



Research Paper

A fragmented code: The moral and structural context for providing assistance with injection drug use initiation in San Diego, USA



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ABSTRACT

Background: Injection drug use initiation is shaped by social networks and structural contexts, with people who inject drugs often assisting in this process. We sought to explore the norms and contexts linked to assisting others to initiate injection drug use in San Diego, USA, to inform the development of structural interventions to prevent this phenomenon.

Methods: We undertook qualitative interviews with a purposive sample of people who inject drugs and had reported assisting others to initiate injection (n = 17) and a sub-sample of people who inject drugs (n = 4) who had not reported initiating others to triangulate accounts. We analyzed data thematically and abductively.

Results: Respondents' accounts of providing initiation assistance were consistent with themes and motives reported in other contexts: of seeking to reduce harm to the 'initiate', responding to requests for help, fostering pleasure, accessing resources, and claims that initiation assistance was unintentional. We developed analysis of these themes to explore initiation assistance as governed by a 'moral code'. We delineate a fragmented moral code which includes a range of meanings and social contexts that shape initiation assistance. We also show how assistance is happening within a structural context that limits discussion of injection drug use, reflecting a prevailing silence on drug use linked to stigma and criminalization.

Conclusions: In San Diego, the assistance of others to initiate injection drug use is governed by a fragmented moral code situated within particular social norms and contexts. Interventions that address the social and structural conditions shaped by and shaping this code may be beneficial, in tandem with efforts to support safe injection and the reduction of injection-related harms.

Introduction and background

The social contexts for injection drug use initiation

Research suggests that a range of influences shape the initiation of injection drug use, including age, gender, socio-economic position and structural shifts (Guise, Horyniak, Melo, McNeill, & Werb, 2017; Harocopos, Goldsamt, Kobrak, Jost, & Clatts, 2009; Syvertsen, Paquette, & Pollini, 2017). Injection drug use initiation has also been linked to a range of meanings and experiences for individuals, including cost-efficacy, pleasure and belonging (Guise et al., 2017). Social networks are also influential (Fast, Small, Krusi, Wood, & Kerr, 2010; Guise et al., 2017) with people who already inject drugs often described as

playing a critical role in assisting initiation by educating, modeling behaviors, or directly injecting individuals (Bluthenthal et al., 2014; Bravo et al., 2003; Bryant & Treloar, 2008; Crofts, Louie, Rosenthal, & Jolley, 1996; Rotondi et al., 2014; Simmons, Rajan, & McMahon, 2012; Small, Fast, Krusi, Wood, & Kerr, 2009). Such a role could be taken by friends, family, associates (Harocopos et al., 2009; Roy, Haley, Leclerc, Cedras, & Boivin, 2002) or by 'hit doctors' who inject in exchange for money or resources (Murphy & Waldorf, 1991). Providing initiation assistance to others has also been linked to pressure and repeated requests for help (Kolla et al., 2015), to ensure an initiate's safe first injection and thereby to prevent harm (Kolla et al., 2015; Rhodes et al., 2011; Wenger, Lopez, Kral, & Bluthenthal, 2016), to increase access to drugs (Kolla et al., 2015), or to the goal of fostering pleasure (Kolla

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et al., 2015).

The potential for socio-structural approaches to preventing injecting drug use initiation

Preventing injection drug use initiation is an ongoing focus of public health efforts (Vlahov, Fuller, Ompad, Galea, & Des Jarlais, 2004; Werb, 2017) owing to how, in the context of limited access to harm reduction services (Degenhardt et al., 2014), drug injection can result in a range of negative health and social outcomes including blood borne disease transmission and fatal overdose (Mathers et al., 2008). Interventions to prevent injection initiation have mainly focused on awareness raising and social marketing; however, these have demonstrated limited efficacy, potentially reflecting their orientation to seeking behavior change rather than to addressing influential social and structural factors (Werb, 2017). In response, there is increasing interest in responses that address the environment and social networks that increase the potential for injection initiation (Rhodes et al., 2011). One such initiative is the *Preventing Injection drug use by Modifying Existing Responses* (PRIMER) study, which specifically aims to reduce injection initiation by addressing the role of people who inject drugs in assisting this process. The study is exploring the hypothesis that increasing access to structural interventions including stable housing, medication-assisted treatment for opioid dependence (Mittal et al., 2017), and medically-supervised injection facilities could support people who inject drugs in seeking to avoid circumstances in which they are asked to initiate others. Such hypothesised effects could come about through these interventions reducing the pressure to assist initiation based on financial need or social pressure, or by reducing the number of situations in which people inject publicly and so minimizing the potential for unwanted requests for assistance (Werb, Garfein et al., 2016). There remain, however, gaps in understanding how social and structural factors shape initiation assistance (Werb, Garfein et al., 2016), and so little insight in to how such a hypothesised strategy corresponds to the lived experience of injection assistance. Addressing this gap is essential for developing an effective intervention strategy acceptable to people who use drugs (Blankenship, Friedman, Dworkin, & Mantell, 2006; INPUD, 2015).

Conceptualizing injection initiation assistance

The process of injection drug use initiation—as well as the context within which people provide assistance—has been described as involving negotiating moral boundaries and values within social contexts that shape the values, norms and resources available to people (Rhodes et al., 2011). Such positions link to theories of ‘risk environments’ and ‘structural vulnerabilities’ where drug use and harms are understood to emerge from the interplay of structure and individual agency (McNeil, Kerr, Anderson et al., 2015; Rhodes, 2009). Initiation assistance can then be understood as the product of individuals enabled and constrained by specific contexts, mediated by local configurations of relations and resources (Rhodes et al., 2011).

Prior analysis of injection initiation assistance has explored an experience of ‘moral ambivalence’ in response to conflicting pressures and norms (Wenger et al., 2016), grounded in a prohibitory ‘code’ that proscribes injection initiation assistance (Fast, Shoveller, Small, & Kerr, 2013; Small et al., 2009). Following others, we define a code as ‘a set of social norms that prescribes, proscribes and describes how a specific set of people ought to behave’ (Jimerson & Oware, 2006). Such moral codes, and the moral economies intertwined with them, can be linked to the enactment of other widely proscribed behaviors, whether assistance to initiation or the sharing of drugs and needles (Bourgois, 1998; Karandinos, Hart, Castrillo, & Bourgois, 2014; Wakeman, 2016). These analyses situate particular moralities in specific social and structural conditions. Prominent analyses in this vein include Bourgois’s ethnography of urban social marginalization (Bourgois, 2003) and

Anderson’s (1999) study of urban violence, both undertaken in the USA. In these accounts the actions of people engaged in criminal or otherwise damaging actions are linked to a ‘street culture’ that is in opposition to ‘mainstream society’ (Bourgois, 2003). For Anderson, violence is understood as emerging from a ‘code of the street’ that is in opposition to a sense of ‘decency’ that seeks to uphold ‘mainstream’ values. This code is reliant on ‘street justice’ in the absence of civil law in distressed communities. Individual reputation and respect become a focus, with a moral code mandating violence as a means to ensure respect and so in turn improve or protect an individual’s social position or their access to resources under conditions of scarcity and official neglect (Anderson, 1999; Bourgois, 2003). Moral codes are then socially situated sets of norms proscribing and prescribing behavior.

Whilst an understanding of moral codes governing social conduct has long been central to social analysis (Hitlin & Vaisey, 2013)—particularly in contexts of urban poverty—they are as yet undertheorized in respect to injection initiation assistance, in terms of their origins, effects and their interaction with other social conditions (Wacquant, 2002). Elucidating the previously reported code in-depth (Small et al., 2009) could provide insight in to the local and specific configurations around injection initiation assistance.

San Diego, California, USA and the PRIMER study

PRIMER is a multi-cohort mixed methods study exploring the hypothesis that structural interventions to address injection-related health harms may provide secondary benefits in disrupting the process of injection initiation assistance. San Diego, USA is one of seven sites across four countries included in the study, along with Vancouver, Canada; Tijuana, Mexico; and Paris, Marseille, Bordeaux, and Strasbourg, France (Werb, Garfein et al., 2016). The full methodology has been described in full elsewhere (Werb, Garfein et al., 2016); briefly, the study links existing cohort studies of people who inject drugs to quantitatively and qualitatively explore the contexts, roles and processes of injection initiation assistance provision. In this paper we report on qualitative study of experiences in San Diego.

San Diego’s estimated population of approximately 21,000 people who inject drugs is dispersed across the county (Friedman et al., 2004). Injection drug use focuses on black tar heroin, methamphetamine (Roth et al., 2015), cocaine (Muñoz, Burgos, Cuevas-Mota, Teshale, & Garfein, 2015), and prescription opioids (Pollini et al., 2011). Previous studies report hepatitis C virus prevalence of 27% and HIV prevalence of 4% amongst the city’s population of people who inject drugs (Garfein et al., 2013); this population also experiences significant health and social harms (Roth et al., 2015) reflecting the limited availability of harm reduction services (Siddiqui et al., 2015) as well as ongoing police violence and persecution resulting from the criminalization of drug use (The Sentencing Project, 2015; Werb, Strathdee et al., 2016).

We sought to explore the social norms and contexts related to assisting injection drug use initiation in San Diego. We draw in particular on previous analyses of morality and ‘moral codes’ in urban settings, in an effort to understand the social and structural context for assistance to injection initiation. Through this we sought to critically explore the potential for social and structural interventions to prevent the process of injection drug use initiation.

Methods

The study used a qualitative approach nested within the *Study of Tuberculosis, AIDS, and Hepatitis C Risk* (STAHR) II cohort study in San Diego, USA (Robertson et al., 2014), which is participating in the multi-cohort PRIMER study (Werb, Garfein et al., 2016). Semi-structured interviews were used to explore peoples’ experiences and perceived social norms related to assisting others into drug injection.

We used a purposive sampling strategy to identify people who inject drugs who had experience of assisting others in injection drug use

Box 1

Illustrative data for core themes in accounts.

Requests for help

R: *As time went on, both of them said ‘well let me try’. I said ‘whatever, you know, that’s on you’, and they said ‘well, you’re going have to help me’, and I said ‘ahh I don’t know about that’. I mean, I did eventually [help] with both of them.*

I: *So uh, can I ask you a question? Why, why were you a bit wary of that? And how, what was the process around it? How long did it take you?*

R: *Probably not long... I mean, you know, you know a few different, a few times. I mean, probably not a month of them asking. But after they asked like three or four, maybe five times I said ‘alright, let me try’.*

I: *Okay. And what were you thinking? I mean why, why didn’t you want to?*

R: *I think it was, ‘I don’t want you later down the road to come put this back on me that I got you started doing this’.*

(Agnes, age 56)

Harm reduction

R: *It was just an acquaintance, you know, I was in the bush over there by the [laughs] [deleted for anonymity] and he just happened to come by and he had these, I’d not know what kind of rigs he had but they weren’t clean or nothing and I couldn’t see him, I just couldn’t see him doing it, you know what I mean, and he was going to do it regardless if I was helping or not...*

I: *So that was his first time?*

R: *Yeah.*

....

R: *You know, so uh, he was going to proceed, so I said ‘no wait if you are going to do it, then I want to show you how to do it the right way’.*

....

R: *I just wanted to make sure he was going to do it the right way.*

(Kevin, age 52)

Access to resources

R: *He begged me to get him high, cause I didn’t want to, I was like ‘no, I don’t want you getting too into this blah, blah’, and he said ‘I’ll pay you’, and kept begging me and begging me and so I said ‘fuck it, alright once you do this, you will never be the same’ and I shot him up and that was it. He blacked out and I left him and I had my girl call the ambulance.*

I: *Okay, okay, so he was he was begging you, he was, why, why were you reluctant, why did you not want to do it?*

R: *Because it sucks [laughs].*

(Miguel, age 27)

Pleasure

R: *[Recounting conversation] ‘You girls are wasting it’ and ‘what do you mean we are wasting it’ you know...*

I: *Mhmm*

R: *‘You never slam, you never use a needle...’*

I: *Mhmm*

R: *They were like ‘no’, and ever since I introduced them to a needle...*

I: *Mhmm*

R: *And they just end up you know, same thing; they end up using the needle.*

(Aaron, age 34)

Unintended initiation

R: *She knew the rule and she had asked me, and I told her ‘no’ because she had never slammed or whatever, or at least I thought she didn’t. But then you know, she goes to tell me that she had already done it a few times but she just didn’t know how to hit herself. I said ‘okay, well then if you have done it before I have no problem helping you if you can’t do it’. And so I, uh, I injected her in her in her home and then she turned around looked at me and said ‘wow, that’s really neat, thanks for doing it for my first time for me’ and I was really upset because she lied to me just so that she could do it.*

(Tom, age 41)

initiation, seeking a range of age and gender (Coyné, 1997). Participants in the STAHR II study cohort had previously completed interviewer-administered surveys at baseline (2011) and every six months (Robertson et al., 2014). The last visit (24-month follow-up) included questions on their experiences assisting others with their first injection; respondents for this qualitative study were identified based on endorsement of relevant survey items on this topic. A small sub-sample of STAHR II respondents that did not report assisting others was also included to triangulate with accounts of assistance, in anticipation of the stigma associated with assistance. We called eligible respondents, explained the study and invited them to our central San Diego STAHR II study office. STAHR II respondents who visited the office were also invited to participate if they met the eligibility criteria.

We used an in-depth approach to qualitative interviews, seeking to elicit respondents’ experiences and meanings. Interviews were conducted by AG, MLM and CR, all social scientists with qualitative research experience with communities of people using drugs. All

interviews were conducted in English, audio recorded and then transcribed. Interviews were conducted in the San Diego STAHR II office within a University owned building. The office is frequently used by study respondents, with staff and procedures familiar through repeated contact. A primary consideration in data collection was managing the stigma and guilt potentially attached to assisting initiation (Small et al., 2009). Our interview guide included open-ended questions reflecting on respondents’ current life situation, their own experience of injection drug use initiation, their experience of assisting others and the perceived potential for interventions to prevent this phenomenon. We explored these questions whilst allowing respondents to elaborate on these issues on their own terms, and did not probe in-depth if either verbal or non-verbal cues suggested an unwillingness to discuss the issues raised or if accounts revealed contradictions. Instead, we left these to be explored through analysis. Interviews commonly lasted one hour, but varied from 20 to 90 min.

We used a thematic and abductive approach to analysis that

involved working with existing concepts and theory, whilst developing these based on insights from the collected data (Burawoy, 1991). As interviews were conducted, we wrote memos and reflected on transcribed interviews as a team, a process that informed ongoing data collection. As data collection ended we finalized an initial coding framework and, following reliability checks across the team, we organized the data around ‘first order’ codes shaped with reference to existing research, such as accounts of assistance linked to harm reduction (Ezzy, 2002). Based on the resulting descriptive analysis we further explored the data with reference to existing theory (Burawoy, 1991) drawing on an analytical framing of moral codes and ‘codes of the street’ (Anderson, 1999), and through this process identified new codes as well as themes across codes. In the results section below we principally draw on respondents’ accounts of their own experiences of assistance and triangulate these with their views of others’ experiences and the views of people who had not assisted others into injection.

We obtained ethical approval from the Human Research Protections Program of the University of California, San Diego. All respondents provided informed consent and received \$25 USD compensation for their time and travel costs. All respondent names are pseudonyms to preserve anonymity.

Results

We interviewed 21 people, of whom 17 had reported helping others with their first injection in the STAHR II survey (5 women, 12 men) and 4 had reported not assisting others (2 women, 2 men). The average age was 44 (range: 27 to 62). Of those interviewed, 13 described themselves as white, 4 as Hispanic, 2 as black and 2 as Native American. In the STAHR II survey, qualitative study respondents had reported providing injection initiation assistance to a mean of 3 people (range: 1 to 10) compared to a mean of 7 for the 132 participants in the STAHR II cohort who reported providing injection initiation assistance (range: 1 to 100). A majority were living with a long-term health condition, and many were currently or had previously been homeless or insecurely housed, and were accessing social assistance. We reflect on the sample characteristics in detail below and in our discussion, although highlight here how our respondents were varied in age and race, though many shared a dominant experience of poverty and exclusion.

Through first order coding key themes emerged in accounts of assisting in injection initiation, corresponding to past studies (Kolla et al., 2015; Rhodes et al., 2011; Simmons et al., 2012). Often overlapping, and expressing ambivalence (Wenger et al., 2016), people described assisting initiation as an effort to reduce harm, in response to persistent requests, to access resources, as linked to maximizing pleasure, and as the product of unintended initiation wherein participants did not know that it was the initiate’s first injection. See text [Box 1](#).

Across these themes there was a frequent insistence from both those who had assisted others and those who had not that this practice was wrong or forbidden: people reported it as a ‘rule’ or ‘law’ that ‘you don’t do that’, or it is ‘the worst thing you can do to someone’, echoing reports of a ‘code’ against assistance (Rhodes et al., 2011; Small et al., 2009; Wenger et al., 2016). A taboo on initiating young people and young women in particular was also reported. Jenny, who had assisted one person to initiate drug injecting, at times struggling for words to indicate her anger, described it as follows:

“I would give someone a hard time if, oh you, ‘what, you are just injecting [initiating] young girls?’, because men will do that, and I think that’s fucked up. And uhm, so the taboo on that, I just mean, as a generalized... ‘What are you doing? Are you just pulling out a factory of trying to get young girls addicted to heroin?’” (Jenny)

We developed an analysis of these themes to explore this accounting of a code prohibiting initiation assistance. We used a framework of Anderson’s (1999) analysis of urban violence and similar work by Bourgois (Bourgois, 2003) for how a ‘code of the street’ upholds actions

forbidden or stigmatized by ‘mainstream’ society. The disapproval of initiation assistance described by our respondents is then analogous to Anderson’s account of ‘decency’. Our focus here though is in exploring a ‘moral code’ that supports initiation assistance. Prior analysis has shown how a code forbidding assistance is broken (Small et al., 2009). We show here, building on Wenger et al. (2016) and following the logic of a ‘code of the street’, how assistance is upheld by moral logics that link to particular social conditions (although we draw on Anderson’s analysis we do not seek to equate initiation assistance with violence). Initiation assistance is then not just the breaking of a ‘mainstream’ code, but is also an activity of upholding widely held social norms. Such an analysis reflects a distinction from understanding behavior as individually driven, and instead emphasizes the impact of social and structural conditions.

In what follows we first reflect on how people accounted for assistance, and how this can reveal desirability bias and a prohibitory code for assistance, while also providing insight into other codes. We then explore initiation assistance as a private activity, distinct from norms that emphasize public performance and expression in pursuit of respect. Third, we introduce the linked moral logics that make up a fragmented code, and explore how they are socially situated and reflect distinct meanings of drug use. Last, we focus on claims to unintended initiation and show these reflecting a strategic narrative, but also the extent of the silence and stigma linked to injection drug use, and how this leads to particular processes of initiation.

Performing and experiencing the code

Efforts to manage a desirability bias were evident in our data, and we link these to the framing of the interview: a public health researcher leading an interview in a University-owned building associated with health care. This can explain how respondents sometimes abbreviated discussion of experiences of assistance or denied ever participating in this activity. For example, despite John having reported in the STAHR II survey assisting two people into drug injection, in the interview he said ‘I have never gave anyone their first injection. Uhm, I don’t, I don’t know that I would’. Other respondents also described fewer experiences than previously reported in the STAHR II survey (See [Table 1](#)). Respondents also deflected questions or reported memory challenges: ‘those are the two I can recollect’ (Bob), ‘I am sure I have [assisted someone] but I can’t give you no instances you know’ (Samuel). Accounts also reflected efforts to deflect responsibility (Kolla et al., 2015). For instance, Sandra described to us injecting her then girlfriend and not knowing it was her first injection:

“I, I could never do that to somebody... intentionally. I’ve done it, but that person didn’t tell me it was their first time. After the fact they, that I did it, they were like ‘oh. It was my first time’. And I was like... pissed off... because uhhh that’s the worst thing you could do to somebody”

Sandra’s claim is contradicted by subsequent parts of her interview where she described the ambivalence she felt when administering this first injection and wondering whether it was the right thing to do. In part, respondents’ accounts reflect an editing or construction of experience to narrate a desired identity and create distance from one’s own potential participation in a stigmatized process (Kolla et al., 2015; Rhodes et al., 2011; Simmonds & Coomber, 2009). An accounting of initiation as unwitting or as an effort to reduce harm can then be understood as an effort to accommodate the perceived views of an interviewer while continuing to adhere to a code that prohibits initiation assistance.

The strategic use of a code should not, however, obscure how the retelling of a code can also display a lived experience (Jimerson & Oware, 2006). Robert recounts how “I feel real crappy about it..., because it messed both of them up. Sort of like me”. The consistency across many accounts of experiences like Robert—including from people who had

Table 1
PRIMER qualitative study respondents in San Diego, USA (n = 21).

ID	Pseudonym	Gender (W – Woman, M – Man)	Age	Race/Ethnicity	Substances used in past 30 days	Route of administration to consume drugs in past 30 days	Reported ever providing injection initiation assistance in STAIR survey (# persons)	Reported in interviews	Housing status (past 6 months)	Self-reported health issues
1	Sharon	W	62	Black	Heroin, crack, other opiates	Inject	Did not assist	Did not assist	Subsidized housing	Living with HCV
2	Sandra	W	31	Hispanic	Heroin, alcohol	Inject	Did not assist	1	Housed, previously homeless	Living with HCV
3	Patrick	M	48	White	methamphetamine	Smoke	1	'maybe 10'	Housed, previously homeless	Emphysema, bipolar disorder
4	Kim	W	43	White	Heroin, methamphetamine, cannabis, alcohol	Inject, smoke	4	2	Housed	SSTIs
5	Jake	M	35	White	Cannabis, alcohol	Smoke, ingest	10	'maybe 100'	Housed	Living with HCV
6	Rowan	M	56	Native American	Cannabis, alcohol	Ingest, ingest	1	2	Emergency shelter	Living with HCV
7	Miguel	M	27	Hispanic	Heroin	Inject	1	2	Housed	Living with HCV
8	Kris	M	25	White	Heroin, methamphetamine	Inject, smoke, snort	Did not assist	Did not assist	Informal housing (abandoned house)	Living with HCV, asthma
9	Aaron	M	34	Hispanic	Heroin	Inject	1	3	Housed	None reported
10	Bob	M	55	White	methamphetamine	inject, smoke	5	2	Subsidized housing	Living with HIV, HCV
11	Samuel	M	62	White	Cocaine, cannabis, methamphetamine	Inject	Did not specify number	Did not specify number	Housed	None reported
12	John	M	47	White	methamphetamine	Inject, smoke	2	Denies assistance	Housed	DVT, SSTIs
13	Kevin	M	52	White	methamphetamine, cannabis	Inject, smoke	2	1	Unsheltered	Living with HIV, HCV, SSTIs
14	Peter	M	45	Black	methamphetamine, cannabis	Inject, snort	Did not assist	Did not assist	Housed	Living with HIV
15	Robert	M	37	White	methamphetamine, cannabis	Inject, smoke	3	2	Housed	Living with HIV
16	Warren	M	49	Native American	methamphetamine, alcohol	Smoke, ingest	1	Doesn't state number	Housed	Living with HIV
17	Barbara	W	32	White	methamphetamine, alcohol	Smoke	Did not assist	Supported her son in initiating, with someone else's help	Unsheltered	Living with HCV
18	Agnes	W	56	White	methamphetamine	Smoke	1	2	Single room occupancy	Living with HCV, arthritis
19	Patricia	W	54	Hispanic	Alcohol	Ingest	3	2	Housed	None reported
20	Jenny	W	48	White	heroin, methamphetamine, alcohol, tobacco	inject, smoke	1	1	Housed	Living with HCV, SSTIs
21	Tom	M	41	White	Cocaine, heroin, cannabis, other opiates, alcohol	Inject, smoke, ingest	5	1	Unsheltered	Living with HIV

HCV: Hepatitis C Virus; HIV: Human Immunodeficiency Virus; SSTIs: Skin and soft tissue infections; DVT: Deep vein thrombosis.

not assisted—that assistance is regrettable supports such a norm as both experience *and* performance. That other respondents reported more instances of assistance in the interview than in the preceding STAHR II survey – see Table 1 – also suggests a desirability bias towards harm reduction and the experience of a ‘mainstream’ code prohibiting assistance is not total. Further, some reported initiation assistance as not in need of excuse: ‘*my feeling, its more economical to do it that way*’ (Agnes). Such accounts defy any desirability bias towards public health and harm reduction. Our data then include participant efforts to deflect and construct a desirable identity while also simultaneously generating insight into prevailing codes of conduct.

In search of respect? the privacy of assistance

For Anderson violence in urban settings is enacted to ensure respect and in turn socio-economic position (Anderson, 1999). The public performance of violence is integral to ensure respect. For our respondents, initiation assistance largely represented the inverse of this public pursuit of social respect. The role of assisting was not clearly linked to particular social status or resource. Some accounts referenced a transaction of drugs or money, although these normally emphasized the marginal position of the person in an economy rather than of a high status to be defended. Some described seeking to hide their role in providing initiation assistance. While there were some stories of others who ‘*didn’t care*’ and who would boast about assisting, these did not suggest a high status or power linked to the role: ‘*people saying “I like shooting up people for the first time” and they kind of laugh about it...they’re so stupid*’ (Robert). The description of the specific events around assistance also often emphasized a discrete interaction between two people, rather than a public display of initiation. The idea that a public display or role of ‘*assisting*’ was not sought by our respondents is also clear in the low number of people reportedly helped, even allowing for some abbreviation of accounts. We note here that our sample did not include anyone identifying as a ‘*hit doctor*’, where a profile as a proficient injector of others may be prized. Equally, when we asked about others who helped or assisted initiation, no respondents described anyone taking on this ‘*hit doctor*’ role.

Whilst assistance may not be championed, it was also rarely described as policed or explicitly sanctioned. It was widely disapproved, though any resulting stigma did not appear to be enforced, whether in terms of violence or social isolation. The only accounts of such punishment came from Arran who described a man being pursued from town for allegedly assisting in, or forcing, the initiation of a young woman in order to sexually exploit her; and from Tom who assaulted a man who initiated an ex-girlfriend. Outside of such exploitative accounts (which we return to below), any repercussion from assistance appeared to be experienced privately and was often expressed as guilt. A code in support of assistance of injecting initiation for our respondents is then less clearly about public display to ensure respect (Anderson, 1999; Bourgois, 2003) and instead emphasizes a more ambiguous and private practice. From here, we develop the idea of a fragmented code: the code is not coherent around respect, but shifting combinations of norms (explored in the next section) reflecting a hidden practice experienced differently among a dynamic and diverse group.

A fragmented code

Building on the multiple, linked themes in accounts of assistance, we explore here the dominant moral logics in support of initiation assistance and how they are socially situated. In contrast to a binary code mandating or prohibiting behavior (Anderson, 1999), we suggest that initiation assistance is subject to a fragmented code linked to ambivalence around the pleasures, harms and other meanings ascribed to drug injecting (Wenger et al., 2016). Rather than a coherence around norms of respect and public position, we instead identify overlapping

combinations of norms underpinning initiation assistance: injection as the initiate’s choice, a concern for harm, and understandings of drug use as both regrettable and pleasurable.

Recurrent and linked themes in assistance were oriented to a reluctance to assist and often linked to efforts to reduce harm (Kolla et al., 2015; Rhodes et al., 2011; Wenger et al., 2016). Miguel describes assisting a friend, after recounting his own experience of drug use as his ‘*fault*’, ‘*stupid*’ and ‘*disgusting*’: ‘*he begged me to get him high; cause I didn’t want to, I was like “no, I don’t want you getting in to this blah, blah, blah”, and he said I’ll pay you, and kept begging me and begging me and so I said “fuck it, alright, once you do this, you will never be the same”*’. His frustration is evident as is his acknowledgement of how a narrative of harm reduction could be seen as strategic or scripted (‘*blah, blah*’). Whilst some accounts of reluctance that emphasize harm reduction appeared strategic, for others such reluctance and a focus on harm is grounded in specific experiences (Wenger et al., 2016): they do not want people to ‘*go down the road*’ they had. For Kevin, who described regretting his use and considering it a cause of ill health and lost opportunities, experiences of initiating others were framed by anguish and ambivalence arising from his own drug use. Sometimes a concern for harm, and efforts to manage that harm, were linked to transactions and the formation of specific moral economies reflecting people’s own precarious position: ‘*I tried to deter them you know, but, but a lot of times they got money*’ (Samuel).

Harder to voice, given a discourse prohibiting injection drug use initiation, is a moral logic in support of drug injection as ‘*the best way*’ and a meaningful or pleasurable choice (Kolla et al., 2015), even amidst structural violence. For example, Agnes was wheelchair bound, travelled to the interview with her carer and talked of her chronic pain, physical illnesses and of living in a single room occupancy hotel. And yet her account emphasized her pleasure in drug injecting, the active choices she made in starting to inject and in helping others to do so, and she pushed back against the notion of intervening to prevent injection drug use initiation: ‘*to each individual how they feel, you know? And I mean, I never felt it was a problem that I needed to quit*’. Peter, who reported never having assisted others, and who was homeless and living with HIV, saw assistance as ‘*just help*’, and injection as simply another way of using drugs. So, while providing initiation assistance can involve considering the potential for harm to the initiate, it can also be framed as providing pleasure or meaning that transcends experiences of dependency, and that the emphasis is on the person seeking the injection and it being their choice. For Bob, providing assistance was pragmatic: ‘*they wanted to try it, and asked for my assistance*’. Drawing later on his perspective on drug use, he continued: ‘*I have always told people they should do whatever they want to do*’. These accounts of pleasure and choice can in turn be contextualised with some respondents’ critically questioning drug policy and espousing the freedom to use drugs: ‘*freedom is number one, then health*’ (Samuel), ‘*it feels good, and I want to do it, so why are you going to send me to prison over doing it*’ (Robert).

An even more hidden experience of assistance overlaps with notions of coercion and violence. Jenny, quoted above—as well as others—were concerned at men exploiting young women, a phenomenon described previously by Small et al. as an explicitly prohibited feature of the ‘*code*’ (Small et al., 2009), and reflecting reports from San Diego and elsewhere of gendered coercion and injection drug use (Bourgois, Prince, & Moss, 2004; Ludwig-Barron, Syvertsen, Lagare, Palinkas, & Stockman, 2015; Wenger et al., 2016). Some respondents recounted stories of other’s experiences: ‘*her Mom knew [a man] who kidnapped her daughter, had her in a hotel room...shooting her up with heroin, so you know after the fifth day she’s dependent on it and next thing you know he’s like has her working the boulevard*’ (Patrick). Similarly, Aaron recounted this happening to others, and Tom directly reports violently policing the initiation of his ex-girlfriend by another man: ‘*I beat the living crap out of him...I had almost broke his back*’. There were though doubts such exploitation happened: ‘*I have seen in the movies where it happened, but not in real life*’ (Bob). The reference to films reflects the potentially mythical

quality of such stories of exploitation and how they reinforce broader stigmatizing discourses of drug use as depraved and violent.

Accounts of exploitation were not reported often by our respondents, though limited reporting of such direct criminality and violence is perhaps unsurprising. However, two accounts in our data allow some exploration of a boundary between coercion and exploitation. Robert, often insecurely housed and experiencing mental and physical illness, described assisting two men who were sexual partners: *'I never pushed it on anybody', 'but then there was a sick side of me that was like...if I shoot them up I can get them to do whatever I want', and 'a lot of people use it to control situations, control lovers', but 'I just wanted to have a good time'*. Nathan had a history of gang membership and being in prison, and framed his role in assisting people by saying *'I never really respect anyone's, like, human life that much [laughing]'*, and then described how assisting makes it easier to *'take advantage': 'they are going to be calling your ass every day...and you are going to get some dope every day for free'*. Here, as above, the initiates are described as wanting to inject; there is exploitation if not coercion. This exploitation contrasts with the reports by Tom and Aaron of coercion of women and indicates a particular liberal morality: people should be allowed to harm themselves, but the limit on what is permissible is defined as intentional harm to others (Hunt, 2004). Following this, exploitation and then coercion occupy positions on the extreme boundary of a 'code of the street' that underpins injection assistance, and are marginal in terms of how frequently they occur, while remaining potentially sanctioned and the focus for exclusion.

Unintended initiation and the silence on assistance

Reports of unintended initiation figured prominently in respondents' accounts. Beyond their strategic deployment (as for Sandra above), these show how assistance occurs within a structural context that limits discussion of injection drug use, and which supports a prevailing silence on processes of assistance. Unintended initiation has been described as an active negotiation of the moral boundary around initiation (Rhodes et al., 2011). An emphasis on active and strategic negotiation reflecting how being unaware of another person's drug use, particularly in the context of an intimate partnership as described by Sandra above, may be doubted given the potentially visible signs of drug injection. Other accounts, however, support claims of unintended initiation through suggesting a context where people are little informed about others' past drug use, and that inquiring about it was challenging. Patrick described to us being homeless and people asking for help to inject:

"They knew that, you know, if you never done it before, I was, I was not going to be the one to do it to you, for the first time. And they're like 'oh yeah, I just have a hard time hitting myself'. So, you know, I turn around and help them and then find out later that, you know, that was their first time doing it."

Patrick's account alerts us to linked themes across our data. The first theme is of a general culture where providing help with drug injection was common practice. As Patrick said: *'you know it's, it's believable because you know, I know people that have a hard time doing that, hitting themselves.'* Other respondents agreed: *'I help other people inject themselves, when they are having, uhm, trouble doing it'* (Sandra). Relatedly, respondents described assisting people who never learned to inject. Regular occurrences of requests for general injection assistance can then contribute to a context in which initiation assistance could be sought while circumventing the code that proscribes this behavior.

A lack of knowledge regarding others' drug use histories can also be linked to how people described social relationships and drug-using networks characterized by weak and shifting ties. Patrick described the relationships with those he initiated unintentionally as follows:

I: Do you know these people well or-?

R: No I... they were... I wouldn't say well, but, you know, I know them good enough. I know them from passings and, and little parties we've had, from...you know, passing them on the street and stuff.

I: Would you know their name or where they were from or...?

R: Uhhmm. Nah, not where they're from, you know. They all had nicknames.

Respondents' social networks were often described as shifting, uncertain, sometimes violent or with limited trust. In describing his 'friends,' Miguel corrects himself to 'so-called friends': *"they are not really friends, they are just associates."* Across interviews, respondents often could report little or nothing of other's experiences of injection drug use and would describe how discussing drug use was limited in their social networks: *'They never really talk about it on the street.'* Some described themselves as 'loners' and wanting to keep to themselves. These social networks are then also context in which assisting remains a private—rather than performative—role, as described above.

A general silence on drug use can in turn be linked to two specific themes raised by respondents. First, drug injection was described by some as private, linked in part to felt stigma around this mode of use:

"Ask somebody about drugs and they might slap your ass, you know. It's a touchy subject...uhm it's like somebody asking about your sex life, you know what I am saying...it's touchy for us. It's digging into...into what they are hiding from, they're hiding from that, they like to run from reality, so when you ask them about why they do this it's like an insult on them". (Peter)

Others expressed similar shame about their own drug use, describing how they would use in private and expressing embarrassment about their use. Limited discussion of injection drug use was also linked to fears that talking about drug injection, whether their own or that of others, could lead to difficulty from the police. Kris, homeless and injecting methamphetamine, described recent trouble with the police and how this related to not asking others about their drug use:

"I'm afraid they are [undercover] cops or something [laughs], yeah you know...there is a lot of informants, people tell on you."

Such specific concerns come amidst widespread experiences amongst our respondents of police interference and imprisonment. These are then specific social and political contexts where not knowing about or not being able to ask about others' drug use emerges as possible or necessary to avoid violence or conflict. In such contexts, unintended initiation becomes possible. Further, the delineation of contexts of stigma and silence on drug use further underscore the potential privacy or secrecy of the role of assisting others and the limited social position to which this role is linked.

Discussion

We sought to explore the social norms and contexts for assisting in injection drug use initiation in San Diego, USA. Building abductively on existing studies of this phenomenon (Kolla et al., 2015; Rhodes et al., 2011; Small et al., 2009; Wenger et al., 2016), and framed by Anderson's 'code of the street' (1999), we have shown how norms of initiation assistance are socially situated. Our analysis has indicated potential saturation around a logic of initiation assistance as harm reduction amidst experiences of structural violence (Kolla et al., 2015; Wenger et al., 2016), and we analyze additional contexts contributing to these processes. In particular, we have shown how assistance can be grounded in an experience of pleasure (Kolla et al., 2015) and experienced as a meaningful choice (Preble & Casey, 1972).

By situating injection initiation assistance within a moral code we have shown how this practice may vary across contexts. Our results suggest some forms of assistance may occur across different contexts, reflecting in particular the widespread accounts of initiation assistance

as fostering harm reduction and accessing resources (Kolla et al., 2015). Our analysis of stigma and silence shaping unintended initiation in contrast suggests how initiation assistance could also reflect particular geographies and political economies. For example, the difficulty of discussing injection drug use amidst weak social ties could be linked to specific features of San Diego and Southern California: i) a large, unsheltered homeless population (San Diego Regional Taskforce on the Homeless, 2016); ii) a punitive policing environment for drug use and limited harm reduction services (Garfein et al., 2013; Siddiqui et al., 2015); iii) an extended urban landscape with no identifiable street drug scenes resulting in a lack of knowledge of others' drug use; and iv) the dominance of black tar heroin, a substance difficult to inject (Ciccarone & Bourgois, 2003; Summers, Struve, Wilkes, & Rees, 2017) that may lead to widespread need for help injecting. Similarly, following Rhodes et al. (2011) who explored how initiation is narrated with reference to broader political discourses, the reference to choice, liberty and freedom around use of drugs could reflect an American political discourse of freedom and increasingly prominent critiques of the war on drugs. If norms for providing assistance are shaped by such specific social and structural contexts, they may then vary widely. Understanding this variation around injection initiation requires further development (Guise et al., 2017; Wenger et al., 2016).

A detailed analysis of the codes governing initiation also supports understanding of injection initiation as emerging from a complex interplay of individual actions and structural conditions (Guise et al., 2017). Our analytical framing of moral codes allows insight to specific pathways by which individual-level meanings and structural contexts interact. Further inquiry in this direction could focus on the production and generation of codes, as well as how codes shape behavior (Jimerson & Oware, 2006) and so foster further insight to injection initiation and the provision of assistance to it as a social practice set within broader processes and regimes of living (Fast, Shoveller, & Kerr, 2017).

Our exploration of codes of initiation assistance in San Diego was undertaken in the context of efforts to develop a structural intervention strategy to prevent entry into drug injecting. The PRIMER study specifically hypothesizes that initiation assistance is largely undertaken reluctantly, occurs within networked relations, and that interventions preventing the harms arising from drug injecting (e.g., medication-assisted treatment, supervised injection facilities) may have a secondary preventive impact by disrupting the initiation pathway (Werb, Garfein et al., 2016). Echoing past work (Kolla et al., 2015), we find divergent experiences of providing initiation assistance linked to regret and ambivalence (Wenger et al., 2016) but also to norms of liberty and choice. Therefore, while the provision of harm reduction programming may impact certain pathways to initiation assistance (i.e. those governed by a code of seeking to reduce harm), it may fail to impact those pathways embedded within a code of pleasure and choice. Furthermore, some respondents communicated that initiation assistance is not necessarily something to be avoided. This then points to potential limits of social and structural intervention, given that drug injection figures as a meaningful choice within peoples' lives (Preble & Casey, 1972) and not defined solely by risk (Kolla et al., 2015).

Delineating how moral codes govern initiation assistance points to additional directions for structural interventions seeking to prevent injection initiation. Analysis of a 'code of the street' governing violence is linked to the need to address poverty, alienation and unemployment, in tandem with community level advocacy (Anderson, 1999). A structural intervention strategy to prevent injection initiation could then seek to shift norms of assistance through similar holistic approaches to poverty and alienation. Indeed, poverty reduction interventions could shift norms around injection drug use, in as much as other choices become available to manage the structural violence people experience (Fast et al., 2010). Similarly, the decriminalization of drugs could shift norms that emphasize silence and secrecy and so reduce 'unintentional' initiation events. We recognize, though, that such structural approaches face multiple political, resource and strategic challenges, although

existing evidence points to how structural modifications such as supervised consumption facilities can change social environments and so disrupt specific drug-using practices (McNeil, Kerr, Lampkin, & Small, 2015; McNeil & Small, 2014; McNeil, Small, Lampkin, Shannon, & Kerr, 2014).

Others have reported on the limited likelihood of preventing all transitions to injection drug use, and we have delineated this as not necessarily desirable, given the potential for harm reduction strategies and non-punitive laws to mitigate against the harms of drug injecting (Kolla et al., 2015). Within this framework, having skilled people who inject drugs educate new initiates on injection practices could then provide an alternative strategy to reduce many of the risks associated with this mode of drug consumption (Kolla et al., 2015; Small et al., 2012). An emphasis on safe injection and a related role for people who provide injection assistance would have a clear harm reduction potential and also potentially address the silence we report around injection initiation. If drug injection and its initiation are little discussed, this limits the potential for peer to peer communication of safe injection (Harris & Rhodes, 2012). In the absence of such communication, challenges and tensions around harm reduction and safe injection are managed in isolation, potentially resulting in increased risk for fatal overdose, skin and vein damage and infectious disease. The stigma and limited discussion around initiation that we report could help explain the significant increase in HIV and HCV transmission risk within the first year of injection initiation (Garfein, Vlahov, Galai, Doherty, & Nelson, 1996), as well as widespread unsafe injection practices within San Diego (Armenta et al., 2015; Muñoz et al., 2015).

Our findings are based on a specific sample from San Diego and should be understood as giving insight to the diversity of a localized phenomenon in a particular context, rather than as a readily generalizable account. Further data collection beyond our 21 interviews would give further insight to the fragmented code we describe. The STAHR II study subsample we used potentially does not represent all experiences within the San Diego context. For example, the existence or experience of so called 'hit doctors' was not reported to us, though it has previously been reported in other settings. Our sample was older and represented individuals who may have a greater concern for their health based on their willingness to participate in the study, or who may represent a group with greater stability in their lives given that they were contactable from study records. However, with our in-depth data we still accessed novel insights to a stigmatized phenomenon and brought understanding of the specific context for injection initiation assistance in San Diego. Future studies should seek to extend and elaborate on these findings in particular through more ethnographic and longitudinal investigation that could more fully describe the codes and regimes of living in particular socio-structural contexts (Fast et al., 2017).

Conclusions

Injection initiation assistance in San Diego is governed by a fragmented moral code that reflects multiple meanings of drug injection. Injection initiation assistance in San Diego has similarities to other contexts, whilst also taking on specific forms of unintended initiation shaped by this setting's particular social networks and structural context. Structural approaches to preventing injection initiation are warranted though carry inherent limitations given the diversity of pathways to injection initiation, and should be evaluated in tandem with efforts to support safer injection and interventions to reduce the harm of injection drug use, particularly among recent initiates.

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Conflicts of interest

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