualitative study. All procedures for the study were approved by the institutional review board at RTI International. Enrolled participants participated in digitally recorded, in-depth qualitative interviews which included: (1) baseline interviews, (2) change of status interviews, supplementary qualitative interviews conducted when we learned during a monthly check-in interview (see below) that participants' heroin use status had changed from low-FHI to high-FHI, low-FHI to no heroin use, or high-FHI to low-FHI or no heroin use, and (3) follow-up interviews at one and 2-year intervals. Participants were remunerated $25 for participating in each qualitative interview. Interviews were transcribed verbatim by a professional transcription service. After each interview, interviewers wrote brief summaries regarding the participant's life history, drug use history, current living situation, and anything related to heroin use frequency.

Since the majority of participants were homeless or marginally housed and lacked consistent contact information, participants were asked to attend monthly check-in appointments in an effort to maintain high retention in the 2-year study. During those appointments, participants were asked to update their contact information and participate in a 5-min quantitative survey. Though this methodology was initially introduced as a retention effort, we also capitalized on this opportunity to collect critical temporal data regarding participants' drug use over the past 30 days and changes in health, housing, relationship status, hospitalisations, arrests and incarceration (Lopez et al., 2013). Participants were paid $10 for each 30-day check-in. The research team did not analyse these data quantitatively; instead, the data collected at check-in appointments were used to monitor significant life events and became the central tool to develop individualized qualitative guides that were used during the follow-up interviews. Throughout the course of the