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HEROIN INITIATION AND RISK:

AN ETHNO-EPIDEMIOLOGICAL APPROACH

JENNIFER CRONLY
BA

A THESIS SUBMITTED IN FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF PH.D

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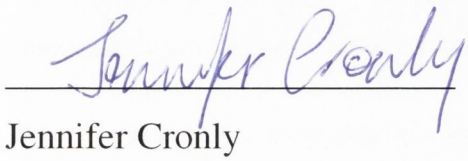

Jennifer Cronly

Summary

This thesis provides an in-depth exploration into the process of heroin and injecting initiation among young people in Ireland. It also presents a detailed investigation of risk perception and behaviour during the early heroin and injecting career. Rather than providing an individualistic account that primarily identifies and locates the causes of behaviour *within* the individual, this study adopts a 'risk environment' framework (Rhodes 2002, 2009). It seeks therefore, to explore the environmental forces and social processes that both contextualise and shape young people's risk behaviour and their pathways to heroin and injecting drug use. The principle aim is to present the views and subjective experiences of young recent heroin or injecting initiates in order to capture the social organisation and construction of risk.

The study adopted an ethno-epidemiological framework within a constructionist, interpretive, ethnographic approach. An epidemiological instrument was incorporated into the design but qualitative research methods were privileged by this study. Four main research techniques were adopted including: a community assessment process, ethnographic observation, the administration of an interceptor survey, and the conduct of life history interviews. The community assessment process involved a process of engagement (including the conduct of formal and informal interviews) with service providers working directly, or indirectly, with young heroin users. Ethnographic observations were conducted in a variety of locations where heroin users are known to congregate (including public and outdoor locations as well as homeless and drug-treatment services). An interceptor survey was administered to 120 young heroin users between the ages of 16 and 30 years, and a sub-sample of 40 young people (23 males and 17 females), between the ages of 16 and 25 years, were selected to participate in ethnographic life history interviews. The life history interviews explored the young people's life and drug histories, the social course of their heroin and injecting initiation, their drug and sexual risk behaviour and their interpretation of significant life events and experiences.

The key findings of this study highlight the role of macro-, meso- and micro-level environmental forces in shaping the process of heroin and injecting initiation in young people. The young people in this study lived in macro and meso-level environments characterised by numerous forms of adversity, including poverty, social exclusion, family breakdown, domestic violence, family substance use, and abuse. These environmental forces shaped micro-level social process which impacted on their pathways to heroin use. In order to uncover these processes in detail, typologies were developed on the basis of micro-level social relationships and interactions that preceded their heroin initiation. This analysis led to the development of three main pathways into heroin use: a 'criminal career' pathway, an 'intimate relationship' pathway, and a 'homeless' pathway. These pathways provide an in-depth understanding of the ways in which macro, meso and micro environments intersected to shape initiation contexts and rationales.

Young people's pathways into heroin use continued to shape drug-using episodes and experiences of risk during their early heroin use careers. Many young men came into contact with older heroin users through their criminal activity and initiated heroin use in their company. Following initiation, they reported an escalation in criminal activity and became more deeply entrenched in criminal social networks. Within these social contexts, the young men were

vulnerable to violence and intimidation. Many young women, on the other hand, entered into intimate relationships with an older heroin user during their early to mid-teenage years and subsequently initiated heroin use in the company of that individual. Gender power dynamics operating within these young women's drug-using networks and their intimate relationships exposed them to the risk of sexual victimisation, exploitation and abuse.

The third pathway into heroin use, the 'homeless' pathway, was identified from the stories recounted by both young men and women. These young people described how the experience of living 'out-of-home' and becoming immersed in homeless social networks impacted on their heroin use trajectories. Many explained that their heroin use created barriers to exiting homelessness and that they felt trapped in a cycle of homelessness and heroin use. Young people also reported that injecting was the dominant route of administration within homeless heroin-using networks and their accounts indicate that experiences of homelessness impacted strongly on pathways into injecting drug use. The vast majority of young people who transitioned to injecting were deeply entrenched in homeless injecting networks at the time of their initiation. They described how their observations of the injecting behaviour of others served to ease their fears about injecting drug use and simultaneously enhanced their curiosity about its effects.

The young injecting drug users in this study were at high risk of negative outcomes such as blood-borne viral infection, near overdose and vein damage during the early stages of their injection careers. Physical contexts of their early injection episodes operated to produce risk; for example, many (particularly those who were living 'out-of-home) reported injecting in outdoor or public environments where fear of interruption, or their limited control over environmental conditions, made safe injecting procedures more difficult. Some young men reported injecting in prison environments where the limited availability of injecting paraphernalia contributed to 'risky' injection practices. Social and contextual factors also impacted on young people's risk perceptions and behaviour; for example, many asked an older, more experienced injecting drug user to facilitate their early injections and therefore, had limited control over the injection procedure. Furthermore, the data indicated that the perceived risks associated with injecting practices were socially constructed and organised, and that social norms and power dynamics operating within drug-using networks impacted on risk behaviour.

These findings indicate the importance of macro-, meso- and micro-level risk environments in shaping the process of heroin initiation and risk behaviour. In order to respond to drug-related harms, these understandings need to be more fully integrated into drug prevention and harm-reduction policy and intervention.

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Chapter One

Heroin Use in Ireland: An Introduction to the Study

This study is about young people, heroin initiation and risk. Methodologically, the research comprises a mix of quantitative and qualitative methods but privileges the latter in undertaking a detailed exploration of young people's initiation to smoking and injecting heroin use. The study's core aims were to investigate the *social course of heroin and injecting initiation* among young people residing in the Dublin metropolitan district, and to examine young people's risk perceptions and behaviour, particularly during the early stages of their heroin 'careers'. In contrast to the dominant individualistic approaches used to investigate 'risk factors' associated with heroin use and risk behaviour among injecting drug users, the study adopted a 'risk environment' framework (Rhodes, 2002, 2009). It thus sought to contextualise young people's heroin use with particular attention to the macro-, meso- and micro-level environmental influences that shape the course of their heroin initiation. This conceptualisation is one that shifts the focus from individuals to the social situations, processes and structures in which individuals participate and are immersed.

The use of non-prescribed opiates has been socially constructed as 'problematic' for the individual and society in most Western countries (Conrad & Schneider, 1992; Schneider, 1985). The medical profession has been primarily assigned the authority and responsibility to regulate the use of opiates, and to treat those who become physically dependent through non-prescribed use (Parran, 1938; Waterston, 1993). Consequently, research on heroin use has traditionally been dominated by the medical profession, and has primarily adopted a positivist, individualistic paradigm (Acker, 2002; Waterston, 1993). The individual heroin user has been constructed as psychiatrically or psychologically 'ill'; causes have been sought within the individual user's biology or personality; and treatment regimens have been designed to address his or her 'addiction' (Lindesmith, 1940; Parran, 1938). However, a significant body of research has challenged this approach. Since the 1930s, sociologists have drawn attention to the environment within which 'problematic' heroin use manifests (Becker, 1963; Dai, 1937), highlighting the importance of social and economic disadvantage in the spread of heroin use, as well as the role of social interaction in the process of initiation. By privileging heroin users' own accounts, ethnographers in particular have drawn attention to the lived experience of heroin use and contextualised drug users' experiences and behaviour within their social and economic environments (Faupel, 1987, 1991; Fiddle, 1967; Finestone, 1957; Gould et al., 1974; Preble & Casey, 1969; Stephens, 1991; Waldorf, 1973).

During the 1980s, the public health movement coupled with the AIDS epidemic fuelled an abundance of research into the transmission of blood-borne viral infection through injecting drug use (Rhodes, 2002). Large-scale epidemiological studies were established in order to determine the rates and correlates of injecting 'risk behaviour', such as needle or syringe sharing, amongst injecting heroin users (Berridge & Strong, 1993; Patton, 1990). Continuing the trend of previous drug research, many of these studies were dominated by individualistic models of behaviour. The causes of injecting risk behaviour were thus sought mainly in reference to the individual, and the interventions subsequently put in place, including messages directed at reducing drug-related harm, were primarily targeted at individual-level behaviour change. More recently, however, researchers have challenged this approach, emphasising the importance of the environment in shaping risk perception and behaviour (Bloor, 1995; Fee & Krieger, 1993; Oppenheimer, 1988; Rhodes et al., 2003a). By exploring macro, meso and micro environmental forces, recent studies adopting a 'risk environment' framework (Rhodes, 2002, 2009) have dramatically expanded understandings of injecting and sexual risk behaviour among heroin users (Burris et al., 2004; Rhodes & Simic, 2005; Rhodes et al., 2003b, 2006; Sarang et al., 2006; Small et al., 2007, 2009) According to Rhodes (2002), the risk environment comprises factors exogenous to the individual and takes account of different levels of environmental influence, including macro-, meso- and micro-level risks. Macro risk environments focus on structural factors, economic conditions and wider cultural beliefs, meso risk environments on community-level norms and practices, and micro risk environments on personal decisions as well as the influence of interpersonal relationships.

While the 'risk environment' framework has contributed much to the injecting drug use literature, and greatly extended understanding of the complex role and interaction of various 'layers' of environmental influence on the drug use behaviour of individuals, understanding of drug initiation in general, and heroin initiation in particular, continues to be dominated by individualistic approaches. Epidemiological studies, particularly those seeking to identify 'risk factors' associated with the onset of heroin use, continue to focus on those factors located *within* the individual (Fuller et al., 2001; Lynskey & Hall, 1998; Pugatch et al., 2001; Roy et al., 2003). Thus, although modern-day epidemiology strives to understand the relationship between individuals and their social environments, its doctrine continues to be dominated by a focus on the individual or agent (Agar, 1997; Susser & Susser, 1996a). As Agar (2003) has argued, what is required is the introduction of qualitative ways of thinking about epidemiology. However, rather than merely "attempting to 'graft' environmental concepts onto individualistic approaches – by focusing on analyses of individuals' perceptions of social relationships and environments" (Rhodes et al., 2003a, p. 322), this study is explicitly theoretically informed by a 'risk environment' framework. This means that the analysis pays attention to the macro-, meso- and micro-level environmental forces that shape the smoking and injecting initiation practices of

recent heroin initiates. The social context of initiation, including social, relational, intrapersonal and structural processes, is, therefore, central to the research and to the analytic focus and orientation of the study. Risk behaviour is likewise located within a complex interplay of environmental forces that shape the risk perceptions and practices of young heroin users.

This chapter introduces the study by first providing an overview of Irish research on heroin use, identifying gaps in existing knowledge, and presenting a clear rationale for the study's focus on heroin initiation among young people in Ireland. The research questions are then briefly outlined, as are the study's data collection methods. The final section of the chapter provides an overview of the structure of the thesis.

An Overview of Heroin Use Research in Ireland

Over the past 30 years, there has been a growing body of epidemiological research on heroin use in Ireland (White & Comiskey, 2007). These studies have greatly enhanced knowledge of the prevalence and incidence of reported problematic drug use and have enabled the monitoring of rates and trends in drug use over time (Dean et al., 1983, 1985, 1987; O'Hare & O'Brien, 1992, 1993; O'Higgins, 1996; O'Higgins & O'Brien, 1994, 1995; Reynolds et al., 2008). The prevalence and spread of opiate use is now relatively well understood and can be mapped, both historically and geographically, thus providing considerable insight into its aetiology and diffusion. Heroin use in Ireland, as in other parts of the world, is not spread evenly across the population and incidence rates tend not to remain constant (Kozel & Adams, 1986; Frank, 2000). It is now reasonably well established that heroin use is a complex social phenomenon that varies according to social, political, economic and historical contexts (Ciccarone, 2005; Parker et al., 1987; Frank, 2000). Trends emerging from both small and large-scale epidemiological studies have helped to shed light on the complex forces that influence the spread of heroin use and have also helped to identify those sub-groups in the population which are most at risk of initiation (Kozel & Adams, 1986).

Until the late 1970s, reported rates of heroin use were low in Ireland (Working Party on Drug Abuse, 1971). However, in 1979, a dramatic increase was observed in the numbers of individuals seeking treatment for problematic use from the National Drug Advisory and Treatment Centre in Dublin city (Dean et al., 1985). This upward trend continued until the early 1980s and constituted Ireland's first 'opiate epidemic', which peaked in 1983 and then appeared to decline (Dean et al., 1987). From the outset, the opiate epidemic was not spread uniformly across the population, but was instead highly centralised in a number of Dublin's inner city communities characterised by high levels of unemployment and social disadvantage (MacLaran, 1993; O'Gorman, 1998; Punch, 2005). The dramatic increase in heroin use in Dublin during this time was, therefore, strongly

linked with broader social, economic and political forces including, among other factors, uneven flows of capital and a public housing policy of decentralisation (Punch, 2005). At this time, there was widespread dereliction across city centre locales, with an estimated 65 hectares of cleared sites and derelict buildings in Dublin's inner city (McGuirk & MacLaran, 2001). The first opiate epidemic in Dublin emerged out of these structural problems and ensured that those who were most affected were living in already marginalised communities (Punch, 2005; O'Gorman, 1998).

At this time, some attempts were made by the authorities to assess and respond to the observed increase in heroin use in Dublin (Butler, 1991). In 1982, the Minister for Health commissioned what was colloquially known as 'The Bradshaw Report', a prevalence study carried out between September 1982 and April 1983 in the north inner city of Dublin (Dean et al., 1983). This study confirmed the scale of the heroin problem and revealed that epidemic numbers had been introduced to heroin during the previous two years. The prevalence of heroin use in the area among those aged between 15 and 24 years had reached 10% and was even higher, at 12%, among those aged between 15 and 19 years. These young heroin users demonstrated poor levels of educational attainment and high levels of unemployment, with over 73% reporting that they were unemployed, and only 5% having formal educational qualifications (Dean et al., 1983). In response to these findings, a Special Governmental Task Force on Drug Abuse was established and subsequently acknowledged that problematic drug use was directly linked to poverty and disadvantage within Dublin communities. It also advised that these areas be identified according to specific indicators[1] of social deprivation and prioritised for additional resources. However, this report was not published and the recommendations of the Task Force were not acted upon at that time[2] (Butler, 1991; Punch, 2005).

By the mid-1980s, the opiate epidemic appeared to have abated to some extent as the number of new heroin users presenting for treatment declined (Dean et al., 1987). There was also evidence of a reduction in drug-related arrests and heroin seizures (Garda Síochána, 1985) and heroin use remained confined to inner city areas characterised by socio-economic deprivation and marginalisation (O'Gorman, 1998). At this time, the majority of heroin users reported 'mainlining' or intravenous injection as their preferred route of administration (Dean et al., 1983), leading to concerns about the transmission of HIV amongst this population. For example, in 1987, one study found that 27% of attendees at a city treatment centre tested HIV positive (Dean et al., 1987). The threat of a HIV epidemic had an important impact on Irish drug policy and practice and led to a shift toward a greater acceptance of harm reduction approaches and interventions. This was reflected in the introduction of methadone maintenance and needle exchange

[1] The indicators suggested by the Special Governmental Task Force on Drug Abuse included rates of drug use, crime and unemployment, poor and overcrowded housing, low levels of educational attainment and a lack of social and recreational facilities.

[2] Although unpublished, the report of the Special Governmental Task Force on Drug Abuse was later leaked.

programmes during the late 1980s (Butler, 1991; Dillon & O'Brien, 2001). Nevertheless, rates of injecting risk behaviour remained high amongst the Irish injecting drug use population into the late 1990s. A 1990 study reported that 84% of injecting drug users in treatment had shared syringes in their lifetimes (O'Hare & O'Brien, 1992) while, in 1997, another study found that 55% of drug users attending a needle exchange service in Dublin reported lifetime syringe sharing (Cassin et al., 1998). Significantly, research conducted during this period also indicated that young injecting drug users were more likely to engage in 'risky' injecting practices (Cassin et al., 1998), particularly during the year following injecting initiation (Mullen & Barry, 2001). Those who injected more than one substance were identified as particularly susceptible to 'risky' injecting practices (Smyth et al., 2001).

Following a relatively short-lived decline in the incidence of heroin initiation, the early 1990s saw a second upsurge in the number of new opiate users in Dublin, evidenced by a sharp increase in the number of individuals presenting for treatment between 1990 and 1994 (O'Hare & O'Brien, 1993; O'Higgins & O'Brien, 1994, 1995). This 'new' wave of heroin users came from the same marginalised areas as those identified during the opiate epidemic of the 1980s. Reflecting previous epidemiological descriptions, they were mainly young men with low levels of educational attainment and high rates of unemployment (O'Higgins, 1996). Unlike their predecessors, however, they demonstrated a preference for smoking heroin, often referred to as 'chasing the dragon', and there was also evidence to suggest that individuals were initiating heroin use at a younger age (O'Gorman, 1998; O'Higgins, 1996; Smyth et al., 2000). Efforts to explain this preference among young heroin users for 'chasing the dragon' included Smyth et al.'s (2000, p. 1217) suggestion that "the greater acceptability of this route of use may be drawing increased numbers of individuals into heroin use". Routes of administration, however, are also governed by heroin purity and price, which are, in turn, influenced by macro-level political and economic forces (Rhodes et al., 2005).

This second wave of opiate users again raised concerns about blood-borne viral transmission as well as particular concern about the possibility that young heroin 'smokers' would transition to injecting drug use (Smyth et al., 2000). Indeed, by 1999, evidence of a return to 'needle culture' had emerged (O'Brien et al., 2002). Around this time, a number of authors suggested that because young people appeared to have become 'habituated' to heroin use, they were likely to transition to injecting drug use following a period of smoking the drug (Cassin et al., 1998; Dillon, 2001; O'Brien et al., 2002).

Despite the introduction in the late 1980s of harm reduction measures aimed at curbing the spread of HIV, HIV prevalence among injecting drug users has remained high; approximately 15% of attendees at a Dublin needle exchange tested positive in 1994 (Johnson et al., 1994); 17%

of clients attending five methadone maintenance clinics in Dublin tested positive in 1997 (Fitzgerald et al., 2001); and 11% of those attending 21 treatment centres in the greater Dublin area tested positive in 2005 (Grogan et al., 2005). Moreover, the available data revealed a fivefold increase in the numbers of new HIV diagnoses between 1995 and 2001 (Clarke et al., 2001). More recently, it has been estimated that approximately 31% of the total 4082 diagnosed HIV cases in Ireland have been infected through injecting drug use (Long, 2006). The spread of blood-borne viral infection through injecting drug use is strongly associated with structural disadvantage (Long et al., 2006; Clarke et al., 2001), with higher rates of HIV reported amongst injecting drug users living in socially deprived areas (Long et al., 2006). Inner city neighbourhoods traditionally associated with the opiate epidemics of the 1980s and early 1990s have also been identified as those that have the highest rates of HIV transmission (O'Gorman, 1998).

Having been long since reported and identified by social researchers from the early days of the opiate epidemic (Dean et al., 1983, 1985, O'Hare & O'Brien, 1992, 1993; O'Higgins & O'Brien, 1994; Reynolds et al., 2008), official recognition of the link between drug use and socio-economic disadvantage in Ireland finally came in 1996 with the publication of the *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs*[3] (Butler, 1991). It is perhaps noteworthy in this context that in one of the first reports commissioned to investigate opiate use in the early 1980s, the authors had explicitly stated;

> It is difficult not to think that these young people in North Central Dublin are the victims of society. They live in a dirty squalid, architecturally dispiriting area; education seems to provide no mode of escape; unemployment is to be their almost inevitable lot; their parents are quite often separated or else dead; abuse of alcohol is a common problem; crime the societal norm; imprisonment more likely than not; heroin taking is regarded as commonplace by quite young children (Dean et al., 1983, pp. 27-28).

Heroin use continues to be a major public health concern in Ireland. Figures from the National Drug Treatment Reporting System reveal that opiates continue to be reported as the main problem drug among Irish treatment attendees (Carew, 2010; Reynolds et al., 2008). Although a decline was observed in the number of new cases seeking drug treatment between 1996 and 1999 (O'Brien et al, 2002), this trend has recently reversed and there is evidence of a gradual increase in new heroin users since 2002. There was a 22% increase in the numbers of new opiate cases entering drug treatment between 2002 and 2007 (Carew et al., 2009), and a further 10% increase between 2007 and 2008 (Carew, 2010). There was also an increase in the numbers of injecting

[3] This official recognition led to the establishment of Local Drugs Task Forces in the areas identified as being most affected by social deprivation and heroin use.

drug users seeking drug treatment in 2008 and reported rates of injecting risk behaviour among this group are high (Carew, 2010; Reynolds et al., 2008). Furthermore, opiate use has spread to areas outside the greater Dublin area and treatment figures indicate that the numbers of new opiate users in the South, West and centre of Ireland are increasing (Reynolds et al., 2008).

Contemporary profiles of heroin users in Ireland remain quite similar to those uncovered in the early epidemiological studies of the 1980s and 1990s. For example, the demographic characteristics of 404 opiate users entering treatment in 2003 and 2004 were indicative of high levels of social deprivation and exclusion, with participants leaving school at the age of 15 years, on average, and only 16% reporting employment (either part-time or full-time); the vast majority (77%) were dependent on social welfare payments, and a significant number (18%) reported homelessness during the preceding three months (Cox & Comiskey, 2007)[4]. Moreover, in 2006, those new cases entering treatment who reported opiates as their main problem drug were more likely to be unemployed, to report unstable housing conditions, and to have lower levels of educational attainment than those who reported the problematic use of other substances (Reynolds et al., 2008)[5].

The link between problematic heroin use and socio-economic deprivation is now well established in the Irish context[6], as it is in the United Kingdom (Neale, 2002; Parker, 2001; Parker et al., 1998b; Pearson, 1987a, 1987b; Pearson et al., 1986) and the United States (Bourgois, 1995; Bourgois et al., 1997; Dai, 1937; Reinarman & Levine, 1997). While research in Ireland and in other jurisdictions has gone some way towards unravelling the complex association between heroin use and socio-economic disadvantage, what is missing is an understanding of how macro-level structural factors shape micro-level environments, and impact upon the process of initiation into heroin and injecting drug use (O'Gorman, 2000). This is a goal that is ideally achieved through the use of qualitative and ethnographic research methods.

The Contribution of Qualitative and Ethnographic Research

Only a relatively small number of Irish studies have used ethnographic or qualitative research methods to explore drug and indeed alcohol use from the perspective of users of these substances, although the number of such studies has increased over the past ten years in particular. For the most part, these qualitative studies have focused on specific sub-groups of the population thought to be vulnerable to problematic drug use and/or negative health and social outcomes. Researchers have, for example, used qualitative methods to investigate drug use among homeless youth

[4] These figures were obtained from the Research Outcome Study in Ireland (ROSIE).
[5] These figures were obtained from the National Drug Treatment Reporting System (NDTRS).
[6] It is important to note that heroin users from impoverished backgrounds may be more visible to treatment services, the police, and researchers than those from middle class backgrounds. It is possible, therefore, that due to the 'hidden' nature of heroin use among middle class individuals, the prevalence of heroin use in this population has been underestimated.

(Beckett, 2004; Mayock & O'Sullivan, 2007; Mayock & Carr, 2008; Mayock et al., 2008), drug use (and non-use) among young people from deprived inner city communities (Mayock, 2000, 2002, 2003, 2005), women drug users' experiences of motherhood (Woods, 2008), drug use among members of the travelling community (Fountain, 2006; Van Hout & Connor, 2008), and heroin users in Northern Ireland (McElrath, 2001).

By valuing user accounts and experience, these qualitative studies have helped to shed light on a range of contextual influences on drug-related behaviour whilst also allowing users' perspectives on their lives and situations to come to the fore. For example, Fountain's (2006) exploratory study of drug use in the travelling community used a mix of qualitative data collection methods, including the conduct of semi-structured interviews and focus groups with one hundred and thirty-seven travellers and thirty-four agency workers. The findings illustrated how macro-level forces, such as social exclusion and disadvantage, made members of the travelling community vulnerable to problematic drug use and created barriers to drug service access. In a qualitative study with a somewhat different orientation, focusing on homeless rather than drug-using youth, Mayock and O'Sullivan (2007) used biographical interviewing to examine the homeless histories of 40 young people aged between 14 and 23 years. Detailed narrative analysis enabled the authors to examine the drug use of a large number of the study's participants and to identify a complex array of contextual influences, including their homelessness, which exacerbated their drug use behaviour and pushed some towards heroin use. Irish qualitative research has also brought greater understanding of how both macro- and micro-level social forces influence the construction of drug user identities. Wood's (2008) Dublin-based study, for example, used a selection of qualitative research techniques, including in-depth interviewing, semi-structured interviewing, focus groups and participant observation, to explore the life experiences of mothers with a history of drug use. Among other important findings, this study demonstrated that drug-using mothers have an identity described as 'precarious'. In particular, their social interactions with family members, partners and treatment providers, played out within a broader context of gendered expectations, social stigma and inequality, impacted on how the women viewed themselves and their parenting abilities.

Although no study in the Irish context to date has specifically set out to investigate heroin initiation, a number of qualitative studies have provided insight into the social circumstances of initiation as well as an understanding of young people's motives for initial and early heroin experimentation (Cox & Whitaker, 2009; Mayock, 2000, 2002, 2004, 2005; McElrath, 2001; Woods, 2008). McElrath's (2001) study of heroin use in Northern Ireland, for example, revealed that curiosity, opportunity and availability were important components of the initiation rationales of heroin users, and also found that other users of the drug played an important role in their injection initiation by 'teaching' them how to inject. Mayock's (2000, 2002, 2004, 2005)

longitudinal ethnographic study of drug use among young people in an inner city Dublin community also addressed the issue of heroin initiation. This research emphasised the complex social negotiations involved in the drug transitions of young people, which were identified as unfolding in tandem with their changing perceptions of safety and risk (Mayock, 2005). Young people frequently initiated heroin use in outdoor settings, often close to their homes and almost always in their home neighbourhoods. Most initiated in the presence of an older, more experienced heroin user, but were simultaneously immersed in social networks in which the drug was easily accessible. Within these social groups, heroin, a drug previously seen as 'dangerous', gradually gained acceptance. This study drew attention to the role of both macro- and micro-level social contexts in shaping young people's risk perception and behaviour. It also highlighted the complexities of young people's drug journeys, drawing attention to the need to more fully understand the role and interplay of macro-, meso- and micro-level forces in the process of heroin initiation.

Heroin use is not simply an eighties problem, nor is it one that has diminished significantly, much less disappeared. Heroin remains the primary drug of misuse in Ireland (Carew et al., 2009; Reynolds et al., 2008) and in many European countries (EMCDDA, 2008). Yet, the topic of heroin initiation remains under-researched both in Ireland and internationally. There may be many justifications for researching heroin initiation, but the high rates of morbidity and mortality associated with heroin and injecting drug use (Tarabar & Nelson, 2003) itself provide a sound basis for a detailed investigation of heroin initiation among young people.

Study Rationale and Research Aims

As documented, the literature on heroin use in Ireland has been evolving since the first opiate epidemic of the early 1980s. The intervening period has produced a very considerable body of research which has greatly enhanced knowledge and understanding of heroin use. Nonetheless, an almost exclusive reliance on epidemiological data, primarily focused on profiling heroin users and establishing correlates of initiation risk and risk behaviour, has produced a knowledge base with significant gaps (Mayock et al., 2009). First, and perhaps most obviously, the dominance of quantitative research methods within drugs research in Ireland has produced a limited understanding of the lived experience of heroin use and of the complex social dynamics surrounding young people's drug-related attitudes, perceptions and behaviours. Second, despite concentrated research attention to the 'problem' of heroin use, including attention to groups considered particularly vulnerable or 'at risk', heroin initiation remains poorly researched and understood in the Irish context. Moreover, research on heroin use in Ireland has been primarily conducted during 'epidemic' times, and there has been far less research attention to heroin use and users since the numbers seeking treatment for opiate use stabilised in the late 1990s. Consequently, there is a relative dearth of information on 'new' or more recent heroin users,

particularly those who initiated use during Ireland's economic boom[7], the period which also coincided with a levelling off in the numbers of new heroin users seeking treatment. Finally, despite continued evidence of high rates of blood-borne viral infection, the 'risk environment' of injecting drug use among young heroin users remains poorly understood, despite the fact that young injecting drug users in Ireland have been identified as particularly susceptible to unsafe injecting practices (Cassin et al., 1998; Smyth et al., 2001). The international literature also suggests that recent injecting initiates may be at higher risk of blood-borne viral infection due to their lack of technical skill and expertise, or their disadvantaged social position within drug-using networks (Fennema et al., 1997; Garfein et al., 1998; Hahn et al., 2002; Kral et al., 2000; Ochoa et al., 2001; Van Beek et al., 1998). More broadly, the existing literature on drug injection is largely restricted to epidemiological data on the prevalence of sharing and lending injecting equipment, and there is a clear absence of qualitative work investigating the complex dynamics, contexts and relationships that surround 'risky' injecting practices.

The gaps in knowledge highlighted above preclude an accurate assessment and understanding of *how* and *why* youth initiate heroin use and of the *nature* of the risks that they may potentially face as their heroin 'careers' progress. In particular, there is a dearth of knowledge about the 'risk environments', social groups and relational contexts in which contemporary youth initiate smoking and injecting heroin use. Although the health and social consequences of heroin use are widely documented and acknowledged in the Irish context, the processes associated with individuals' initiation into heroin use remain poorly understood. Reliable and detailed information on heroin initiation contexts and practices is also scarce in other jurisdictions, where a majority of studies have similarly focused on profiling heroin users and establishing correlates of initiation and subsequent risk behaviour (Fuller et al., 2001; Gossop et al., 1998; Griffiths et al., 1994; Neaigus et al., 2001; Strang et al., 1992, 1999).

This study set out to address these gaps and sources of epidemiological complexity using an ethno-epidemiological approach that aimed to investigate the 'risk environments' of young heroin users. All recruitment for the study took place in the Dublin metropolitan district. The primary research aims were;

- To examine the social course of heroin initiation among new initiates to the drug;
- To explore the 'risk environments' of young heroin smokers and injecting drug users and;
- To examine young people's risk perceptions and behaviour during the early stages of their heroin and injecting 'careers'.

[7] A period of economic growth between 1995 and 2007, colloquially known as the 'Celtic Tiger' years

Methodology

This research uses an ethno-epidemiological approach, which combines traditional epidemiological data with a qualitative focus on context and meaning, to study heroin initiation among young people. Combining both quantitative and qualitative research methods in its design, the study primarily adopts a qualitative, constructionist, interpretive framework, which privileges life history interviewing and ethnographic observation. Similar ethno-epidemiological research designs have been used in other jurisdictions, including the United States (Clatts et al., 2001, 2002), Canada (Small et al., 2007, 2009) and Australia (Moore, 2009), to investigate the risk behaviour of drug users. Ethno-epidemiology is an approach that is primarily informed by anthropological ethnography and one that seeks to extend and develop qualitative understandings of drug use and related risk behaviour. Four main data collection techniques were employed by the study:

1. The Community Assessment Process: This phase of the research involved a period of engagement, involving informal discussions and the conduct of semi-structured interviews, with professionals responsible for the provision of services, either directly or indirectly, to young heroin users. The primary aim of this period of engagement was to gather information about current heroin use trends and practices, with a specific focus on young people. This phase of the research also served to inform service providers about the study aims, and to gain access to the 'field'.

2. Ethnographic Observation: Ethnographic observation was conducted in a variety of public and semi-public settings where drug users are known to congregate. This period of engagement and immersion within both services and outdoor settings helped to inform the sampling and recruitment procedures. It also facilitated the administration of the interceptor survey (see below) and served to inform the sampling of individuals for participation in life history interviews. The researcher's level of participation and engagement also provided critical insight into heroin-using lifestyles, language, social networks and interactions. Multiple opportunities for contact also enabled the researcher to build and maintain rapport with potential research participants.

3. An Interceptor Survey: A brief quantitative survey was administered to 120 young heroin users aged between 16 and 30 years. This instrument was designed to establish a demographic profile of young heroin users, to provide epidemiological descriptions of their initiation environments, and to record rates of injecting and sexual risk behaviour. Designed to literally 'intercept' the potential population of young heroin users, this instrument also served to guide the recruitment of life history interview participants.

4. Life History Interviews: Forty life history interviews were conducted with young heroin users (17 women and 23 men) aged between 16 and 25 years. Using a methodological approach designed to elicit detailed life history narratives, the interview sought to chronicle the main events and experiences in the young person's life, his/her early drug initiation and use, the context of his/her heroin initiation, his/her current heroin-using practices and his/her accounts of sexual and injecting risk behaviour. The interview schedule was flexible and open-ended, but particular attention was paid to the interplay of context and meaning when seeking to elicit accounts of drug-related experiences and behaviours.

The four research methods above were designed to inform and build upon each other over the course of the fieldwork period. The life history interview, designed to locate heroin initiation within a broader appreciation of young people's social, economic, personal and familial circumstances, was privileged as a primary source of knowledge and interpretation. The interpretation of the life history data is, however, connected and strongly related to the data garnered from the interceptor survey (the epidemiological data) and the insights garnered through a lengthy period of ethnographic engagement and observation.

The Structure of the Thesis

This chapter has introduced this study of heroin initiation among young people and provided an overview of research on heroin use in the Irish context. It has been argued that the predominant epidemiological focus of much research on heroin use in Ireland and internationally has produced a knowledge base with serious gaps. Sources of epidemiological complexity have been identified and it has been argued that these complexities cannot be addressed through a sole reliance on quantitative, survey-based research methods. An ethno-epidemiological approach, combining quantitative and qualitative methods, and privileging the context and meaning of heroin initiation, has been proposed and adopted.

Chapter two of the thesis documents the main theoretical frameworks used to understand heroin initiation and injecting risk behaviour. It argues that individualist approaches have traditionally dominated the field and have paid limited attention to the interplay of context and meaning in understanding drug use behaviour. The contribution of epidemiology to the field is acknowledged, but the need to access and understand user narratives in exploring the complexity and dynamics of risk perception and behaviour is argued. A 'risk environment' framework is then proposed for this study of young people's heroin initiation and risk behaviour.

Chapter three provides a detailed description of the study's methodology. It provides a rationale for using an ethno-epidemiological approach and describes the epistemological and theoretical orientation of the study. The process of 'doing the research' is described in considerable detail with particular attention to the issues of sampling and recruitment, as well as the various problems that arose during the course of the fieldwork phase of the study. Later sections address issues of reflexivity and the ethical considerations that impacted on the conduct of the research.

Chapters four through eight document the study's findings, drawing from the data gleaned from the quantitative interceptor surveys and qualitative life history interviews. Each chapter first presents epidemiological or statistical data on emerging trends and then turns to the young people's narratives to explore the contextual forces, social processes and lived experience of relevant themes.

Chapter four, the first findings chapter, provides a demographic profile of the sample and contextualises the early and recreational drug use of the study's participants. It provides a description of the young people's macro-level social, physical and economic environments, and also details their meso-level environments by providing an account of their family circumstances and experiences of family life. This chapter also documents how micro-level social processes operating within peer social networks impacted on young people's early drug use. The final section of this chapter introduces *young people's pathways into heroin use* which were derived from detailed analysis of their 'stories of initiation'. Three pathways into heroin use are identified: a 'criminal' pathway, an 'intimate relationship' pathway and a 'homeless' pathway. These three pathways provide new insight into the micro-level 'risk environment' of heroin initiation.

Chapters five, six and seven, respectively, document distinctive features of each of the three pathways into heroin 'smoking'. Chapter five provides an account of the social course of heroin initiation for the majority of young men in the sample, who demonstrated a 'criminal career' pathway into heroin use. Chapter six provides an account of the 'intimate relationship' pathway into heroin initiation, described by the majority of young women in the sample, and chapter seven describes the social course of heroin initiation for the remaining males and females, who demonstrated a 'homeless pathway' into heroin use.

Chapter eight moves on to discuss the processes involved in initiation to injecting drug use and describes how social and contextual forces impacted on the young people's injecting risk behaviour in their early injecting careers.

The final chapter begins by reflecting on the methodological approach adopted by the study, highlighting the advantages of using ethnography to explore and explain statistical data obtained from epidemiological research methods. The chapter then moves on to discuss the main findings

of the research. It details the macro-, meso- and micro-levels of the risk environment that shaped the processes of heroin and injecting initiation, and risk perception and behaviour in the early heroin career. This chapter concludes by discussing the implications of the research findings for the development of future drug policy and intervention initiatives.

Chapter Two
Theoretical Approaches to Understanding Heroin Use, Initiation and Risk Behaviour

Introduction

This chapter outlines the main theoretical frameworks used in understandings of heroin use, initiation and drug-related risk behaviour. These theoretical approaches are organised and discussed in accordance with their development over time. The perspectives outlined in this chapter range from individualism to structural determination. Contemporary accounts of heroin use explore interactions between individuals and their environments, arguing that social structural forces, social processes and individuals all contribute towards the production of drug-related risk (Rhodes, 2002; Rhodes et al., 2005). This chapter explores how theoretical developments over time have contributed to, and enabled, the balance between structure and agency to be negotiated by modern drug researchers.

First, the chapter documents the early rise and dominance of the theoretical framework of medical individualism. From such a perspective, pathological causes of heroin-using behaviours were sought within the individual, and drug users were seen as victims of psychiatric or psychological morbidity which manifested in 'addictive' behaviour (Lindesmith, 1940). The chapter then proceeds with describing the first comprehensive challenge to the medical model, the sociology of deviance, which drew on theories of symbolic interactionism to explore the social process involved in marijuana initiation and early use (Becker, 1953, 1963). From this work, career models of heroin initiation and use soon developed (Fiddle, 1967; Gould et al., 1974; Stephens, 1991). The contribution of the early ethnographies adopting this framework is discussed. These studies sought to situate heroin use within its environmental context and, in doing so, increased understandings of the lifestyles of heroin users and the subjective meanings that drug use held for them (Preble & Casey, 1969).

By the 1980s, the new public health and harm reduction movements had dramatically altered the landscape of drug use research. Large-scale epidemiological studies were developed to explore the incidence and prevalence of drug use, injecting drug use and to monitor the spread of blood-borne viral infections such as HIV (Berridge & Strong, 1993; Patton, 1990). In addition, risk factor research developed, seeking individual, social and environmental correlates of drug use through quantitative statistical methods (Gorsuch & Butler, 1976; Lloyd, 1998). This chapter both values and critiques these approaches, recognising that epidemiological quantitative research methods rapidly increased information on the spread of heroin use and injecting risk behaviour, but simultaneously suggesting that these approaches neglected the importance of user

narratives and environmental contexts in understandings of heroin initiation and use. Moving away from individualistic perspectives, this chapter then turns to a theoretical approach which recognises the social organisation of risk and risk behaviour (Rhodes, 1997). The 'risk environment' framework is then described with respect to the macro and micro-level environmental forces which impact upon drug-related risk behaviours (Rhodes, 2002). Theories which address the political economy of drug use are then explored with reference to interactions between the individual, immediate social and physical context of drug use and broader social structures (Bourgois, 1995; Maher, 1997).

In concluding this chapter, tensions between structure and agency within the drug use literature are discussed. Modern theories of drug use, including the 'risk environment' framework, draw from concepts within sociological theory which account for how micro-level social interactions and broader political and economic forces become embodied by individuals and acted out through behaviour (Fitzgerald, 2009). Applying these understandings to the drug literature has facilitated accounts of how power imbalances created by social, political, racial and gender inequality foster vulnerability to hard drug use and risk behaviour (Bourgois et al., 2004). Developments gleaned from these theoretical and research endeavours provide the basis for a framework suitable for understanding heroin and injecting initiation.

The Medical Model of Drug Use 'Disorders'

Since its emergence in Western Industrialised societies, illicit opiate use has been subject to 'ownership' by the medical profession (Moore, 1990). Following the Harrison Act of 1914[1], when opiates first became regulated in the United States, early drug policies prioritised either punitive action or medical treatment interventions (Waterston, 1993), and primary responsibility for identifying the causes, treatment and prevention of illicit opiate use was allocated to medical professionals (Parran, 1938). This led to the dominance of a medical approach in understandings of heroin initiation and use. Accordingly, heroin use has been conceptualised as an illness and its causes, biological or psychological 'abnormalities', are thought to lie within the affected individual (Lindesmith, 1940). The heroin user, considered to be suffering from a psychiatric illness, is thought to need protection from, and treatment for, the negative consequences of his or her 'pathological' behaviour (Parran, 1938).

Throughout the 1930s and 1940s, the medical model of drug use remained relatively unchallenged, and underlying psychiatric disorders or psychological disturbances were accepted by many theorists and researchers to directly cause heroin use (Kolb, 1928; Rado, 1933). Using the drug was interpreted as a way of managing the distress and inner conflict resulting from the

[1] Prior to 1914, opiates were widely available in over-the-counter medicines such as laudanum and 'black drop'. The Harrison Act placed opiates under strict federal control (Musto, 1991).

mental disturbances that medical professionals had observed. The widespread acceptance of such a theoretical perspective was echoed in the words of the American historian and sociologist, Harry Barnes;

> It is now definitely demonstrated that the most serious cases of drug addiction are the result of neurotic conditions, namely mental and nervous disorders growing out of deep-seated mental conflicts in the individual. The narcotic drug produces a sense of euphoria or well-being which temporarily removes the sufferer from his mental conflicts and fears (Barnes, 1939, cited in Lindesmith, 1940, p.914).

Research demonstrating that 'neurotic conditions' underlined problematic drug use was predominantly carried out by medical professionals within psychiatric treatment facilities (Kolb, 1928; Kolb & Ossenfort, 1938). Social disapproval and strict punitive action imposed on opiate users during this time period ensured that knowledge of, and access to, opiate users outside of these settings was highly limited (Courtwright, 1983; Kolb, 1939). Research conducted by medical professionals within treatment settings was dominated by a positivist epistemology which sought the psychiatric determinants of heroin use (Feldman, 1968). These studies continued to dominate heroin use research throughout the 1950s and 1960s (Chein et al., 1964; Zimmering et al., 1951, 1952). A particularly noteworthy example of this was the widely cited work of Chein and others. Based on their study of 100 institutionalised adolescent heroin users, the authors concluded as follows;

> The evidence indicates that all addicts suffer from deep-rooted personality disorders. Although psychiatric diagnoses are apt to vary, a particular set of symptoms seems to be common to most juvenile addicts. They are not able to enter prolonged, close, friendly relations with either peers or adults; they have difficulties in assuming a masculine role; they are frequently overcome by a sense of futility, expectation of failure, and general depression; they are easily frustrated and made anxious; and they find both frustration and anxiety intolerable. To such an individual, heroin is function; it offers relief from strain, and it makes it easy for them to deny and to avoid facing their deep-seated personal problems. Contrary to common belief, the drug does not contribute rich positive pleasures; it merely offers relief from misery (Chein et al., 1964, p. 14).

Such an approach to understanding heroin use and its users has continued to prevail over the last century. For example, these assertions were reiterated by the "self-medication hypothesis" developed in the 1980s[2] (Khantzian, 1985). Similarly to Chein (1964), Khantzian argued that individuals are predisposed towards addiction because of the painful affective states resulting

[2] The 'self-medication hypothesis' has driven a considerable body of literature, and numerous authors have elaborated on the theory, arguing that drug use is an adaptation to the negative affective states resulting from schizophrenia (Dixon et al., 1990), depression (Weiss et al. 1992), and sexual abuse (Freeman et al., 2002).

from psychiatric disorders. Current research now seeks increasingly complex causes of heroin use within the individual, including genetic predisposition, personality disorders or multifaceted emotional disturbances (Comings et al., 1997; Khantzian, 1985; Saxon et al., 2005; Zhang et al., 2008). This approach may be useful for medics whose specific career objective is to diagnose and treat illnesses in the individual; but an overemphasis on individualistic approaches has thwarted social and environmental understandings of heroin initiation and use.

Symbolic Interactionism and the Deviant Career

Despite the dominance of the individualistic approach in the early illicit drug use research, the medical model did not go unchallenged and other theoretical perspectives began to emerge. Researchers from the Chicago School of Sociology in the 1930s, for example, recognised that studying the individual in isolation could not provide a full account of opiate use and, instead, sought to investigate the social environment in which it occurred (Dai, 1937). Their findings revealed that opiate initiation usually occurred in a social context, and that most of their participants reported being introduced to the drug by a significant other. Highlighting the importance of social processes in the spread of heroin use, their research was the first major work to refute claims that opiate initiation could be attributed solely to causes lying *within* the individual. The authors claimed that in order to understand opiate use more fully, it was essential that future research explore the social processes contributing to its spread;

> If two-thirds of these addicts attributed their addiction to the influence of other addicts, in order to have an adequate understanding of the aetiology of the drug habit, it is clear that we must have a thoroughgoing exploration of the social situations in which the influence of drug addiction is said to be contagious (Dai, 1937, p. 188).

The findings of the Chicago School paved the way for future research to develop frameworks which accounted for the social dynamics of drug initiation environments. Through the work of Howard Becker (1963), a comprehensive theory emerged. In his book *'Outsiders'*, Becker challenged the dominant theoretical view at that time, that factors within the individual created a predisposition to behaviours such as drug use, which were considered 'deviant'. Alternatively, he argued that 'deviance' is a socially constructed phenomenon (Berger & Luckmann, 1967), created by society through the formulation and enforcement of rules and the labelling of those who break them (Lemert, 1951, 1967). Drug use, therefore, cannot be considered in isolation from social forces because there is nothing inherently deviant or pathological about such behaviour. Instead, it was considered as part of a social process involving the responses of others to the individual's behaviour (Becker, 1963).

This argument called for an entirely different approach. Allocating individual characteristics as the sole cause of such behaviour was not considered sufficient in explaining the process of becoming and being labelled a 'drug addict' (Lemert, 1967; 1974). Alternatively, the focus shifted to understanding the role of social forces and processes in the emergence of drug-using behaviour. Strongly influenced by the principles of symbolic interactionism and its emphasis on the construction of 'self' through social interactions with others (Goffman, 1956; Mead, 1934), Becker outlined the social processes involved in developing a drug-using identity and adopting a 'deviant' lifestyle (Becker, 1963).

Using a qualitative methodology, Becker investigated the process of *'Becoming a Marihuana User'* during the 1950s (Becker, 1953, 1963). Adopting a career model to describe the sequence of changes in an individual's attitude and behaviour, he highlighted the importance of social interactions with other drug users. The first step in the drug-using career was considered to be initiation, which occurred when the individual arrived at a point at which the drug was available and he or she was willing to try it. In order to learn how to use marijuana for pleasure, the individual had to learn how to smoke the drug in a way that would produce effects, learn how to recognise the effects associated with the drug and learn how to enjoy the effects perceived. Social interactions with other users were deemed vital in this process. More experienced marijuana users demonstrated or explained the correct method of administration, spoke about the sensations involved in 'getting high' and eased the novice user's fears when experiencing the effects. If or when the individual came to perceive the effects as pleasurable, the advantages of marijuana use became apparent, thus facilitating and motivating further use. Through interactions with other users and non-users, the individual became labelled and identified as a marijuana user and became increasingly immersed in the marijuana-using subculture.

Highlighting the individuals' interactions with others in the development and adoption of drug-using motives and interests provided an alternative avenue of exploration for drug use research, and Becker's work provided a comprehensive framework to challenge the dominant individualistic theories of initiation into illicit drug use (Kandel, 1980; Moore, 1990). Becker summarised this approach as follows;

> The presence of a given kind of behaviour [such as marijuana use] is the result of a sequence of social experiences during which the person acquires a conception of the meaning of the behaviour, and perceptions and judgements of objects and situations, all of which make the activity possible and desirable. Thus, the motivation or disposition to engage in the activity is built up in the course of learning to engage in it and does not antedate this learning process. For such a view, it is not necessary to identify those 'traits' which 'cause' the behaviour. Instead, the problem becomes one of describing the set of changes in the person's conception of the activity and of the experience it provides for him (Becker, 1953, p. 235).

Questioning assumptions that drug use was an inherently deviant activity motivated by traits within the individual (Lemert, 1951) facilitated the move towards exploring subjective meanings and constructions of drug-using behaviours (Becker, 1953). These elements paved the way for future drug research and can still be seen to influence contemporary theories and research which seeks to situate heroin use within the social and political environment, and explore the social processes involved in drug use and initiation (Feldman & Aldrich, 1990).

With respect to contemporary drug research in general, and the normalisation hypothesis in particular (Measham et al., 1994; Parker, 2002, Parker et al., 1998a), Becker's work may appear dated. Cannabis use has become a prevalent part of youth culture and young people's identities (Hammersley et al., 2001) and is no longer conceptualised as a 'deviant' activity by many researchers. However, changing social perspectives on behaviours such as illicit drug use only serve to illustrate the social construction of what is deemed inappropriate or 'abnormal'. Becker's work emerged in a social and historical context in which cannabis use was considered a 'deviant' activity caused by individual pathology (Becker, 1963). The causes of heroin use continue to be sought within the individual by much of the current drug research (Moore, 1990) and thereby, the framework posed by Becker in the 1950s regarding cannabis initiation is highly relevant to modern approaches to heroin initiation.

Social Processes and the Heroin Career

During the 1960s, 1970s and 1980s, a number of researchers applied the career model, as outlined by Becker, to studies of heroin use and initiation (Faupel, 1987, 1991; Fiddle, 1967; Gould et al., 1974; Stephens, 1991; Waldorf, 1973). A similar sequence of events was reported to occur in the process of becoming a heroin user. Gould and others (1974) described how heroin initiates first had to learn how to use the drug, learn how to perceive its effects and learn how to enjoy the sensations. Again, the authors noted how the social interactions between the initiate and significant others were crucial to this process. For example, the administration of heroin, which requires considerable skill, could only be mastered through the observation or guidance of other users. New initiates also had to learn how to experience and enjoy the effects of the drug. The effects of heroin were not necessarily described as solely enjoyable by novice users. In fact, at initiation, the vast majority of participants experienced nausea and vomiting and had to be reassured by other users that this was a normal reaction and would pass. Similarly to novice marijuana users, therefore, new heroin initiates had to learn how to experience the pleasurable effects of heroin by overcoming their fears and learning to enjoy the sensations that they perceived through the guidance and advice of other users (Becker, 1953; Gould et al., 1974).

Perhaps one of the main limitations of Becker's work on *'Becoming a Marihuana User'* was that the exploration only began with the individual who had reached a point at which he or she was exposed to and willing to try marijuana[3]. Although suggesting that an individual had to begin participating in a social group with access to the drug and values conducive to marijuana use, an explanation of how and why some individuals became exposed or immersed in such a group was omitted. Currently, marijuana use is prevalent among youth populations and exposure to the drug is common (Parker, 2002), but this was not the case in 1950s America. Similarly, heroin use in modern societies has relatively low prevalence rates in the general population (Kraus et al., 2003) and many youth may never be offered the drug (Strang & McCambridge, 2005). Exploring the social processes preceding initiation can increase understandings of how and why some youth embark upon a heroin-using career.

Later heroin researchers, who adopted the career model, sought to explore the processes preceding heroin initiation in order to address the question of how and why some individuals became exposed to heroin (Faupel, 1991; Feldman, 1968; Fiddle, 1967; Hendler & Stephens, 1977; Stephens & McBride, 1976; Waldorf, 1973). Rosenbaum, for example, in one of few studies investigating female heroin users, explored the early life histories of her participants in order to gain greater insight into the processes of initiation (Rosenbaum, 1981b). Her findings demonstrated that prior to using heroin, the women had been immersed in three main 'deviant' subcultures; the 'hippie trip', the 'outlaw world' and the 'fast life'. The 'hippy trip' was a pathway into heroin use that was demonstrated by middle class women who had participated in a social group in which unconventional behaviour and rebellion against societal norms were highly valued. The 'outlaw world' was characteristic of female gang members who valued toughness, violence and partying, and the 'fast life' was the pathway demonstrated by sex workers who sought opulence, consumption and excitement. The social relationships and interactions resulting from the women's immersion into these subcultures facilitated and encouraged their participation in drug use, paving the way to their heroin initiation (Rosenbaum, 1981a).

Similarly to Rosenbaum's findings, a number of qualitative studies investigating the heroin-using career demonstrated that heroin users had been immersed in 'deviant' subcultures, such as street gangs, criminal or recreational drug-using networks, prior to their heroin initiation (Faupel, 1991; Feldman, 1968; Fiddle, 1967; Hendler & Stephens, 1977; Stephens & McBride, 1976; Waldorf, 1973). Through participation in these subcultures, individuals became exposed to heroin or heroin users which served to raise the individuals' curiosity about the effects of the drug and provide opportunities to initiate. Within their social networks, using heroin was seen as a way of gaining status or becoming part of a more prestigious social group (Hendler & Stephens, 1977;

[3] Becker himself recognised this limitation in 'Becoming a Marihuana User' when he stated "This paper covers only a portion of the natural history of an individual's use of marihuana, starting with the person having arrived at the point of willingness to try marihuana" (Becker, 1959 p.236)

Stephens & McBride, 1976). The role of older, more experienced users was shown to play a significant role in heroin initiation. Young people were almost invariably introduced to the drug by an older male heroin user who instructed them on administration techniques, and provided them with the information necessary to adopt a heroin-using lifestyle (Fiddle, 1967). The process of heroin initiation was thereby seen to be the result of social interactions between the novice and others. Within their own peer group, values congruent to the lifestyle were adopted, and older, more experienced users introduced new users to the drug and facilitated its use (Gibbons et al., 1981; Rosenbaum, 1981a; Stephens, 1991; Stephens & McBride, 1976).

The career model theorists helped to develop an understanding of heroin initiation. They drew attention towards the important role of others in the adoption of values and beliefs that were conducive to the first step in the heroin-using career, and highlighted the necessity of having more experienced users introduce the drug and demonstrate its usage (Waldorf, 1973). In doing so, they moved away from perspectives that examined the individual in isolation, and provided a more comprehensive and detailed account of the social processes leading to heroin initiation. By focusing predominantly on micro-level aspects of this drug transition, however, these readings tended to isolate subcultures of heroin users from the broader social context, thus failing to situate heroin use in its social, economic and political environment (Anderson, 1994). Doing so limited knowledge and understanding of how macro-level social, political and economic forces impinge upon the lives of drug users, and neglect to account for why such lifestyles are adopted by particular sub-groups of the population (Agar & Reisinger, 2002).

Situating Heroin Use in the Environment

As described above, the career model of drug use focused in on the micro-level social interactions between individuals within 'deviant' subcultures and tended to neglect the role of broader social forces (Anderson, 1994; Stephens, 1991). Recognition of the association between social structural factors and opiate use had been made many years previously by investigators from the Chicago School of Sociology. They had revealed that demographic areas with the highest prevalence of illicit opiate use were those characterised by physical deterioration, low economic status, poor educational attainment and unstable housing arrangements (Dai, 1937). The authors argued for a situational approach to understanding opiate use;

> Such a knowledge of the spatial distribution of drug addicts in the city is considered an essential, though preliminary, step in exploring what may be called the addicts' social and cultural environment, in light of which only can we expect to understand drug addiction (Dai, 1937, p. 13).

Despite this early recognition and research impetus, the role of the broader social and economic environment in the spread of opiate use was neglected in the early literature. Feldman (1968)

proposed two main reasons for the dominance of individualistic models in drug use research. He argued that researchers attached to large drug treatment facilities and those educated within a positivist framework tended to neglect social and contextual information;

> The failure to explore how features in the slum neighbourhood may contribute to the spread of drug use developed from two major research difficulties: (1) the investigators, for the most part, were attached to large institutions specialising in the treatment of addicts; or (2) they were educated to seek causal explanations in the pathology of individuals, a kind of trained incapacity that disallowed creative use of social information about life styles in the slums (Feldman, 1968, p. 131).

The landscape of drug research described by Feldman gradually changed throughout the 1960s and 1970s, as many researchers increasingly recognised the need to place heroin use within its social and economic context. More detailed investigations into the relationship between heroin use and the social environment ensued (Feldman, 1968; Finestone, 1957; Preble & Casey, 1969; Sutter, 1966; 1972). Adopting qualitative or ethnographic methodologies, these studies sought to understand drug-using subcultures in the social and economic environment within which they were embedded. These studies recognised the importance of user narratives in understanding how heroin users perceive and interpret their own drug use and the world around them, and examined the interacting social and economic forces that impacted upon their lives. The ethnographers purported that heroin use was not an isolated behaviour caused by individual pathology nor one that could be explained solely by social interactions with other 'deviants' but, rather, was part of a lifestyle adopted in response to harsh economic and social circumstances (Agar & Reisinger, 2002; Preble & Casey, 1969).

Earlier theorists had explored the link between social structures and 'delinquent' behaviour more generally. Robert Merton (1938), for example, developed Structural Strain Theory in an attempt to explain the association. This theory was based on the premise that Western societies place strong emphasis on the goals of acquiring wealth, success and status, yet social structures restrict access for certain groups within the population. Merton proposed that a state of 'structural strain' or 'anomie' then occurred which could lead to the individual turning to illegitimate means to acquire them, or rejecting the values of society altogether (Merton, 1938). Drawing from this perspective, 'escapist' or 'retreatist' theories posited that the drug user retreated from society due to the 'structural strain' resulting from his or her limited access to the goals of wealth and status. Cloward and Ohlin (1960) cast drug users as 'double failures' because they had failed in both legitimate and illegitimate attempts to acquire status and success. Drug users were seen as resorting to drug use as a means of escaping from the sense of hopelessness that resulted from the deprived social and economic conditions of their lives (Cloward, 1959; Cloward & Ohlin, 1960).

Moving away from these restricted representations of drug users as passive or deficient 'double failures', ethnographic studies provided an alternative view of the heroin user. In the words of Joanne Neale;

> These [ethnographic studies] portrayed street addicts as innovative, self-determining individuals who carved out an active and fulfilling role for themselves and others in an otherwise hostile world (Neale, 2002, p. 35).

In one such ethnography, Preble and Casey (1969) provided a rich description of the lifestyle of heroin users, contextualising their experiences and activities within the harsh social and economic conditions of slum neighbourhoods. They argued that rather than being an "escape from life", heroin use gave meaning to life on the street by motivating the individual to "accomplish a series of challenging, exciting tasks every day of the week" (Preble & Casey, 1969, p. 3). Moving away from depictions of the heroin user as a hapless victim of powerful structural forces, they stressed the adaptive and resourceful nature of the heroin-using lifestyle.

Ethnographic drug researchers sought to contextualise their data within the social and physical environment, and this enabled them to develop understandings of how structural forces impinge upon heroin use and related behaviours. For example, Finestone, in his study of young male African American drug users from the most deprived areas of Chicago, noted that his participants spoke with pride about their lifestyle and resolutely rejected conventional attitudes and norms. Demonstrating disdain for structurally imposed subordination, these young men created a new way of life, adopting creative variations of begging and stealing in order to survive without official employment and avoid menial jobs that required them to accede to authority figures. Heroin use was an act that was seen as the 'ultimate kick' by the participants in this study. Being a highly stigmatised activity, according to the middle-class social norms that they abhorred, it provided an intense experience whereby they felt distinctly removed from conventional life (Finestone, 1957). Linking the broader social and economic context to these strategies and behaviours, Finestone described the emergence of the African American heroin user, or 'stand-up cat'[4], as follows;

> The cat as a social type is viewed as a manifestation of a process of social change in which a new type of self-conception has been emerging among the adolescents of the lower socio-economic levels of the coloured population in large urban centres...the personal counterpart of an expressive social movement. The context for such a movement must include the broader community, which, by its policies of social segregation and discrimination, has withheld from individuals of the coloured

[4] The 'stand-up cat' was a term used by the young African American men in Finestone's study to refer to the ideal masculine social type in their neighbourhoods. The 'stand-up cat' personifies strength, daring and 'ultimate toughness', and is committed to what he believes is the 'code of the street' (Feldman, 1968).

> population the opportunity to achieve or to identify with status positions in the larger society (Finestone, 1957, p. 6).

Finestone emphasised the role of social structural forces, particularly those of inequality and marginalisation, in fostering attitudes and identities conducive to heroin use. Other authors reiterated this perspective, contextualising social ideologies of drug-using subcultures within deprived social environments. Feldman (1968), for example, described male youth subcultures in lower socio-economic environments as prioritising status and prestige through "toughness, strength and daring". This was considered an act of rebellion or "challenging the bleak fate of being poor" (Feldman, 1968, p. 132). The 'stand-up cat' was the epitome of these qualities, an ideal male role model whom younger adolescent youth were eager to emulate. Heroin distribution and use was often the activity of the 'stand-up cat' and young recruits rushed to experiment with the drug to prove their worth. It was this 'anticipatory excitement' that Feldman believed explained the rapid transmission of heroin use across socially deprived communities (Feldman, 1968).

The ethnographies discussed above sought to situate heroin use within its social context. Emphasising the importance of social structural forces in the spread of heroin use, they avoided 'escapist' theories and depictions of the heroin user as a passive victim (Preble & Casey, 1969). Alternatively, heroin use was seen as resulting from attitudes and ideologies that developed as a form of resistance to the inequality and oppression faced by slum youth (Sutter, 1972). These ethnographies, therefore, made an important contribution by offering explanations of how social and economic factors influenced the more immediate social processes involved in the spread of heroin use. However, for the most part, they were limited to specific drug-using populations and contexts. For example, Finestone's description of 'stand-up cats' served to contextualise the heroin use of young African American males within the slum neighbourhoods of Chicago, and could not account for the activities of those from different ethnic groups, of a different gender, or those occupying different physical environments[5]. The aim of these ethnographic studies, to contextualise heroin use within the environment in which it occurs, facilitated understanding of the social forces and process impacting upon the particular sub-group under study, but the applicability of their findings to other social contexts and populations was limited (Agar, 1986). Nevertheless, the role of social and economic forces in shaping sub-group ideologies, and the importance of these attitudes and values in the individual's use of heroin, had been recognised (Feldman, 1968; Finestone, 1957; Sutter, 1966; 1972). Contextualising heroin use within the social and physical environment is crucial if heroin use and its spread across specific communities are to be understood. The principles emerging from the early heroin ethnographies

[5] This is not to suggest that ethnographic studies must capture the experiences of people from all social backgrounds, ethnic groups, gender or sexual orientation. Such an approach would not be feasible and, in the case of Finestone's (1957) study, would not be in line with the research aims.

have carried forward to contemporary drug research and have greatly influenced current theoretical developments in the field (Feldman & Aldrich, 1990).

The New Public Health Model

The new public health movement and the HIV crisis of the 1980s instigated a new body of research into heroin use (Rhodes, 2002). This new movement shifted mainstream understandings of health and illness from individualistic models towards social and environmental influences, and placed an impetus on collective action in improving individuals' health and well-being (Ashton & Seymour, 1988; Diex-Rouz, 1998; Susser & Susser, 1996a; 1996b; World Health Organisation, 1986). HIV was rapidly spreading across injecting drug-using populations in Western countries during the 1980s, and heroin use and its associated behaviours were consequently placed high on research and policy agendas. Large-scale epidemiological studies establishing the prevalence of injecting drug use, as well as the rates of injecting risk behaviours and HIV across drug-using populations were conducted (Berridge & Strong, 1993; Patton, 1990).

During the early 1980s, heroin use made its first significant appearance in the UK and Ireland, spread rapidly across communities and was firmly placed on the research agenda (Butler, 1991; Pearson, 1991). Prior to this, there had been reports of small numbers of heroin users in London city, but these were primarily associated with hippy or bohemian subcultures, and heroin outbreaks were rare (Stimson & Oppenheimer, 1982). Previously considered 'the American disease' (Musto, 1987), heroin use rapidly spread across many British and Irish urban communities, giving rise to the first heroin 'epidemics' of the 1980s (Dean et al., 1983, 1985; Parker et al., 1988, 1998b; Pearson, 1991, Pearson & Gilman, 1994). The rapid spread, and the dearth of knowledge on heroin use, injecting drug use and HIV-related risk behaviours instigated research endeavours seeking to explain and explore the nature of the 'epidemics' (Weeks, 1989). Epidemiology, with its positivist approach, was a favoured methodology, not just because it was so closely associated with the new public health movement of the 1980s, but because it provided 'hard' data on the prevalence and incidence of heroin use.

A number of community-based epidemiological studies reported that rates of heroin or injecting drug use were rising in England (Hartnoll et al., 1985; Parker & Gay, 1987; Parker et al., 1986, 1987, 1988), Scotland (Frischer et al., 1991; Haw, 1985) and Ireland during the 1980s (Dean et al., 1983, 1985). Aligned with the new public health movement, many of these studies sought to explore the social and environmental factors associated with the epidemics by providing socio-demographic profiles of the new heroin users. Parker and others, for example, in their study of a heroin outbreak in Wirral, Merseyside, reported a dramatic rise in the number of heroin users from almost no users in the early 1980s to over 4,000 six years later. These heroin users were young (mainly between 18 and 25 years), predominantly male and came from deprived urban

environments (Parker et al., 1988). Similar studies in the north of England and Ireland also reported that heroin users were poor, undereducated, unemployed, marginalised young men (Pearson, 1987a, 1987b; Dean et al., 1983, 1985). Heroin use was not spreading uniformly across geographical areas but was highly concentrated in socially deprived urban communities (Pearson & Gilman, 2005). Overall, epidemiological studies mapping the spread of the heroin outbreaks throughout the 1980s and early 1990s provided 'hard' evidence that heroin use in the UK and Ireland was predominantly occurring within environments of socio-economic deprivation, a finding that heavily influenced theoretical and research models in the coming years.

Adopting an approach that recognised the importance of social and economic factors, and based on the findings of epidemiological research methods, British researchers and theorists put forward a new model of heroin use (Parker, 2001; Parker et al., 1986, 1987, 1998b; Pearson & Gilman, 1994; Pearson et al., 1986; Peck & Plant, 1986). The model highlighted the role of social structures in the shaping of heroin epidemics, and availed of modern epidemiological methods of data collection and analysis. The 'hard' evidence supporting a structural model of heroin use, and the 'urban clustering' effect observed in many parts of the UK (Pearson & Gilman, 2005) called for new theoretical perspectives. Differing from previous structural models which adopted an 'escapist' or 'retreatist' approach to understanding heroin use, these British theorists avoided judgements of heroin users as passive victims or 'double failures' (Cloward, 1959; Cloward & Ohlin, 1960; Neale, 2002), maintaining an objective evidence-based approach rooted in findings from a combination of qualitative and quantitative research methods. This evidence pointed towards indicators of social and economic marginalisation such as poor education and high levels of unemployment, as shaping the spread of heroin use at a macro level, and impacting upon the micro-level processes involved in heroin initiation.

Pearson and Parker emphasised the link between heroin use and indicators of social disadvantage, such as poor housing and infrastructure, high levels of crime, and mass unemployment, and highlighted the vulnerability of socially excluded or 'marginalised' adolescents such as those in state care, the homeless and early school leavers (Parker et al., 1998b; Pearson & Gilman, 1994). Structural forces were seen as inextricably linked to heroin initiation, with compounding elements of social disadvantage interacting to create individual and community vulnerability. This perspective on heroin use acknowledged the complexity of the interactions between social structural forces at an individual and community level, detailing how specific aspects of disadvantage could impact upon heroin initiation and use. For example, Pearson offered an explanation as to why rising rates of heroin use were statistically associated with high unemployment (Peck & Plant, 1986). He argued that the heroin-using lifestyle offered a solution to the devastating consequences that unemployment had on the individual's routine and time

structures, and that an absence of a 'work identity' created a psychological burden that could be alleviated by adopting an active and sociable alternative (Pearson, 1987a, 1987b, 1992).

Poor quality local authority housing was also considered an important factor in the spread of heroin use within this framework (Pearson & Gilman, 2005). By concentrating social deprivation in specific areas and cultivating increasing social problems, poor housing policies created 'embattled neighbourhoods' conducive for heroin epidemics;

> Where a so-called problem estate begins to attract a reputation for various kinds of notoriety, only those with the most urgent housing need will be prepared to accept a tenancy. These will include those who are homeless or near-homeless, single parent households and women escaping from domestic violence, together with other groups with limited options in the housing market such as the elderly poor. One characteristic which problem drug users share with these other groups is that they, too, will often be marginal to the housing market. These social and economic forces conspire to gather together in these already embattled neighbourhoods a variety of otherwise unrelated social and personal difficulties (Pearson & Gilman, 2005, pp. 111-112).

With heroin users concentrated in marginalised and poor quality housing tenements, heroin availability could be seen to increase and local youth were thereby more likely to come in contact with the drug and its users (Pearson & Gilman, 2005). The process of micro-diffusion (Parker et al., 1998b), or the spread of heroin use from one individual to the next through personal contact, ensured that a high concentration of heroin users in deprived locales compounded transmission, leading to epidemic numbers of new initiates.

Parker (2001) linked social deprivation and exclusion factors to the heroin epidemics through manifestations in family life which were related to poverty and created vulnerability to heroin use. In a small qualitative study, Parker 'scrutinised the childhoods and family backgrounds of [a] sample of young heroin users to assess the nature and level of underlying exclusion factors' (Parker et al., 2001, p. 103). He documented numerous 'disruptive' incidences in childhood, a high level of contact with social services, parental or sibling problematic substance use and enforced exclusion from school. Parker argued that these factors were indicative of social marginalisation and exclusion, circumstances that placed young people 'at risk' of drug and heroin use during adolescence. Yet, not all participants fitted this socio-economic profile and Parker acknowledged the complexities of drawing causal links between exclusion and heroin initiation;

> A reasonable conclusion is that while the risk criteria of social exclusion are important they are not definitive. The childhoods and family life of our subjects are best seen as towards the 'at risk' end on a series of dimensions but also embracing those with tolerable, unremarkable backgrounds we

> find among a significant minority of contemporary youth. This suggests that in these English regions with new outbreaks, susceptibility to heroin trying must be viewed as embracing a slightly wider population than the classically socially excluded (Parker, 2001, p. 108).

Parker and Pearson, therefore, advanced a structural model of heroin use by exploring the associations between social deprivation, marginalisation and the diffusion of heroin use across society. Recognising the complexities of these associations, they did not attribute causality to specific exclusion factors and avoided overly simplistic notions of the relationship between structural forces and heroin initiation. Their objective evidence-based approach brought the role of structural forces into mainstream theories surrounding heroin use and promoted harm reduction approaches aimed at community, rather than individual levels. However, this model of heroin use failed to elaborate on how macro-environmental forces influenced micro-level social processes, leaving a gap in understandings of how structural inequality impinged upon young heroin users' attitudes, identities, relationships and behaviour.

Risk Factor Research

Since the 1980s, epidemiological and public health models have dominated drug use research (Rhodes et al., 2003). Primarily adopting quantitative methodologies, three main avenues of research into heroin use have emerged from this approach. First, the monitoring of prevalence and incidence rates of heroin and injecting drug use across populations; second, reporting and examining the rates of injecting risk behaviours related to the spread of blood-borne viral infections; and third, a body of research investigating the 'risk factors' associated with 'problematic' drug use. Epidemiological studies monitoring the prevalence of heroin use, injecting drug use, blood-borne viral infections and injecting risk behaviours emerged in direct response to the early heroin and HIV epidemics, and continue to prevail (DesJarlais et al., 1992, 1993). This research is the cornerstone of harm reduction, and aims to ensure that policy interventions, treatment facilities and community drug programmes are up-to-date and adaptive (Drucker et al., 1998). The third main research endeavour, 'risk factor' research, is driven by the 'Prevention is better than cure' adage (Rhodes et al., 2003a). It appears more closely aligned with developing understandings of initiation because it seeks to address the questions of who uses drugs and why they use them, in order to inform and target drug prevention strategies (Daugherty & Leukfeld, 1998; Jones & Bates, 1985; Kandel et al., 1978).

Risk factor research aims to identify the antecedent causes of a disease or behaviour such as drug use (Susser, 1987; 1998) by seeking statistically significant differences between the general population and the relevant sub-group on an array of variables. When differences are found, the variable in question is said to be 'associated' with drug use. Within the literature, numerous variables have been associated with problematic drug use. These can be broadly categorised into

personal risk factors, family characteristics, and social and environmental influences (Gorsuch & Butler, 1976; Lloyd, 1998). Personal risk factors that have been linked with problematic drug use include a variety of psychological variables, such as depression, anxiety and low self-esteem (Hoffmann & Cerbone, 2002; Hofler et al., 1999; Newcomb et al., 1986; Vega et al., 1993). Family characteristics such as divorce, separation, bereavement, substance use, parental monitoring and discipline have also been linked to adolescent drug use (Denton & Kampfe, 1994; Frisher et al., 2007; King & Chassin, 2004; Stoker & Swadi, 1990). Finally, social and environmental factors including association with drug-using peers (Bauman & Ennett, 1996; Lloyd, 1998), socio-economic status, drug availability and levels of education, have all been statistically linked to illicit drug use (Lloyd, 1998; Poulton et al., 2002). Not all of this research is heroin specific. In fact, the risk factor research is extremely varied, and often quite vague, in how it measures and defines 'problematic' or 'illicit' substance use (Lloyd, 1998). The few studies that have focused solely on heroin use have reported that social deprivation, family breakdown, homelessness, unemployment and early initiation into recreational drug use are statistically significant 'risk factors' (Hopfer et al., 2002; March et al., 2005; Neaigus et al., 2001) for initiation. Initiation into injecting heroin use has been linked to homelessness, exposure to injecting social networks, having close interpersonal relationships with injectors, and childhood abuse (Des Jarlais et al., 1992a; Neaigus et al., 2001).

With the aim of identifying factors that are statistically linked to drug use, risk factor research has served to increase understanding of groups in society that may be 'at risk' of developing problematic patterns of substance use[6] (Daugherty & Leukfeld, 1998; Hawkins et al., 1992; Jones & Bates, 1985; Kandel et al., 1978). Yet, isolating specific factors from the complex system of drug, individual and environment has proved problematic, because these variables are not only linked to drug use but are also statistically associated with each other (Frisher et al., 2007; Gorsuch & Butler, 1976). Theorists have noted that 'risk factors' are highly interconnected and propose that substance use results from an interacting 'web of causality' (Lloyd, 1998), a complex combination of biological, psychological, familial and social variables. Therefore, the social and environmental context of drug use must be accounted for if initiation is to be understood. By statistically linking heroin use to factors associated with socio-economic deprivation, social exclusion and compounding adversity (Hopfer et al., 2002; Neaigus et al., 2001), as well as injecting social networks and interpersonal relationships (Des Jarlais et al., 1992a; Neaigus et al., 2006), the literature indicates that there are complex environmental forces at work that impinge upon individuals' drug trajectories. These relationships cannot be understood solely through the use of an approach that aims to isolate them from each other and the broader environment.

[6] Populations that have been identified as being at 'high risk' of problematic drug use include young offenders, early school leavers, homeless youth, those in state care and sex workers (Kral et al., 1997; Lloyd, 1998; Smyth et al., 2000; Teplin et al., 2002).

Epidemiological 'risk factor' research, although rooted in the new public health movement that acknowledges the role of social and environmental forces in health and illness, has, in many cases, reverted to individualistic or medical models of drug use. Studies seeking 'risk factors' associated with heroin use have tended to isolate the user from the environment, seeking explanations for his or her behaviour in co-existing psychiatric disorders, genetic variants or psychological problems (Khantzian, 1985; Kokkevi et al., 1998; Kreek et al., 2004; Lopes et al., 1996). The individual heroin user is seen as deviating from 'normal' functioning by virtue of his or her use, and comparisons are made between him or her and the general population. A similarity and continuity between older theories of deviance and this research is apparent. Both conceptualise the drug user as differing from 'normal' individuals, explore factors to determine differences between them and then attribute drug-using behaviour to the factors that emerge (Becker, 1963). Becker's (1963) critique of deviance theory, therefore, equally applies to individualistic risk factor research.

Despite an overall tendency to gravitate towards individualistic approaches, evidence from risk factor research has revealed statistically significant associations between heroin use and indicators of social deprivation and exclusion (Kozel & Adams, 1986). This has served to provide 'hard' scientific evidence that elements of the social and physical environment are important in understanding heroin use. Identifying risk factors alone, however, cannot account for the nature of these associations, nor can it provide a description of the subjective meaning of heroin use for individuals living in socially deprived neighbourhoods. If satisfactory social and environmental explanations of heroin use are to be developed, the statistical data must be interpreted with reference to the political, economic and cultural forces that shape the researcher and the drug user (Susser, 1998; Waterston, 1993).

The Limitations of Contemporary Epidemiology

Epidemiological models have continued to dominate research on heroin and injecting drug use in Ireland and elsewhere. Primarily by using a quantitative approach, this literature has provided crucial data on changing heroin prevalence and incidence, revealing trends across time and place. Available indicators suggest that although the heroin epidemics had subsided in most European countries by the late 1990s, the numbers of new heroin users continue to rise steadily (EMCDDA, 2008). Heroin is cited as the main problem drug in the majority of treatment cases[7], and treatment demand has increased across Europe (EMCDDA, 2008). Rates of injecting drug use are high, and heroin users are more likely to inject than are users of any other illicit drug (EMCDDA, 2000). The epidemiological data, therefore, indicate that heroin use remains a

[7] Although the majority of treatment cases cite heroin as their main problem drug, there has been a rise in reported polydrug use amongst this population (EMCDDA, 2008).

significant health issue in Europe and other Western countries and must remain on the public health and research agenda (EMCDDA, 2000; Fischer et al., 2002; Hall et al., 1999).

Epidemiological studies have also shown that rates of morbidity and mortality are high among heroin users (Tarabar & Nelson, 2003) and injecting drug users, in particular, are at risk of overdose and blood-borne viral infection (Fischer et al., 2002; Frischer et al., 2002; Van Beek et al., 1998). HIV transmission continues to be a major health concern, and rates of hepatitis C infection amongst injecting drug users have reached epidemic proportions in many countries (Coutinho, 1998; Desenclos, 2003; Pybus et al., 2005; Thomson, 2009). Consequently, epidemiology has sought to identify the behaviours associated with the spread of blood-borne viral infections across injecting drug-using populations. Within this body of literature, monitoring injecting 'risk behaviours', or the behaviours associated with blood-borne viral transmission during the preparation and administration of the drug, has been prioritised. 'Risk factors' associated with injecting risk behaviours are also sought in order to identify high-risk sub-groups within drug-using populations. Once 'risk behaviours' such as the loaning or borrowing of needles or other injecting paraphernalia have been identified within a population, harm reduction strategies then strive to target these individuals and behaviours through education and prevention programmes. This approach has had mixed success. Rates of HIV transmission appear to have subsided in many Western countries, but hepatitis C has continued to spread across injecting drug-using populations despite harm reduction efforts (Garfein et al., 1998; Hickman et al., 2004; Mathei et al., 2002; 2006).

It has been suggested that the dominant theoretical model adopted by epidemiological research and harm reduction strategies has limited our understanding of risk and risk behaviour (Davis & Rhodes, 2004; Davis et al., 2004; Mayock, 2002; Moore, 1990; Rhodes, 1997). With its focus on the individual, this most common perspective draws from cognitive theories of 'planned behaviour' or 'reasoned action' (Ajzen, 1991; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) and conceptualises drug use as a product of individual decision-making processes. Drug users' knowledge, perception and views of risk and risk avoidance are seen as key determinants of their behaviour, and changes at the individual level are seen as crucial in motivating and constraining specific practices. Such a perspective is reflected in research that seeks the individual determinants of HIV risk behaviour (Samuels et al., 1992; Valente & Vlahov, 2001; Vlahov et al., 1990) and neglects the role of factors exogenous to the individual. Epidemiological research on HIV transmission and injecting behaviour demonstrates that it has been almost exclusively moulded by individualistic approaches (Bloor, 1995; Fee & Krieger, 1993; Oppenheimer, 1988) and the interactions between individuals and their social environment have thereby been neglected (Mayock, 2002).

Accounts of drug initiation, as well as injecting risk behaviours, have similarly been dominated by individualistic understandings of behaviour. For example, studies highlighting agency[8] propose that the first use of an illicit drug is mediated by a decision-making process on the part of the individual (Beyth-Marom & Fischhoff, 1999; Boys et al., 1999a; 1999b; 2001). Internal cognitions such as attitudes, expectations and perceptions of illicit drugs are thought to factor in cost-benefit appraisals that then impact upon the individuals' motivation to use (Benthin et al., 1993; Boys et al., 1999a). Individual level differences in the perceived function of illicit drugs are, therefore, seen as crucial in young people's drug decisions and trajectories. For example, substances such as amphetamines or cannabis are perceived by some young people as aiding concentration or relaxation, and these expectations are seen as motivating forces for initiation (Boys et al., 1999b). Although accounting for social-level influences in the decision-making process, such as peer drug use and social pressure (Boys et al., 1999a; 2001; Wright & Pearl, 1995), the individual is the core unit of analysis. These readings of drug initiation tend to neglect the complex interplay between individuals, their micro-social environments and macro-level social and economic forces.

Modern paradigms of health and illness, with their conceptual underpinnings of 'individual rationality' (Petersen, 1997; Rhodes, 1995, 1997), tend to assume that there is a single, shared and objective measure of what constitutes risk behaviour (Douglas, 1992). Behaviours are identified as 'risky' because they carry a probability of resulting in drug-related harm. Risk avoidance or minimisation is considered synonymous with rationality while actions deemed risky are seen as irrational even when based on adequate knowledge regarding potential outcomes (Douglas, 1986). 'Risk behaviours' are thereby defined according to the scientific rationale and statistical parameters of epidemiologists. Yet, perceptions of risk differ across social groups and an epidemiologist's definition of risk does not necessarily translate to the subjective experiences of drug users. Such an approach, therefore, does not take into account how perceptions of 'risk' are socially constructed and organised (Lupton, 1999). By reducing 'risk behaviour' to discrete units of analysis, epidemiology fails to capture the complexities of the social world and neglects how risk is organised, experienced and perceived by the drug users themselves. As expressed by Tim Rhodes, 'epidemiological constructions of risk have a quality that is more imagined than real' (Rhodes 1995, pp.126-127). These constructions produce a rather distorted view of drug users' actions and lifestyles and fail to develop understandings of the lived experience of drug-related risk (Connors, 1992; Duff, 2003; 2007).

Drug research in Ireland is dominated by epidemiological approaches that seek to establish accurate estimates of heroin prevalence and comprehensive profiles of opiate users in treatment (Comiskey, 1998; O'Brien et al., 2002; O'Higgins, 1996; O'Higgins & O'Brien, 1994, 1995).

[8] Agency refers to human action carried out in order to produce a particular result (Oxford English Dictionary, 2008).

Epidemiological studies have consistently identified indicators of social disadvantage, including poor educational attainment and high unemployment as risk factors for heroin use (Dean et al., 1983, 1985, 1987; O'Gorman, 1998; O'Kelly et al., 1988), yet this has not fuelled research into the social worlds and physical environments of Irish heroin users. Social and environmental theories are thereby under-represented in the Irish literature. In relation to drug-related risk behaviours, epidemiological constructions of risk have dominated. The majority of studies in the Irish context have monitored the prevalence of blood-borne viral infections, investigated rates of injecting 'risk behaviours' or sought the individual-level 'risk factors' associated with viral transmission (Allright et al., 2000; Cassin et al., 1998; Dorman et al., 1997; Fitzgerald et al., 2001; Geoghan et al., 1999; Grogan et al., 2005; Long et al., 2001; 2006; Smyth et al., 1998, 2005). Documenting these trends within Irish heroin-using populations has enabled harm reduction strategies to keep abreast of current injecting practices, but the underlying definitions of risk create a 'myopic vision of the social aspects' of risk (Rhodes, 1995, p. 126). Without the contribution of theoretical models and research, which account for the social worlds of heroin users, the Irish literature has neglected the subjective nature and lived experience of risk (Mayock, 2002).

The Social Organisation of Risk

In contrast to depictions of drug users as passive victims of structural and environmental forces, some theorists have identified the active role that individuals play in drug-related decisions (Boys et al., 1999a, 2001; Parker, 2002; Parker et al., 1998a; Wibberley & Price, 2000). Such research values user narratives in understanding how risk is perceived and negotiated, and acknowledges the subjective meanings that drug-using behaviours and outcomes have for individuals (Clegg-Smith et al., 2007). However, theories of agency often neglect the role of social processes and broader environmental forces. Consequently, drug decisions are defined and explored according to the individual's cognitions and attitudes rather than the interactions between individuals and their social, physical and political environment (Moore, 1990).

Understandings of drug initiation have been dominated by 'single rationality' theories of risk behaviour. Based upon the assumption that risk is an objectively existing phenomenon rather than one that is socially constructed and subjective, single rationality theories equate rationality with risk avoidance. By shunning risk avoidance, individuals wilfully participating in risk behaviours such as heroin initiation are seen as engaging in faulty or irrational decision making (Beyth-Marom & Fischhoff, 1999; Douglas, 1992). Within this mode, cognitive processes and internal psychological mechanisms are seen as crucial to understanding why young people make these choices (Baumrind & Moselle, 1985; Beyth-Marom & Fischhoff, 1999). In line with this approach, harm reduction education programmes aim to eradicate what are regarded as youth misconceptions about drug-related risks by increasing knowledge of the potential negative

outcomes of use (Coggans & Watson, 1995; White & Pitts, 2002). Yet, drug initiation is unlikely to result from an isolated cost-benefit analysis based on individual-level risk appraisals. Rather, drug journeys are subject to constant revision and change, moulded by social interactions and experience (Mayock, 2000). Therefore, a 'single rationality' theory of risk behaviour cannot account for the fluid nature and extended processes involved in heroin initiation.

A more encompassing approach is one that accounts for the 'situated' nature of drug use behaviours and transitions. Rather than artificially isolating drug use from other important aspects of young people's lives, 'situated' accounts consider the social, cultural and political context in which drug use occurs (Connors, 1992; Mayock, 2002). The costs and benefits entering the individual's analysis are seen as socially and contextually dependent rather than predetermined by scientific or epidemiological drug-specific knowledge (Rhodes, 1997) . As expressed by Tim Rhodes;

> The costs and benefits of risk-related actions are influenced by contextual factors, which may have less to do with the calculation of scientific probabilities of risk and harm than with the calculation of social costs and benefits associated with acting in certain ways (Rhodes, 1995, p. 128).

From a 'situated rationality' perspective, the social costs and benefits of actions are seen as playing a central role in drug-related risk behaviours with an emphasis on context-dependent 'rationality' (Miller, 2005). Accordingly, heroin initiation is a 'decision' based on rational contingencies specific to the social environment. For example, the potential negative outcome of physical addiction may be outweighed by the social benefit of gaining status and respect within one's social network. However, any theory that views heroin initiation as a decision or choice is limited. Studies testing the efficacy of decision-making models have in fact demonstrated that 'rational choice' cannot adequately explain why young people use drugs or engage in drug-related risk behaviours (Burgess, 1997; Loxley & Davidson, 1998). As noted by Robin Burgess, 'a host of infinite and unpredictable variables interfere with rational choices' (Burgess, 1997, p. 277). Conceptualising initiation as a 'decision' neglects these forces and depicts initiation as an isolated, overly calculative event rather than a dynamic social process through which an individual gradually becomes exposed to activities and motives congruent with heroin use (Gould et al., 1974; Stephens, 1991). Perhaps most importantly, the concept of 'individual rationality' when applied to drug-using behaviours neglects the way in which risk perception is 'socially organised' (Rhodes, 1995, 1997).

Social action theories account for the situated nature of drug use but move away from understandings of risk behaviour as an outcome of individual decision making. In contrast to mainstream perspectives, risk is not seen as an objective or fixed phenomenon, but rather one that

is socially constructed and organised (Austen, 2009; Rhodes, 1995). With risk-related perceptions varying across social groups and contexts, risk behaviours are considered to be socially, as opposed to individually, calculated (Bloor, 1995; Rhodes, 1995, 1997). Risk behaviour is, therefore, viewed as an outcome of 'negotiated actions' between individuals (Lear, 1997; Rhodes, 1997) rather than resulting from a cost-benefit analysis on the part of the individual. Micro-level social relationships, as well as the meso-social context and the macro physical, political and economic environment, are all thought to influence the social interactions that shape risk perceptions and behaviours.

Social action theories of risk have two main advantages over paradigms that presume that risk is individually calculated (Rhodes, 1997; Rhodes & Quirk, 1998). First, they acknowledge how situated pressures in decision making and imbalances of power in social encounters constrain individual choice (Bourgois et al., 1997; Friedman et al., 1998). Power differentials, moulded by structural forces and embedded within social relationships, can cause more powerful individuals to exert an influence over the behaviour of another (Burgess & Nielsen, 1974; Cook & Emerson, 1978; Molm, 1981). Risk behaviours then are rarely an outcome of one individual's rational decision-making process (Rhodes, 1997). Social action theories acknowledge this and seek to explore the power imbalances that shape group and individual risk behaviour. Second, social action theories avoid judgements of behaviours as inherently or objectively risky. Behaviours deemed risky by epidemiologists may not be perceived as such by drug users, particularly when those behaviours are routine, everyday activities (Douglas, 1986; Miller, 2005). An accurate understanding of risk needs to account for the subjective and differential perception of risk and risk behaviour. Social action theories, unlike individualistic perspectives, recognise that exploring the social relationships, social interactions and power dynamics embedded in drug-using networks is vital if drug-related risk behaviours are to be understood (Rhodes, 1997; Sibthorpe, 1992).

Research has demonstrated the applicability of social action theories to drug users' risk perceptions and behaviours. For example, a qualitative study carried out by Rhodes and others between 1993 and 1994 noted that risk was socially organised, negotiated and processual (Rhodes, 1995, 1997; Rhodes & Quirk, 1996, 1998). Their findings, based on in-depth interviews with 72 male and female opioid users[9] aged between 20 and 44 years, provided insight into how social network norms influenced risk susceptibility and acceptability. Unprotected sex, for example, was often perceived by the study's participants as a common and normal aspect of sexual relationships, and thereby considered by many to be an acceptable risk (Rhodes, 1997). Such 'norms' were widespread and socially organised as opposed to individually surmised or

[9] All 72 participants had used either heroin or methadone in the four weeks prior to interview and 92% reported lifetime injecting. 64% were male.

evaluated. Risk behaviours could also be seen to be the outcome of 'negotiated actions' (Rhodes, 1997, p. 218) rather than individual choices. For instance, unsafe sex was an outcome of negotiations between individuals and was not always consensually determined. Gender power dynamics created social situations in which young women were pressurised into having unprotected sex despite being fearful of contracting HIV from their partners. Therefore, not all individuals had equal power within social negotiations regarding risky actions. This research also revealed that risk perception was processual rather than static, and risk boundaries were changeable and context-dependent. Behaviours once seen as risky were habitualised over time. For example, injecting drug use was invariably perceived by non-injectors as a risky activity, and often operated as a 'risk boundary' in their drug-using activities. Injecting initiation had symbolic meaning for those who saw the act as signifying personal deterioration and disintegration. Injecting drug users, however, who had at one point been non-injectors, perceived injecting as an ordinary, everyday and routine activity. What was once perceived as unacceptably risky had become habituated over time, particularly with repetitive engagement without negative consequence.

Research in the Irish context has demonstrated how drug-using behaviour in general and drug transitions in particular are socially constructed and organised. In a rare ethnographic study of 57 young people from a Dublin inner city community, Mayock examined the social and contextual influences on young people's drug journeys (Mayock, 2000, 2002, 2005). Individual interviews, focus groups and participant observation were conducted with young problematic drug users, recreational drug users and non-users aged between fifteen and nineteen years. The findings indicated that risk boundaries were fluid and dynamic, perceptions were socially constructed and organised and behaviours were often habitual rather than an outcome of individual decision-making processes. In Mayock's words;

> Analyses of change in drug use behaviour over the study period demonstrate that drug transitions unfold alongside dynamic and changing perceptions of safety and risk. Responses to 'risk' within youth drug scenes were contextually shaped, open to situational revision over time, and, in many instances, drug taking was habitual, not calculated. Put differently, young people 'script' risk as they gain experience in the world (Mayock, 2005, p. 349).

Mayock's work is of particular relevance because it incorporates social action theories of risk into understandings of drug initiation. Situated accounts of initiation into heroin and injecting drug use as well as recreational drug use were included in the analysis. The findings revealed that perceptions of risk associated with heroin and injecting initiation were processual, as young people's negative views were gradually eroded through exposure to social settings in which hard drug use was accepted. Within these 'street-based' drug scenes, the young people's risk

boundaries were extended and their behaviour renegotiated. Drug transitions were seen, therefore, as a product of social interactions and habituation rather than individual decision making. Overall, elements of the social environment worked to constrain young people's choices and push them towards drug-related risk.

Risk behaviours associated with drug use are shaped by the dynamics inherent in young people's social worlds. Through their social interactions, young people construct their perceptions of risk, and their risk behaviours are thereby socially organised. If risk perception and behaviour is the outcome of social processes, relationships and situations, these elements need to be considered in accounts of heroin and injecting initiation. Rather than conceptualising heroin and injecting initiation as a consequence of individual pathology or decision-making processes, the interplay between individuals and their social environment must be explored.

The Risk Environment

Recognising the dearth of social and environmental understandings of risk behaviour in drug research and policy, Rhodes (2002) proposes the concept of the 'risk environment'. This framework shifts the focus of analysis away from the individual and towards the environment, heralding community, environmental and structural change for harm reduction. The 'risk environment' can be conceptualised as a myriad of factors exogenous to the individual which impact upon risk behaviour. It comprises a range of physical, social, economic and political forces, all operating at micro, meso and macro levels. The micro-level forces include those within the individual as well as interactions between individuals and significant others, meso-level forces include family, community and network norms and influences, while the macro-level forces emphasise the importance of structural factors, the political context, economic conditions, legal issues and broader cultural beliefs (Rhodes & Simic, 2005). These macro, meso and micro-level forces interact in complex and dynamic ways to produce the 'risk environment' (Rhodes et al., 2005).

Recent research on the meso and micro-level risk environment has indicated that risk perception and behaviour are an outcome of an array of interacting forces including perceived social norms, interpersonal relationships, the immediate physical and social setting in which drug use occurs, and the local community in which drug users live (Rhodes, 2002). Studies have shown that micro-level forces, such as the nature of interpersonal relationships (Misovich et al., 1997), and meso-level social network norms and influences (Costenbader et al., 2006, Latkin et al., 2003) can promote or inhibit HIV-related risk behaviours. Also, the physical and social environment has been shown to constrain safe and sanitary injecting practices, heightening risk to viral transmission (Rhodes et al., 2006; Small et al., 2007). Small and others (2007) demonstrated this relationship in their ethnographic study of injecting drug users in Vancouver. Incorporating

observational methods and interviewing techniques, they investigated the physical and social contexts of public injecting episodes. Public injecting in Vancouver's Downtown Eastside predominantly occurred in a network of alleyways, frequented by pedestrians, vehicular traffic and locals, and heavily patrolled by the police. Within these meso-level physical environments, 'injecting niches', such as alcoves or doorways, were used so as to provide limited protection from the rain and wind, and a degree of privacy from the public or police. These 'injecting niches' were highly unsanitary, were often used as latrines and had no running water available for injectors to wash their hands or injection sites. Respondents were aware of the risk of injecting in such conditions and were often preoccupied with the risk of interruption, assault or fatal overdose. Their 'heightened risk awareness', resulting from the physical and social dynamics of the environment, impacted on injecting practices, placing the injectors' need to complete the injection quickly above the desire to perform it safely. As a result, injectors often eliminated time-consuming practices, such as filtering or swabbing, from their injecting routines and were more likely to make mistakes in the injecting process (Small et al., 2007).

This study provides a detailed example of how micro and meso-level physical environments shape drug-related risk behaviours. Within these physical environments, social interactions between drug users, members of the public, and the police, construct injecting contexts and impact upon exposure to risk. Without accounting for these contextual forces, the individual's injecting behaviour could not sufficiently be explained or addressed by harm reduction approaches. For drug-related behaviours to be understood, therefore, the micro and meso-level environment must be explored with reference to how elements of the physical and social context shape interactions, perceptions and behaviours. Similarly to injecting risk behaviours, initiation into heroin and injecting drug use are behaviours that are contextually shaped and socially organised (Mayock, 2005). As the Vancouver study demonstrates, using an approach that values contextual forces is beneficial for developing a more complete understanding of such behaviours.

Recently, Harocopos and others (2009) incorporated such a theoretical framework into their study of injecting initiation in New York City. Adopting a longitudinal ethno-epidemiological approach, and using the narratives gleaned from qualitative in-depth interviews, they described how injecting initiation was influenced by the social environment. Similarly to Mayock's study on drug transitions (2002, 2005), they found that the move to injecting drug use was processual and a product of social habituation. Prior to their initiation, many respondents expressed negative views of injecting drug use. Initiation occurred when the stigma and fear of injecting were displaced through a gradual process of observation, communication and experience. This process occurred through micro-level social interactions with friends or sexual partners who were already engaging in injecting drug use. Over time, and through a gradual immersion in these meso-level social networks, using a needle to administer the drug became acceptable and, in many cases,

alluring. It was perceived as more efficient and cost-effective than other methods and, for some, it carried a glamorous or exciting appeal. The authors concluded that injecting initiation was a process influenced by a myriad of individual, social and interpersonal factors, where the pull to inject was the result of spending time in a social environment in which injecting was acceptable and desirable (Harocopos et al., 2009).

This recent study demonstrated how a theoretical framework highlighting the importance of the micro and meso-level social environment can be applied to understandings of heroin initiation. Micro-level social interactions and experiences within meso-level social networks of drug users altered young people's drug perceptions and shaped their trajectories towards injecting drug use. Capturing these processes was vital in explaining their initiation. By focusing on the micro and meso level, this study sheds light on the complex social dynamics between individuals and their immediate social environment. Yet, these environments do not exist in a physical or social vacuum. They are, in turn, likely to be shaped by broader social, cultural, economic and political forces. Other researchers have focused their efforts on exploring how these macro-level environments impact upon drug use.

Social, Political and Economic Forces

According to the 'risk environment' framework outlined by Rhodes (2002; 2009) macro-level forces at the social, political and economic level play a crucial role in the production of risk behaviour among injecting drug users. Poverty and social deprivation are key structural forces that impact upon the spread of HIV across communities (Sikkema et al., 1996; Zierler & Krieger, 1997; Zierler et al., 2000), a finding that has been observed in the Irish context (Clarke et al., 2001). Law enforcement and policing practices appear to have adverse effects on HIV prevention policies and on drug users' risk reduction strategies (Bluthenthal, 1995; Burris et al., 2004; Maher & Dixon, 1999). Cultural forces and racial segregation also impact upon HIV risk with ethnic minorities being more susceptible to transmission (Craib et al., 2003; Zierler & Krieger, 1997). As a result, injecting risk behaviour cannot be considered solely at the individual or micro level. A myriad of macro-level forces act to constrain individual choices by shaping the proximal social networks and community environments within which drug-related behaviours occur.

Injecting drug use has played a central role in the HIV epidemics of the United States, Europe and other Western countries (Alcabes & Friedland, 1995; Des Jarlais et al., 1992b; Hamers et al., 1997; Nelson et al., 2002) and continues to be a major public health concern (Wood et al., 2003). It is also disproportionately distributed among socially and economically excluded populations in Western countries (Galea et al., 2004; Latkin et al., 2003; Waterston, 1993). Social and economic marginalisation, therefore, not only impacts upon the risk behaviour of injecting drug users, but also influences who is likely to inject drugs and become exposed to this potential form of

transmission. Despite this, the role of the macro environment in drug and injecting initiation has generally been neglected in the literature (Bourgois, 1998; Bourgois et al., 2004). This trend is beginning to change, however, and a small number of contemporary researchers have investigated the dynamics of the relationship between drug use and the macro-level social, political and economic context.

Perhaps the most influential researcher advancing political and economic theories of hard drug use is Philippe Bourgois. The theoretical foundation of his approach is that 'structural violence', or forces of social inequality, racial segregation and economic marginalisation produce environments conducive to the development of underground drug economies (Bourgois, 1995, 2003). Based on findings gleaned from extensive and prolonged ethnographic fieldwork, Bourgois has explored the dynamics of this relationship, providing accounts of how interactions between macro political and economic forces, deprived inner city communities, social youth networks and the individual forge exceptionally high levels of substance use. Ethnographic fieldwork conducted by Bourgois in El Barrio, East Harlem between 1985 and 1992 revealed that many of its inhabitants struggled to subsist while working long, hard hours in the legal economy, and had few opportunities for upward mobility despite living in one of the richest industrialised societies in the world. Living in a cultural environment in which financial gain is conceptualised as the cornerstone of individual success, the underground economy provides an attractive alternative means of financial and social progression for young people;

> Why should these young men and women take the subway to work minimum wage jobs – or even double minimum wage jobs – in downtown offices when they can usually earn more, at least in the short run, by selling drugs on the street corner in front of their apartment or school yard? (Bourgois, 1995, p.4).

In addition to the relative economic and status advantages of the underground economy, Bourgois' work revealed how macro-level forces work to develop attitudes favourable to youth participation in hard drug use. Within socially deprived and culturally excluded neighbourhoods such as El Barrio, a complex web of social values, beliefs and attitudes develop in opposition to macro-level social and cultural oppression. This subculture or 'street culture' enables youth to maintain their feelings of autonomy and dignity in the face of the 'social suffering' resulting from their marginalisation. Resistance and rebellion are valued and cultivated within these social networks, rendering hard drug use powerfully appealing to the young people. Crack, with its highly destructive pharmacology, is considered to be a drug that appeals primarily to individuals experiencing extreme forms of structural violence and racial segregation or 'inner-city apartheid' (Bourgois, 1995) Such extreme inequality and exploitation, Bourgois argues, has not been a feature of European economies, and crack has not taken over as the primary drug of choice

among street-based drug users (Bourgois, 2003). Such an assertion may be correct, but European countries, including the United Kingdom and Ireland, have been subject to 'social suffering' and 'inner-city apartheid' in the form of heroin epidemics which have devastated inner-city communities and individual lives (Dean et al., 1987; Parker et al., 1998a).

Other researchers have explored different aspects of the macro environment/drug use relationship. For example, Rhodes and others have applied the 'risk environment' framework to explore how and why HIV has spread so rapidly among injecting drug-using populations in Eastern Europe (Rhodes & Simic, 2005; Rhodes et al., 1999a, 2003b, 2008). These studies suggest that drastic political transition has led to widespread social and economic dislocation, facilitating the development of underground economies with increasing levels of injecting drug use and drug-related risk behaviour. In Russia, for example, a rapid increase in drug injecting coincided with political transition and increased migration, and in Ukraine, economic restructuring facilitated the development of local underground economies, leading to rapid increases in drug use and sex work (Rhodes et al., 1999b). Such rapid political and economic transitions, it is argued, may weaken social bonds and fragment communities, create uncertainty in social identity, diminish social cohesion and exaggerate economic hardship (Farmer et al., 1993; Rhodes & Simic, 2005; Rhodes et al., 1999a, 1999b). These factors interact to create environments conducive to the spread of injecting heroin use (Rhodes et al., 1999a).

Dramatic economic changes have been observed in Ireland since the mid-1990s. From a society with high unemployment, low demand for labour and high emigration in the 1980s, rapid economic growth transformed it to what was known as the 'Celtic Tiger' economy (Layte & Whelan, 2002; Whelan et al., 2004). Recent deterioration of economic activity and a steep rise in unemployment have once again dramatically changed the economic landscape which is likely to have a significant impact on already deprived neighbourhoods and households (Combat Poverty Agency, 2009). As revealed by the research of Rhodes and others (1999a), such macro environmental changes are likely to impact upon underground economies and drug subcultures, perhaps increasing susceptibility to risk behaviours and negative outcomes. Adopting an approach that acknowledges and values the macro environment can shed light on how drug trends and epidemics evolve over time, in conjunction with political, economic and social change.

Power and Gender

One important element of the macro environment which affects drug and risk behaviour is the structure of gender. Females have traditionally been in the minority within heroin-using populations (Hser et al., 1987), but recent figures indicate that this gap is beginning to narrow in the UK and Ireland (Measham, 2002; Mullen & Barry, 2001; Neale, 2002; Parker et al., 1998a; Taylor, 1993). Due to their minority status, women's opiate-using experiences are often ignored

or assumed to be the same as men's (Ettorre, 2004; Neale, 2004; Taylor, 1993). The male experience is, therefore, considered the 'norm' within the drug use literature, and research on female opiate use tends to be restricted to specific 'female' issues such as reproductive outcomes or treatment access and retention (Marsh & Simpson, 1986; Rosenbaum, 1981b). It has been suggested that women 'do drugs differently' from men (Measham, 2002) and that this must be acknowledged if the impact of gender upon drug use and risk behaviour is to be explored (Powis et al., 1996).

Theoretical representations of women drug users have been dichotomised into extremes on the agency continuum, with individualistic approaches tending to adopt images of passive victims, and feminist readings depicting emancipated drug consumers (Maher, 1997). From a 'risk environment' approach, however, gender power dynamics, which are omnipresent in the macro environment, interact with micro-level social contexts and individual factors to shape drug-related behaviours and influence risk exposure. For instance, the increased presence of women in the illicit drug economy has been interpreted as reflecting the relative emancipation of women in the wider society (Maher, 1997). As noted by Bourgois (1989), young women from marginalised communities are no longer expected to remain at home and are instead free to pursue careers that offer the chance of upward mobility within the underground economy;

> More women, even if a small minority, are also resisting exploitation in the entry-level job market and are pursuing careers in the underground economy and seeking self-definition and meaning through intensive participation in street culture (Bourgois, 1989, p. 644)

Despite an increased participation in street-based drug culture, gender power imbalances in both macro and micro social groups have made women particularly vulnerable to oppression, domination and violence within these social contexts (Bourgois, 1989). Traditional gender inequalities embedded within wider society are reproduced in the drug economy with women more likely to be involved in high risk occupations with inferior financial rewards such as sex work or low-level drug dealing (Maher, 1997; Maher & Daly, 1996; Measham, 2002). Women are thereby subject to social, economic and power inequalities that constrain and restrict their choices, rendering them at increased risk of violence and abuse within drug-using contexts. Paradoxically, therefore, the process of women's emancipation, which has led to their increased presence in the street drug economy, has, in turn, led to their increased sexual exploitation and victimisation (Bourgois, 1989; Bourgois et al., 2004).

Research has suggested that women's heroin-using careers are shaped by gender inequalities within drug-using networks and the illegal economy. While men usually fund themselves through high-earning criminal activity, such as drug dealing or burglary (Marsh & Simpson, 1986),

women often struggle to finance their heroin habit with limited options available to them, commonly having to resort to gendered activities within the drug economy, such as shoplifting or sex work (File, 1976; Hser et al., 1987). Female drug suppliers are rare and tend to either occupy roles at the lower levels of drug-dealing hierarchies (Maher, 1997; Measham, 2002) or find it difficult to maintain their positions as street sellers (Bourgois, 1989). As men usually have greater access to heroin supplies, women have to negotiate this power dynamic to their advantage (Murphy & Rosenbaum, 1997) by forging sexual relationships with heroin-using males (Moore, 1991). Some studies have shown that, post-initiation, women find it difficult to fund their habit without the support of a male user (Fiddle, 1967; File, 1976; Hser et al., 1987) and this tends to cultivate dependence within their sexual relationships (Hser et al., 1987; Rosenbaum, 1981a, 1981b). Women who are introduced to heroin by their sexual partners tend to become more heavily immersed in the drug world, develop higher levels of consumption and build up a more costly habit than other women (Gerstein et al., 1979), further exemplifying their 'double dependence' on heroin and heroin-using men (Rosenbaum, 1981a, 1981b).

Women's subordinate position within drug-using networks, dictated by the constraints of gendered power dynamics, also makes them more vulnerable to risky injecting practices, sexual risk behaviour and negative health outcomes (Bourgois et al., 2004). Epidemiological studies have shown that women who inject drugs are at higher risk of HIV and HCV infection than their male counterparts, and this is particularly the case for young, female, recent injecting initiates (Booth et al., 1995; Doherty et al., 2000a; 2000b; Evans et al., 2003). Broader social forces of inequality operate at the micro level, influencing HIV and HCV-related risk behaviours. Women are more likely to have sexual relationships with other injecting drug users, engage in high-risk sexual behaviours such as exchanging sex for drugs, and participate in sex work. Women's narratives of sexual risk and agency also suggest that gender power imbalances within sexual relationships place them in a disadvantaged position in negotiating condom use (Rhodes & Cusick, 2002), further placing them at risk of HIV transmission (Booth et al., 1995).

Female injecting drug users are also more likely to engage in riskier injecting practices as a result of gendered power dynamics in their environment. Young, inexperienced women, who are often first injected by a male sexual partner (Powis et al., 1996), are exposed to high levels of injecting risk due to their rudimentary knowledge of safe injecting practices and their lack of control over the injecting process. The power dynamics inherent in the social context of a young woman being injected by a more experienced man exacerbates her vulnerability to HCV transmission through the borrowing of injecting paraphernalia (Bourgois et al., 2004), a risk behaviour that is the highest predictor of infection (Hahn et al., 2002). Young, female injecting initiates within these scenarios are not simply the victims of manipulative controlling men; rather, the gender constraints of their environment encourage reliance on their sexual partners for their drug supply

and administration. Women immersed in street-based drug scenes are exposed to multidimensional violence in their everyday lives and sexual partners can shield them from these immediate dangers (Bourgois et al., 2004). The possibility of acquiring blood-borne viral infection may be rendered a secondary concern in such contexts (Epele, 2002).

Although epidemiological studies have indicated that macro forces of gender inequality impact upon the social context, dynamics and processes involved in heroin initiation, few studies have explored the dynamics of this relationship. Women are more likely to be introduced to heroin by a man, and are more likely to receive their first intravenous injection from a male sexual partner (Powis et al., 1996). Female heroin users are more likely to be in a relationship with a heroin or injecting drug user (Anglin et al., 1987; Eldred & Washington, 1976; Gossop et al., 1994), and are more likely to live with them throughout the course of their heroin careers (Gossop et al., 1994). Despite this, many women report self-initiation and demonstrate an active role in their own drug involvement (Bryant & Treloar, 2007), challenging depictions of women as passive victims. However, women's initiation into heroin use has been neglected in the research literature and only a small number of ethnographic studies have examined the social processes involved in women's heroin initiation (Maher, 1995; Rosenbaum, 1981b). Gender inequality is a key element of the macro and micro-level environment which is likely to impact upon the social processes of heroin and injecting initiation. A full and comprehensive account of drug initiation, therefore, must address gender power dynamics and how they impact upon the early stages of young women's heroin-using careers.

Structure, Agency and Embodiment

The 'risk environment' framework has sought to move away from understandings of drug use and risk behaviour as products of individual choice or decision making. Yet, adopting a primary focus on environmental forces can potentially lead to neglecting the role of the individual in action. Integrating structure and agency in accounts of human behaviour is a constant and ever-evolving challenge within sociology, and is fraught with tensions (Berger & Luckmann, 1967; Bourdieu, 1977; Giddens, 1984) but some important theoretical contributions can facilitate understandings of how environmental forces at the micro or macro level interact with the individual to produce drug-related behaviours. The principles of symbolic interactionism can be used to explain how individuals create meaning through social interactions and actively construct their behaviours and identities through the interpretations of those meanings (Blumer, 1969; Mead, 1934). By applying these principles to drug use, individuals can be seen as playing an active role in their drug journeys through observing and interpreting the activities of other users, assigning meanings to drug use and constructing a dynamic identity that engages in risk behaviour. Research has long since documented the crucial role of social interactions in the process of drug initiation (Becker, 1963; Gould et al., 1974; Rosenbaum, 1981a; Stephens, 1991).

Indeed, symbolic interactionism has greatly influenced understandings of how micro-level social forces interact with the individual to shape drug-using attitudes and behaviours.

Perhaps at the macro-level, the structure-agency dynamic becomes even more complex. Macro social environments may appear distant from individual experience and behaviour, and theories that portray drug use as being produced by socio-cultural structures can be interpreted as overly deterministic (Fitzgerald, 2009). Rather than depicting individuals as puppets of social structures, however, political and economic theories of drug use seek to unpack how macro environmental forces are reproduced in the everyday lives of drug users (Rhodes et al., 2005). Influenced by the work of Bourdieu (1998, 2001), some researchers have described how social structures are embodied by individuals, creating vulnerability to drug use and its associated harms. For example, economic superstructures and free market capitalism have been seen as becoming embedded into the dreams and aspirations of young people living in socially deprived areas (Fitzgerald, 2009), motivating them to seek out opportunities for upward mobility, which are often only available through the underground economy (Bourgois, 1995). Multiple forms of structural subordination imposed on marginalised communities can be interpreted as translating into normalised violence and oppression within street-based drug subcultures (Bourgois, 2003). Power inequalities within the macro environment can be seen to become embodied by networks of injecting drug users, who then act out these social dynamics, increasing risk of negative outcomes. Social constructions of gender manifest in elevated HIV risk through male control of the administration of injections (Farmer et al., 1993; Miller & Neaigus, 2001) and cultural domination and racial segregation can create cultural barriers to harm reduction services (Bourgois, 2003). In this way, structural forces are seen as being internalised at the individual or micro level, impacting upon drug users' lifestyles, experiences and exposure to harm (Bourgois, 1995).

Theoretical dichotomies between individual and environment have limited application in understanding drug use and risk behaviour. Contemporary theoretical approaches seek to integrate the two. Risk environments are not considered to be spaces that exist in isolation from the actors within them. How they are shaped and perceived depends on social interactions between individuals and other forces (Rhodes, 2002). They are simultaneously created and embodied as part of the everyday actions and experiences of the drug users themselves (Rhodes, 2009). In other words, individuals collectively construct their environments and are, in turn, shaped by those environments (Agar, 2003; Duff, 2007; Fitzgerald, 2009). Political, economic, social and cultural forces, rather than being causal determinants of individual action, are reproduced in drug-using spaces through practices of meaning-making and memory inscription (Duff, 2007; Riano-Alcala, 2006). It is individuals' activities and communication that reproduce macro social structures at the micro social level (Giddens, 1984). From such a perspective, the

individual is not seen as a passive victim of social forces nor an independently existent decision-maker. Macro and micro-level social forces are threaded into the everyday experience of drug users (Maher, 1997), shaping individual attitudes, values and behaviours through active processes of interpretation and internalisation. Challenging as it is for drug research to capture these dynamics, it is necessary if the role of the macro environment in drug initiation, use and risk behaviour is to be more fully understood.

A Framework for Understanding Heroin Initiation

This study seeks to incorporate current theoretical understandings of drug use and risk behaviour by adopting a 'risk environment' framework (Rhodes, 2002; Rhodes & Simic, 2005). It will attempt to move away from individualistic accounts of drug use by situating young people's experiences within their social and physical environments. In doing so, the macro structural forces and micro social contexts of drug use, as described by the participants themselves, will be explored. The main focus of the study is heroin and injecting initiation, and risk behaviour in the early stages of the drug-using career. Social, economic, physical and political aspects of the environment will all be considered in understanding how young people become exposed to heroin, initiate use, begin to inject and experience associated harms.

Initiation is a process rather than a static event in an individual's life (Stephens, 1991). Therefore, a key aspect of this study will be investigating how environmental forces change over time, shaping young people's life histories and drug-using trajectories. Heroin initiation is a process that is usually preceded by an immersion into street-based subculture, and an early involvement in recreational drug-using networks (Feldman, 1968; Fiddle, 1967; Stephens & McBride, 1976; Waldorf, 1973). In order to understand the processes by which individuals become exposed to these different social environments in their early teenage years, life history accounts of social and behavioural changes over time must be considered. In this way, the 'risk environment' framework can be applied over the life course, exploring how micro-level social processes, such as family and peer interactions, and macro-level forces, such as social and economic deprivation, impact upon the gradual process of young people's drug, heroin and injecting initiation.

Prioritising user narratives is crucial in situating accounts of drug use within the environment, and understanding social constructions of risk can only be achieved if subjective accounts are valued. For this reason, adopting a 'risk environment' framework necessitates qualitative research methods that can capture subjective experiences, social interactions and constructions of behaviour. This study will aim to adopt a methodology that facilitates this and enables the investigation of environmental forces over the life history of its participants.

Conclusion

This chapter provided an overview of the main approaches used to explore heroin use, revealing that traditional frameworks have contributed to a developing body of knowledge but cannot sufficiently explain heroin initiation. This chapter has proposed the adoption and application of a 'risk environment' framework (Rhodes, 2002) to understanding heroin initiation, use and risk behaviour. Incorporating contemporary models that move away from individualistic perspectives, this framework acknowledges the role of macro and micro environmental forces in the production of drug and risk behaviours. Social processes and structural factors have long since been recognised as playing an important role in the spread of heroin use across social groups (Dai, 1937), but this approach seeks to incorporate these observations into a more comprehensive understanding of how macro and micro forces interact to create vulnerability to drug-related risk (Rhodes, 2009).

Having predominantly been applied to injecting risk behaviour, the 'risk environment' framework has much to offer to understandings of heroin initiation. Overall, theories of drug initiation are dominated by risk factor research which continues to be shaped by individualistic models of behaviour (Susser, 1998; Susser & Susser, 1996a, 1996b). User narratives, subjective experiences and situated accounts of drug-related behaviours are thereby neglected. Challenges to this approach, which seek to address the environmental contexts of heroin use, have tended to focus either on micro-level social processes (Becker, 1953; Stephens, 1991) or on macro-level political and economic forces (Parker et al., 1988, 1998b; Pearson, 1987a). More contemporary theories, incorporated within the risk environment framework, aim to account for how both macro and micro forces interact with the individual to shape drug-using behaviours and trajectories (Anderson, 1994; Bourgois, 1995; Fitzgerald, 2009).

Tensions between structure and agency have pervaded the drug use literature, and for drug initiation in particular, the complexities of this relationship become immediately apparent. Some theorists have posited that drug initiation is a decision mediated by numerous factors, but ultimately one that is made by the individual through cost-benefit analysis (Boys et al., 1999a, 1999b). Others have argued that drug initiation is a process, rather than a choice, and is likely to be one that is socially organised (Rhodes, 1997). Theoretical perspectives which err on the side of agency, fail to account for how risk perceptions and behaviours are socially constructed (Lupton, 1999), and those that adopt an extreme structuralist position neglect user narratives that typically stress individual agency (Mayock, 2005). This produces a complex conundrum that can only be resolved through an intermediary approach, one that accounts for the role of the individual and the environment in the process of heroin initiation.

Modern theories, which address the role of the macro political and economic environment in the manifestation of hard drug use, draw from Bourdieu's concept of 'symbolic violence' in exploring how social inequality and oppression are embodied by individuals. Gender power dynamics, social marginalisation and economic deprivation are thereby played out within drug-using networks, impacting upon the everyday lives of individuals and shaping their exposure to suffering and risk (Bourgois, 1995, 1998; Bourgois et al., 2004). By adopting such a theoretical understanding, the role of the macro environment, at political, economic, cultural and social levels, can be acknowledged without resorting to depictions of drug users as social structural puppets. Such an approach can benefit understandings of heroin initiation, particularly in Ireland where the spread of heroin use has been strongly associated with macro-level environmental forces such as poverty and exclusion (Dean et al., 1985; O'Gorman, 1998).

Chapter Three
Methodology Chapter

Introduction

This study aimed to examine the social course of young people's heroin initiation and to investigate their experience of risk, particularly during the early stages of their heroin 'careers'. This chapter outlines the methodological approach used to achieve these aims. It begins by establishing the theoretical orientation of the study, and outlines the rationale for the study's use of an ethno-epidemiological approach within a qualitative constructivist epistemology. Within this framework, four main data collection methods were employed and are described in detail in later sections of the chapter. These include: a community assessment process; ethnographic observation; the administration of an 'interceptor' survey; and the conduct of qualitative life history interviews. The chapter also discusses the research process in considerable detail, paying particular attention to the study's four data collection techniques which aimed to build upon and enrich each other over the course of the study. Discussion of the research process also includes a detailed overview of the study's recruitment strategy. A number of researchers have highlighted the difficulties of recruiting young recent heroin initiates (Pearson, 1987a; Parker et al., 1988; Egginton & Parker, 2000) and this study was no exception. The challenges associated with locating young recent initiates to heroin are detailed, as are the approaches used to overcome these challenges.

The chapter moves then to describe the study's sampling, data collection and data analysis procedures, which were undertaken concurrently. The importance of gaining insight into the subjective experience of participants within a constructivist framework is noted, and the role of the researcher in co-constructing the text is acknowledged in a later discussion of reflexivity. Ethical procedures and issues are then addressed, with emphasis placed on the need for sensitivity in the collection and dissemination of data on vulnerable populations. Finally, the limitations of the study are identified.

The Problem with 'Black-Box' Epidemiology

Since the new public health and harm reduction movements of the 1980s, drug research has primarily employed quantitative epidemiological methodologies to monitor heroin prevalence and rates of blood-borne viral infections, and to provide demographic profiles of heroin and injecting drug users (Des Jarlais et al., 2000; EMCDDA, 1997; Frank, 2000; Frischer et al., 1991; Garfein et al., 1998; Hamid et al., 1997; Hartnoll, 2003; Hartnoll et al., 1985; Hickman et al., 2004; Kraus et al., 2003; Miller et al., 2001; Zafar & Ul Hasan, 2002). This body of research is positivist in orientation and aims to explore the aetiology of heroin use by adopting large sample

sizes and modern statistical techniques (Greene, 1974; Ouellet et al., 1995). Epidemiological studies therefore, have increased available information on heroin use and have enabled more efficient targeting of treatment and prevention services, accessing those most at risk of developing problematic patterns of use.

While large-scale epidemiological studies provide invaluable information on heroin and injecting drug use, an excessive reliance on statistical analysis of survey-based data has restricted contemporary drug use research (Diex-Rouz & Auchincloss, 2009). Among other issues, there are a number of methodological limitations associated with survey-based research, particularly in its generation of numerical data in isolation from macro and micro environmental forces (Susser, 1994a; 1994b; Susser & Susser, 1996a; 1996b). First, basic contextual factors, such as the wording of the survey, the location of the interview and the social identity of the interviewer, will dramatically affect the data obtained from epidemiological instruments (Bourgois, 2002a). Second, epidemiological data cannot capture how drug-using environments shape and organise risk (Rhodes, 1995; Rhodes, 1997). Third, the focus within epidemiological data on biomedical individualism fails to acknowledge how social structures and economic inequality create vulnerability to drug use (Waterston, 1997). As argued by Susser and Susser (1996b), epidemiology must move away from the "black-box[1]" paradigm and towards an ecological approach. Such a perspective can offer deeper insights into the social context in which drug use occurs, and the social roles that drug users assume (Carlson, 2000).

An Ethnographic Approach

Ethnography is, in its essential form, one of the most basic forms of social research because it attempts to capture how people make sense of their social worlds by being a part of it (Hammersley & Atkinson, 1995). Ethnography is committed to studying the social world in its natural state rather than in artificial settings (Denzin, 1971; Hammersley & Atkinson, 1995; Matza, 1969; Schatzman & Straus, 1973) and recognises that "human behaviour is continually constructed and reconstructed on the basis of people's interpretation of the situation they are in" (Hammersley & Atkinson, 1995, p. 8). Through a process of immersion in the social worlds of others, ethnographers seek to investigate the subjective meanings that guide people's behaviours (Denzin, 1971; Hammersley & Atkinson, 1995). The aim is to provide a 'thick description' of these social worlds (Geertz, 1973), resisting the over-simplifications that are characteristic of the physical sciences, and providing a rich and detailed account of the experiences and beliefs of those living in a complex and dynamic social world (Hammersley & Atkinson, 1995).

[1] The "black box" metaphor is used to describe a closed system in which the inner processes are obstructed from view. Modern epidemiology, which aims to understand chronic diseases, seeks to relate exposure (or risk factor) to outcome without being obliged to address intervening process, and so, could be said to adopt the "black box" paradigm (Susser & Susser, 1996b).

Contemporary ethnography has moved on from its foundations in both colonial anthropology and the Chicago School of Sociology and has become a complex and diverse method of inquiry (Atkinson et al., 1999). Numerous disciplines have adopted and adapted it, influencing its development (Deegan, 2001), and it has been shaped by the movements of positivism, post-positivism, post-structuralism and post-modernism (Potter, 1996; Denzin, 1994; Berger & Luckmann, 1966). Emerging from the "post-modern turn" (Best & Kellner, 1997; Denzin & Lincoln, 1998a; Denzin, 1997), contemporary ethnographers question the belief that there is a 'reality' that exists independent of the researcher and whether any research product can possibly or potentially represent 'reality'. If individuals construct their worlds through social interactions, researchers must also create and produce their data through similar processes (Brewer, 2000). Consequently, all forms of knowledge, including ethnography, are social constructions (Longino, 1990), shaped by the historical, cultural, social and political contexts in which they are created. These contexts determine the topic under investigation, the theoretical presuppositions made about it and the methods used to explore it (Dey, 1993). They also shape how research findings are interpreted and disseminated (Kuhn, 1970).

Arising from these epistemological debates, ethnography faced what is referred to as a "double crisis" (Denzin & Lincoln, 1998b), one of representation and legitimacy. Post-positivist, post-modernist and post-structuralist[2] movements of the late 1980s led ethnographers to question whether it was possible to capture the nature of the social world and, if so, how this representation might be evaluated as authentic or accurate (Denzin & Lincoln, 1998a). The crisis of representation emerged from a constructivist perspective and cast doubt over the existence of a universal social 'reality' that could be captured by ethnography. The crisis of legitimation arose from a concern that all ethnographic accounts of the social world could only be partial, selective constructions of the ethnographer (Brewer, 2000), calling issues of 'reliability' and 'validity' into question, and placing the authority of the ethnographer under threat (Clifford, 1983; Gubrium & Holstein, 1999).

Postmodern and post-structural thought presents quite a challenge for researchers in that it questions the epistemology within which the research is grounded; whether there is, in fact, any 'reality' to research and, if so, whether it is possible to represent it accurately (Hammersley, 2002). The work of Foucault epitomised this challenge[3], rejecting realism and conceptualising social research as a socio-historical phenomenon reflecting the social control and power relations

[2] Post-positivists challenged the dominant positivist paradigm that scientific research can be objective and capture reality without bias. Postmodern and post-structural movements both rejected the existence of a universal social reality and argued for the validity of multiple perspectives based on group affiliations such as gender, race or class. There is considerable overlap between post-structuralism and postmodernism, but the former could be described as a theory of knowledge and language, and the latter a theory of society, culture and history (Agger, 1991).

[3] Poststructuralist writers, such as Foucault, argued that all knowledge is located in and shaped by historical, political and cultural contexts. As there is no absolute or uncorrupted 'truth', research endeavours which aim to represent social 'truths' are rejected (Rosenau, 1992).

endemic in modern society (Hammersley & Atkinson, 1995; Gubrium & Silverman, 1989). Although not necessarily abandoning realism altogether, many ethnographers have embraced the postmodern challenge and managed to, albeit tentatively, incorporate it into a new paradigm that attempts to negotiate the complexities of the modern philosophical climate (Alasuutari, 1995; Atkinson & Coffey, 1995; Clough, 1998; Denzin, 1997; Denzin & Lincoln, 1994; Vidich & Lyman, 1998). The "double crises" of the later 20th century required that traditional ethnographic frameworks, shaped and possibly biased by Western middle class ideals, be abandoned. Ethnographers sought to adopt a new reflexive approach, recognising the ways in which political, historical, social and cultural contexts influence their values and ideologies which, in turn, impinge upon the research process (Denzin & Lincoln, 1994; Foley, 2002). As expressed by Vidich and Lyman (1998), however, there is little comfort or security in adopting such a paradigm;

> Crossing the postmodern divide requires one to abandon all preconceived values, theories, perspectives, preferences and prejudices as resources for ethnographic study (Vidich & Lyman, 1998, p. 92).

Ethnography requires the ethnographer to become immersed in the lives of participants so that a deep understanding of their social worlds can be obtained. This enables the ethnographer to contextualise and interpret the stories told by the active constructors of a given reality (Denzin & Lincoln, 1998a). From this perspective, ethnography can be seen as a dual construction; one that is created by both the ethnographer and participants (Holstein & Gubrium, 1995; Kvale, 1996; Silverman, 1993). This removes the impossible task of portraying a single objective 'reality' from the research process (Agar, 1986; Potter, 1996) and upholds the view that social realities are constructed. Social research is thus co-constructed by researcher and participants (Kvale, 1996; Michrina & Richards, 1996; Rubin & Rubin, 2005; Sherman-Heyl, 2001). As explained by Michael Agar, the value of this construction lies in how its creation may serve to increase social understandings of different groups by "mediating two worlds through a third" (Agar, 1986, p. 19).

Ethnography has made a significant contribution to understandings of drug use over the past several decades (Moore, 1993) and is particularly effective at capturing the social worlds of 'hidden' populations of drug users, including heroin users. It is a research approach that aims to capture subjective interpretations and constructed meanings, and recognises the importance of placing the individual in context (Guba & Lincoln, 1998; Denzin & Lincoln, 1994; Long & Long, 1992; Marshall & Rossman, 2006). In the words of Michael Agar;

> Something about ethnography taps into ways of understanding that are lost in the story of human evolution. Much of ethnography consists of bringing those ways of understanding into awareness, making them explicit and public, and building a credible argument that what one learned should be believed by others who were not present (Agar, 1996, p. 1).

As highlighted in the introduction to this work, information on heroin initiation in Ireland and elsewhere is primarily limited to psycho-social descriptions of those 'at-risk' of initiation. There is therefore a need to capture the heroin user's own insight and expertise in order to develop understandings of the lived experience and social course of heroin initiation (Carlson et al., 1995). Ethnography seeks to describe the shared understandings, values and beliefs that shape behaviour (Moore, 1993) and is particularly effective at casting aside traditional conceptualisations of drug use (Carlson et al., 1995). It has also made a valuable contribution to the Irish literature by shedding light on the perspectives, experiences and behaviours of drug users (Beckett, 2004; Mayock, 2000; 2002; 2003; 2005; Woods, 2008). In order to develop understandings of heroin initiation and risk behaviour, to capture user narratives and contextualise drug user experiences within their social, political and economic environments, an ethnographic orientation was deemed essential to the achievement of this study's aims.

Towards an Ethno-epidemiology

Ethnography and epidemiology are rooted in such vastly different epistemologies that, at first glance, reconciliation may seem impossible (Sale et al., 2002). From the epidemiologist's perspective, a positivist approach enforced with scientific rigour can reveal important correlates of disease and tackle serious threats to public health (Susser & Susser, 1996a). Postmodern theoretical debates may seem irrelevant and futile, particularly in relation to the humanistic matter at hand (Bourgois, 2002a). Alternatively, the ethnographer, emerging from the vast epistemological movement of postmodern and post-structuralist discourse, views scientific thought as a socially constructed phenomenon, perhaps even an agent of structurally enforced "biopower[4]" (Foucault, 1978). This theoretical grounding makes it difficult for the ethnographer to consider the statistical outcomes of epidemiology as representing 'truth' or retaining meaning. Perhaps for these reasons, mainstream researchers from positivist quantitative and constructivist qualitative fields have tended to avoid mixed model studies (Tashakkori & Teddlie, 1998). Yet, qualitative and quantitative research methods may have much to offer one another in exploring how macro and micro social environments interact with the individual, creating vulnerability to drug-related harm (McKeganey, 1995).

[4] The term "biopower" as described by Michel Foucault refers to scientific knowledge as a historical process that works to control deviant members of society through scientifically imposed rationality and morality (Foucault, 1978).

Due to the relative dominance of epidemiology in the field, the incorporation of mixed methods into drug research is often conducted under the umbrella of a positivist paradigm (McKeganey, 1995). Ethnography is berated for being too subjective and is forced to adhere to scientific principles which it was never designed to meet (Moore, 1993). Using quantitative and qualitative research methods in this way creates a "mixed-up model" (Datta, 1994) which fails to resolve the epistemological divide between the two approaches. Although arguably fostering greater receptivity within the scientific community (Moore, 1993), conducting qualitative research within a positivist paradigm neglects postmodern critiques and denies the constructivist foundations upon which it is based. Retaining these principles does not mean that quantitative research methods cannot be adopted within a qualitative research framework, however. Multiple methods can be used by ethnographic studies in a complementary way (Sale et al., 2002). For example, ethnographers can use epidemiological instruments to collect basic demographic data on their subjects (Schensul et al., 1999), to refer to existing socio-demographic datasets so as to situate their subjects (Bourgois, 2002a), or to recruit suitable participants from large-scale epidemiological cohorts (Fast et al., 2009; Small et al., 2009).

Modern-day ethnography is rooted in a post-modernist theoretical framework that questions the existence of an objective reality, and recognises that there are multiple, and equally valid, views of phenomena (Hammersley, 2002; Seale, 1999). This challenges the authority of scientific findings, questions the legitimacy of experimental research methods and, above all, attacks the 'naive realism' held by positivist approaches (Lincoln & Guba, 1985). A pluralist perspective recognises the value in different forms of socially constructed knowledge and, in so doing, does not hail a single approach as depicting a universal 'truth'. Epidemiological research has facilitated understandings of complex phenomena related to health and illness and has forged rapid advancement in improving community health, minimising the spread of infectious diseases and identifying factors that increase vulnerability to various forms of suffering (Susser & Susser, 1996a). This pragmatic approach has had 'real[5]' benefits. Epidemiology, therefore, should not be dismissed by those who aim to assuage the social suffering associated with 'hard' drug use (Bourgois, 2002a) but can to be incorporated within a qualitative epistemological framework that aims to place the 'person-in-context' (Agar 2003).

Despite the important contribution of both epidemiology and ethnography to drug research (Feldman & Aldrich, 1990; Hartnoll, 2003), there has been little dialogue or cooperation between the two disciplines (Moore, 1993; Bourgois, 2002a). Internationally, however, a small number of researchers have promoted the idea of cross-methodological dialogue and cooperation. Ethno-epidemiological approaches have been used to study drug and sexual behaviour among men who

[5] Recognising that what is considered to be of 'real benefit' is, of course, socially constructed and subjective, epidemiology is held within a framework that aims to ameliorate human suffering by reducing the spread of disease, and lengthening life expectancy.

have sex with men (Clatts & Sotheran, 2000; Clatts et al., 2002), injecting initiation and risk behaviour in ketamine users (Lankenau & Clatts, 2004), HIV risk among heroin users in Vietnam (Clatts et al., 2007), hepatitis C sero-conversion among young female heroin injectors (Bourgois et al., 2004; Hahn et al., 2002; Evans et al., 2003), the life histories of adolescent drug users attending treatment (Reisinger, 2004) and the social influences on injecting initiation among street-involved youth in Canada (Small et al., 2009). These researchers have combined epidemiology and ethnography in a pragmatic and mutually beneficial way while retaining a qualitative epistemological perspective.

Clatts and Sotheran (2000), for example, used ethnographic research methods, including participant observation, to disentangle the complexities of epidemiological findings in a New York population of drug-involved men who have sex with men. Their ethnographic data revealed the diverse nature of this sample, and the complex interactions between sexual identity, social stigma, economic forces and drug and sexual risk behaviour. Recently, in Vancouver, Small and others (2009) have been using ethnographic research to explore how social structural forces and physical environments contribute towards risk behaviour amongst young drug users. They used demographic findings from the large-scale epidemiological At-Risk Youth Study (ARYS), to target and recruit participants for life history interviews. This strategy enabled them to locate their smaller sample within a larger population of at-risk youth, whilst exploring the macro and micro-level forces that shape risk perception and behaviour. Bourgois and others (2004) have also used in-depth ethnographic methods to explore the relationship between structural inequality and risk behaviour amongst young injectors in San Francisco. Their research was guided by the findings of a large-scale epidemiological study, reporting that young women were sero-converting to HCV at almost two times the rate of men (Hahn et al., 2002; Evans et al., 2006). Through in-depth participant observation and qualitative interviewing techniques, they described how complex gender power dynamics manifest in injecting practices enhancing female susceptibility to HCV sero-conversion.

These studies demonstrate the advantages of combining both epidemiological and ethnographic research methods in exploring drug-related perceptions and risk behaviour. Reisinger (2001) has described the relationship emerging between the two disciplines as tense, but mutually beneficial;

> The thread that emerges in every relationship between epidemiologic and ethnographic approaches is ethnography's openness to surprises and new frameworks of understanding in tension with the prior structures of epidemiologic data collection. Ethnographers attempt to understand "what's going on" from multiple perspectives of those involved, whereas epidemiologists bring a systematic structure to the collection of data over time. Epidemiology grounds the possibilities; ethnography stretches them. Working with this tension is essential, as both disciplines seek shared goals of promoting universal health and well-being (Reisinger, 2004, p. 242).

Despite the tension described (Reisinger, 2004), epidemiology and ethnography can be incorporated in a mutually beneficial way without sacrificing the open and investigative nature of ethnographic research (Ciccarone, 2003). As suggested by Michael Agar, "the link between qualitative research and epidemiology makes perfect and powerful sense" (2003, p. 975). Ethnography can enhance understandings of the 'person-in-context' (Agar, 2003), disentangle the complexities of epidemiological data (Clatts & Sotheran, 2000), and reveal the subjective meaning of drug-using behaviours. Without this insight into the interplay of context and meaning, statistical relationships are left in a state of ambiguity, thus limiting knowledge of how and why they operate. This is the case in the Irish context, as indeed elsewhere, where a strong drug epidemiology has been established but the statistical correlates and relationships within this epidemiology remain relatively unexplored.

Gaps in Knowledge and Sources of Epidemiological Complexity

For the most part, Irish research on heroin use has adopted an epidemiological approach and has provided valuable information on prevalence rates (Comiskey, 1998; Comiskey & Barry, 2001), demographic profiles of opiate users (Cox & Comiskey, 2007; Dean et al., 1983; 1985; 1987; Fagan et al., 2008), rates of blood-borne viral infections amongst injectors (Grogan et al., 2005; Smyth et al., 1998), and correlates of injecting risk behaviour (Dorman et al., 1997; Geoghan et al., 1999). These epidemiological studies have generated a considerable body of knowledge on opiate use which has enhanced understanding of heroin and other 'problematic' forms of drug consumption and also helped to inform national drug policy, particularly in the implementation of harm reduction and drug prevention programmes. However, an almost exclusive reliance on survey-based research has created significant gaps in the Irish heroin use literature[6] (Mayock et al., 2009). For example, survey-based research in Ireland has uncovered numerous sources of epidemiological complexity that cannot be explained or explored using quantitative methods alone. While epidemiological profiles suggest that a complex array of macro and micro-level forces impact upon heroin use patterns and practices (Cox & Comiskey, 2007; Dean & Power, 1984; Dean et al., 1983; 1985; 1987; Fagan et al., 2008; Reynolds et al., 2008) there is a lack of understanding of how epidemiological 'risk factors' interface with the 'lived experience' of heroin use in the Irish context. By way of example, Fagan et al's (2008) recent study on adolescent heroin users uncovered multiple forms of psycho-social adversity in their sample, generating a profile in many ways similar to young heroin users in the 1980s (Dean et al., 1983). The study examined the demographic characteristics and drug histories of 86 young people under 19 years of age. The sample was accessed through Dublin's largest drug treatment centre between October 2000 and September 2006 and demonstrated high levels of family breakdown

[6] The major gaps in the Irish literature identified by Mayock et al. (2009) include the social course of heroin initiation, the homelessness/heroin use nexus and injecting risk practices and behaviour.

(70%), homelessness (48%), care histories (27%), and early school leaving (mean age 14.4 years) (Fagan et al., 2008). This research strongly suggests that a complex array of social and environmental forces impacts upon the process of heroin initiation in young people. However, understandings of *how* social processes impact upon young people's drug-using trajectories, how 'risk factors' are subjectively experienced, and how risk behaviour is contextualised within an individual's life history, remain lacking in the Irish context.

Irish research on injecting risk behaviour similarly reveals sources of epidemiological complexity. For example, intravenous injection remains a dominant route of administration amongst heroin users (Carew et al., 2009; Reynolds et al., 2008; Smyth et al., 2001), and rates of HCV infection are high (Fitzgerald et al., 2001; Long et al., 2001; Smyth et al., 1999), despite the implementation of harm reduction strategies. It also appears that young injectors are more likely than other (older) groups to engage in 'risky' injecting practices associated with blood-borne viral transmission (Cassin et al., 1998; Mullen & Barry, 2001; Smyth et al., 2001). International studies likewise suggest that recent initiates and younger injectors are at high risk of blood-borne viral infection but have identified their limited knowledge and technical skill, or their disadvantaged positions within drug-using networks as contributing to their 'high risk' status (Fennema et al., 1997; Garfein et al., 1998; Hahn et al., 2002; Van Beek et al., 1998). Knowledge of the social and environmental context of injecting behaviour is far more limited in the Irish context and there has been little dedicated research attention to the 'risk environments' of young injecting drug users.

Epidemiology, as Agar (2003) suggests, is limited in its capacity to explore the 'person-in-context' and neglects the environmental forces and social processes involved in drug transitions and behaviour (Ouellet et al., 1995). The predominant focus of much Irish research has been on the individual characteristics of heroin users, with much less attention to the social organisation of drug-related beliefs, perception and behaviour. Indeed, a considerable number of Irish authors have highlighted the need for qualitative research to address current gaps in knowledge, particularly those related to heroin initiation and injecting risk behaviour (Mayock et al., 2009; Mullen & Barry, 2001; Smyth et al., 2005). In contrast to the dominant positivist paradigm adopted by most survey-based research, a constructivist approach posits that human beings construct their social realities through their interactions with others and with broader social structures (Berger & Luckmann, 1966). Gaining insight into the interplay of context and subjective meaning can thereby facilitate deeper understandings of complex phenomena such as drug use (Crotty, 1998). By adopting ethnographic and epidemiological research methods within a constructivist approach, this study sought to gain insight into the social worlds and life histories of young heroin users with the aim of fostering greater understanding of the social course of

heroin initiation and the role of contextual forces in shaping risk behaviour during the early stages of young people's heroin 'careers'.

An Ethno-epidemiology of Heroin Initiation and Risk Behaviour

This study adopted an ethno-epidemiological approach to address three key research aims: first, to investigate the social course of young people's heroin and injecting initiation; second, to examine the 'risk environments' of young people's heroin smoking and injecting and; third to explore risk perception and behaviour during the early heroin career. Within the constructivist framework guiding this study, it was deemed essential to use a variety of research methods that could potentially capture both macro and micro-level forces influencing their initiation and subsequent risk behaviour. Four main research methods were adopted[7];

1) A community assessment process
2) Ethnographic observation
3) An 'interceptor' survey
4) Life history interviews

The study began with a community assessment process, which was essentially a process of engagement with professionals from services targeting drug-using and/or homeless youth. The objectives of the community assessment process were to inform service providers about the nature of the study; to access existing knowledge about 'new' heroin users in Dublin; and to forge connections with professionals who might potentially provide information on how to access and recruit young heroin initiates. It was anticipated that the community assessment process would enable the researcher to identify appropriate locations for ethnographic observation (which in some cases also required the permission of service providers), and that service providers with whom contact was made might be in a position to facilitate introductions to potential research participants.

Ethnographic observation was conducted in a variety of settings including drug treatment, harm reduction, and homeless services, as well as in a number of outdoor locations where drug users are known to congregate for the purposes of social and economic exchange. These observations focused on the presence of different groups of drug users within a range of settings as well as on their social interactions and activities. The main aims were to develop familiarity with the language and social worlds of heroin users, to establish rapport with prospective participants, to inform the study's sampling strategies[8], and to develop contextual understandings of the social interactions, peer networks and physical environments of young heroin users.

[7] A more detailed description of the four data collection methods is provided in later sections.
[8] Targeted sampling is discussed in a later section detailing recruitment and sampling strategies.

Access to the field, assisted by the community assessment process and the ethnographic observations, enabled the targeting and recruitment of young heroin users for participation in the study's interceptor survey and qualitative life history interviews (although challenges arose and these are discuss in detail later). The interceptor survey was a quantitative instrument administered to 120 individuals between the ages of sixteen and thirty years who reported lifetime[9] heroin use. The survey took approximately ten minutes to administer[10] and the young people were offered a five euro gift voucher[11] as a token of appreciation for their time and participation. This survey instrument aimed to generate a broader demographic profile of heroin users than could be generated through the conduct of a smaller number of life history interviews, and to provide social and epidemiological descriptions of the physical environment, social groups and contexts within which young people initiated and administered heroin, particularly during the early stages of use. Information gleaned from the interceptor survey also facilitated the identification of youth suitable for participation in the life history interviews and assisted decision-making about sampling techniques and strategies, particularly as the fieldwork progressed[12].

Life history interviews were conducted with a sample of 40 young heroin users, including 17 young women and 23 young men, between the ages of 16 and 25 years. The life history interviews aimed to elicit life story narratives and, in this sense, sought to 'locate' their heroin initiation and use within the 'life' in which it evolved. These interviews took between one and three hours to complete. All those who participated in this interview also completed the interceptor survey and received a twenty euro gift voucher to compensate for their time.

The four methods contributed to the unfolding research process and provided crucial contextual information on young people's lifestyles, drug use behaviours and their social networks, however data obtained from the community assessment process and ethnographic observations were not incorporated into the analysis. The life history interviews and interceptor surveys were the primary sources of data used for this purpose. The community assessment process was an important mechanism that assisted entrée to the field, aided the study's sampling techniques, and provided information on current drug-using practices and trends within the services' catchment area and target population. Establishing connections with key professional informants also facilitated access to potential participants (both for the completion of the survey and the life

[9] Young people who had used heroin on at least one occasion in their lifetime were targeted.
[10] This was the length of time taken to administer the interceptor survey when it was conducted without added conversation. In practice, this rarely occurred as items on the survey often elicited narrative from the participant. For this reason, the interceptor survey often took up to thirty minutes to administer.
[11] Ethical approval for the study was granted on the condition that young people were offered gift vouchers and not cash in exchange for their participation.
[12] The sampling techniques used included purposeful and theoretical sampling as well as chain referral techniques. These are discussed in detail in a later section.

history interview). Ethnographic observations enabled the researcher to gain familiarity with the recruitment sites and to foster rapport with the study's population, a 'hard to reach' group, prior to administering questionnaires or conducting life history interviews. Information obtained through ethnographic field notes also served to contextualise information gleaned from the interceptor surveys and life history interviews. The administration of the interceptor survey also served to increase the researcher's level of contact with young heroin users, foster greater familiarity with the language and 'culture' of the target population, and draw attention to themes for inclusion or further development throughout the interviewing process. This data collection method also facilitated the targeting and recruitment of suitable participants for the life history interviews. The research process, including a more detailed account of the four main data collection techniques, is described in detail below. However, it is useful to first provide an overview of the fieldwork orientation and approach, and to describe the evolving research process.

Ethnographic Fieldwork: ***A 'Messy Business'***

Ethnographic research is a 'messy' business (Maher, 1997) and cannot be described in the discrete categories often presented in methodological descriptions adopted within positivist paradigms. Ethnographers avoid imposing boundaries on the research process and tend to merge and alternate tasks such as gaining access to the field, selecting participants, carrying out participant observation, conducting interviews and analysing data. The nature of ethnography dictates that these events are non-linear, recurrent and often concurrent, occurring in what has been termed "the ethnographic cycle" (Spradley, 1980). The ethnographic component of this ethno-epidemiology was no different. From the outset, the research process was fluid and dynamic with many tasks occurring simultaneously, and it remained relatively non-linear throughout the course of the fieldwork. During the time period, between January 2007 and September 2009, activity fluctuated between 'community assessment', engagement, recruitment and data collection. Quantitative data entry, interview transcription, coding and data analysis also occurred in conjunction with these processes. Themes were developed through the analysis of data, and this, in turn, served to focus and inform subsequent data collection (Charmaz, 2003). In these ways, the research process developed along many lines simultaneously rather than in a systematic step-by-step pattern.

The research procedure could be compared to the telling of a story in that it gradually unfolded over time and constantly changed and evolved in unanticipated ways. This, as described by Lisa Maher, is the way in which ethnographies are often carried out;

> As opposed to the process of 'retrospective' construction typically assumed by most research methodologies, ethnography involves the active construction of an (ongoing) story (Maher, 1997, p. 207).

Although the ethnographer may wish to tell a story of smooth, unchallenged excellence, a more accurate portrayal of ethnographic research will present the difficulties implicit in the process. Keeping ethnographic research open and transparent in this way ensures that authenticity is retained (Agar, 1996). The story of this ethnography, as depicted below, is one which aims to acknowledge the cyclical nature of the research process, as well as the challenges in accessing and representing the social worlds of young heroin users.

The Community Assessment Process

As stated earlier, the 'community assessment process' (Clatts et al., 2002) was designed to inform service providers about the study, facilitate entry to the field, gather information about current or recent drug trends and practices, and to identify suitable recruitment locations for carrying out ethnographic observations, the administration of the interceptor surveys and the conduct of life history interviews. The process began in January 2007 when contact was established with professionals working in services targeting young drug users and continued until data collection was complete in September 2009. Personnel from 11 of the 13 local drug task forces in the greater Dublin area were contacted and over 30 services[13] in both suburban and city-centre locations[14] were identified as potential recruitment sites. In the following months, informal discussions with numerous service providers from these services were carried out and semi-structured interviews were conducted with twelve key informants who provided services, either directly or indirectly, to young drug users or 'at risk' youth.

During the early months of the community assessment process it became apparent that some professionals working with drug users, particularly in areas outside of the city-centre, felt that heroin was not the main 'problem' drug among youth and that cocaine had surpassed heroin as the drug of choice of young people. There was considerable dialogue around what was described by these professionals as a growing "cocaine epidemic[15]" and some of the study's key informants (and others with whom the researcher engaged less formally) reported that heroin had not maintained its position as the main problem drug. Several suggested that young people growing up in areas associated with the heroin epidemics of the 1980s or 1990s considered the drug to be

[13] Statutory and voluntary services were included.

[14] In addition, contact was made with three services outside of the greater Dublin area (two in the Southeast and one in the Southwest of Ireland). Professionals in these services, however, did not have contact with young heroin users under the age of 26 years.

[15] The media also referred to the "cocaine epidemic" during 2007 and 2008 when this stage of the fieldwork was underway. For example, on the 23rd December 2007, the *Sunday Independent* published an article entitled "Cocaine Epidemic Leads to Rise in Brain Seizures" and on the 20th January an article in the *Sunday Tribune* entitled "Teenage Kicks" referred to the "cocaine epidemic".

'dirty' and stigmatising. Indeed, a number of service providers felt that heroin was not a major "issue" or "problem" at that time and that the use of cocaine, benzodiazepine and/or polydrug use had surpassed the problems associated with heroin use. The researcher was of course aware that the heroin use situation would not be described in 'epidemic' terms at the time fieldwork was initiated. Nonetheless, evidence from the available treatment figures during the period from 2001 to 2008 (Carew, 2010; Carew et al., 2009; Reynolds et al., 2008) did not accord with the views of these service providers since the majority of new cases entering treatment continued to cite heroin as their main problem drug. Concerns surrounding what was depicted as a dramatic rise in cocaine use were substantiated by epidemiological evidence, however, with an evident increase in cocaine treatment demand observed between 2002 and 2006 (Bellerose et al., 2009). Nevertheless, these figures represented less than one fifth of all treatment cases, and the vast majority of problem drug users continued to report opiates as their primary concern (Carew, 2010).

Young heroin users are at high risk of negative outcomes, due in no small part to their hidden and stigmatised status (Fennema et al., 1997; Garfein et al., 1998; Van Beek et al., 1998). As the early months of fieldwork progressed it became apparent that many services, particularly those in suburban communities, had little contact with or knowledge about new heroin initiates. Indeed, the challenges facing service providers in their efforts to target and attract recent heroin initiates to their services were in many ways exemplified by the relative invisibility of young initiates (Egginton & Parker, 2000). The difficulties experienced in recruiting young heroin initiates from these services therefore arguably point to the larger problem of their marginalisation, exclusion and stigmatisation, particularly during the early stages of their heroin careers.

As the community assessment process continued, it was clear, however, that many city-centre services, as well a small number of drug treatment centres in suburban areas, did have contact with young heroin users. The professionals working in these services considered heroin initiation to be a very significant concern and identified heroin as the main problem drug among their client groups. In Dublin, the concentration of services in the city centre means that young heroin users have to gravitate into the city centre in order to access treatment, harm reduction or homeless facilities (Department of Community Rural and Gaeltacht Affairs, 2008). This dynamic was in fact observed during the community assessment process, with young heroin users more visible in city centre services. One outreach worker based in a city centre service described the drug-use patterns of the majority of that service's clients;

> *"It's the end of the market we're in, in the city centre, homelessness. I think the drug that we're most inclined to see is heroin. Tablets are always there and hash as well but, generally, most young people would primarily be using heroin and anything else in*

between. Everyone would try it [heroin], and smaller numbers would be injecting coke as well as heroin, but it can change quite quickly" — Outreach worker (City Centre Hostel).

During the study's community assessment process, contact was made with over 30 services targeting young drug users across the greater Dublin area. The professionals working within these services provided valuable information about drug-using trends within their client group. This enabled the selection of suitable sites for ethnographic observation and the potential recruitment of interceptor survey and life history interview participants. Homeless hostels and drop-in centres, harm reduction programmes and youth drug treatment centres in the city centre, as well as a small number of drug treatment centres in suburban locations, were selected as recruitment sites.

Recruitment and Sampling

The study adopted a range of sampling techniques including purposeful and theoretical sampling, as well as chain referral techniques. Both the sampling techniques and selection criteria varied according to the data collection methods and differed for the recruitment of survey and life history interview participants, respectively. Males and females between the ages of eighteen and thirty years, reporting *lifetime* use of heroin, were targeted for participation in the interceptor survey. The sampling strategy targeting the recruitment of these participants was purposive, that is designed to fulfil the requirements of the study (Glaser, 1978), since the inclusion criteria for participation in the survey (both male and female, over the age of 18 years but under the age of 31, experience of lifetime heroin use) were decided prior to the commencement of fieldwork. The 120 respondents (78 males and 42 females) were recruited through a range of city-centre and suburban drug treatment services, drop-in centres, homeless services and, also, in a number of street-based settings.

Young recent heroin initiates between the ages of 18 and 25 years, but with *shorter heroin use histories*, were targeted for participation in life history interviews. However, in order to develop an understanding of drug-using lifestyles and trajectories, and to situate the sample in a broader social context, the ethnographic net was cast over a larger population. Participant observation was conducted in a variety of settings where older heroin users congregated, including drug treatment centres, harm reduction services, outdoor locations[16] and homeless services, in order to gather information about larger heroin-using social networks, to develop an understanding of younger users' positions within these networks, and to gain knowledge about the heroin use trajectories of different age groups. For example, older heroin users provided insight into how their heroin use evolved over time, from initiation to problematic use, to treatment, relapse and

[16] Participant observation was conducted in outdoor locations where drug users are known to congregate, including alleyways, boardwalks, and areas outside drug treatment centres.

recovery. By reflecting on their experiences, these older drug users provided insight into how their heroin use and/or homeless 'status' or 'identity' impacted on their lives. These insights were gleaned through informal interaction with heroin users of all ages within a range of sites (including indoor and outdoor locations) where drug users were known to congregate. These interactions also revealed that young recent initiates to heroin did not socialise solely in heroin-using networks made up of like-aged peers; alternatively, they tended to mix with older heroin users and often had close relationships with users in their late twenties or thirties. Thus, the decision to cast the ethnographic net over a broader population than those targeted for participation in the study's life history interviews not only provided important contextual information but also helped to inform the recruitment strategy.

A combination of purposeful, theoretical and chain sampling were used to recruit young initiates for (life history) interview. At the outset, the aim had been to conduct life history interviews with a sub-sample of interceptor survey participants who were *recent initiates* to heroin. The selection criteria devised included young people: a) aged 18-25 years; b) male or female; c) initiated heroin during the five years prior to interview. To this end, a purposeful sampling strategy was used during the early stages of fieldwork and it was planned young heroin users would be selected in accordance with the research aims (Coyne, 1997; Crabtree & Miller, 1999; Patton, 2002; Schatzman & Strauss, 1973). It was hoped that the temporal proximity to heroin initiation, as well as the salience of the event, would facilitate memory recall and provide 'information-rich' cases for analysis (Patton, 2002).

However, in keeping with the difficulties noted elsewhere relating to the recruitment of young heroin users (Pearson, 1987a; Pearson et al., 1986; Parker et al., 1988; Egginton & Parker, 2000), gaining access to young recent initiates of the drug proved challenging from the outset. Even during the early days of the community assessment process, it quickly became apparent that few recent heroin initiates were accessing community-based services such as suburban youth clubs or drug treatment centres. Furthermore, professionals working in suburban youth services targeting drug users reported that they did not have attendees who reported lifetime heroin use and that most were engaged in recreational use of marijuana, ecstasy or, in some cases, cocaine. For example, one professional working in a suburban local drugs task force area reported;

> *"No. Heroin isn't coming up. The main concerns would be alcohol number one, hash number two and there's a bit of talk around cocaine use. They're (young people) drinking a lot, they're smoking a lot of hash and they're probably doing a bit of cocaine on the weekend and maybe some tablets, but not heroin" — Education Officer (Suburban LDTF).*

Suburban methadone clinics, although willing to facilitate the research study, had small numbers of clients under the age of 25. Perhaps to put these challenges in context, it is important to note that figures from the National Drug Treatment Reporting System indicate that the majority of clients will have used opiates for *over* five years before accessing drug treatment (Carew, 2010; Carew et al., 2009). This was certainly the case for many attendees at the drug treatment centres contacted during the course of this research. These factors created obvious challenges to the recruitment of recent initiates for participation in the life history interviews. In addition to this, discussions with both young heroin users and service providers during the community assessment process and ethnographic observation revealed that many heroin users had initiated heroin use prior to the reported average of seventeen years (Gervin et al., 2001). To ensure that interviews were carried out as soon as possible subsequent to the initiation event, it therefore became necessary to recruit individuals younger than the stipulated age range of 18-25 years. Those young people at the younger end of this spectrum were considered to be particularly important in terms of generating an interview sample of young recent heroin initiates. However, young people were less likely than their older or more drug experienced counterparts to access drug treatment facilities or to have disclosed their heroin-using status to family members, professionals or non-drug-using peers. Furthermore, young people in the early stages of their heroin-using careers were reported to be more 'chaotic' and difficult to engage. One key worker emphasised the challenge of recruiting younger users;

> *"With young people, like 18 year olds, they're going to be very chaotic*[17]*. You'll need a carrot. What are you going to use to entice them? To be honest, for an 18 year old, spending 150 euro on their heroin habit a day, twenty euros is not going to be much use to them*[18]*. They're a very difficult group to work with, to talk to, you'd be better off asking older people about when they started using. Older people around 26 who have stopped using. I can see you might have a problem with memory recall, but looking for people within the first two years, you'd have to ask 14 or 15 year olds because a lot of people start using heroin at 12 or 13" — Key worker (City Centre Service).*

Despite the challenges of recruiting participants at the younger end of the 16-25 year spectrum, a number of services proved fruitful in this regard. In particular, homeless youth services and drug treatment services targeting younger users provided access to young recent heroin initiates. Alternative recruitment settings revealed different groups of young heroin users with diverse

[17] 'Chaotic' young heroin users using large quantities of heroin on a daily basis were, as suggested by this key worker, difficult to locate, engage and interview. Strategies for purposeful sampling include selecting participants who are 'articulate, reflexive and willing' (Morse 1991) and young heroin users with heavy patterns of use often did not fulfil these criteria. Those in the early stages of heroin use, with moderate levels of use, accessing substitution treatment or abstaining, generally provided more information-rich accounts of their heroin initiation and risk behaviour.

[18] The key worker is referring to the twenty Euro voucher offered to young people for their participation in the life history interviews.

patterns of heroin use (from 'occasional' to 'problematic[19]'), and fieldwork conducted in these locations also informed the sampling strategy. For example, young people from adult homeless services were often deeply immersed in the street-based heroin scene and had chaotic lives and living arrangements. Conversely, those from youth drug treatment centres were often living in their own communities, had greater access to a variety of resources, and tended to have the support of their families. Although reporting heavy and problematic heroin use, these young people did not tend to demonstrate such 'chaotic' lifestyles as those from youth and adult homeless services. Therefore, they were better equipped in some cases to engage in the quite lengthy interview process and tended to give quite detailed accounts of their heroin initiation and early risk behaviour. Nevertheless, a number of young people in youth homeless services were recent initiates, reported 'occasional' use of the drug and did not consider their heroin use to be 'problematic'. For these reasons, drug treatment and homeless services specific to young people were targeted for the purpose of recruitment for life history interview.

Early interviews were transcribed, coded and analysed. Using theoretical sampling (Corbin & Strauss, 2008; Glaser & Strauss, 1968; Glaser, 1978) further participants were targeted in an effort to develop and extend emerging themes and to examine the interrelationships between emerging analytic categories. Snowballing sampling or chain referral (Biernacki & Waldorf, 1981) proved useful in achieving this aim since participants often had social connections with other heroin users with experiences similar to their own. Five participants were recruited for interview using 'snowballing' techniques.

A number of key themes emerged from the coding and analysis of data that directed theoretical sampling; first, gender could be seen to impact upon heroin initiation and risk behaviour; homelessness also began to emerge as a common experience among young heroin users. With respect to gender, it became clear even from the early stages of fieldwork that young people's 'stories of initiation' were mediated by gender. Young women who were recent initiates were targeted in order to fully explore and unravel this emerging theme and this process extended until the data had reached saturation. For this reason, 17 young women were included in the final sample of 40, an over-representation of females according to the three-to-one ratio of male-to-female heroin users reported in the Irish literature (Cox & Comiskey, 2007; Reynolds et al., 2008). Homelessness also emerged as a strong theme during the early stages of data analysis. As a result, contact was made with a number of additional services targeting homeless youth in an effort to ensure a comprehensive understanding and analysis of the relationship between homelessness and heroin use, which is a well-established 'connection' in the Irish drug literature (Cox & Lawless, 1999; Lawless & Corr, 2005: Lawless et al., 2004). Within the final sample, a

[19] The subjective nature of 'occasional' and 'problematic' patterns of heroin use was recognised. The aim was to recruit young people who did not consider their heroin use to be 'problematic', 'unmanageable' or 'disruptive'.

variety of housing arrangements were represented, including living in the family home, private rented accommodation, local authority housing, homeless hostels, B&B accommodation and sleeping rough.

The recruitment process extended over a far more lengthy period than originally planned. Nonetheless, progress was made steadily, if slowly, in part through persistence and constant contact with both city-centre and suburban services targeting drug using or 'at risk' youth. As new information was gleaned over the course of many months (often in the context of an informal meetings or telephone conversation with a service provider), theoretical sampling was used to target particular individuals or groups. The process, while lengthy, provided many new insights particularly as time progressed. In the final sample of 40 who participated in life history interviews, five reported their heroin use as 'occasional' or did not consider it to be problematic. Eleven had initiated during the previous two years, 14 had initiated between two and four years previously, and six had initiated between four and five years prior to interview. The remaining nine young people initiated over five years prior to the interview but were recruited because they initiated at a particularly young age, described a different 'story of initiation', and/or initiated injecting drug use during the five years prior to interview.

Ethnographic Observation

When conducting qualitative or ethnographic research, considerable time must be spent in the field in order to develop relationships with participants and to enable the researcher to gradually develop an understanding of how they perceive themselves and the world in which they live (Agar, 1977). For this reason, participant observation is the cornerstone of ethnographic research. In this study, participant observation contributed in a variety of ways: it facilitated the recruitment and sampling processes; contextualised information obtained from the interceptor surveys and life history interviews; and provided insight into the activities and social interactions of street-based heroin users.

Spending time in the field enabled the researcher to gain insight into the social world of the heroin users. As described by Agar;

> Participant observation means you are actually there, that you enter the world of the people you're working with rather than bringing them into your world. In this sense, participant observation is a diagnostic feature of ethnography (Agar, 1996, p. 9).

Over five hundred hours of participant observation were conducted in a variety of public and semi-public settings where drug users are known to congregate. However, locating groups of young recent heroin initiates for the purpose of informal interaction continued to pose challenges.

Heroin users are a 'hidden' population, and recent heroin initiates in particular are difficult to locate and recruit (Wiebel, 1990). Periods of participant observation were therefore often spent in settings and groups dominated by an older population of heroin users. The majority of heroin users identified through observations in city-centre street- and service-based settings were in their late 20s or 30s. It was more difficult to locate or identify groups of younger heroin users in these public settings (field notes 08.03.07, 14.05.07, 15.05.07, 21.05.07, 30.05.08).

Interactions with older heroin users demonstrated their willingness to participate in the research and many often spoke at great length about their lives and experiences, often describing extended periods or repeated episodes of service involvement. They were also quite familiar with researchers. As a result, many held beliefs surrounding the purpose of research; a number, for example, assumed that the research aimed to evaluate and improve drug treatment services. Many others provided accounts of their recent treatment and recovery experiences, often disclosing information about the suffering associated with a heroin-using lifestyle. For example, on one occasion, a heroin user in his early 30s initiated conversation with me on the 'boardwalk[20]'. He was very willing to discuss his drug use, life circumstances and HIV status, as indicated in the field notes;

> *"I explained to Nigel that I was doing some research with drug users and that I planned to interview them. He began to tell me all about himself and his life; that he was a drug user for 15 years, that he was 31, that he had a 16-year-old son, and that he had 'the virus'. I asked him if he was on anti-viral medication and he told me that he wasn't because his cell count was fine, but that his wife was on triple therapy" — Field notes (06.06.07).*

Older heroin users were open about their drug-using experiences, and were knowledgeable, and often opinionated, about drug-related issues. These interactions were invaluable to the research process and enabled the development of local knowledge of Dublin's street-based drug scenes, drug-using practices, language and daily routines.

Over time in the field, it became apparent that the younger generation of heroin users were not as visible and accessible as their older counterparts. A small number of young heroin users were observed 'tapping[21]' on city centre streets and, over time, and by spending time in homeless services, these individuals became known to me (field notes 22.05.07, 24.07.07, 05.11.07,

[20] The 'boardwalk' is a riverside walk along the north Liffey Quays in Dublin's city centre. Drug users have been known to congregate on certain sections of the boardwalk, an issue that sparked some media attention. On the 24th August 2006, for example, the *Irish Independent* published an article entitled "Brazen Drug Dealers Take Over City Tourist Trail". Participant observation was conducted in these locations.

[21] 'Tapping', 'begging' or panhandling, was the method that some young people used to supplement their income. Most would sit in strategic locations with a high flow of human traffic such as outside bank machines, on bridges over the River Liffey or outside regularly frequented shops. There was often competition for these 'spots' and so, there was often a high turnover with different individuals being observed from one day to the next.

12.11.07). On one occasion, I accompanied an outreach worker to various locations where young homeless heroin users were know to 'tap'. In the space of two hours, we met two young men whom I had met previously in a homeless drop-in service for young people[22]. We conversed with the first young man at length, but did not engage the second for the reasons described;

> *"We saw Seamus tapping beside a bank machine on [Dublin city centre] Street. Jane [the outreach worker] said 'hi' and waved to him, but we moved on. She told me that Seamus would be embarrassed to be seen begging and that's why she didn't stop to chat to him" — Field notes (24.07.07).*

Observations conducted in a range of settings also revealed that young heroin users did not generally associate with larger groups of street-based heroin users and were rarely visible in public locations. There were some exceptions to this rule and, on a number of occasions, I did come across younger people, although they were not easy to identify as 'heroin users'. For example, on one occasion, I observed two young men relaxing on the 'boardwalk'. Their dialogue revealed that they were in fact users of the drug;

> *"As they smoked their joint, the two young men chatted away. The young man lying down on the bench asked the other, who had just rolled the joint, about skin popping. He asked, 'Skin popping? How do you do that?' The other young man demonstrated on his stomach. 'Like that? Is it painful? Can you do it anywhere?' The young man who demonstrated said he was strung out and that he had been injecting in the back of his neck" — Field notes (03.05.07).*

Generally, young heroin users were only observed in outdoor locations during the summer months when the weather was exceptionally warm and sunny. Consequently, indoor settings including services targeting young drug users, homeless youth and adults, drop-in services and treatment centres, tended to generate more direct contact with young drug users. Many of the most valuable interactions with young initiates over the course of the study occurred within these settings where it was easier to converse with the young people privately, and gradually and informally cultivate relationships. Participant observation in these settings enabled the development of rich and extensive field notes which helped to locate and contextualise the data garnered from both the interceptor surveys and life history interviews. For example, young people's narratives from the life history interviews revealed how homeless experiences often preceded their immersion into street-based heroin-using networks. However, direct contact with members of these social networks enhanced and extended understanding of such experiences and

[22] The service targeted homeless young people under the age of twenty-six.

accounts. Information obtained through spending time in the field also facilitated the more 'formal' processes of data collection and fostered greater rapport with prospective participants. Finally, the field notes served to support and extend the information obtained through the study's survey instrument and ethnographic interviews. Triangulation is a key method of ensuring internal consistency within a study that uses a variety of research tools (Hammersley & Atkinson, 1995). Many of the issues and themes emerging from the life history interviews were also observed during ethnographic fieldwork and were supported by the data obtained from the interceptor survey.

The Interceptor Survey

The interceptor survey instrument was designed to provide an epidemiological profile of a larger sample of young heroin users than could be obtained through the conduct of a smaller number of life history interviews. This instrument was also designed to literally 'intercept' the population of young heroin users to enable the selection of a smaller sample for in-depth interview. Although a quantitative instrument, its administration also proved a valuable source of qualitative data. This was a largely unanticipated outcome which arose out of the willingness of participants to speak at length about their experiences (field notes 15.01.07, 08.03.07, 10.07.07, 31.04.08, 15.09.08, 24.09.08). Thus, in addition to providing quantitative data, from which dominant statistical patterns and sources of epidemiological complexity could be identified, the interceptor survey provided insight into the lives and drug-use practices of young heroin users. Conversation occurred easily and naturally during the administration of the interceptor surveys, and an informal, private environment proved conducive to producing valuable narratives. The young people were reflective and self-aware, revealing not only events or experiences but also interpreting their own and others' responses and motives. Often, a five-minute 'chat' evolved into a lengthy discussion about the young person's life, or a specific issue or event. The interceptor surveys thus provided a valuable opportunity to engage with the young people while completing a specific and discrete task. These narratives, although not tape recorded, provided important data and also highlighted issues for exploration in the life history interviews.

Over 70 items were included in the survey instrument spanning the following areas: demographic characteristics, drug use history, heroin initiation, injecting initiation, current injecting practices, sexual history, current sexual practices, service utilisation and criminal behaviour. Questions investigating heroin and injecting initiation and current injecting practices included those on the social and physical environment as well as individual behaviours and rationale. A copy of this instrument can be found in appendix seven. All lifetime users of heroin under the age of thirty were eligible for participation. While a five Euro voucher was offered, this did not appear to influence participation. Almost all agreed to complete the interceptor survey before the voucher was mentioned, and those who refused did not change their mind once it was.

Life History Interviewing

Life history interviewing is closely associated with the ethnographic tradition (Agar, 1980; Atkinson, 1998; Becker, 1970; Spradley, 1979) and seeks to understand the lives of individuals as they unfold within a particular social, cultural, political and economic context (Cole & Knowles, 2001; Denzin, 1989). It is a research method that aims to uncover and interpret the subjective meanings that individuals attribute to their environment, experiences and social interactions (Denzin, 1989; Roberts, 2002; Sherman Heyl, 2001; Spradley, 1979). It is therefore inextricably "connected to a central epistemological construct illuminating the intersection of human experience and social context" (Cole & Knowles, 2001, p. 9). Within the constructivist approach adopted in this study, life history interviewing was privileged as the main data collection technique.

Life history interviewing has been used to explore constructions of 'deviance' since the early 1960s. Challenging individualistic perspectives, a number of researchers have used biographical narratives to illustrate how individuals enter 'deviant careers' through social interactions with others and broader social structures (Becker, 1963; Lemert, 1967; Matza, 1969). This form of data collection is conducive to studying the drug-using 'career' because it can capture 'turnings', 'transitions' or 'trajectories' within the life course of the individual (Roberts, 2002). Since the 1960s, numerous researchers have effectively adopted the life history interview to study the heroin 'career' (Faupel, 1987; 1991; Preble & Casey, 1969; Rosenbaum, 1981; Taylor, 1993; Waldorf, 1973), giving individual heroin users a 'voice' (Roberts, 2002) and revealing the lived experience of the heroin-using lifestyle.

In-depth life history interviews can explore the interplay of macro and micro-level environmental forces, and reveal how they operate at the individual level (Anderson, 1994). Although traditionally used for the study of micro-level social interactions, ethnographic research methods in general, and life history interviews in particular, can reveal how changing macro-level forces shape human experience (Clatts et al., 1995; Hammersley & Atkinson, 1995). Within the rapidly changing social and economic climate of Dublin city, life history interviewing offered a valuable opportunity to place the individual's experience within a broader macro-level context (Clatts et al., 1995). Simultaneously, micro-level forces such as the immediate social context of initiation and interactions within drug-using networks can be explored. Life history interviewing can therefore effectively capture the 'risk environment' of young people's heroin-use trajectories and experiences. Previous studies have used in-depth qualitative interviews to examine the role of the 'risk environment' in injecting risk behaviour (Razzaghi et al., 2006; Rhodes et al., 2003; Small et al., 2007) and sexual risk behaviour (Mill & Anarfi, 2002; Rhodes et al., 2008).

In this study, life history interviews were conducted in a similar way to that described by Clatts and others;

> Youth were invited to tell the ethnographer their life stories in their own terms, in their own way, and with an emphasis on what they felt was important for the ethnographer to understand about them (Clatts et al., 1995, p. 124).

An interview schedule was prepared, but questions were open-ended and there was considerable opportunity to divert the discussion to issues raised spontaneously by the participant. The young people were encouraged to talk about their lives, reassured that everyone has a 'life story' worth telling, and that their life stories were particularly important for the purpose of understanding heroin initiation. Flexibility was prioritised in the interview process so that the young people could openly reflect on their life experiences (Maher, 1997) and so that new and interesting themes could emerge and be pursued (Atkinson, 1998). At the beginning of the interview, the young person was invited to tell his or her 'life story'. Several key topics were then discussed, including their early life experiences, family life, drug-using history, heroin and injecting initiation, heroin-using 'careers', injecting risk behaviour, sexual relationships, physical and mental health and service utilisation. The social worlds of the young people were a key focus of the interview and participants were asked about their relationships with 'significant others' such as family members, peers, friends and sexual partners. Considerable attention was paid to the circumstances preceding heroin and injecting initiation, and to the social and physical environments within which young people smoked and injected heroin. A copy of the life history interview schedule is contained in appendix eight.

As outlined in the previous section, the interceptor survey was most often administered during the conduct of ethnographic fieldwork and the administration of this instrument was also important in selecting and recruiting participants for life history interview. However, as documented by others (Agar, 1973; Dai, 1937; Stephens, 1991), drug users lead busy and active lives and have immediate and pressing priorities that need to be addressed and negotiated. Developing relationships with willing participants did not, therefore, necessarily translate easily or quickly to the completion of life history interviews. The young people were often difficult to locate and engage because they were rapidly moving in and out of services, were preoccupied with other concerns or issues, or unable to complete an interview because they were drug intoxicated. It often took some time to arrange and complete life history interviews, although some were conducted within a relatively short time of first meeting a young person. Over the course of the fieldwork period, 40 young people, including 17 young women and 23 young men, participated in the life history interviews[23]. All were between 16 and 25 years, with an average

[23] All of these young people also completed the interceptor survey.

age of 20 years. The young people were recruited from several different sites, including community and inner city-based drug treatment services, homeless services and generic youth services. Consequently, a variety of housing arrangements were represented in the sample; 17 young people were living in their family home, five were living in local authority housing, three in private rented accommodation, nine were living in emergency homeless accommodation, three in transitional housing, one was living on a halting site, and one in the home of his grandparents. Of the 40 young people, 31 were attending drug treatment services and were receiving suboxone or methadone substitution at the time of interview.

The information generated through the life history interviews provided insight into the macro and micro environmental context of heroin initiation and risk behaviour. Key to making sense of these data was the ability to locate events, experiences and behaviours within the chronology of the individual's life (Clatts et al., 1995; 2001). Consistent efforts were thereby made during the interview to ensure topics and events were located within a historical frame so that, as far as was possible, a clear chronology of events could emerge from young people's accounts of their life experiences both prior to and immediately following the event of heroin initiation. To ensure internal consistency, quality checks were used to clarify comments made by the participant if they were unclear, or if they appeared contradictory (Roberts, 2002). This technique was not used to obtain a 'historical truth' of events, but rather to develop understandings of how the individuals create meaning by connecting events and experiences in their lives. It also helped to ensure that the participants' comments were understood and interpreted correctly by the interviewer. In order to ensure accuracy and in line with privileging the narratives of study participants, the life history interviews were audiotaped.

The life history interviews provided a rich source of data and, in general, the young people openly shared and described their experiences and interactions. Participant observation and one-to-one contact during the interceptor surveys aided the establishment of rapport with participants and facilitated this openness. The majority of young people were interviewed in a quiet private setting, and a relaxed informal environment was created through seating arrangements[24]. The researcher offered tea and a snack where possible when engaging in casual dialogue prior to the interview. This enabled both the researcher and the participant to relax and feel at ease. In many instances, the interviews lasted over two hours because the young person wished to elaborate or reflect on his or her experiences. Some young people were hesitant during the early stages of the interview and required a period of time to 'warm up', but the flow of dialogue invariably became more fluid and developed as the interview progressed. When narratives emerged spontaneously,

[24] In drug treatment or homeless settings, interviews were conducted in a private room. Care was taken to move tables to the side, so that they did not come between the researcher and participant, and to offer the participant a comfortable chair.

the individual was "allowed to hold the floor without interruption" (Atkinson, 1998, p. 31) and this technique produced lengthy, information-rich interviews.

Data Analysis

As described in previous sections, this study adopted four main research methods. However, data obtained from the community assessment process and the ethnographic observations were not included in the analysis. These research techniques were primarily used to facilitate recruitment, to inform theoretical sampling, to develop and refine the research instruments and to identify themes for exploration in the life history interview. Therefore, community assessment interviews and ethnographic fieldnotes guided and supported the process of developing and conducting the research but were not incorporated into the analysis or used to generate the findings.

The questionnaires and the life history interviews were the primary sources of data used in the analysis. Immersion into the data was considered vital to the analytic process. From the early stages of fieldwork, questionnaires and life history interviews were written up or coded and the data were continuously examined and reflected upon. Questionnaire data were immediately entered into SPSS software[25], and descriptive statistics were run in order to monitor the demographics of the sample as the numbers grew. The life history interviews were listened to shortly after their completion to monitor data quality and to identify important details or clarifications which may have been required upon re-engaging with participants. The interviews were transcribed within a couple of weeks, thus facilitating greater familiarity with the data. A summary was prepared documenting the 'life history' of each participant with particular attention to the social course of heroin initiation, and to the young people's exposure to risk and risk behaviour. This process enhanced familiarisation with the data and facilitated the development of 26 coding categories that were identified mid-way through the fieldwork period. The interviews were subsequently coded into these categories using N-Vivo software[26].

Based on the summaries gleaned from the life history interviews, and the relevant coding categories, key themes were identified in relation to the social course of heroin initiation. Coding categories related to injecting, sexual and criminal risk behaviour were examined. Using pattern analysis (Quinn-Patton, 2002), themes related to participants' demographic information and the social course of their initiation were also identified. The life history interviews were then re-examined to clarify and check for the integration of these themes, with particular attention paid to negative instances. Contradictory cases can be used to challenge existing arguments (Mayock & O'Sullivan, 2007) and gain deeper insight into the nature of patterns and themes within the data,

[25] Statistical Package for the Social Sciences, or SPSS, is a computer programme used for the statistical analysis of quantitative data in social science research.

[26] N-Vivo software is a research tool for organising qualitative data. It cannot analyse the data for the user as such a function would not be desirable, but aids in the manual tasks associated with qualitative analysis.

so this procedure was invaluable to the research findings. It was the overarching aim of the analytic procedure to reflect and represent, as far as possible, the social world views of the study's young people.

Reflexivity and the Research Process

From the traditional positivist paradigm, limiting the effects of the researcher on variables is paramount, and an objective, value-free and rigorous approach is encouraged in the dissemination of findings (Guba & Lincoln, 1998; Denzin & Lincoln, 1994; Reid, 1994). Nonetheless, the influence of the researcher cannot be completely removed from even the most controlled research experiments since the questions asked, the methods used, the interpretation of findings and the presentation of results all reflect a subjective epistemological perspective (Crotty, 1998).

Qualitative researchers accept there is no 'objective' social reality and acknowledge that they are connected to, and have an important impact on, their research (Denzin & Lincoln, 1998b). When ethnography is adopted as a research method, this position is even more salient due to the high degree of interpersonal contact between ethnographer and participant, and the immersion of the ethnographer into their social worlds. Reflexivity, therefore, as defined by Davies, is a key characteristic of postmodern ethnography;

> Reflexivity, broadly defined, means a turning back on oneself, a process of self-reference. In the context of social research, reflexivity at its most immediately obvious level refers to the ways in which the products of research are effected by the personnel and process of doing research (Davies, 1999, p. 4).

The life history of the researcher, the discipline within which the research is conducted, as well as the larger social, historical and political context will all dramatically affect the topic of interest, the theoretical approach, the methodological process and the interpretation and analysis of the data. In conducting this study, my academic background in psychology, my current position as a student in the school of social work and social policy, being female and coming from a white, middle class background, invariably influence my perspective on 'reality' and on heroin use. It was necessary to maintain awareness of this worldview whilst, in so far as possible, suspending my own judgements, perceptions and belief system. Understanding the world from another's perspective requires "stepping out of one's usual framework for making sense of daily life and stepping into the unfamiliar world of others" (Carlson et al., 1995, p .11). In conducting this ethnography with young heroin users, who have very different life experiences from my own, the ability to step out of one world and into another was a skill that had to be cultivated.

During fieldwork encounters, young people often asked me about myself and, in particular, wished to know where, in Dublin, I was 'from'. I found this question difficult to answer[27] and usually explained to participants that I had lived in many different locales since my early childhood[28]. I initially feared that this ambiguity in my identity would create barriers in social interactions, for example, that young people would believe I was withholding information, would find it difficult to 'relate' to me or would perceive me to be 'posh' or 'foreign'. However, these circumstances did not arise during fieldwork and my origins were rarely scrutinised after a polite customary inquiry. A more significant challenge that emerged in my early fieldwork encounters was overcoming barriers created by age differences. I was between 28 and 30 years during this period, and found it more difficult to approach and interact with young teenagers than participants closer to my own age. Over time, I learned how to initiate conversation with the younger people by referring to popular culture such as music, television or celebrities. Gender was also a significant dimension of the researcher-participant relationship. I found it easier, and quicker, to establish positive rapport with young women and often, young men were less forthcoming about their experiences until trust was established within a one-to-one interaction. Irrespective of age or gender however, the majority of participants responded positively when they were approached with interest and friendliness, and I gradually developed more confidence recruiting and interviewing teenagers and young men.

The social interaction and the relationship that develops between the researcher and participants over the course of ethnographic research are what enable the ethnographer to develop an understanding of the topic from an alternative worldview. Through the interpretation of data, the researcher must make sense of what has been observed and, in doing so, creates a meaningful text that can help others to understand the particular phenomena under investigation (Denzin, 1994). In a sense, interpretations are stories that we tell ourselves and each other in order to create meaning out of experiences, behaviours and events. It is the role of the ethnographer to actively construct observations into meaningful stories. In doing so, the researcher cannot be considered in isolation from the research product. The researcher is intimately involved in the construction of the data and in how that information is represented (Davies, 1999). This is an inescapable conclusion, but is one which raises the question of whether research is *only* a construction of the researcher and if social research is, therefore, about anything other than itself, a construction of a construction. The knowledge that one's reflexive knowledge is also socially constructed has been referred to as the 'tu quoque[29]' argument (Ashmore, 1989) and is one that creates a certain degree

[27] During my childhood years I lived in two main locations, a socially disadvantaged suburban area in West Dublin, and Bahrain, a small country in the Middle East where I was born. In my mid-teenage years I moved to a predominantly middle class area in South Dublin.

[28] In addition to living in Bahrain, Australia and the UK, I have lived in 11 different locales in the greater Dublin area, including inner-city, suburban, socially disadvantaged, working class and middle class areas in North, South and West Dublin.

[29] 'Tu quoque' translated from Latin means 'you, also'. It is used as a retort to accuse an accuser of a similar offense or behaviour (*The Oxford English Dictionary*, 1989).

of researcher angst. If one accepts that there are multiple realities that are socially constructed, then one must also accept that research is itself a social construction and not a single objective truth about a particular phenomenon (Crotty, 1998; Potter, 1996). This acceptance, however, does not necessarily lead to an unending inward spiral of denunciation because to accept that a certain reality is socially constructed is not necessarily to deny its value (Guba & Lincoln, 1998; Lincoln & Guba, 1985).

The difficulty that arises in response to the acknowledgement of researcher interpretation in constructing an ethnographic text is the postmodernist doubt that any discourse can claim authoritative knowledge on a given subject (Scheurich, 1997; Richardson, 1991; Clifford & Marcus, 1986). To place the ethnographic discourse above and beyond any other discourse on a particular phenomenon is to deny that, like all others, it is a construction influenced by a myriad of social circumstances and a particular social context. Nonetheless, this acceptance can be both liberating for the researcher and extremely beneficial for the quality of the research text. Recognising one's own lack of authority creates a space in which the perspective of others can be incorporated and developed. Reflexivity, from this perspective, can be seen in a positive light and it does not have to be, nor can it be, avoided. Researcher and participants are engaged in co-constructing a world, a process that gradually creates the research product (Steier, 1991). This construction of knowledge is unusual in the sense that there is an inbuilt recognition that the knowledge is a construction, but, in abandoning the obligation to represent objective 'reality', fluidity and flexibility develop, creating opportunities to develop meanings and understandings without rigidity. Furthermore, concern over representing 'reality' diminishes when 'reality' itself is under question. Constructions of reality are as valid as reality itself, since they are the only ways in which reality can be apprehended (Berger & Luckmann, 1966). Despite this, if the researcher remains rigidly stuck in his or her worldview without any real reference to the realities of those being investigated, the work cannot capture or understand the constructions that they hold. Such research can only serve to solidify the ethnographer's concepts without providing deeper insight into the group under study (Carlson et al., 1995). In this juxtaposition, the process of constructing ethnography could be compared to a dance (Janesick, 1998); one is constantly moving between suspending one's own views and assertions, interpreting events and experiences, gaining insight into how others view the world and attempting to create a meaningful way of presenting those interpretations.

Although consistently striving to increase my knowledge about young drug users' lives, I tended to adopt a 'laid-back' role in fieldwork encounters. In quantitative research, the researcher attempts to control interactions with the participant, but qualitative researchers must relinquish control and adopt a subordinate position if they are to understand the perspectives of others (Agar, 1977). For me, this involved stepping back and abandoning preconceived expectations of

the fieldwork as well as acknowledging my lack of first-hand knowledge of heroin use. I always tried to refrain from pushing my own ideas onto the research process and allowed encounters and interactions to naturally evolve without letting the pressures and time constraints of the project take over. This required letting go of the desire to control the research and its outcomes, to abandon any set strategies of achievement and to, essentially, let the project take on a life of its own. Rather than being the work of a lone researcher therefore, the written product is a co-constructed by researcher and participants, and emerged from social interactions that were part of the research process (Wasser & Bresler, 1996).

Ethical Procedures

Substance users have been described as a 'vulnerable population' (Aday, 2001), and young, homeless or injecting heroin users, in particular, are vulnerable to negative outcomes (Roy et al., 2003; Miller et al., 2007). Ethical approval for this study was sought and granted by the School of Social Work and Social Policy[30], the Children's Research Centre[30] and the Drug Treatment Centre Board[31]. The physical risks to respondents associated with their participation in this study were minimal, but in order to avoid potential psychological distress or discomfort, the ethical procedures adopted by the study were comprehensive and adhered to rigidly.

Young people were approached in a variety of public, private and semi-private settings, and upon making contact I openly declared my role and the purpose of the research. On occasion, observations were made of drug users in outdoor settings without their knowledge, but no identifying information was obtained or revealed in the field notes subsequently prepared. When appropriate, young people were asked to complete the interceptor survey, which did not require any self-identifying information and was entirely voluntary. A five Euro voucher was offered for participation, the young person was informed that the receipt of this voucher was not contingent on their completion of the survey, and that he or she could withdraw from the research at any point. If the young person was deemed eligible for the life history interview, he or she was invited to participate and a suitable date, time and place were arranged. Consent for participation in the life history interviews was given in writing[32], but the consent form was verbally explained to the young person before requesting a signature. In addition, an information sheet clearly outlining relevant issues such as the study aims, the voluntary nature of the interviews and confidentiality procedures, was distributed to all potential participants. The information and consent sheets used during the course of the data collection process are contained in appendix one, two, three, four and five.

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[30] Trinity College Dublin

[31] The Drug Treatment Centre Board is one of the countries largest drug treatment centres and is located in Dublin's city centre. It is statutory organisation funded by the Health Service Executive.

[32] Written consent was an ethical requirement of the study. Once signed, consent forms were placed in a locked cabinet. They are to be destroyed on completion of the study.

Prior to participation in the life history interview, the young person was informed verbally about the study, its purpose and the nature of the interview. It was stressed that participation was voluntary and the young person could withdraw at any point. A 20 Euro voucher was offered as a token of appreciation and the young person was informed that this was not contingent on completion of the interview. This interview process aimed to maintain an approach to questioning that would pose minimal psychological risk to the participants. However, it was recognised that some individuals might feel uncomfortable or reluctant to discuss aspects of their drug or life histories. Participants were informed that they could refuse to answer any of questions asked, or decline to discuss topics or issues that may cause distress or discomfort. It was planned from the outset that if a young person became distressed or upset during an interview, the interview would be terminated and the necessary or required supports secured. However, none of the participants displayed signs of upset during the interview. A contact list of relevant support services was prepared and all participants were offered this list following the completion of the interview (see appendix nine). Two of the young people stated that they wanted to stop the interview prematurely because they were experiencing fatigue. In both of these cases, contact was re-established with the young person at a later date.

Participants were informed that the information obtained from the life history interviews would remain confidential unless they divulged that they, or someone whom they knew, were in danger. It was explained to the young person that if this occurred, another individual would be consulted prior to following up on such disclosures. However, this situation did not arise during the conduct of any of the interviews. The life history interviews were audiotaped and permission was sought from the young people in advance. However, two protested this arrangement; one young woman explained that she found the tape recorder visually distracting and asked me to place it in my bag[33], and the second young woman refused to allow her interview to be audiotaped[34]. To preserve the anonymity of the study's participants, no personal identifiers such as the young person's name, address, or contact details appeared on survey or individual interview instruments; instead, a unique code was assigned to each participant. Identifying materials, such as consent forms, contact information or audiotaped interviews, were stored separately in secure files. A pseudonym has been assigned to each participating young person and these fictitious names are used alongside the data excerpts presented in later chapters. All identifiers, such as place names and the names of friends and family members, were removed from transcript material.

[33] This young woman did not wish to see the tape recorder but agreed to the recording of the interview.
[34] In this case, the young woman's life history was recorded through note-taking.

Additional ethical considerations arose in the case of research participants under the age of eighteen years. Parental consent was a requirement and had to be sought for these young people. In these cases, consent was sought and obtained from the young people's parents, usually with the help of service providers[35]. A small number of young people in the qualitative sample were under the age of 18 years and not attending drug treatment services. These young people were located through homeless services and had limited contact with their parents. Consent was thereby sought and obtained from their social workers, who were contacted through professionals working in the homeless services where the young people resided.

This study was carried out according to the principles and guidelines for ethical research practice (British Sociological Association, 2002). The welfare, dignity and rights of participants were safeguarded and their accounts were reported accurately and truthfully. Relationships with participants were cultivated with interest and integrity but care was also taken not to intrude on personal space or privacy. The overarching concern, throughout the research process, was not to cause harm to any of the study's participants.

Exploitation or Emancipation?

Using ethnography to explore the social worlds of marginalised social groups is a sensitive process and the role of power relations must be considered (Foley, 2002). Particularly when the ethnographer comes from the dominant social group, and arguably possesses greater 'social capital' than the participants, care must be taken in how the research process is conducted and how the marginalised group is represented in the final product. In this study, the principle of 'not causing harm' to young participants was prioritised and care was taken not to coerce or pressurise them into discussing topics that may cause discomfort or distress. Nevertheless, many interviews contained harrowing accounts of abuse or victimisation and these accounts had a strong impact on the research process. In particular, stories of suffering highlighted the importance of ethical considerations in the conduct of interviews and the dissemination of findings. Initially, I felt anger towards those individuals I perceived to have caused young people harm, but gradually, and through the process of data collection and analysis, I came to recognise the importance of accurately representing accounts of trauma or suffering. Young people rarely expressed anger towards any one individual and did not attribute 'blame' to their friends, families or partners. The complex dynamics reported in young people's accounts of their relationships and environments had to be acknowledged and represented in the findings. Furthermore, it was an important ethical decision not to 'demonise' young people's loved ones in the dissemination of findings, particularly considering that they too, in the majority of cases, were part of a socially and

[35] The majority of young people under 18 recruited by this study were attending drug treatment services with the knowledge and consent of their parents. Those who were not, were attending or residing in homeless services and consent was obtained from their social worker.

economically marginalised group. The intention not to 'cause harm' to young participants therefore, was extended to include their social and family networks.

The young people in this study were subject to the macro environmental forces of social stigma, political marginalisation, economic inequality and gender power dynamics which create vulnerability to suffering and negative outcomes. As explained by Foley;

> The stigmatizing discourses about inferior 'cultural others' reproduce inequality and 'steal' people's subjectivity and humanity in much the same way that labouring in commodity-producing factories does (Foley, 2002, p. 471).

This study aimed to understand and represent the experiences of marginalised young heroin users, but in doing so, the stigmatising discourses surrounding heroin use had to be recognised. There is no such thing as non-political research (Agar, 1996) and it can be difficult to avoid conceptualisations of heroin users that have been so strongly concretised through dominant discourses. Furthermore, researchers may have limited control over the interpretation or use of their findings by practitioners, policy makers and the media (Woods, 2008). Every effort has been made not to contribute to 'stigmatising' accounts of heroin users throughout the conduct of this research.

Ethnography must be seen as a political enterprise because not only is it constructed within, and influenced by, the political context, but it also has political consequences. Many ethnographers fail to acknowledge the power relations that shape social suffering amongst the poor and excluded (Bourgois, 2002b) and this selective omission needs to be addressed. Bringing attention to the importance of larger power structures in shaping drug use and marginalisation is crucial, and some would even argue that the role of the ethnographer is that of emancipator (Foley, 2002). The potential to bring about change in policy and practice carries responsibilities and this is particularly pertinent to a study of young heroin users where extreme social, political and economic marginalisation has been noted (McElrath, 2001; Moore, 2008; Simmonds & Coomber, 2009). This responsibility was not taken lightly and it is hoped that this is transmitted through the written presentation of the study's findings.

Study Limitations

The main limitations of this study pertained to the recruitment and sampling of young recent heroin initiates. This study privileged qualitative research methods and a combination of purposeful or selective, theoretical and chain sample was used. Young recent heroin initiates

reporting diverse patterns of heroin use (from 'occasional' to 'problematic'[36]) were initially targeted for the life history interviews. However, young recent heroin initiates reporting 'occasional' use of the drug were difficult to locate. Researching recreational heroin users, particularly younger users and recent initiates, is known to be fraught with methodological problems[37] due to the 'hidden' nature of this population (Egginton & Parker, 2000). The majority of young heroin users in this study were either homeless or had identified their heroin use as 'problematic', and these circumstances brought them into contact with services, often a number of years following their initiation. As a result, only a small number (five of the forty) of the life history interviewees reported 'recreational' or 'occasional' heroin use and some (nine of the forty) had initiated use over five years prior to the interview.

Initially, the aim was to target young heroin users in Ireland rather than restrict recruitment to the greater Dublin area and, a number of services in the South and South-West of Ireland were contacted in the early stages of the community assessment process. However, professionals in these services did not have contact with young heroin users and, due to the constraints of the study and the difficulties involved in accessing young heroin users, it was considered essential to focus efforts on locating and recruiting young people from the Dublin area. In the final sample, the majority of participants resided in the greater Dublin area, with a small number living in commuter towns. As discussed in chapter one, treatment figures have indicated that heroin use in the South, West and centre of Ireland has increased in recent years (Reynolds et al., 2008), and therefore, it would be adventitious to explore heroin initiation among young people from these locales.

Numerous attempts were made to recruit young people outside of drug treatment or homeless settings, particularly through 'snowball' sampling techniques, but due to the 'hidden' and sensitive nature of young people's early heroin use, this recruitment strategy was problematic and brought limited success. Although the final sample was diverse, and young people discussed a broad array of circumstances and experiences, there are important limitations associated with recruiting from drug treatment and homeless services. The majority of young people in the qualitative sample (31 of the 40) were attending drug treatment at the time of the interview and many were recruited with the assistance of 'gatekeepers' or interviewed within service settings. These conditions may have affected the young people's responses, and, in particular, may have decreased their willingness to discuss recent heroin-using episodes or affected their drug-related

[36] Those reporting 'problematic' use explained they had used heroin on a daily basis for a period of time and this result in physical dependency and symptoms of withdrawal. Alternatively, those reporting 'occasional' use said they only used heroin on a small number of occasions and did not consider their heroin use to be 'problematic'.

[37] Egginton and Parker (2000) note that when less than twenty-one years of age, it is too early in an individual's heroin career for him or her to be represented in harm reduction, drug treatment or correction agencies. Yet, attempting to identify young heroin users in the early stages of their heroin careers in the community is exceptionally difficult because they do not access street or community level drop-in services.

perception and behaviour. In this study, however, over half of the young people in the sample were using heroin at the time of interview, and openly discussed recent heroin-using events. Furthermore, 20 of the 31 young people receiving drug treatment were recent attendees and had entered drug treatment less than six months prior to interview. Nevertheless, the results discussed in the forthcoming chapters of this thesis pertain to the sample of young heroin users recruited by the study[38]. Unfortunately therefore, these findings do not necessarily enhance understandings of the heroin initiation pathways or drug-using experiences of young heroin users 'hidden' from services.

As highlighted earlier in this chapter, young recent heroin initiates were often difficult to locate and engage, and these difficulties had to be negotiated in order to develop relationships with prospective study participants. In outdoor locations, young recent heroin initiates were difficult to identify, with older users being more 'obvious' and easier to engage in informal conversation. When younger users were approached, some initially demonstrated an understandable sense of suspicion and seemed reluctant to talk to an 'outsider' about subjects that they perhaps thought would be judged or misunderstood. In many settings, I was introduced to the young people by 'gatekeepers', predominantly project or key workers in homeless or treatment services who worked with the young people with the main aim of curbing their heroin use. These introductions had a tendency to place me in the category of 'social worker' or 'staff', at least initially, and within a dichotomy of 'us' and 'them' that sometimes existed in these services. In order to minimise the creation of these barriers, formal introductions were avoided in some situations. In other settings, however, introductions were essential in order to have my presence and identity 'validated' by trusted service providers. In some cases, these introductions also served to alleviate any suspicion that a young person may have felt (see field notes 22.05.07). Thus, the 'hidden' nature of young recent heroin initiates, and their reluctance to divulge their heroin use at such an early stage in their heroin-using career, meant that locating and establishing contact with this group of young people was not an easy task. Nevertheless, the recruitment effort yielded a vast amount of data, despite these obvious challenges. Indeed, the challenges themselves reveal a great deal about young heroin users and the difficulties associated with finding ways to intervene in their lives to empower them to reduce the potential harms associated with their drug consumption.

Conclusion

This chapter outlined the theoretical and methodological approach of the study. It began by acknowledging the limitations of contemporary drug-use epidemiology, arguing for the implementation of an ethnographic approach that values the subjective experiences of young

[38] Acknowledgment of this limitation does not diminish the importance of the existing narratives on heroin initiation and risk behaviour. It is the overarching aim of this study to value these young people's experiences and accounts.

heroin users and acknowledges the importance of context and meaning in drug-using behaviours. The rationale for employing both qualitative and quantitative research methods within this epistemological framework was discussed, and an ethno-epidemiological approach to the study of heroin initiation and risk behaviour was proposed. The focus then turned to identifying the gaps in knowledge, as well as the sources of epidemiological complexity, in the existing epidemiological data on heroin use in Ireland. It was argued that a dearth of qualitative or ethnographic research in the Irish context has limited understandings of the contextual factors, at both macro and meso levels, that shape young people's heroin initiation and drug-using practices. In light of these limitations, the main aims of the research are to investigate the social course of heroin and injecting initiation in young people, to explore the 'risk environments' of heroin smoking and injecting, and to examine risk perception and behaviour during the early heroin use career.

The unfolding story of the research process was then described in detail. Four main data collection techniques were employed including: a community assessment process; ethnographic observations; an interceptor survey, and qualitative life history interviews. These data collection techniques were discussed and the contribution of each noted. In order to gain insight into the social worlds of young heroin users, and capture the subjective experience of risk, the qualitative interviews were privileged as the main data collection technique. A number of difficulties arose during the fieldwork period and the process of overcoming these difficulties was discussed in detail. In particular, young recent heroin initiates were difficult to locate and recruit, but over time, and through a variety of recruitment strategies, a large and diverse sample was established.

The chapter then moved on to discuss the important issues of ethics and reflexivity. The well-being of all participants in the study was prioritised and ethical guidelines and procedures were rigidly adhered to. However, the difficulty in representing research findings in a way that accurately reflects the worldviews of the young people was acknowledged. Heroin users are a marginalised group in society, and this study seeks to avoid adding to the stigmatising discourse surrounding them. Alternatively, it is hoped to represent the young people in such a way that builds understanding and inclusion while acknowledging the role of social inequality and political exclusion in the production of drug-related harm (Bourgois, 1995; 2003; Rhodes, 2002; 2009).

Chapter Four

Structural Forces, Family Adversity and Early Drug Use

Introduction

This chapter, the first of five reporting the findings of the study, provides a demographic profile of the sample, and contextualises the young people's early and recreational drug use with reference to the macro-, meso- and micro-level 'risk environment'. Data obtained from the 120 interceptor surveys and the 40 life history interviews are presented. The first section of this chapter provides an epidemiological profile of the interceptor survey participants, revealing that they were a socially and economically disadvantaged group with high rates of unemployment and low levels of educational attainment. The chapter then turns to the qualitative life history interviews in order to explore the 'risk environment' and social processes shaping the young people's early drug use. The macro-, meso- and micro-level environments are described with reference to the young people's neighbourhoods, family circumstances and social networks. The social processes involved in early school leaving and 'soft' drug use are also discussed. The final section of this chapter maps the three dominant routes or pathways taken by young people to heroin initiation.

An Epidemiological Profile of Young Heroin Users

One hundred and twenty young heroin users, 78 men (65%) and 42 women (35%), completed the interceptor survey. All were aged between 16 and 30 years and their average age was 23.4 years. Young people initiated heroin use at an average age of 15.8 years. Most left school at an early age; almost half (48%) left before the age of 15 and a further 50% left school just after sitting their Junior Certificate examinations[1]. Less than 2% completed their Leaving Certificate examinations[2]. The vast majority (93.3%) of the young people were receiving social welfare payments and less than 4% were in full or part-time employment at the time of the interview. Similar findings have been reported in the Irish literature, with heroin users typically demonstrating high rates of unemployment and low levels of educational attainment (Dean et al., 1983; O'Higgins, 1996; Smyth et al., 2000).

There were other indicators of social and economic exclusion. For example, survey participants reported high rates of current and lifetime homelessness; almost half (49.2%) were living in a hostel or bed and breakfast (B&B), or were sleeping rough at the time of interview, and over 80%

[1] The Junior Certificate is a state qualification awarded by the Department of Education for those who have successfully completed examinations based on the lower cycle of secondary education, a compulsory period of schooling for children usually between the ages of 12 and 15 years.

[2] The Leaving Certificate is a state qualification awarded by the Department of Education for those who have successfully completed examinations based on the senior cycle of secondary education. They are usually taken upon the termination of post-primary schooling when the student is 17 or 18 years.

reported that they had experienced homelessness in their lifetimes. Almost 10% of the sample were from the travelling community, a minority group that has been recognised as socially and economically excluded (Cemlyn & Clark, 2005). The survey participants also reported high rates of drug use within their families, with over 70% reporting that a family member was a heroin user.

Data from the interceptor survey indicate that the young people are a socially disadvantaged and economically marginalised group. The life history narratives were analysed in order to explore more fully the macro, meso and micro-level environmental forces which shaped the young people's childhoods and early teenage years.

The Macro-level Risk Environment:

Socially and Economically Deprived Neighbourhoods

The vast majority of the young people in the qualitative sample came from socially disadvantaged areas of the Dublin metropolitan district where high rates of problematic heroin use have previously been reported (Dean et al., 1983, 1985, 1987). Twelve came from inner-city locales and eighteen from socially and economically deprived suburban areas. Of the remaining ten participants, nine came from commuter towns where recent treatment figures have indicated increasing numbers of heroin initiates (Bellerose et al., 2009; Reynolds et al., 2008). Only one young woman came from a predominantly middle class area in South Dublin.

Many of the study's participants, particularly those living in deprived inner-city areas, described heroin as ubiquitous in their locales. They explained that heroin use and drug dealing were overt activities within their communities and said that they became aware of both during their childhood years. However, young people rarely identified social structural factors as the *cause* of their own heroin use or that of others. They simply acknowledged that, in their neighbourhoods, heroin use was particularly prevalent;

> *"If we just went around [suburban area], just to see, every second person is either on [heroin] or selling it" — Richard (21 years).*

> *"Well I grew up around drugs all me life in [inner-city community]. Around Dublin anyway, it's the biggest place for the drug use" — Luke (24 years).*

The 12 young people from inner-city areas where high rates of heroin use have been documented since the early 1980s (Dean et al., 1983), became aware of heroin use in their neighbourhoods at a young age. Many explained that there were large numbers of heroin users, or former heroin users, attending methadone maintenance programmes in their communities. Often in their 30s or

40s, these heroin users were significantly older than the young people in the study, and it is likely that they initiated heroin use during the 1980s or 1990s.

Young people from inner-city areas often commented on the prevalence of heroin use in their communities, a characteristic which they claimed to have been aware of from their early childhood years. These young people were born in the late 1980s and early 1990s, after the first opiate epidemic of the 1980s, and shortly before the second wave of heroin use during the mid-1990s. Some spoke about the history of heroin use in their locales, indicating that they were very aware of previous heroin-using trends and practices. Orla, for example, spoke about the 'needle culture' amongst heroin users in her inner-city locale during the 1980s, explaining that during this period, she and others were unaware that heroin could be administered by 'smoking':

> *"When heroin hit that area, it hit it fucking hard. The [notorious drug dealers] that brought all the gear into our area were from them flats, and they were just flooding the flats with everything. So even before I was born, like in the 80s and all, they told everybody, no one knew you could smoke gear even; they just told them you put it in the needle and this is what you do. So by the time I was born they were all addicted to the needle, you know what I mean?" — Orla (18 years).*

The macro-level 'risk environments' of these young people's early childhood and teenage years were characterised by high rates of heroin and injecting drug use and associated social problems such as criminality, viral illness and unemployment. Indeed, some linked social and economic disadvantage in their communities with the high rates of heroin use. For example, Orla believed that heroin use became prevalent in her inner-city area during the 1980s and 1990s because it appeared to offer economic advantages;

> *"You'd think things like [heroin use] would just be [for] upper class people 'cause they can afford it. Everyone was poor around there, but I think it's 'cause [notorious drug dealers from the 1980s] made it look so glamorous and it was so cheap. People thought 'If I start selling it, maybe I'll have a car like that' and they'd just start taking it, as everyone did. I thought that meself. If I'd start selling drugs, I thought I'd get nice stuff and all, and just curiosity, you know what I mean?" — Orla (18 years).*

As Orla explained, selling heroin offered young people in economically deprived communities the opportunity for a more lucrative and rewarding life. Researchers have previously noted that at the lower levels of the drug market, heroin *sellers* are usually heroin *users* (Fagan, 1989; Pearson, 1987a; Preble & Casey, 1969). The young people in this study spoke about the variety of rewards that selling heroin brought to individuals in their areas. By observing these benefits, some came

to believe that a heroin lifestyle could bring greater access to material resources, connections with new and larger social networks, and higher positions of status. These themes are discussed in depth in chapter five.

Within communities with high rates of heroin use, young people were exposed to the drug at an early age, influencing their perception of the risks and benefits. Depending on their experiences and interactions with other heroin users, they perceived the advantages or disadvantages of using the drug. For example, young people observed the negative consequences of long-term or heavy-end heroin use, and resolved not to use or become physically dependent on the drug. Simultaneously, however, heroin dealing was perceived as bringing about a 'glamorous' lifestyle, and exposure to the drug served to rouse the curiosity of many about its effects. A number reported that these social processes contributed to the spread of heroin use across their communities. Orla, for example, believed that it was inevitable that many young people would initiate heroin use in her local authority housing complex where rates of heroin use were high;

> *"A lot of people in the flats, it was just going to be a lot of people's fate to be on it. Even now when you go into them flats, you see people and you just know that they're going to do it" — Orla (18 years).*

The 12 young people who grew up in inner-city communities with high rates of heroin use indicated that they because largely accustomed to the presence of heroin in their home neighbourhoods during their childhood years. Living in small pockets of concentrated heroin prevalence, some of these young people did not contemplate its social acceptability until stigma and disapproval from the wider community infiltrated their experience. Contradictory messages surrounding heroin use created some confusion for youth within these environments. Heroin was so prevalent in their immediate locale that it was perceived as acceptable; yet, this assumption was directly contradicted through their interactions with the wider society. This dichotomy created some confusion about what was 'normal', particularly during the young people's teenage years when they began to form larger social networks and were exposed to strong messages surrounding the negative consequences of heroin use. Orla described this process. In her early teenage years, she met a group of young people from a neighbouring area who strongly disapproved of heroin users, referring to them as "knacker junkies". However, her parents and two siblings had been using heroin since her early childhood and, coupled with this, heroin maintained a ubiquitous presence in her local authority housing complex. She explained that the contradictory messages surrounding heroin use – those communicated by her 'new' friends, on the one hand, and those permeating her immediate environment, on the other, led to a sense of confusion about what was 'normal';

"To me, [heroin use] was just an everyday, normal thing. It sounds crazy but it was; it was pretty much all I'd ever known. And then I started hanging around with other people that were from [neighbouring area] which is like the houses on the other side of [my flats] which wouldn't have much gear in them; and if there was someone banging up or having a smoke in their stairs, they'd get fucking bet [beaten] to death. And it was just a whole different [thing] because they grew up ignorant, you know what I mean? I thought they were better than me 'cause I'd seen in my flats, a lot of [the people] were kind of dirty and [heroin] had just taken over them. They were kind of scruffy and [my friends] were saying 'Oh they're this that and the other' and I'd think, are they? Maybe am I? Is me ma? I kind of questioned meself about if I was like that 'cause you think, well it's normal to me, it's not normal to them, so is there something wrong with me? Or is there something wrong with them? But initially you think there's something wrong with you" — Orla (18 years).

The majority of the young people in the sample did not come from areas in which heroin use was so highly concentrated and, therefore, did not experience these contradictory messages. Young people from suburban areas or commuter towns generally described heroin use as a more hidden or 'deviant' activity associated with specific social networks. For the 27 young people living in these areas, heroin was less visible during their childhood years and only became a part of their social worlds when they were exposed to it through friends, acquaintances or siblings who were part of heroin-using networks. Nevertheless, these suburban and commuter areas were characterised by high social and economic disadvantage, and although heroin use was not as highly concentrated as in inner-city communities, the young people indicated that their locales had high rates of substance use;

"Where I grew up, in my square [in a suburban area], there was always people on phy[3] and sitting on the ground drinking and all" — Kieran (17 years).

"I didn't know exactly what it [heroin] was at the time, but as I was getting [to] about 11, I like started hearing people get called junkies, and I began to know what it was" — Richard (21 years).

The narratives above provide descriptions of the environments in which young people grew up, and therefore provide an important backdrop to the social processes at work during their childhood and teenage years. Importantly, the macro-level 'risk environment', characterised by social and economic disadvantage as well as high rates of substance use, impacted upon meso-

[3] 'Phy' is a colloquial abbreviation of physeptone, or methadone, a synthetic opioid analgesic used for maintenance treatment of problematic opiate use.

level family circumstances as well micro-level social processes. These dynamics are discussed throughout the following sections.

Meso-level Environmental Forces:

Experiences of Childhood Adversity

The majority of participants experienced adversity in their childhood years, including one or a number of the following: poverty, family breakdown, parental substance abuse, domestic violence, abuse or bereavement. These forms of adversity were interconnected, and the young people's narratives highlighted how one exacerbated or impacted upon another. For example, some young people explained that parental alcohol use exacerbated family conflict or domestic violence. Within the epidemiological literature, associations between socio-economic status, family breakdown, parental substance use, domestic violence, premature mortality and mental health problems have been observed (Amaro et al., 1990; Claussen, 1999; Dohrenwend, 1990; Fergusson et al., 2000; Kiernan & Mueller, 1998; Makela, 1999; Pomerleau et al., 1997; Straus & Gelles, 1990; Straus et al., 1980; Tolman & Raphael, 2000) and these experiences have also been linked to adolescent drug use. This literature suggests that young drug users are more likely to come from families from which one parent is absent due to separation, divorce or death (Denton & Kampfe, 1994), to have parents with problematic patterns of substance use (King & Chassin, 2004; Lloyd, 1998) and to come from low socio-economic groups (Poulton et al., 2002; Reinherz et al., 2000). However, statistical associations between poverty, adversity and substance use cannot reveal the complexity of these social dynamics, and can disregard the lived experience of social deprivation, family adversity and substance-using careers. Qualitative or ethnographic studies of heroin users, on the other hand, tend to avoid descriptions of childhood experiences or family circumstances, not wishing to imply causal associations between adversity and later drug use (Woods, 2008). Those ethnographic studies that have explored the life histories of heroin users (Neale, 2002; Maher, 1997; Roberts, 1999) acknowledge that they are often subject to parental substance use, abuse, bereavement and family disruption during their childhood years, and recognise the complexities of the association between these early forms of adversity and later heroin use.

The study's young heroin users faced considerable hardship in their early lives, including family instability, parental substance use, bereavement and abuse, which occurred primarily within a social context of disadvantage exacerbated by parental unemployment, low incomes, poor housing and low levels of educational attainment. Of the 40 young people, 26 described experiences of family breakdown, 11 of problematic parental alcohol use, six of parental heroin use, 12 of sibling heroin use, eight of family bereavement and seven of domestic violence.

Descriptions of problematic patterns of parental or sibling substance use were pervasive in the life history narratives. The young people described how substance use impacted upon family life leading to, or exacerbating, illness, parental conflict, family instability and domestic violence. Barry, for example, believed that his father's alcohol use led to his parents' separation;

> *"My family were a bit mad. My ma and da [were] off the wall. Old fella was an alcoholic...chronic alcoholic until me ma kicked him out" — Barry (20 years).*

Another young man, William, said that his mother, father and two of his brothers demonstrated problematic patterns of alcohol use in his childhood years. He reported that their substance use had devastating effects on family life, culminating in the death of his father and brother from cirrhosis of the liver. A second brother was very ill with the disease at the time of interview. William's account of his brother's alcohol-related behaviour is one of a number to draw attention to the level of family conflict, illness and/or violence arising from sibling or parental alcohol abuse;

> *"I have a brother Jack. He's the eldest. He's 41. He has three kids and he's not supposed to be drinking. He has cirrhosis in the liver, very sick over it, and he only comes down to me mother's when he decides to go back on the drink. He's a big handful. He's very very violent with drink on him. And nobody can get violent back with him because he's too sick" — William (22 years).*

Although acknowledging the negative impact of substance use on family life, the young people also frequently stated that they became aware of its benefits. For some, substance use was interpreted as an effective way of coping with the worry or stress associated with family conflict, abuse, bereavement or unemployment. One young woman, Hannah, believed that her father drank alcohol to cope with negative emotions associated with unemployment and marital conflict. She explained that by observing his behaviour and demeanour, she began to associate 'being drunk' with 'being happy';

> *"Me ma and da, they were always fighting, just killing each other, so he just went out and got drunk. I used to sit up in me room, just listening to them arguing and trying to block it out, but I always noticed that the only time me da was happy was when he was drunk. That had a big effect on me 'cause it just made me think that maybe if I was drunk I'd be happy" — Hannah (18 years).*

By observing the effects of alcohol on her father, and noting its ability to assuage negative emotions, Hannah began to perceive drinking as an effective way of coping with difficulties.

Almost half of the young people in the sample said that they also believed that substance use could ease negative emotions associated with childhood adversity or traumatic events. William, a young man from the travelling community, explained how negative emotions following experiences of victimisation and family bereavements impacted upon his early alcohol consumption. During childhood, he was excluded from mainstream schooling and victimised by peers in his neighbourhood. After the tragic death of two family members, William began to drink heavily, believing this to be an effective way of dealing with ensuing negative emotions;

> *"I grew up a lot with the drink around me and, actually, I'd see people dealing [with grief] in a certain way. I wouldn't look at the way they were doing it, I would look at how they would feel after they did it and I'd say, 'Jesus look at me over here feeling depressed. I want to feel that way'" — William (22 years).*

Over half of the young people in the sample referred to the adverse effect of alcohol and/or illicit drug use on their family lives, believing that substance use had led to, or exacerbated, difficulties within their families. Many said that problematic alcohol use increased conflict between their parents, and some believed that it led to parental separation or divorce. Simultaneously, however, substance use was perceived by many young people to alleviate negative emotions associated with family adversity.

Twenty-six of the 40 young people experienced family breakdown in their childhood years. In most cases, separation or divorce was described as a distressing experience that led to feelings of anger or grief. A number of young people also highlighted how parental separation exacerbated family difficulties such as problematic substance use or poverty. Dylan, for example, spoke about how his mother's lack of income, following the breakdown of his parents' marriage, added to experiences of adversity during his childhood. This lack of economic security in turn led to insecure housing arrangements, social exclusion, poor school attendance and family instability;

> *"It was a shitty childhood, to tell you the truth. We were always sort of moving around 'cause me ma had fuck-all money, so she had to move out of the house and into different areas. So we were always the new sort of person in school and there was no sort of stability there. Everything was just pure chaos, you know? No security. I suppose I blame that on a lot of me problems" — Dylan (20 years).*

As evidenced by Dylan's account, poverty ensuing his parents' separation led to a lack of security and stability in his childhood. Dylan believed that these circumstances contributed towards his later experiences of homelessness and drug use. Other young people described similar periods of instability following family breakdown. For example, Barry explained how his

parents' separation, which he attributed to his father's alcohol use, created problems in his housing stability. A tense relationship with his new step-father led to his move out of his mother's house, and financial difficulties that emerged when living with his biological father led to his homelessness at 16 years;

> *"When my ma kicked him out, I was living with me da for a while and I think when the novelty wore off for him, he just decided that he couldn't financially keep me" — Barry (20 years).*

Family breakdown and economic issues affected the housing situations of many others, with 11 of the 26 who experienced parental separation stating that a lack of economic or family stability led to their first 'out-of-home' experience.

Seven participants described experiences of inter-parental violence during their childhood years. In all cases, domestic violence was perpetrated by the young person's father or step-father, and almost invariably occurred in conjunction with parental substance use. Experiences of domestic violence were described as distressing and traumatic, and they dominated the childhood memories of a considerable number. One young man, Joe, emphasised the distress associated with exposure to domestic violence;

> *"I've had a really hard life though. Just watching me mother getting bet all the time. At five, I seen her getting bet with a hammer...getting dragged around by the head and beaten with a hammer. How would you be able to deal with something like that?" — Joe (17 years).*

Those who described experiences of domestic violence invariably drew attention to how it affected their mental health and well-being. Joanna, for example, spoke about the intimate partner abuse experienced by her mother, highlighting how this impacted on her sense of well-being in childhood and adolescence;

> *"I had not a very nice childhood now. I was a very quiet child, very deep into meself. Me mother was in a relationship where she was abused, you know, emotionally and physically and sexually. I think that's where most of me problems stem from" — Joanna (19 years).*

The experience of domestic violence impacted strongly on these young people's sense of well-being, but it was not the only form of adversity that they experienced. All those who described these experiences were also subject to other forms of hardship, including poverty, parental substance use, abuse and family breakdown.

As evidenced by these accounts, experiences of childhood adversity shaped many young people's meso-level 'risk environments'. They reported parental substance use, domestic violence, abuse and/or family breakdown and these experiences were often depicted as dominating their early lives and experiences. These forms of adversity also impacted upon the young people's sense of well-being during childhood and adolescence. The following section discusses the young people's family relationships, emphasising how experiences of adversity led to conflict and tensions between family members.

Family Dynamics and Relationships

Of the 40 young people, 14 were reared in families headed by both parents. Twenty-six reported experiences of parental separation or divorce; 12 of these were reared in families headed by one parent, usually their mother, nine grew up in reconstituted families, and five spent lengthy periods in state care. Almost all of the young people described tensions within their families, which they said permeated relationships between their parents, parents and children, and siblings. Following parental separation or divorce, many described an escalation in family conflict, in particular, emphasising growing tension in their relationships with their parents or their parents' 'new' partners. Sarah, for example, spoke about the strained relationship that she had with her parents following their separation. She explained how confusion over the 'causes' of her parents' marital breakdown led to her feeling anger towards her mother and her father;

> *"I hated my mam...but my father, I got on with great, until he left I got on with him great. But when he left, then I was blaming him for leaving and then I couldn't talk to him either, you know? As soon as he left, I turned it all around. I got on great with my mam and hated my dad, but I kinda hated both of them, cause I was saying, 'Well maybe my mam could have made my dad happier', and then I'm saying, 'Well my dad's after falling in love with somebody else, it's his fault'. I didn't know who to blame" — Sarah (18 years).*

Sarah did not grow up in a reconstituted family as her mother did not enter into a new relationship following her separation and later divorce. However, at the time of interview, Sarah's father was engaged to be married. Sarah described her relationship with her father's 'new' partner, explaining how the distress associated with family breakdown created feelings of animosity between them;

> *"Sometimes it still hurts, you know? That he left my mam for another woman. He's getting married, he's engaged. I don't like her. She's a bitch. I fucking hate her. The poor woman is terrified of me. Terrified...and he always fucks off on holidays with her and stuff, so that doesn't help. And he doesn't ask me to go or anything" — Sarah (18 years).*

Following parental separation, most of the twenty-six young people had to negotiate new relationships with step-parents or the partners of their parents, step-siblings and half-siblings. These new relationships were often described as tense, and, in some cases, family conflict led to the young persons' exclusion from family life during their early teenage years. Young people described a range of difficulties with their step-parents; some felt resentment towards them, some described verbal conflict, while others reported physical abuse or violence. Aaron, for example, experienced increasing levels of physical abuse, perpetrated by his step-father, from when he was nine years old. This violence escalated during his teenage years and led to one particularly violent altercation;

> *"He used to hit me when I was small and the older I got, I just started hitting him. I tried to kill him one day with a machete. I ran after him. He locked himself in the bathroom and I chopped down the bathroom door to try and get him. Then the guards came to the front door and I chased them out with the machete. They wouldn't come in the house" — Aaron (17 years).*

Not all parents entered into 'new' relationships following separation or divorce. Nine young people grew up in families headed by one parent, usually their mothers. They often described their mothers as struggling to provide and care for large families with few material resources, and a small number believed that experiences of adversity restricted their parents' ability to fully participate in their lives. Orla, for example, spoke about how her parents, who were both heroin users, "tried really hard to be good parents" under challenging circumstances. She described how her mother struggled to look after her and her six siblings when her father was incarcerated for a drug-related homicide;

> *"They tried really hard to be good parents. I wouldn't say they were bad parents; they were good parents, but I don't know. I got on great with me ma when I was younger and me da was always in prison so I didn't really know him. He kind of disappeared when I was about nine or ten. But me ma tried really hard. It's hard when you're struggling with a load of kids and you're strung out" — Orla (18 years).*

Orla also spoke about how her father struggled to care for his family under conditions of economic hardship. She believed that his criminal activity was primarily motivated by the wish to provide for and benefit his children;

> *"Apart from the murder— that was just over drugs stuff, feuding — anything else he [father] was locked up for really was for our benefit. The only reason he done all those*

things was to put food on the table and dress us and all. So you can't really think badly of him. He was only trying to look after us" — Orla (18 years).

Shortly after her father's incarceration, Orla and her siblings were placed in state care. Orla went on to explain her home circumstances, stating that her mother was not "capable" of caring for seven children alone. Others similarly emphasised the importance of a father figure and some who grew up in families headed by their mothers maintained that the absence of a father figure during childhood led to what they depicted as a lack of discipline or 'rules' pertaining to their behaviour and that of their siblings. Eight young men reported that their mothers were unable to maintain control over their behaviour in the absence of their fathers and a number talked openly about missing an 'authoritative figure', stating that their mothers were unable to fulfil both parenting roles. Christopher, for example, noted what he perceived as the negative consequences of the absence of his father;

"Your ma lets you away with so much. I don't blame her, she's deadly. I love her to bits. It's just that she's very soft with us and probably spoilt us in a way. Whereas, if me da had been here, we'd have had no choice but to toe the line, cause that's what the male figure does in the family. You do what he says" —Christopher (25 years).

Some young men linked the 'lack of discipline' in their homes with their early involvement in criminal or drug-using activities. Jack, for example, explained that when his father left the family home, he had the freedom to socialise with his peer group until late at night, and did not have to return home at the early hour previously designated by his father. Jack began to participate in alcohol and 'soft' drug use at this time;

"When me da left it was different. You could take advantage of [me ma] and she wouldn't say anything. She'd only say [something] if me da was there, cause she'd have to say it. But I don't know what it was; we just took advantage of her. That was when I started smoking hash and started going drinking and stuff like that" — Jack (25 years)

The majority of the twelve young people living in homes headed by one parent said that their mothers had difficulties raising a family alone. Generally very young when they had their children, these women had little social support. They also faced economic hardship and, in some cases, abuse and victimisation, often coupled with substance use and mental health problems.

Many of the young people reported a complex array of social and environmental forces that impacted on their early life experiences. Parental substance use and mental health problems, coupled with socio-economic disadvantage and family breakdown, impacted on their family

relationships and interactions. These macro, meso and micro-level forces shaped the 'risk environment' of their early drug trajectories.

Social Processes in Adolescence:

School Exclusion

In keeping with the survey findings, a majority (25 of the 40) of the qualitative cohort reported leaving school before, or just after, their Junior Certificate, and five young people reported never attending secondary school. Only one young woman completed the Leaving Certificate, but a small number were planning to return to education at the time of interview. The young people offered a variety of reasons for leaving school at a young age; some stated that they wished to secure employment, while others emphasised the negative aspects of their school experience and indicated that this was their motivation for leaving. A smaller number reported that drug use impacted upon their ability to attend school during their mid-teenage years.

Some young people's accounts of primary school were positive. Indeed, many enjoyed primary school and recounted positive memories of playing with other children or participating in sporting activities. However, a clear contrast most often appeared between experiences of primary and secondary school in the young people's narratives;

> *"The primary school, like up till 6th class, I loved going and playing Gaelic [football]. In 5th class and 6th class [I] played in Croke Park twice on the Gaelic team. [I] have a winner's medal and a loser's medal. It was brilliant. I loved school until I went to secondary school" — Darren (25 years).*

> *"When I was younger, I was brilliant in school. I was top of the class. I used to be up the front. I was in the front row where they used to keep all the good kids. This was from when I was young. As I got older, I started to drift away" — Christopher (25 years).*

Even the one young woman who completed her Leaving Certificate reported that she did not like secondary school but stayed because of the encouragement she received from her siblings;

> *"Primary school was alright and then secondary school, I didn't like it at all. I did right up to me Junior Cert and Leaving Cert 'cause me sisters were saying, 'Oh please just do it' and all" — Charlotte (17 years).*

The majority of young people did not enjoy school and highlighted different reasons for school disaffection. Many reported that they were bullied in school, did not enjoy academic subjects,

were unable to concentrate in class, demonstrated poor educational performance, and/or had adversarial relationships with their teachers. Eleven young people stated that they were bullied or victimised by pupils or teachers in the school environment and a considerable number of these believed that they were perceived as 'difficult' or 'different', and were excluded from their peer groups or from school activities. A number of others explained that family circumstances, such as the substance use or criminal activity of a parent or sibling, impacted on how they were perceived by their teachers.

Kenneth believed that his older brothers' behaviour led to his exclusion from school trips or outings. His three older brothers, who had attended the same school, had been heavily involved in drug use and criminal activity and Kenneth was consequently perceived to be a 'troublemaker' by authority figures in his community. He believed that the teachers "had something against" him, and described how this impacted upon his school experience;

> *"I always thought the teachers had something against me. I was never allowed to go on trips or anything 'cause I did something a few weeks before that. You know things like that? Me ma used to go over to the school and ask why was I not allowed to go and all of this. And so I didn't like them. I still survived in that school and I went to [secondary school], but I left in second year" — Kenneth (24 years).*

Parents' substance-using behaviour also appeared to impact on how some young people were perceived within the school environment. Violet believed her mother's drug use influenced how she was perceived and treated by her teachers;

> *"It wasn't that I didn't like [school]. The teachers picked on me because they knew that my ma had been going into a [drug] treatment centre...that's why I left the school as well. The teachers, they just picked on you" — Violet (16 years).*

Not only did young people feel that they were treated differently by their teachers, some were also excluded by their peers. Accounts of victimisation were not uncommon, and being bullied in school featured strongly in their rationales for early school leaving. Joanna believed that being bullied in school was linked to her experiences of childhood adversity. She said that she 'lacked confidence' due to experiences of childhood abuse and domestic violence, and felt that this left her vulnerable to victimisation in the school environment;

> *"I was a very quiet child and had no confidence. I was bullied as well in school before I went over to England. I think that's why I had no confidence with the stuff going on at*

home... When I was getting bullied, it was 'cause I was a very quiet child and I hated school, I just hated every minute of it" — Joanna (19 years).

Early adversity, as Joanna explained, often had negative consequences for individuals' sense of well-being, affecting their behaviour while they were in school and thereby rendering school life more difficult. Joanna implied that the childhood abuse that she experienced at home led to her social withdrawal in school, but others described 'acting out' against pupils or teachers in anger or distress. A number of young people who had experienced physical, emotional or sexual abuse described expressing anger in a school environment that was not responsive to their needs. Their accounts suggest that violent or aggressive behaviour towards pupils or teachers could not be managed within schools, and that they were excluded at a young age. Two young women, Hannah and Natalie, who had experienced physical and sexual abuse in their homes, explained how fear and anger impacted upon their education, leading to their violent behaviour and resulting in their eventual expulsion;

"Me da started sexually abusing me so that just made things worser. It made me afraid of all adults, afraid of me teachers, afraid of me parents and it just made me angry with them as well. So I started acting out wherever I could...so I started getting in a lot of trouble at school. I was being suspended all the time" — Hannah (18 years).

"I was in school, but I was moved to a lot of different schools and then I was doing tuition at home because I was so violent in school. I wasn't violent, [it was] because I was getting bet [beaten] at home. I was getting kicked at home and then when I was going off to school, I had a lot of anger from getting hit and can't do nothing about it. And then people in school the next day slagging me black eye or something and I'd dive[4] on them" — Natalie (19 years).

Violent behaviour in school, such as that described by Hannah and Natalie, was relatively common across the sample and was often depicted by the young person as linked to difficult family circumstances or early traumatic experiences. Many participants not exhibiting aggressive behaviour in school also described themselves as disruptive because of their inability to concentrate or stay in one location for a long period of time. Although the majority who experienced expulsion or suspension from school identified their own behaviour as the direct cause of their exclusion, it was apparent from their life history accounts that their behaviour was also shaped by contextual forces. Those who had difficulty concentrating in class and considered themselves a disruptive influence had often experienced multiple adversities in their home life.

[4] Physically attack

Like many others, Orla perceived the school environment to be too restrictive and linked her 'disruptive' behaviour to early school leaving. However, she also believed that her "wild" behaviour was shaped by her early life experiences;

> *"I hated school. I left school in 5th class[5]. I had ADHD and I didn't like being in. I was very wild 'cause I was meant to be on Ritalin, but I didn't like it. I don't know what was wrong with me as a kid, but I just think everything that happened fucked me up a lot more in the head than I think it did...it's only now that I'm older and a bit more mature, I think it must have affected me a lot more than I thought it did. Which it would, when you think about it" — Orla (18 years).*

Young people frequently acknowledged that their early childhood experiences affected their school performance and also appeared to believe that their experiences of adversity influenced their behaviour and how others responded to them, contributing to their 'voluntary' or enforced exclusion from school. Nevertheless, most simultaneously emphasised their agency, expressing their dislike of educational structures and depicting their early school leaving as an act of rebellion. Many could not relate to the subjects that they were expected to study in school, reporting that they held no relevance to their lives and would not provide them with employment opportunities. As two young men explained, leaving school was a way of resisting an enforced, yet seemingly futile, social institution;

> *"I did learn, but I always thought school was a load of bollox to be honest with you. Like ya go somewhere to learn about things that you can just learn on your own time, like maths and all that, algebra, I'm never going to use that in me life so why should I sit there and learn it all... I didn't think I should be there if I didn't want to learn" — Barry (20 years).*

> *"I was always a destructive little fuck in school. I was in school but me head wouldn't be in school; me head would be out the gate or acting the bollox. I didn't want to learn anything...I just went for the doss because everybody else went. School is a load of bollox, to be honest with you. Sorry for me language but I've mates that fucking have their junior certs, bleeding lads not even working; good results and all in their leaving certs and fucking no bloody work" — Derek (24 years).*

The lack of motivation described by Barry and Derek might be understood as a response to limited career choices and educational opportunities as well as a form of 'rebellion'. Poor academic records were a consequence of numerous interconnected factors including poor

[5] Orla left school in 5th class but continued her education in residential care and juvenile detention centres.

concentration, disruptive behaviour, withdrawal and early adversity, but led young people to believe that, even if motivated to succeed, they would be unable to achieve good grades. All of these processes contributed to their early school leaving.

Drug-Using Social Networks

During their early teenage years, young people described a gradual move away from family life and towards adolescent social networks. This is well-documented within the sociological literature as a process that typically occurs during teenage years (Bell, 1981; Brown et al., 1986; Douvan & Adelson, 1966). In their late childhood or early teenage years, the young people in this study often spent lengthy periods socialising in outdoor locations with peer groups from their locales, which often led them into social settings and interactions with older youth. Through these social connections, the young people became exposed to 'soft' drugs such as cannabis or ecstasy and, in some cases, 'hard' drugs such as cocaine.

Some of the young people made associations between experiences of family adversity and the process of moving away from family life and towards peer drug-using social networks. Joanna explained that difficult circumstances in her family home, including family breakdown, parental heroin use, and domestic violence, encouraged her to spend more time with older peer groups in the disadvantaged suburban community in which she lived, facilitating her entry into recreational drug-using networks;

> *"I went into a different type of group that were more harder. The boys were very hard, the girls were drinking. So between 13 and 14, I was drinking heavily, probably five days a week, and I was just going wild. I had no respect for me family and I was out 'til all hours in the night and that. Then I started to take ecstasy when I was 14 and that went on till I was about 15, 16 and in between that I started taking cocaine and speed" — Joanna (19 years).*

Like Joanna, almost all the participants initiated drug use at a young age. The majority used their first illicit drug, usually cannabis, when they were between the age of 11 and 13 years. Recollections of early cannabis use were often vague, however, and the event was not usually depicted as a significant one in young people's lives; neither was it considered to be a 'deviant' or unusual activity. Barry, like most other young people in the sample, did not classify cannabis as a 'drug', seeing it as innocuous and harmless relative to other substances;

> *"I never really thought hash was a drug. I still don't to this day consider it as a fucking illicit substance. It's just something to relax you or put you in a different mind frame. I wouldn't consider it to be something that would really fuck you up" — Barry (20 years).*

Similarly, Kieran stressed that cannabis use was "normal", believing that "everybody" smoked it, irrespective of social class, age or occupation. He asserted that even the professionals in the drug clinic that he attended — adults who were far removed from him in terms of age, social background and status — probably smoked cannabis;

> *"Hash is normal. To me it would be, yeah. Everyone smokes hash. I suppose even the [staff] in here would smoke a bit of hash" — Kieran (17 years).*

Although cannabis was almost invariably the first drug that the young people tried, there was no clear chronology in young people's drug use careers from that point forward. A small number experimented with LSD[6] or amphetamines and most described a period of ecstasy[7] use, but a substantial minority began using cocaine or heroin close to their first use of cannabis.

The young people almost always spoke about the importance of their social networks and interactions in their early drug use. For example, Kenneth explained how using cannabis with his peers facilitated a sense of belonging, security and higher status. He first used cannabis in outdoor locations in his local authority housing estate where, he explained, many youth from his locale smoked the drug. His account highlights the social rewards that he associated with using cannabis with older male youth;

> *"I actually smoked hash. I used to get it off the bigger people. Just say there was a lot of people down in the park, they'd have hash or something like that and you think you're great. You're sitting around with them or one of your brothers or something and like that, you smoke hash. You kinda hang on to people like that when you're small; older people. It's a sense of security as well, you know that kind of thing? You think you're great. You think everyone's going to look up to you" — Kenneth (24 years).*

Early cannabis use usually occurred in the company of peers in outdoor locations or the young people's homes, and the drug was often acquired from older male youth. Within these social networks, the young people also initiated other 'soft' drugs such as ecstasy. However, ecstasy use predominantly occurred at social events such as 'parties'. Sophie described her ecstasy initiation at 14 years of age;

> *"I was actually with a friend and she was a bit older. I'd say I was about 14 and I think she was 17 or 18. I was with her one night and she was going to a party. [We] went to the*

[6] Lysergic Acid Diethylamide
[7] Ecstasy is the common name given to tablets containing MDMA or Methylenedioxymethamphetamine

party and everyone in the house was after taking Es and it was like [I was] the odd one out kinda sitting there. So after about half an hour of them asking me and asking me and asking me, I ended up taking it" — Sophie (23 years).

Fifteen young people initiated cocaine use within peer social networks during their early to mid-teenage years (in all cases prior to their heroin initiation). All of these young people first used cocaine in social settings such as parties, nightclubs or pubs. For example, at the age of twelve, Sarah started using cannabis, ecstasy and cocaine with a group of older female friends from her suburban area. She described the social and physical environment of her early drug use;

"I started taking coke in a pub. I went to a pub. I was only 12, but I was always tall and I looked older. We used to go to [a pub and nightclub] out in [suburban area] and that's where I started taking coke. I took me first pill[8] down there and I smoked hash from a younger age, like about 11, in and around the estate. You know, smoking it after school" — Sarah (18 years).

Many participants highlighted the social rewards of their early drug use and particularly emphasised feeling accepted by, and belonging to, peer group networks. Despite this, they did not describe experiences with cannabis, ecstasy or cocaine as motivating their initiation to heroin use. In fact, the young people rarely initiated heroin use within the same social networks in which they participated in 'soft' drug or cocaine use. Heroin was a drug that was generally rejected by young people whilst they were participating in early drug use with their peers. Darren (25 years), for example, explained that at 14 years old, when offered heroin by an older youth, he felt that it "wasn't [his] thing" and was something in which "older people" in his community engaged. Other young people held very negative perceptions of older heroin users in their neighbourhoods. Damien, for example, a young man who grew up in a local authority complex in which heroin use was prevalent, told how he "hated" the heroin users in his community;

"I hated the junk. I hated the heroin addicts. There were a few smack heads in the flats and I used to give them an awful life" — Damien (18 years).

These negative perceptions of heroin and heroin use can be contextualised within social environments in which the effects of the heroin epidemics of the 1980s or 1990s were visible to emerging youth. Associations between heroin, injecting drug use and viral infections were made by many, stigmatising heroin use for the younger generation and causing them to reject heroin and heroin users during the early stages of their drug careers. Ian, for example, said that

[8] The term 'pill', as used here, refers to a tablet containing MDMA, commonly known as 'ecstasy'.

observing the negative physical effects of injecting heroin use on members of his community affirmed his determination not to initiate;

> *I just didn't like it [heroin]. I don't know. I just wasn't into it. I think what stopped us*[9] *from doing it was looking at the old generation in bits over it, you know what I mean? I said, 'No way. I'm not going to be like them', you know what I mean? So I just chose not to go near it. I could have got it if I wanted it but just chose no. I didn't want that life. I didn't want to look like them in bits and all because if you look at the older generation, they never knew how to smoke it on foil. All they knew was just to get a needle and whack it into their arm, you know what I mean? They didn't know how to smoke" — Ian (25 years).*

Thus, during the early stages of their drug-using careers, young people frequently believed that they would never initiate heroin use. This, some explained, was due to the social stigma that they perceived to surround the drug. Sarah, for example, explained that she believed that she would never use heroin because it was a "dirty drug";

> *"I thought, 'Oh Jaysus, I'd never do that, that's not the kinda person who I am, and I'd never go there...' Heroin was a dirty drug. People on heroin were junkies, whereas people on coke were able to maintain a normal life. That's how I thought of it" — Sarah (18 years).*

Young people who reported heroin use amongst their family members also stated that they had negative views of the drug and were determined not to initiate. Dylan, for example, had been exposed to the heroin use of his mother's partner and brother during his childhood and early teenage years. He explained that observing the consequences of heroin use on his family members shaped his negative perception of the drug;

> *"I just thought it was bleeding horrible. After seen what it had done to me brother and me ma's fella and whatever, ya know? I just didn't want anything to do with it. So I thought. Just, you know, I suppose everyone says it, 'I'll never touch that'" — Dylan (20 years).*

The dichotomous views of 'soft' drug use and heroin use described by the young people correspond to commentaries focusing on the dual dimensions of drug consumption. Conceptualising two distinct types of drug user, recreational users are seen as being motivated to use soft drugs such as ecstasy or amphetamines for pleasure; while problematic drug users, usually associated with the use of heroin or crack cocaine, are driven by despondency and

[9] Ian and his friends

dependence (Gilman, 1992; Plant & Plant, 1992). This distinction is perhaps overly simplistic, and it is likely that motives for use, as well as drug choices, are more fluid throughout the drug careers of individual users (Measham & Shiner, 2009; Simpson, 2003). Nevertheless, the narratives of young people in this study strongly suggest that, during the early stages of their drug careers, they differentiated between two drug-using groups: those who used drugs such as cannabis, ecstasy or cocaine 'recreationally', and those who used heroin. Young people received messages from within their peer groups that heroin was 'bad' and 'dangerous' and, therefore, not an 'attractive' drug. Heroin use was associated with negative consequences such as dependence, physical deterioration and viral infections, all of which were unappealing to young people. 'Recreational' drug use was seen, in contrast, as offering enjoyment and increased sociability, without impinging on their personal freedom, status or well-being.

Pathways to Heroin Initiation

This chapter has, thus far, provided a description of the macro, meso and micro-level 'risk environments' which shaped young people's early illicit drug-using careers. Social environments characterised by socio-economic disadvantage and family adversity impacted on the production of drug-related risk and on young people's initiation of illicit drug use during late childhood or early adolescence. For the majority, early drug use was characterised by contexts in which friends were present and included both indoor and outdoor locations. However, the vast majority of young people in the sample did not initiate heroin use within the peer networks where they participated in 'soft' drug use. As demonstrated, they, as well as their peers, often held negative perceptions of heroin and heroin users and rejected the notion of initiating use. In order to explore how young people moved from 'soft' drug use to heroin initiation, a detailed analysis of the associated social processes, interactions and changing perceptions of heroin use was conducted.

The analysis of events and experiences preceding heroin initiation revealed a high degree of complexity and variability. In order to make sense of this data, typologies[10] were generated from a detailed analysis of young people's 'stories of heroin initiation[11]'. The typologies focused to a large extent on social relationships which contextualised young people's exposure to, and first use of, heroin. The development of these typologies revealed that young people in this study came into contact with heroin users through three main social routes: a 'criminal career' pathway,

[10] The identification of typologies has previously been used to analyse pathways into homelessness (Mayock & O'Sullivan, 2007) and criminal activity (Francis et al., 2004). In this study, it proved useful for developing understandings of pathways into heroin initiation; but these typologies were generated on the basis of similarities in configuration rather than a single variable or trait. They were not simplistic or uniform, therefore, and considerable diversity was demonstrated within each category.

[11] Data from each life history interview pertaining to events and circumstances immediately preceding heroin initiation were summarised into a 'story of initiation'. The typologies were generated from the analysis of these summaries.

an 'intimate relationship' pathway, and a 'homeless' pathway[12]. The analysis further revealed that, through their social interactions with heroin users, they then came to perceive heroin more positively and were provided with numerous opportunities to initiate use. The following three chapters describe these three pathways and the social course of young people's heroin initiation in detail.

There was some degree of overlap between the three pathways into heroin use identified. However, it was possible to categorise the majority of young people in the qualitative sample according to one of the three pathways (only two of the forty young people did not 'fit' one of the three social routes into heroin use identified[13]). The number of young people in each of the three pathways, as well as those whose accounts indicated an overlap between two of the pathways, are presented in Table 1.

Table 1: Pathways to Heroin Use

Pathway	Description
Criminal Career Pathway (n=15)	➢ Only young men described a criminal career pathway ➢ They were extensively involved in criminal activity prior to their heroin initiation ➢ Twelve of the 15 demonstrated *only* this pathway into heroin use
	➢ Three young men demonstrated *both* a criminal career and homeless pathway into heroin use
Homeless Pathway (n=15)	➢ Both young men and young women described a homeless pathway into heroin use ➢ They experienced homeless or were deeply entrenched in homeless scenes prior to their heroin initiation ➢ Ten young people (seven men and three women) demonstrated *only* a homeless pathway into heroin use
	➢ Two young women demonstrated *both* an intimate relationship and a homeless pathway into heroin use
Intimate Relationship Pathway (n=13)	➢ Only young women described an intimate relationship pathway into heroin use ➢ All entered into a relationship with an older heroin using male prior to their heroin initiation ➢ Eleven young women demonstrated *only* an intimate relationship pathway into heroin use

[12] It is important to note that, as discussed in chapter three, the vast majority of young people in the qualitative sample were recruited from drug treatment or homeless services. Heroin users recruited through alternative strategies, and not accessing these services, may not demonstrate one of these three pathways into heroin use and may, in fact, describe 'new' or 'alternative' pathways not documented by this study.

[13] One young woman initiated heroin use, while living in her family home, with an older male who was not a sexual partner. One young man initiated heroin use alone while living in his family home. He was not heavily immersed in criminal activity prior to his heroin initiation but had a number of older male acquaintances who were using the drug.

The *criminal career* and *intimate relationship* pathways were strongly associated with gender and there was no overlap between them. Of the 40 young people interviewed, 15 — all young men — came into contact with heroin users through their criminal activity, and initiated use within these social networks. Thirteen young women reported involvement in a sexual relationship with an older heroin user at the time of their initiation to the drug, and the majority stated that they first used heroin in the company of this sexual partner. The third pathway into heroin use, the *homeless* pathway, was shared by young men and women. Eleven young people experienced homelessness prior to their heroin initiation, and a further four described an immersion into social networks of homeless heroin users despite living in stable accommodation. For these 15 young people, street-based heroin-using networks shaped the course of their heroin initiation.

There was some overlap between the homeless and the criminal pathways, and also between the homeless and the intimate relationship pathways. Two young women who reported involvement in a sexual relationship with an older heroin user, and three young men who were participating in criminal activity, were also living 'out-of-home' or immersed in street-based heroin-using social networks at the time of their initiation. The accounts of these participants are primarily discussed in chapter seven, along with those who demonstrated a homeless pathway, since their accounts of heroin initiation were strongly connected with their experiences of living 'out-of-home'.

Conclusion

The aim of this chapter was to describe the macro, meso and micro-level 'risk environment' of the young people's early drug use. At the macro-level, the life history interviews revealed that the majority of the young people lived in deprived neighbourhoods with high rates of drug use and criminal activity. Data from the interceptor survey also indicated that the sample consisted of a socially and economically marginalised group; the participants reported high rates of early school leaving, unemployment and homelessness. Similar findings have previously been reported in Ireland (Dean et al., 1983, 1985, 1987; O'Gorman, 1998) and the UK (Parker, 2001; Parker et al., 1986, 1987, 1988, 1998b; Pearson, 1987), indicating the need to situate heroin initiation and use within the context of macro-level social and economic environments (Feldman, 1968; Preble & Casey, 1969).

At the meso-level, the young people experienced numerous forms of adversity during their childhood and early teenage years, including parental substance use, domestic violence, family breakdown and childhood abuse. Previous epidemiological studies have linked these to adolescent drug use (Denton & Kampfe, 1994; Frisher et al., 2007; King & Chassin, 2004) but 'risk factor' research tends to isolate these forms of family adversity from each other (Lloyd, 1998) and from the broader social and economic environment (Waterston, 1993). Parker (2001) argued that experiences which place young people 'at risk' of heroin use, including 'disruptive'

life events, parental or sibling substance use, high levels of contact with social services and enforced exclusion from school, are shaped by experiences of social exclusion and poverty. Consequently, experiences of childhood adversity cannot be isolated from the broader social and economic environment. The young people in this study faced numerous forms of childhood adversity which exacerbated and compounded each other, and which occurred within macro-level environments characterised by socio-economic deprivation.

The micro-level 'risk environment' was documented through the young people's accounts of social process and interactions in their early teenage years. Macro, meso and micro-level forces interacted, shaping their exclusion from school and increased immersion in peer drug-using social networks. Within their peer social networks, the young people initiated cannabis, ecstasy and/or cocaine use. Similar to the findings of previous research (Becker, 1963; Kandel, 1985), the young people in this study highlighted the social nature of their early illicit drug use and emphasised social rewards in their initiation rationales.

Experiences of 'soft' drug use and immersion into peer drug-using networks, however, did not lead to heroin initiation. Heroin use was considered a stigmatised activity and the young people explained that they, as well as their peers, held negative views of heroin and heroin users. Previous research in Northern Ireland (McElrath & McKevoy, 2001) and elsewhere (Klee, 1998; Parker et al., 1998a; Solowij et al., 1992) has suggested that non-opiate drug users perceive heroin and heroin users in predominantly negative terms. Likewise, most young people in this study emphasised that they believed during their early teenage years, when using illicit drugs such as cannabis, ecstasy or cocaine, that they would never initiate heroin use. These negative perceptions of heroin use changed, however, when young people formed social connections with older heroin users.

The final section of this chapter identified three dominant routes or pathways taken by the study's young people into heroin use based on a detailed analysis of their 'stories of initiation', including: a 'criminal career', 'intimate relationship' and 'homeless' pathway. These three pathways form the basis of the following three chapters of this thesis.

Chapter Five

Criminal Careers, Heroin Initiation, Violence and Risk

Introduction

This chapter is the second to address findings and the first to document young people's pathways into heroin use. Chapter four provided a description of the young people's macro-, meso- and micro-level 'risk environments', revealing that young people in this study grew up in areas characterised by socio-economic disadvantage and in families facing various forms of adversity. Within these environments, young people were vulnerable to early school leaving and adolescent illicit drug use. However, most did not initiate heroin use within the peer social networks in which they initiated cannabis, ecstasy or cocaine use. Rather, they formed social connections with heroin users through three main pathways, and were exposed to and initiated heroin use with them. This chapter documents the first pathway into heroin use; the criminal career pathway.

Findings from the quantitative instrument revealed high rates of criminal behaviour and incarceration, particularly among the young men in the sample. The young people's life history narratives demonstrated that criminal activity often preceded heroin initiation, but that this dynamic was gender-specific. The majority of the young men, 19 of the 23, participated in criminal activity prior to their heroin initiation. Fifteen of these young men described how an immersion into criminal social networks shaped their heroin initiation. Three main criminal trajectories brought the young men into contact with social networks of heroin users;

1. An extensive involvement in acquisitive crime,
2. Drug-dealing activities and/or
3. A period of incarceration.

Through their criminal involvement, young men became exposed to the heroin use of others, and initiated in their company. Only one young woman reported a high level of criminal activity prior to her heroin initiation. During her childhood years, she assisted her two older brothers in their drug-dealing activities, but did not initiate heroin use with them or within their social network. This chapter, therefore, describes young men's early criminal activity, their immersion into criminal social networks, and the processes involved in their heroin initiation.

This study is not solely about heroin initiation, however. By examining young people's early heroin-using careers, it also seeks to explore their exposure to and experience of risk. Analysis of young people's life history interviews revealed that criminal activity shaped many young men's 'risk environments' during their early heroin careers. As reported in previous research (Ball et al., 1981; Chein et al., 1964; Hanlon et al., 1990; Jarvis & Parker, 1989; Kaye, 1998; McGlothlin et

al., 1978; O'Donnell, 1966; Weissman et al., 1974), an increase in criminal activity following heroin initiation was reported by many young people in this study. Young men and women who did not report criminal behaviour prior to their heroin initiation explained that the financial demands of regular heroin use required participation in minor acquisitive crime. Young men who reported criminal activity prior to their heroin initiation however, described an escalation and acceleration[1] in their criminal behaviour and a deeper immersion into criminal social networks. More serious involvement in criminal activity shaped these young men's 'risk environments' and they were exposed to multiple 'harms', including incarceration, victimisation and violence.

Quantitative Data

Analysis of the interceptor survey revealed that rates of criminal activity were high, with 83% of participants reporting that they had been charged with a crime in their lifetimes. This is similar to other Irish studies which have found high rates of criminal activity within the heroin-using population (Cox & Comiskey, 2007; Dean et al., 1985). Drug-related offences were common; 45% had been charged with drug possession and 36% with intent to supply. Many participants had also been charged with theft (67%), robbery (35%) or burglary (25%). Criminal activity was not limited to drug offences or acquisitive crime, however; half of the young people (50%) had been charged with a public order offence, 41% had been charged with assault and 16% had been charged with armed robbery. Rates of conviction and incarceration were also high; 70% had been convicted of a crime in their lifetimes, and 62% reported that they had been incarcerated on at least one occasion.

The high rates of criminal activity were not evenly spread across the sample, with notable gender differences apparent. Males were significantly more likely to have been charged with a crime (92% vs 66%, Chi-square=13.7, $p<0.01$); they were more likely to have been charged with drug possession (48% vs 39%), intent to supply (39% vs 29%), theft (71% vs 59%), robbery (43% vs 20%), burglary (33% vs 10%), armed robbery (21% vs 7%), assault (46% vs 32%) and public order offences (61% vs 29%). Males were also significantly more likely to have been convicted of an offence (82% vss 46%, Chi-square=16.9, $p<0.01$) and were more likely to have been incarcerated than their female counterparts (73% vs 39%, Chi-square=13.5, $p<0.01$). Although gender differences were notable, rates of criminal activity for females were also high, and the majority of both men and women had participated in criminal activity.

These quantitative data demonstrate high rates of criminal activity within this sample of young heroin users. Similar findings have been noted elsewhere (Ball et al., 1981; Jarvis & Parker, 1989), suggesting an association between heroin use and criminal activity. These statistics,

[1] An 'escalation' indicates a move to more serious offenses whereas an 'acceleration' indicates an increase in frequency of offending (LeBlanc, 1990).

however, cannot reveal the temporal sequence of criminal and drug-using involvement within an individual's life history, nor can they explore the complexities of the drug-crime relationship. The following sections in this chapter examine the qualitative findings pertaining to criminal activity and heroin use. They reveal that criminal careers preceded and impacted on the social environments of 15 young men's heroin initiation. Many other young people in the sample, however, did not demonstrate extensive criminal involvement prior to their heroin initiation. Their accounts reveal that following heroin initiation, they began to participate in acquisitive criminal activity in order to fund their drug use.

Early Criminal Activity and the Macro-Risk Environment

The majority of young men in the qualitative sample, 19 of the 23, reported criminal involvement prior to their heroin initiation. The onset of their criminal careers usually occurred in childhood, before the age of 12 years, with participation in theft or vandalism. Many subsequently progressed to robbery, burglary or, in a smaller number of cases, armed robbery. In concurrence with the quantitative data, criminal careers differed according to gender, and early criminal activity was predominantly reported by young men. Only one of the 17 young women reported criminal activity prior to heroin initiation, and she assisted in the drug-dealing activities of her older brothers.

As outlined in chapter four, the majority of young people in the sample came from socially deprived neighbourhoods. Descriptions of the young people's communities often spontaneously included accounts of criminality;

> *"Well basically, you see, the way [the area] is now, it used to be literally a graveyard of cars, like all burnt everywhere" — Kenneth (24 years).*

> *"Where I grew up, in my square, there was always houses getting burned and stuff like that. It's a rough area, people getting shot and all that. It is a rough area" — Jack (25 years).*

> *"There's loads of estates and all in it. It's a little [commuter] town but anyone from outside it now can't walk into it. He'd be stabbed or robbed. It's just very dangerous like, the people" — Aaron (17 years).*

The young men's early criminal behaviour occurred within physical and social environments characterised by high density local authority housing, poor infrastructure and few recreational facilities. The young men described high rates of drug use, criminal activity, early school leaving and unemployment within their communities and, at an early age, became aware of social

networks of predominantly male youth in their locales who participated in car theft, 'joyriding', vandalism and acquisitive crime.

The young men highlighted the impact of the macro-level environment on their early criminal activity. Some explained that a lack of recreational or leisure facilities contributed to their involvement in 'deviant' activities. For example, Kenneth, a young man who began stealing cars and 'joyriding' in his early teenage years, stated that the limited availability of recreational pursuits led to feelings of monotony during his childhood, explaining that the lack of alternative activities to occupy and motivate him encouraged participation in 'deviant' behaviours;

> *"There's nothing really exciting [in my area]. There's never really anything exciting. In my day, exciting things were robbed cars, things like that, something to excite you because there was nothing else to do" — Kenneth (24 years).*

Invariably, the young men portrayed their early criminal behaviour as a sociable activity and many described participating in 'deviant' behaviour within large social networks. They explained that theft, 'joyriding' and vandalism were commonplace amongst youth in their locales. Most participated in a variety of acquisitive crimes and described an escalation in their criminal careers during their early teenage years. They emphasised how criminal activity provided increased access to material resources and a higher position of status within their social networks. Damien, an ambitious young man from a deprived suburban area, explained that a criminal career appealed to him from an early age;

> *"When I was a kid and in the school, they were saying 'What do you want to be when you grow up?' People in the class were saying 'fireman' or 'policeman' or 'brain surgeon' and they came around to me and I said 'international arms trafficker'; you know, like Tony Montana out of Scarface? That's what I wanted to be. I wanted to be a big gangster" — Damien (18 years).*

Damien's narrative uncovers a belief that a criminal career was the most feasible option for social and economic success for individuals within his community. He explained that limited access to educational structures blocked career paths and enhanced the appeal of drug dealing and other criminal activities;

> *"I think the people that I was with in the flats, the people that I would have been around, they're not going to be doctors or that, you know what I mean? Drug dealing and things like that is kind of all they're left with. They've no kind of education" — Damien (18 years).*

Kieran also spoke about the relationship between education and criminal activity. He believed that his poor levels of educational attainment contributed towards his increasing participation in 'deviant' activities such as car theft. Kieran's account illustrates how young men often perceived educational success and criminal careers to be separate and incompatible life trajectories;

> *"We'd rob cars; nothing major though, just sort of robbing cars. The older boys would be robbing back then and all that sort of stuff. It wasn't that it was cool; it was just that I knew I wasn't going to be a good boy forever because I was never really smart in school. I failed me Junior Cert as well" — Kieran (17 years).*

Many of the young people described thriving informal economies within their communities, of which they became aware during their childhood and early teenage years. Young men often explained that they perceived older criminally-involved men to be 'role models' because they represented the status and success of a lucrative criminal career. Damien, for example, spoke about 'the General', a well-known criminal who lived in his locale during the 1980s, who he claimed was held in high esteem by many members of his local community. Damien explained that he and his peers held 'the General' in high regard and "looked up to him";

> *"The General[2] was from the area and everyone used to [say] 'Your man, he's the best!' He used to go around my old flats years ago, giving all the auld ones[3] nappies, when he had nothing. In the early 90s when there was poverty, he used to go around giving all the auld ones nappies and whatever, to keep them happy, to keep them on his side; but everyone just thought he was brilliant. And he was from [my area] as well, you know what I mean? They were the kind of people we would look up to" — Damien (18 years).*

Others similarly told how they admired well-known criminals during their early teenage years. Barry said that he too held men like 'the General' in high regard. He disregarded negative media accounts of notorious 'drug dealers' such as John Gilligan[4] because he believed that this coverage was biased;

> *"Especially back then when we were growing up, we didn't know about John Gilligan back then. Even when they were in the papers, we weren't paying attention to them. They were*

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[2] 'The General', or Martin Cahill, was a prominent criminal in Dublin during the 1980s and early 1990s. He was convicted of burglary and robbery and was assassinated in 1994 outside his home in a Dublin suburb.
[3] 'Auld ones' is an Irish colloquial term for mothers.
[4] John Gilligan is a notorious Irish criminal who is currently serving a twenty-year prison sentence for possession of forty million (Irish) pounds worth of cannabis. He has also been convicted of robbery, burglary, larceny, assault and receiving stolen property. John Gilligan was suspected of the murder of journalist Veronica Guerin but was never convicted of the offence.

just 'ordinary decent criminals'. They were just the next General, somebody for the media to pick on" — Barry (20 years).

In addition to prominent Dublin-based criminals, some of the young men admired criminally-involved youth in their immediate locales. They observed these men enjoying the advantages of a criminal career and articulated a desire to emulate their achievements during their teenage years. Damien spoke about a man who lived in his local authority housing complex who had acquired social and material success through drug-dealing activities, explaining that he viewed this man as a "role model" and wished to acquire similar symbols of success;

"A bloke in the flats, he used to drive a BMW, he had the blonde bird and I used to see him and I'd say, 'Yeah that's what I want to be like', ya know what I mean?" — Damien (18 years).

The young men's narratives illustrate that the macro-level 'risk environment' influenced the development of criminal careers. Although emphasising their agency by highlighting motives such as the wish to obtain material wealth and social status, the young men's early criminal behaviour occurred within a social environment of disadvantage. These environments limited their access to conventional occupations, exposed them to the criminal activity of older men in their locales and enhanced the appeal of a criminal career.

Criminal Social Networks

During their early teenage years, 19 young men became immersed in social networks of youth participating in criminal activity. In many cases, access to criminal networks occurred gradually through friends or acquaintances; but family members, mainly older brothers, provided a social route into criminal activity for seven of the young men. Early criminal behaviour was invariably portrayed as a social activity and the young men highlighted the social rewards of participation. Many explained that early criminal activity was an entertaining way of spending time with other male youth in their areas. One young man, Ian, indicated that early involvement in petty theft and vandalism brought a sense of affiliation with youth in his locale. He also emphasised the feeling of autonomy, independence and amusement that he associated with participation in these activities;

"Well I grew up in [a deprived inner-city community] and just the same as everybody else, just young fellas, we do what we want like, you know what I mean? I used to go off all the time robbing and just messing around, making fires and all, smashing aerials, everything else" — Ian (25 years).

For most of the young men, early recreational drug use and criminal activity occurred simultaneously and within the same social network, with 17 of the young men having committed theft and initiated cannabis use by the age of 14 years. These young men identified their early teenage years as marking the onset of their drug and criminal careers, a time when they also started to veer away from educational structures and family life. Some young men highlighted the direct and practical associations between drug use and crime. For example, payment for stolen goods was occasionally given in the form of drugs, and two young men, Joe and Aaron, explained that older peers would give them ecstasy or cannabis in exchange for stolen bicycles or electronic equipment;

> *"I used to rob push bikes. I used to rob and just sell it for hash. They'd give me hash for the push bikes" — Joe (17 years).*

> *"Mostly the big drug dealers we used to go to and that. They'd take all the stuff[5] off us. Probably give us ecstasy tablets and that for them like, ya know?" — Aaron (17 years).*

Theft and burglary, therefore, could lead directly to the acquisition of illicit drugs. As described by Aaron, early acquisitive crime also brought the young men into contact with increasing numbers of individuals involved in both drug use and criminal activity. For many young men, crime and drug use were inextricably linked within their social networks during their early teenage years. Kenneth described how social interactions with youth in his locale exposed him to both criminal activity and 'soft' drug use;

> *"That's how you're led into the life, the crime and drug life from there. Hanging out with friends, thinking it's great, rob cars, and then using hash and then from there, from hash to E, all that" — Kenneth (24 years).*

The sequential order of young men's involvement in criminal activity and 'soft' drug use differed, with some participating in criminal activity and then drug use, and others initiating drug use followed by participation in criminal activity. While Kenneth described participating in criminal activity prior to his initiation to recreational drug use, Darren described a reverse sequential order. He started smoking cannabis with his friends during his early teenage years and later began participating in acquisitive crimes to finance his cannabis use;

[5] In Aaron's narrative, 'the stuff' referred to household goods that he obtained through burglary; DVD or Mp3 players for example.

"I just liked sitting around, make a joint, having a joint, a few cans even with it, and then you'd have to be going out actually robbing for it. At that young [twelve or thirteen years] I was robbing. I wasn't on heroin or anything. I was just going off shoplifting to get money for hash" — Darren (25 years).

Despite evidence of variation in the chronology of young men's initiation to drug use and criminal activity, these activities occurred within the same social networks. Within these networks, in which they were participating in early criminal activity and 'soft' drug use, young men came into contact with older youth who were more extensively involved in criminality. In many cases, these older peers played an important role in the young men's evolving criminal 'careers'; they had more experience and knowledge of criminal activity, they introduced the young men to more serious crimes such as robbery and burglary and educated them in the required techniques. As Damien explained, his criminal 'career' evolved in conjunction with the guidance of older peers who instructed him on techniques required to commit theft, robbery and burglary successfully;

"And then it was with an older crew that were creeping gaffs [burglary] and this was when I was getting a bit older then. First, I started robbing cars...no mopeds; first, I started robbing mopeds. I learned how to just put me hand up and pull the plugs and then kick start it. And then motorbikes, learnt how to wire them. And then cars, just learnt how to rob cars with people I know. They used to call it 'training in', ya know what I mean? They'd say 'Right, come with us and we'll train you in' and showing you how to rob cars and showing you how to use guides to open front doors and things like that. So a gradual build up, you know what I mean?" — Damien (18 years).

Twelve of the young men in the qualitative sample described a key relationship with a specific individual, usually an older male who was more heavily immersed in crime, who they believed to have encouraged and facilitated their developing criminal careers. In some cases, the young person was introduced to acquisitive crimes such as robbery or fraud, but others were recruited into criminal drug-dealing gangs through an association with an older acquaintance.

Eight of the young men described being asked to facilitate older men's drug-dealing activities during their early teenage years. Their involvement in drug dealing increased their access to money, and facilitated experimentation with new 'harder' drugs. Dylan, for example, started selling cannabis at the age of thirteen in the company of an older youth in his area. This activity became more lucrative over time and he began to buy other illicit drugs for his own personal use;

"When I started selling it and all, I'd be just making a decent few quid off it. So I was always buying new clothes. Then I had loads of hash to smoke meself. I just got fed up with it, ya know? Started spending the money on...I started taking Es then" — Dylan (20 years).

The 12 young men who formed a social connection with an older criminally-involved male said that they admired or "looked up to them". Some, who had limited contact with their biological fathers during their childhood years, referred to the absence of a male 'role model' in their lives, believing this to have impacted upon their relationship with these older peers. In his early teenage years, Aaron, for example, was recruited into a criminal drug-dealing gang by an older male. He had limited contact with his biological father following his parents' separation in his early childhood and explained that this older peer was like a "father figure" to him. He developed a close relationship with this man throughout his teenage years which, he believed, influenced his own immersion into criminal activity and subsequent drug use;

"See, they [gang members] were nice to me and that. There was one of them I kind of looked at; he was like a father figure. I used to be in the house with him the whole time and when I started getting older, about 13, I used to start doing drug runs and that for him" — Aaron (17 years).

Young men who participated in criminal activity alongside older youth acknowledged their vulnerability during their early teenage years. They explained that they were unaware of the severity of the potential negative consequences of criminal involvement, such as violence and 'hard' drug use. In some cases, the young men's criminal careers escalated rapidly due to their associations with older criminally-involved men. Criminal drug-dealing networks, for example, were rigidly hierarchical and a social connection with an existing member was necessary for upward mobility. When a young man gained entry into a criminal network through an association with an individual occupying a high-level position, it accelerated his criminal career. A number of young men became immersed in what they portrayed as a violent world of gang-related crime through their relationships with older males. Damien believed that even the most notorious 'drug dealers' gained access to criminal gangs through similar processes. His account illustrates how he believed the micro-level risk environment shaped escalating criminal trajectories;

"You get caught up in a world. I'd say that's how half of the people that you'd see in the papers now, that's how they started, do you know what I mean? That's how most people get into it. They're kids, they look up to [older criminal gang members], they start doing things and then they just keep going" —Damien (18 years).

Damien was recruited into a criminal gang when he was just 13 years of age by a man whom he described as a notorious 'drug dealer' in a West Dublin area. His reflections on this period uncovered the belief that the absence of a 'father figure' in his childhood enhanced his vulnerability within this context, and impacted upon his ability to perceive the negative aspects of this relationship;

> *"See, back then I was looking at it from my point of view, but now I can see that he didn't give a rat's about me. Your man, John, he didn't care that I was getting strung out on gear. I was just his run-around. I was just a young fella that was vulnerable 'cause I was young and looked up [to him]. He probably knew that I looked up to him [because] I'd no father figure, so someone like that was there to kind of [take his place]" — Damien (18 years).*

Other young men highlighted the advantages of associating with an older 'street-wise' male when living in a community in which crime, violence and victimisation were commonplace. Aaron, for example, had witnessed gang violence, such as stabbings and shootings, in his locale, and explained that he felt "safer" with his older male friend, feeling better "protected" by his connection with him;

> *"I liked him so I did, and I kinda felt safer, if you know what I mean. I kind of felt like he'd protect me and stuff like that. I just felt safe with him" — Aaron (17 years).*

While an association with an older criminally-involved male may well provide some with protection, economic and status advantages, being 'recruited' into criminal networks or drug-dealing gangs often accelerated both criminal and drug-using careers. Drug dealing, in particular, was a lucrative endeavour and brought the young men into contact with large social networks of drug-using and criminally-involved youth. With increased access to drugs and money, these young men described a rapid escalation into 'harder' forms of drug use.

Whether participating in drug dealing or other forms of criminal activity, an immersion into criminal social networks exposed many young men to 'hard' drug use. Fifteen young men described how social interactions within these micro-level environments shaped the process of their heroin initiation. Older, criminally-involved acquaintances introduced them to heroin, and the young men initiated use in their company. The social processes impacting upon these young men's heroin initiation are discussed in detail in the following section.

Criminal Careers and the Social Course of Heroin Initiation

For 15 young men, criminal peer networks played a key role in the social course of their heroin initiation. Many of these young men reported heavy-end criminal activity such as burglary,

robbery, armed robbery or drug dealing, through which they came into contact with older, criminally-involved men who were immersed in 'heavy-end' drug use. Detailed analysis of these young men's pathways revealed that exposure to heroin users occurred through three main criminal trajectories;

1. An extensive involvement in acquisitive crime,
2. Drug-dealing activities and/or
3. A period of incarceration.

By means of these three pathways, the young men came into contact with older heroin users through their criminal activity and formed relationships with them. When exposed to their heroin use, the young men explained that the negative views that they previously held of heroin (described in chapter four) began to change, and they became curious about its positive effects. All 15 young men were introduced to heroin by their older criminally-involved peers, and most initiated in their company.

The following sections will describe the three sub-routes of the 'criminal career' pathway into heroin use; the acquisitive crime, drug dealing and incarceration pathways. Although they will be discussed separately, there was some overlap between these three pathways. A number of the young men with extensive criminal involvement participated in both acquisitive crime and drug-dealing activities, and, were at high risk of incarceration as a result. Nevertheless, most of the young men demonstrated a trajectory towards either drug dealing or heavy-end acquisitive crime such as burglary. The third route into heroin use, incarceration, was often exhibited by young men who had committed only minor criminal offences such as trespassing or public order offences.

The Acquisitive Crime Pathway

The young men did not generally form associations with heroin users through minor acquisitive crime such as shoplifting; many had participated in these crimes during their childhood or early teenage years without coming into contact with 'hard' drug users. It was only through an involvement in heavy-end acquisitive crime such as car-theft, robbery or burglary that five young men formed social connections with heroin users. Richard, for example, regularly participated in car theft and 'joyriding' with a group of older youth from his locale. These men regularly used heroin in his company, although Richard refused offers to initiate for a number of years, despite being the only member of his social network not to use heroin. He explained that he eventually acquiesced, however. His account of initiation locates the event in the micro-level social environment and demonstrates how the context of his initiation was shaped by his criminal career;

"I actually do remember the first time I ever had a blow, like gear. We'd robbed a car, me and me mates. We drove into someone's garden and got it ready and a young fella, he asked, 'give us a joyer and I'll look after you'. I wasn't smoking at the time, but the two of them were having one in the front [of the car]. So I just, curiosity says, 'ah go on, give us a line'" — Richard (21 years).

Richard's participation in car theft and joyriding brought him into contact with older heroin users and, over time, he became increasingly immersed in this social network. He was regularly exposed to their heroin use and explained that this enhanced his curiosity about its effects. The accounts of other young men revealed similar social interactions preceding heroin initiation. Along with his older brother, Alan participated in car theft and joyriding during his early teenage years, which brought him into contact with his brother's social network of criminally-involved heroin users. Alan initiated heroin use in the company of his brother's friends, following the incarceration of his brother;

"Where I lived, I seen a few people that was on it [heroin], but my brother hung around with them. It ended up that my brother went to jail and that's how I ended up getting onto it [heroin]. When he got locked up, then I ended up hanging around with all his mates, so that's how I ended up getting strung out on gear" — Alan (25 years).

Alan came into contact with these older heroin users through participation in criminal activity with his brother and, over time, became an accepted member of their social network. Relationships with older heroin users, strengthened through mutual participation in crime, had a significant influence on other young men's initiation into heroin use. Adam also described how he formed social connections with older heroin users through participation in acquisitive criminal activity. He began committing fraud, robbery and forgery with an older heroin user when he was 17 years of age. Prior to this, he described no criminal involvement. His connection with this man, a friend's older brother, developed in combination with escalating criminal activity and brought Adam into contact with a social network of criminally-involved heroin users. Adam described the process of his initiation;

"[I initiated heroin use] about a year and a half ago when I was 17. It was just, one day I was hanging around with me friend and his brother in his 30s, and he asked me to go in the car with him just to go down the town. I just started going in the car with him then once every couple of days or whatever. Then he started going around robbing and getting me to rob the stuff and that, going into places and that. And he was using heroin at the time, but he told me if I ever used it he'd kill me. But then it was his other brother, there was three of them using it [and I] started using it then" — Adam (18 years).

Through participation in crimes such as car theft, robbery or burglary, these young men formed social connections with older youth who were engaging in heroin use. Within these social environments, they had numerous opportunities to initiate use and explained that their regular exposure to the drug increased their curiosity about its effects. The young men also highlighted that they were the only individuals within these social networks who had not used heroin. This, coupled with their younger age, isolated them from the group, and the young men were often eager to participate in heroin use with their older peers.

These accounts reveal that heroin initiation was not an isolated event in a young person's life, but rather a gradual social process. Criminal careers pre-dating heroin initiation shaped these young men's social 'risk environments', bringing them into contact with older heroin users. For the five young men in the 'acquisitive crime pathway', participation in car theft, robbery and/or burglary alongside older heroin users regularly exposed them to heroin use and enhanced their curiosity about its effects. These young men initiated heroin use in the company of their older criminally-involved heroin-using peers.

The Drug-Dealing Pathway

Other young people came into contact with heroin users through participation in drug-dealing activities, with five young men reporting involvement in drug dealing during their early teenage years. Street-level heroin selling, as has been reported elsewhere (Faupel, 1991; Maher & Dixon, 1999; Preble & Casey, 1969), was often conducted by young people *following* their heroin initiation in order to fund their drug use; but these young men described involvement in higher-level drug dealing *prior to* their heroin initiation. This invariably occurred through their social connections with large-scale drug dealers in their community. The drug market, as a lucrative endeavour within the young men's deprived neighbourhoods, was aggressively contested and defended and was not an activity that was accessible to the young people without a mentor. In all cases, older drug-dealing males played an important role in recruiting the young persons into a drug-dealing network, requesting that they assist them in their activities.

Barry explained that he became involved in drug-dealing activities when he was 14 years old. He explained how being the younger brother of a well-known and respected drug dealer aided his access to drug-dealing social networks;

> *"My brother got locked up [incarcerated] and every second fella I'd see on the street then would be like 'Howaya?' Then you'd start talking to these people and they'd be little sort of miniature gangsters. They'd get [drugs] for me because of who me brother was, and these people knew me as so-and-so's little brother. I'd get good deals, good stuff, they'd*

tell me what way to do it and all[6]*. They'd ask me would I work for them and all, so that's when everything started to go wrong" — Barry (20 years).*

Young men were invariably recruited into drug-dealing networks through an association with an existing member, but some explained that it took a period of time before other members "trusted" them. Barry explained that profit-making potential was crucial to upward mobility within the illicit economy;

"Having connections when you don't even know these people [older drug dealers] and they're being nice to you and you think it's all 'cause they know you. They know your brother, but they also see that you can make them money and they can make you money" — Barry (20 years).

Young men with older drug-dealing brothers were introduced to drug-dealing networks and thus drug suppliers, but they were also introduced to potential buyers. This facilitated their profit-making abilities and hence their upward mobility within drug-dealing social networks. Three of the five young men were introduced to drug-dealing activities by their older brothers, and two became involved through other social connections; one through his uncle's friend, and another through a friend's uncle. The two young men who were not introduced by a family member emphasised the need to 'prove' themselves before they could fully participate in the large-scale selling of 'hard' drugs. At first, they assisted the older drug dealers in their activities; dividing the drugs into smaller quantities for sale, delivering them to clients or carrying the drugs on their person to reduce the chances of police seizures. Through these activities, they described how they increased profits for older dealers while reducing their risk of imprisonment. The young men explained that they were given a small share of the profits — a substantial sum during their early teenage years — which motivated further participation. Simultaneously, they earned the "trust" of high-level drug dealers who assigned them increasing levels of responsibility;

"Then he actually started trusting me. He gave me a scales and he showed me how to cut it [heroin] and bag it into the dealing stage. Selling it for the street sellers, ya know what I mean? So he had me bagging up all of these and then he just said, he handed all the custom over to me, and he said, 'Right, for every ounce you sell, I'm going to give you 200 euro' and I was making big money, ya know?" — Damien (18 years).

[6] How to mix the drugs with additional substances, weight them into smaller quantities and distribute them to customers

Through increasing participation in drug-dealing activities, the young men held higher positions of status within their social networks and had increased access to material resources. Barry, for example, described his early cocaine-dealing career as busy, sociable and lucrative;

> *"I met an awful lot of people. There was so much of it [cocaine]. There was different people asking me to take it off them or do I know somebody who has nicer stuff because I was making so much money... When you're selling drugs, you're always on the go. There was always someone looking for something somewhere. So you're always busy, you know that way?" — Barry (20 years).*

Selling cocaine was a profitable activity, but all the young men who participated in drug dealing stated that heroin had the greatest financial turnover due to the large numbers of daily users within their communities. As the young men progressed in their criminal careers and became increasingly immersed in criminal networks, they invariably moved to selling heroin. By this means, they became exposed to the heroin that they sold, and the heroin users to whom they sold.

Damien told how he began to weigh, pack and distribute heroin for a large-scale heroin dealer in his area when he was 12 years old. His participation in the illicit drug economy brought him into contact with many heroin users and dealers, and within two years, he had established a large 'client base' through his successful 'dealing' activities. Damien regularly observed the heroin use of his 'clients' and initiated in the company of one when he was 14 years of age;

> *"I used to start using gear then with that lesbian English bird. I used to start going around to her place when I started selling it to her. I used to start selling to her and using with her and, through her, I found a few other different people that used and I could go and use with them" — Damien (18 years).*

Damien, like many young people, had negative views of heroin in his early teenage years and believed that he would not initiate use. However, when he became exposed to the heroin use of his 'clients', these views gradually began to change. His account indicates that social interactions with heroin users enhanced his curiosity about the effects of heroin, influencing his initiation rationale;

> *"What about heroin? The thing I said I'd never do...me curiosity killed the cat" — Damien (18 years).*

Young men explained that exposure to the heroin use of other individuals enhanced their curiosity about its effects and motivated them to initiate use. However, some also described how

social forces operating within drug-using networks increased the risks of this drug transition. Damien, for example, worked for a heroin dealer who did not use the drug, and explained that large-scale dealers occupying high levels in the illicit economy often did not use heroin and did not approve of nor trust heroin users to facilitate their drug-dealing activities. Other young people explained that large-scale drug dealers were reluctant to work with heroin users because they perceived a greater risk of financial loss and information being divulged to the police. Damien, therefore, used heroin in secrecy during his early heroin career, and feared that his drug-dealing superior would discover that he had initiated. Although large-scale drug dealers were said by many to abstain from heroin use, those occupying lower positions in the illicit economy were often users of the drug. The young men in this study, who occupied middle to lower end positions in drug-dealing hierarchies, were exposed to, and had access to, large quantities of heroin during their early teenage years. They also became immersed in social networks of heroin users through their 'drug-dealing' activities and initiated heroin use within them.

Participation in drug dealing impacted upon the young men's heroin initiation in complex ways. High-level heroin dealers were often portrayed by these respondents as disapproving of heroin use, believing that it affected the sellers' trustworthiness. However, the young men became exposed to heroin and heroin users through their drug-dealing activities. An abundant supply of the drug, and regular exposure to the heroin use of others, enhanced the young men's curiosity about the effects and provided opportunities to initiate.

The Incarceration Pathway

Five young men described becoming more deeply immersed in criminal and drug-using social networks during a period of incarceration or detention. Incarceration in adult prisons and detention in young offenders' institutions served to expose the young men to a social network of individuals who participated in more extensive criminal activity as well as harder drug use. High rates of opiate use have been reported within the prison population in the UK (Bird et al., 1997; Mason et al., 1997; Singleton et al., 2003) and Ireland (Allwright et al., 2000), and for the young people in this sample, the prison environment placed them in close proximity to social networks of heroin users. Five young men explained that being incarcerated and exposed to the heroin use of other inmates changed their negative views of heroin, piqued their curiosity about its positive effects and influenced their initiation within the prison environment.

Luke, who initiated heroin use in prison when he was 18 years of age, believed that his incarceration was a 'turning point' in his life, leading to an escalation in 'hard' drug use and criminal activity;

"I said, 'I'll never go on that drug [heroin]', but as soon as I went to prison, I just tried it and ever since, I just kept dabbling in it, and I just got strung out on it then. And when I couldn't rob no more, then I just went tapping for the money. And it all went downhill then" — Luke (24 years).

In some cases, the young men did not describe extensive involvement in criminal activity prior to their incarceration, having been sentenced for minor offences, such as trespassing or driving without tax and insurance, or for public order offences. While incarcerated, they formed social connections and initiated with other incarcerated men, some of whom were heroin users. Jack, a young man from a suburban area in West Dublin, was incarcerated when he was 16 years old for driving without tax and insurance. At first he was reluctant to initiate heroin use but explained how exposure to heroin and heroin users within the prison, impacted on his initiation rationale;

"He told me 'Take this and your jail will fly through [pass quickly]' and I said, 'Oh no, I don't take drugs', which I didn't. I only smoked hash, but there was no hash in jail...so two weeks later he got [heroin] in and he came into me cell and asked me for a bit of tinfoil. Jail just started flying through when I started taking it and up until I got out" — Jack (25 years).

Heroin was reported by many to be the most popular and commonly used drug in Irish prisons, and other drugs such as cannabis or ecstasy were rarely available. The limited availability of other drugs, coupled with regular exposure to others' heroin use, facilitated and motivated the young men's initiation. Michael was incarcerated for a public order offence at 21 years old. Prior to his incarceration, he had used a variety of drugs, including ecstasy, liquid MDMA, speed and cocaine. He explained that he preferred these drugs, which he described as "uppers", to those that he called "downers" which included heroin and tranquilisers. However, while in the prison environment, "uppers" were not available to him and he initiated heroin use;

"That's the drug they had inside [in prison]. They were chasing the dragon and I said, 'Nice one', straight away. Got the heroin straight into me and sat down and relaxed... I would probably have preferred to get ecstasy more than anything else because I wanted to keep away from the hash completely, but [the heroin] was nice. It was a nice experience. I enjoyed it" — Michael (23 years).

Following his imprisonment, Michael never used heroin again. He said that heroin use was not appealing outside the prison environment because it was not an "upper" and he enjoyed using drugs that enhanced his sociability at parties. He explained that his heroin initiation in prison was

facilitated by other inmates who were using the drug, and that he was motivated by the wish to alleviate the monotony that characterised prison life;

> *"There was nothing else there and you get bored and you're looking at the other fellas off their head and you think, 'Nice one, I'm going to do the same thing just to pass the time'... It was just 'cause I was in prison and there was nothing else going around" — Michael (23 years).*

As Michael emphasised, the young men faced long stretches of time without recreational or leisure activities while incarcerated. The monotony of prison life impacted upon their wish to use illicit drugs because they believed that they would help to "pass the time". However, 'soft' drugs such as cannabis or ecstasy were often unavailable and heroin was the most popular and accessible drug in the prison environment. Their physical proximity to heroin users and regular exposure to their heroin use provided numerous opportunities to initiate. The prison environment, therefore, impacted on the young men's exposure to heroin, provided regular opportunities to initiate and influenced their initiation rationales.

Criminal Activity Post-Initiation

The previous sections described how criminal careers impacted upon heroin initiation for 15 young men. However, this study is not solely about heroin initiation; it also seeks to explore young people's experiences of risk during their early heroin careers. Following heroin initiation, almost all of the young people in the sample described an increase in criminal activity, which shaped their environments and influenced their exposure to risk in their early heroin careers. This increase was observed in young people who were extensively involved in criminal behaviour, as well as those who had limited or no involvement in crime, prior to their heroin initiation. The former group described an escalation and acceleration in their criminal behaviour following heroin initiation. They had already developed the technical skills and social connections to participate in the illicit economy, and their heroin initiation was often followed by a rapid increase in the frequency and severity of their criminal involvement. For the latter group, participation in acquisitive crime followed heroin initiation, and these young people began to commit crimes such as shoplifting or street-level heroin selling, which they explained was necessary to finance regular heroin use. Heroin initiation, therefore, impacted upon the criminal activity of virtually all of the young people in the sample.

Following heroin initiation, it was necessary for young people without prior criminal involvement to engage in income-generating strategies to finance their heroin use. As described in chapter four, the majority of young people were early school leavers and did not sustain either full or part-time employment after leaving education. Therefore, financing heroin use through

employment did not provide a realistic solution to the financial demands of the habit. Young women did not have equal opportunities within the illicit drug market (see chapter six for a detailed discussion) and primarily relied on their partners for their heroin supply. Nevertheless, some young women did participate in criminal activity to finance their heroin use, or to at least contribute towards the cost. Seven of the young women assisted in their partners' drug-dealing activities, seven engaged in shoplifting, and one participated in sex work.

Shoplifting was not a highly lucrative activity and a number of young women described ways in which they developed the means to maximise their income. Orla, for example, explained how she supplemented her partner's drug-dealing income during the Christmas period;

> *"I robbed loads of make-up and I made up little sets. I was like, 'Look do you want these for your mates for Chrimbo [Christmas]? I'll sell you them for a fiver or a tenner'. It was about 50 euro worth of make-up in each of them and I was selling them for 10 euro" — Orla (18 years).*

Other young women who participated in shoplifting described alternative but equally innovative means of generating an income to fund their heroin use. Maeve, for example, targeted high street clothing stores for her shoplifting activities. Selling the stolen goods in her locale proved to be lucrative;

> *"I'd rob clothes and stuff and I'd bring them down to the flats and sell them and I'd get about 150 euro. So that'd last a day or two" — Maeve (19 years).*

Maeve financed her heroin use solely through shoplifting activities, but the majority of young women in the sample relied on their sexual partners to provide their heroin supply. None of the young men in the sample relied on their sexual partners for their heroin supply. They predominantly resorted to criminal activity to finance their heroin use, and their criminal careers tended to develop along two main trajectories; an involvement in acquisitive crime such as theft, robbery and burglary, or the selling of hard drugs. One young man believed that these two options, "robbing or selling", were the only ones available for new male initiates to finance their heroin use;

> *"If you're on drugs then you'll start, you'll have to start, you can't fund a heroin habit with working or anything, you're going to have to start robbing or selling. There's only two ways for a heroin addict to survive — go on methadone or start robbing or selling. That's the only way" —Damien (18 years).*

Four young men funded their heroin use primarily through burglary. They explained that although this was a lucrative activity, acquiring a regular income was difficult and the likelihood of prosecution was high. Perhaps the most accessible and common way of financing heroin use was through street-level drug selling. Dylan, for example, sold heroin on a city centre street to support his own, and his partner's, heroin use;

> *"I was with her [girlfriend] for a while. I was selling gear up on Thomas Street and all, just to support the two of our habits. I suppose she was letting me live in her gaff, I was feeding her habit... Anyone can do it*[7]*. It's just easy like to get a [phone] number for weight*[8] *off anyone" — Dylan (20 years).*

Young men who participated in drug-dealing activities post-initiation usually occupied lower positions in drug-dealing hierarchies, and sold small quantities of heroin directly to the consumer. These young men explained that they only sold enough of the drug to recover the money that they spent while supporting their own heroin use. These young men did not move upwards in drug-dealing hierarchies because their heroin use curtailed their ability to make the money necessary to purchase increasingly larger quantities of heroin. More importantly, however, they had not made the contacts needed to gain trust within the drug-dealing social network and, therefore, could not occupy higher positions in the dealing hierarchies.

Young men often described an escalation in their criminal careers following their heroin initiation. Heroin consumption was linked to supply, and those who had high accessibility to money or 'hard' drugs through their 'drug dealing' or criminal activities also demonstrated a more rapid transition to heavy and regular use of the drug[9]. In turn, as has been observed in previous studies (Best et al., 2001, Stewart et al., 2000), an escalation in heroin use led to increase in criminal activity due to the financial demands of higher levels of heroin consumption. Consequently, these young men described becoming embroiled in a cycle of drug use and crime, rapidly developing a physical dependency on the drug (or becoming "strung out"), and becoming more deeply immersed in a criminal and drug-using social networks. Luke believed that striving to avert withdrawal symptoms associated with physical dependency led to an all-consuming heroin-using lifestyle;

> *"Once you're strung out on it, you just have to do the same thing every day. You have to get the money to buy it, you have to smoke it, back out to get money to get it again and you*

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[7] Sell small quantities of heroin directly to consumers

[8] 'Weight' refers to small quantities of heroin, such as an eighth of an ounce, which are sold to street-level heroin sellers.

9 Young women with drug-dealing sexual partners also had access to large quantities of heroin and demonstrated a similar rapid trajectory into heavy heroin use (this is described in detail in chapter six).

have to get gear for the next day. When you wake up, it has to be there, 'cause if you don't you'll be dying sick[10]*. You'll end up robbing your own mother for money to get a bag" — Luke (24 years).*

Some young people explained that when they became physically dependent on the drug, they participated in crimes that they previously would have considered unacceptable. Many spoke of these activities with regret and remorse, indicating that the periods of escalating criminal activity occurred in conjunction with 'problematic' patterns of heroin use;

"The bad times came when you're robbing on your family, you're robbing in shops, selling drugs in the street, robbing people in the streets. Just doing everything, anything you can just to get money for the drugs 'cause it's a habit, d'ya know what I mean?" — Darren (25 years).

Even during periods of escalating drug use and criminal behaviour, the young people maintained limits with respect to their criminal activity. They acknowledged that developing a physical dependency on heroin stretched their boundaries, but they placed restrictions on the behaviours in which they were willing to engage in order to obtain money or drugs. Richard, for example, spoke about the boundaries that he placed on his involvement in acquisitive crime explaining that he would not commit burglary;

"Every day then we started robbing for it [heroin]. We were just going off robbing then to get it. It was just they [friends] were starting to get into creeping gaffs [burglary of a private residence] so then it started getting a bit too far. They were creeping gaffs on their own road. I'd never robbed anybody's house. There's a few things I haven't done" — Richard (21 years).

Other young men placed alternative limits on their criminal activities. Luke, for example, regularly burgled private residences in his neighbourhood to finance his heroin use and described himself as the "friendly neighbourhood thief". Unlike Richard, he considered burglary to be an acceptable form of criminal activity but emphasised that he would never resort to "violent" crime;

"I never hit anyone for money. I'd never be violent to get money. I was always a friendly neighbourhood thief. I'd just do it [burglary] when there was no one there, and if anyone seen me I'd run away from them. I wouldn't try to bait them [beat them] or grab them or

[10] 'Dying sick' refers to the experience of physical and psychological withdrawal from heroin, usually experienced as a combination of flu symptoms and psychological distress.

things like that. That's one thing heroin never made me do is rob on me mother or [become] violent or anything like that" — Luke (24 years).

These accounts illustrate how, despite demonstrating an escalation in criminal activity following heroin initiation, young people placed limits on their criminal activity and retained these 'boundaries' throughout their early heroin-using careers. The boundaries that the young people placed on their income-generating techniques were associated with subjective perceptions of the acceptability or appeal of different criminal behaviours. While subject to revision, young people typically stated that they retained these boundaries throughout their drug-using careers, even when experiencing withdrawal symptoms or during times of financial hardship. These accounts illustrate that young people retained a sense of agency in their criminal careers, despite simultaneously drawing attention to the necessity of engaging in criminal activity to finance heroin use and prevent symptoms of withdrawal.

This section provided an account of the young people's criminal activity post-initiation. The majority of young people participated in criminal behaviour following their heroin initiation, whether or not they had previously engaged in crime, due to the financial requirements of regular heroin use. Similar findings have previously been reported (Chein et al., 1964; McGlothlin et al., 1978; O'Donnell, 1966; Parker & Newcombe, 1987; Wesissman et al., 1974). Criminal activity exposed the young people to two main categories of risk; those associated with the criminal justice system, including police intervention, sentencing and incarceration; and those imposed by criminal social networks including violence and death. Most young people reporting limited criminal involvement were subject to risks associated with the former. However, young men who became deeply immersed in criminal social networks experienced both forms of risk. The social 'risk environment' that influenced their heroin initiation, therefore, continued to shape their experiences of risk in their early heroin careers.

Experiences of the Criminal Justice System

The majority of the young people in the sample had contact with the criminal justice system as a consequence of their drug use or criminal behaviour. Punitive actions imposed by the criminal justice system included police searches, fines, arrests, detention or incarceration. Twenty-two of the young people, including five women, had been charged with a crime and fourteen, including three women, experienced detention or incarceration. Generally, the young people described these experiences in relatively neutral terms, believing that intervention by the police was unavoidable, if not desirable, and that they were treated fairly by the criminal justice system. There were, however, six exceptions. Of the six, four were from the travelling community, and they gave accounts of victimisation by the police, discrimination within the judiciary system, or mistreatment while incarcerated or detained.

Descriptions of police brutality were rare, but two young men from the travelling community said that they were subjected to police violence from a young age. These young men were involved in minor criminal activity in their early childhoods and became known to the police. They explained that the police responded to their misdemeanours with physical violence and that this violence was ongoing and recurring throughout their childhood and early teenage years. Both of the young men described feeling powerless to defend themselves or prevent this abuse, and these experiences created feelings of anger and hopelessness. One of these young men, Joe, described the police violence that he experienced. He believed that his brother, who suffered from a physical disability, was specifically targeted;

> *"The guards pick on [my brother] a lot now. They'd bring us up the Phoenix Park, kick the shite out of us. We'd be crawling out of the Phoenix Park, the baiting [beating] they'd give us. Over nothing. [My brother] and all, they'd bring him up the Phoenix Park and give him a baiting [beating] and he used to be crawling out. They'd come in with wet towels and beat us for nothing. They're bastards" — Joe (17 years).*

These two young men believed that there was a connection between their membership of the travelling community and their mistreatment by the police, stating that police officers called them "scumbags" or "knackers" in order to aggravate and insult them. The young men also indicated that they were powerless to report or retaliate against this mistreatment because of their minority status. Tom explained that the only way to avoid further violence was to adopt a submissive demeanour;

> *"All my old fella used to say to me was, 'Any time you get arrested, all you say to the guards is yes sir, no sir, three bags full sir', basically telling him, 'Yes sir, no sir'. So you're trying to keep them sweet so they won't bait [beat] you up" — Tom (17 years).*

Two other young people from the travelling community, one man and one woman, believed that they were treated unfairly by the criminal justice system. The young man, Luke, believed that he was given an overly harsh six-month sentence for trespassing because of his family name, which the judge associated with criminal involvement. The young woman, Natalie, stated that, through isolation and marginalisation, she was mistreated by staff when placed in detention at the age of eleven years. Two other young men, not from the travelling community, stated that they were given overly harsh sentences, believing that the "personality" of the judge determined the outcome of their trial.

In general, the young people were not fearful of the punitive measures enforced by the criminal justice system but perceived them as a disadvantageous, and often unavoidable, outcome of their criminal behaviour. For some, the risks posed by the criminal justice system were overshadowed by the more extreme threats emerging from their criminal and/or heroin-using lifestyle. This was particularly the case for the young men who were deeply involved in criminal activity, and who faced violence or victimisation within their own criminal networks. The following section describes how, for some young men, increasing immersion into criminal social networks shaped their social environments, bringing them into a "world" in which they were exposed to risks associated with violence and victimisation.

Risk of Violence

Through their criminal activity, many young men became immersed in social environments in which violence and intimidation were common. In particular, violence was enmeshed in 'drug-dealing' networks within which it was considered acceptable and necessary. The young men who had been recruited into drug-dealing 'gangs' said that they participated in violent activities as their criminal careers progressed, but that they were simultaneously at risk of violence being committed against them. The young men, who did not have the necessary contacts to participate in higher-level drug dealing, did not report such high levels of violence, but they were also at risk of victimisation within their criminal social networks.

Violent crime was not reported by any of the participants as a method of financing heroin use. However, some young men, who became immersed in criminal networks in which physical violence was common, said that they participated in violent crime or intimidation. These young men provided numerous accounts of acts of violence committed by their older peers in drug-dealing networks, explaining that they were committed in order to defend drug-dealing 'territory' from drug dealers in neighbouring locales, assert dominance within drug-dealing hierarchies, punish or intimidate those who owed money or drugs, or defend themselves. These young men, who had been recruited into drug-dealing gangs in their early teenage years, gradually became immersed in a lifestyle in which they experienced increasing levels of violence, were repeatedly exposed to the threat of injury or death and exhibited increasing levels of violent behaviour in response to their social environment. They were repeatedly placed in social contexts in which they were subjected to high levels of risk, and often suffered from associated negative emotions such as anxiety or paranoia.

One young man, Damien, became immersed in social context of violence through his participation in a drug dealing gang. He described one particularly violent altercation with his drug dealing 'superiors' following their discovery he had taken a small quantity of heroin for his own consumption;

"They were all big on steroids, like the bloke I was [selling] it for, he could kill you with his bare hands and he was very very aggressive. I've seen him do serious damage to people. So I said, 'fuck this, I'm going to die'. So I was shaking and I was terrified, but they tied me up on the bed. First, they pulled out a blade, but his mate said, 'don't stab him in here [the flat]. He'll get blood everywhere'. I was screaming, crying, 'no, no don't kill me', and they ripped out a hammer then and just started whacking me legs out of it. He just caught me a few bad blows. I don't think he broke any bones, but I just couldn't walk for a few days" — Damien (18 years).

Damien explained that leaving a drug dealing gang was difficult; his superiors would not 'allow' him to leave because his drug-dealing activities were highly profitable, and Damien had information which could be used to prosecute them within the criminal justice system. He stressed was under constant threat of violence within this social network and experienced intense anxiety and paranoia as a result;

"Sometimes I used to go up and lie in me ma's bed when she was asleep and just start crying beside her. I was full of fear and everything" — Damien (18 years).

Kenneth also described the difficulties of leaving a criminal drug-dealing gang, emphasising how violence associated with his former drug-dealing activities continued to dominate his life;

"Anytime you want to try and leave, it seems to come back to you for some reason. I was fighting with this fella...he started saying that he wants gun fights, things like that...I was trying to leave all that and then things like that come back to you" — Kenneth (24 years).

In addition to the physical risks associated with violence and intimidation, young men described how participation in violent activities within criminal gangs led to feelings of guilt and depression. Aaron, for example, was ordered by a higher-ranking drug dealer to attack and kill a man who owed money for drugs. He emphasised his remorse at participating in this violent act, but simultaneously described the pressure that he was under to carry out the orders of his superior;

"I stabbed a lad as well, but I still regret it to this day 'cause your man nearly died. I didn't stab him 'cause I had anything against him, but I had to do it. If you're told to do something, you have to do it. That's the way it is. He owed money" — Aaron (17 years).

Aaron explained that, as a result of the violent act that he committed when he was fourteen years of age, he believed he was a "bad person". He suffered from debilitating depression and attempted to take his own life on numerous occasions.

Violence was not solely associated with high-level drug dealing. Other young men were exposed to violence through alternative criminal networks and contexts. Prison, for example, was an environment in which the young men were at risk of violence and intimidation. Kenneth described the level of violence that commonly occurred in the prison in which he was incarcerated, but which was rarely reported or reprimanded;

> *"At first, it was alright; but when you've seen people get cut up every day...but it's the worst prison for it, and the outside hears nothing about what goes on inside a prison. If it was out on the street or in a shop, if someone got slashed, even if it was a small slash, it would be all over the paper; but the guards or nothing get involved if different people get cut up [in prison]"— Kenneth (24 years).*

None of the young men reported having been physically attacked within the prison environment, but one young man, Keith, was attacked shortly after his release by a man he had been incarcerated with;

> *"Seven times I was stabbed. They said I was nearly dead for seven minutes and they were keeping me alive with heart machines and all. Then I just came through, I did. They couldn't believe it, the doctors, they said it was a miracle" — Keith (24 years).*

An immersion in criminal social networks, particularly drug-dealing gangs, placed young men in social environments where they were at risk of violence, intimidation and even death. Similar findings have previous been reported (Fagan, 1989; Fagan & Chin, 1990; Sherman & Latkin, 2002). The young men in this study also described how the threat of violence within these social contexts contributed towards feelings of anxiety, paranoia, depression and suicidal behaviour. Moreover, some young men emphasised the difficulties associated with leaving a criminal social network indicating that violence associated with criminal activity often posed long-term risks. Social environments, therefore, shaped by criminal activity, strongly impacted on these young men's experiences of risk during their heroin careers.

Conclusion

This chapter discussed criminal activity, which was highly prevalent among young people in this study. Quantitative analysis revealed that 95% of male, and 66% of female survey participants had been charged with a crime. These data, however, did not reveal the temporal sequence of

criminal activity and heroin initiation. Analysis of the qualitative data revealed that involvement in criminal activity preceded heroin initiation for many young men. Similar findings have previously been reported (Chambers, 1974; Chein et al., 1964; Greenberg & Adler, 1974; Robbins & Murphy, 1967; Vaillant, 1966), leading some researchers to suggest that involvement in a criminal sub-culture is a prerequisite for heroin initiation (Eldridge, 1967). However, a small number of young men and virtually all the young women in this study did not report criminal involvement prior to their heroin initiation. Conflicting reports of the temporal sequence in the onset of heroin use and criminal behaviour have been documented (Ball et al., 1981; Greenberg & Adler, 1974; Kaye et al., 1998), and indicates that the relationship is not a simplistic causal one (Hammersley et al., 1989; MacGregor, 2000; McBride & McCoy, 1993; Simpson, 2003; White & Gorman, 2000). A criminal career was not a 'prerequisite' for heroin initiation in young people in this study but rather, shaped the social environments of young men's heroin initiation by bringing them into contact with older heroin users.

Heroin initiation was not an isolated event in a young person's life, but was a process that occurred over time and was influenced by a changing social environment. As noted by previous researchers (Connolly, 2006; Krivo & Peterson, 1996; Warr, 2002), criminal activity occurred in an environmental context of social disadvantage and adversity, and was shaped by social interactions with criminally-involved peers. For 15 young men, criminal careers, which developed during their late childhood and early teenage years, impacted on the social course of their heroin initiation. Through their criminal social networks, the young men came into contact with heroin users who introduced them to the drug and thus facilitated their initiation. Three main criminal trajectories brought these young men into contact with heroin users; heavy-end acquisitive crime, drug-dealing activities and/or incarceration. Within each of these pathways, social interactions with heroin users impacted upon the young men's heroin initiation in a number of ways; their negative views of heroin were challenged, the drug was made available to them, they were provided with numerous opportunities to initiate, they became curious about its effects and they wished to feel part of their heroin-using network. These processes featured in young men's initiation rationales, and they explained that over time, and after regular exposure to the heroin use of others, they initiated use.

Many studies have indicated that increasing participation in criminal activity follows initiation into heroin use (Chein et al., 1964; Kaye et al., 1998; McGlothlin et al., 1978; O'Donnell, 1966; Parker & Newcombe, 1987; Wesissman et al., 1974). All the young people in this study, whether reporting criminal involvement prior to their heroin initiation or not, demonstrated an increase in criminal activity post-initiation. Individuals with minor or no criminal involvement prior to their heroin initiation began to participate in property crimes such as shoplifting or theft, and those who had an existing criminal career demonstrated an intensification of burglary, robbery or drug-

dealing activities. Similarly to heroin users in other studies (Chaiken & Chaiken, 1990; Parker & Newcombe, 1987; Parker et al., 1986), these young people explained that they were unable to meet the financial requirements of regular heroin use through legitimate means and, therefore, had to resort to illicit income-generating strategies. Many young people described how increasing levels of heroin consumption amplified offending behaviour and how, in turn, increasing levels of criminal activity funded higher levels of heroin consumption. They, like heroin users in previous studies (Dorn et al., 1994; Bennett & Write 1986; Chaiken & Chaiken, 1990; Faupel, 1988; Parker et al., 1986), described an increasing upward spiral of drug use and crime following the onset of what they described as heroin dependency.

The findings discussed above revealed a complex interaction between heroin use and criminal activity. For some, criminal activity predated heroin initiation, but for others, heroin initiation preceded criminal involvement. Therefore, as noted by previous authors (Connolly, 2006; McBride & McCoy, 1993; Parker & Newcomb, 1987; Seddon, 2000; White & Gorman, 2000), there is no simple unilateral causal relationship between crime and drug use. Rather, macro, meso and micro-level environments intersected, shaping criminal and drug-using trajectories, and the interactions between them. As noted by Simpson (2003), the drug-crime relationship is likely to be mediated by local social environments and, therefore, cannot be generalised across different drug-using populations, in different locales, at different times. For the young men in this study, micro-level social environments, which evolved in combination with participation in acquisitive crime, drug-dealing activities or a period of incarceration, shaped their heroin initiation by bringing them into contact with older heroin users. However, young women did not demonstrate this pathway into heroin use (see chapters six and seven for detailed discussions of young women's pathways into heroin use). Following heroin initiation, young men and women demonstrated an increase in criminal activity, but young men, particularly those reporting criminal involvement prior to heroin initiation, became more deeply immersed in criminal social networks. Therefore, their social environment influenced their criminal and drug-using careers, but their criminal activity and heroin use, in turn, shaped their social environment.

Interactions between the social environment and young people's criminal activity played an important role in the production of risk in their early heroin careers. Most young men and women participated in criminal activity post-initiation, and this exposed them to risks posed by the criminal justice system, such as police intervention, sentencing or incarceration. The young men reporting extensive criminal activity *prior to* heroin initiation, however, demonstrated an escalation in criminal activity *following* heroin initiation, leading to a deeper immersion into criminal social networks. Previous research has documented that participation in the illicit drug economy exposes drug users to many risks (Fagan, 1989; Sherman & Latkin, 2002) and the young men in this study were exposed to violence and intimidation within these social 'risk

environments'. The social context which impacted on their heroin initiation, therefore, continued to shape their experiences of risk in the early stages of their heroin career.

Chapter Six

Gender, Heroin Initiation and Sexual Risk

Introduction

This chapter is the second of three to discuss young people's pathways into heroin initiation. Chapter five described the social course of heroin initiation for 15 young men who became immersed in criminal and heroin-using social networks through their involvement in extensive acquisitive crime, drug-dealing activities or incarceration. This chapter describes the social course of heroin initiation for eleven young women in the qualitative sample who entered into intimate relationships with heroin users in their early or mid-teenage years.

The quantitative and qualitative data indicated that the social contexts of heroin initiation were influenced by gender. Almost half of the young women surveyed reported that they were introduced to heroin by their sexual partners, compared to less than 2% of men. Eleven of the 17 young women in the qualitative sample were in an intimate relationship with a heroin user when they initiated use, compared to just one young man. Similar findings have previously been reported (Hser et al. 1987; Powis et al. 1996) leading to oversimplified accounts of women being coerced into heroin use by men. However, numerous researchers have challenged depictions of female drug users as passive victims, arguing that women play an active role in their initiation (Eaves, 2004; Maher, 1997; Payne, 2007; Rosenbaum, 1981a; Taylor, 1993; Woods, 2008). This chapter examines the young women's accounts in order to explore the role of gender dynamics and female agency in heroin initiation pathways.

The chapter moves on to discuss how, following heroin initiation, the young women's intimate relationships continued to impact upon their drug use and their experience of risk. Previous authors have observed how gender power dynamics operating in drug-using environments enhance young women's susceptibility to risk (Bourgois et al., 2004; Maher, 1997; Rhodes et al., 2005) and the young women in this study were at risk of sexual exploitation, victimisation and violence. Macro-level gender norms and inequalities played out in the young women's intimate relationships and, similar to the findings of previous research (Rhodes & Cusick, 2002), they were also at risk of sexually transmitted infections due to their disadvantaged position in negotiating condom use.

Quantitative Gender Differences

Of the 120 participants who completed the interceptor survey, 65% were male and 35% were female. To analyse gender differences across the sample, Chi-square and t-tests were run on non-parametric and parametric variables accordingly. Analysis revealed a number of statistically

significant differences. In the young people's demographic data, there were few differences, but young women were less likely to report current homelessness. They were more likely to currently live in rented accommodation and less likely to live in emergency hostels than young men (Chi-square=13.34, $p<0.05$). However, there were no significant differences in lifetime homelessness. Women reported slightly higher levels of educational attainment than young men, but this difference was not statistically significant.

On average, the women were slightly younger than the men in the sample, with an average age of 22.1 years compared to 24.1 years. Women were younger than men when they first used heroin (15.3 years vs 16.2 years, not statistically significant) and cocaine (15.9 years vs 17.5 years, $t=2.44$, $p<0.05$), and when they first injected a drug (17.0 years vs 18.1 years, $t=2.3$ $p<0.05$). The majority of both males and females reported that they were introduced to heroin by a specific person. Women were significantly more likely to be introduced to heroin by a sexual partner (48.6% vs 1.7%, chi-square=32.7, $p<0.01$) and men were more likely to be introduced to heroin by a relative (25.8% vs 8.6%), friend (37.9% vs 28.6%) or acquaintance (34.5% vs 14.3%, chi-square=32.7, $p<0.01$). Young men were also significantly more likely to report that a family member had used heroin (77.5% vs 56.1%, chi-square=5.61, $p<0.05$). Although the majority of both males (98.6%) and females (92.3%) said that they smoked heroin at the time of initiation, women were more likely to report injecting heroin on first use (7.3% vs 0%, chi-square=6.2 $p<0.05$). Women were also slightly more likely to report having shared needles in their lifetimes (60% vs 50.8%), but this was not a statistically significant difference.

On average, women first had sex at a slightly younger age than men (13.7 vs 14.2 years), yet their first sexual partner was older (20.3 years vs 15.6 years, $t=-5.3$, $p<0.05$). On their first occasion, therefore, women reported having sex with a man on average 6.6 years older than themselves, whereas men reported having sex with a woman on average 1.4 years older than themselves.

The women in the sample were, on average, younger than the men, but their current sexual partners were significantly older (27.2 years vs 24.4 years, $t=-2.8$ $p<0.01$). Women were more likely to report that their sexual partner was an injecting drug user (62.5% vs 30.4%, chi-square=10.67, $p<0.01$). They were less likely to have used a condom the last time they had sex (30% vs 39.2%) and were more likely to report using condoms 'none of the time' (64.1% vs 51.0%).

Thus, statistical analysis of the survey data revealed that the sample of men and women were similar in terms of their demographic profiles, but that young women reported significantly higher rates of drug and sexual risk behaviour. Similar findings have previously been reported in the Irish context (Dorman et al., 1997; Geoghegan et al., 1999; Mullen & Barry, 2001; Smyth et

al., 1995). However, these epidemiological data cannot uncover the complex dynamics of the young women's social environments and experiences, leaving gaps in our understanding of the impact of gender on heroin initiation and risk. The life history interviews were analysed to investigate the social course of the young women's initiation into heroin use, and to explore how their social environments contributed towards their experiences of risk.

Meeting a "Bad Boy"

As described in chapter four, young men and women became immersed in recreational drug-using networks during their early teenage years and through various means, came into contact with older youth, predominantly males, who were participating in 'harder' forms of drug use or criminal activity. These older youth were not an integral part of their peer network, but were connected to them through social interactions or relationships; for example, they were relatives or acquaintances of members of their peer group, or they came into contact with them through the selling or exchanging of recreational drugs. Twenty-five of the young people in the sample described forming a close social relationship with an older male heroin user through these connections. However, the nature of the relationships that they formed with these older men was influenced by their gender. Young women were more likely to form a sexual relationship with an older male, whereas young men were more likely to adopt an older male as a 'role model'. The young men's social relationships with older heroin-using, or criminally-involved men, was described in chapter five. The following sections detail the young women's intimate relationships with older heroin-using men.

During their early teenage years, 13 of the 17 young women in the qualitative sample began a sexual relationship with a significantly older heroin-using male. These men were usually in their early to mid-twenties; on average, seven years older than the young women who were generally aged between 12 and 16 years at the time. This corresponds with the findings of the interceptor survey reporting that, on average, the young women first had sex at 13.7 years with a man on average 6.6 years older than they, and that the women were more likely to be in a relationship with a heroin-using partner. As described in chapter four, the young women in the qualitative sample were engaging in recreational drug use within social peer networks during this period, but ten of the 13 young women had never been exposed to heroin prior to meeting their partner.

The young women emphasised agency in the instigation of their sexual relationships, explaining that they found their partners physically attractive and actively sought out a relationship with them. Eight of the ten young women said that their partners' drug-using and dealing activities added to their appeal. Sarah and Violet, for example, described their immediate attraction to their heroin-dealing partners upon meeting them. Violet explained that she had never been interested

in initiating sexual relationships with the young men in her own peer group network, but that her partner's "bad boy" image attracted her to him;

> *"There was just something unusual that I liked about him. I don't know. Any other young fella that would show an interest I'd be like, 'No', but there was just something about him, a bit of a bad boy. I think all girls go for bad boys really. Well, not all girls but most girls" — Violet (16 years).*

Sarah explained that her partner's physical appearance was an element of his appeal, but that his heroin-dealing activities added to this;

> *"I thought, 'Oh he's selling gear, he must be great!' I think that's 'cause I liked him. I didn't like him. I liked the way he looked. I thought he was gorgeous" — Sarah (18 years).*

Within the young women's social networks, men who were older, dealing or taking hard drugs held higher positions of status than younger males in their peer groups. These older men were not associated with the negative aspects of the 'junkie' lifestyle described in chapter four, because they were heroin user-dealers who did not display problematic patterns of use. They lived a more affluent lifestyle in which they had access to drugs and money, enjoyed high positions of social status and had numerous social connections in the young people's locales. Initiating a sexual relationship with such a man offered the young women numerous social benefits: they had access to drugs and money, a higher position of status and an exciting lifestyle with increased social connections. One young woman, Emma, who met an older heroin-dealing man when she was 14, explained that the "glamorous" drug-dealing lifestyle held strong appeal;

> *"I didn't know how it evolved, but the whole gangster lifestyle was very appealing to me. It was very glamourising. It was very appealing" — Emma (18 years).*

In addition to the "glamour" and excitement offered by instigating a sexual relationship with a drug-dealing male, some young women believed they would be provided with easy access to a supply of drugs. Sarah, who met her partner when she was 12 years of age, explained that not having to pay for cocaine added to the appeal of her cocaine-dealing partner;

> *"I was like, 'My god he sells coke! That'll be grand then I won't have to pay for it" — Sarah (18 years).*

When the young women met their partners, they often drifted away from peer social networks and spent more time with their partners and their friends or acquaintances. Ten of the young

women also moved away from their family homes to live with their partners. These events increased their exposure to drugs and accelerated their drug-using careers. Sophie explained that when she met her boyfriend and moved into his home, she "lost interest" in other activities and friends. She said that she was "in love" and focused all of her attention on the relationship and her partner;

> *"I'd loads of plans and then just lost interest. I think it was just, young kids and they meet a fella and they think they're in love. I think it was just all that and I kind of just lost interest then. It was just me and him then. [I] lost interest in me friends as well" — Sophie (23 years).*

The young women described the commencement of their intimate relationships as having a dramatic effect on their lives; they were exposed to heavy-end drug use and criminal activity, in which they had previously had little or no involvement. Emma, for example, described herself as 'innocent' when she met her heroin-using/dealing partner at the age of 14. She met him when a male acquaintance from her social network asked her if she wished to join him and his friend on a road trip to the north of Ireland. Emma explained how commencing a relationship with his friend had a significant effect on her life;

> *"I was always at that age real innocent, didn't give a fuck, everything didn't matter. And I got up that morning, I got into the lorry and that was the day I'd say my whole life went downhill, dramatically. His friend was 24 or something. I was going on 15, and I ended up falling madly for his friend" Emma — (18 years).*

Other young women spoke about the changes that occurred subsequent to meeting their heroin-using sexual partners, emphasising the escalation and acceleration in their drug-using careers. Sarah moved from recreational to heavy use of cocaine when she met her 28-year-old, cocaine-dealing partner, explaining that accessibility to large quantities of the drug played a vital role in this transition;

> *"I was 12. I was taking coke. I was smoking hash. I was drinking. I was taking pills on a really regular basis. I was doing coke in school. I was bringing coke into school and doing lines off the toilet seats. I'll never forget I [had] thrown a bag out onto the toilet. I was chopping it up and I had a headache, not knowing I was addicted to the stuff. I just thought I could take it every day 'cause I was going out with a fella who sold it" — Sarah (18 years).*

The young women's relationships with older heroin-using/dealing men also played a role in the social course of their heroin initiation. Findings from the interceptor survey revealed that almost half of the women in the sample (49%), yet less than 2% of the males, reported that they had been introduced to heroin by a sexual partner. Eleven of the 17 young women in the qualitative sample were in a sexual relationship with a heroin user when they initiated heroin use. The following section further explores the social course of their initiation into heroin use.

The Social Course of Heroin Initiation

The majority of the young women, 11 of the 17, were in a sexual relationship with a heroin user at the time that they initiated heroin use. In almost all of these cases, the young women initiated during the early stages of their relationship, and this drug transition was strongly mediated by the social circumstances of their relationship. Having a heroin-using partner, who was often dealing the drug, created a social environment in which the young women were regularly exposed to heroin, and this increased their curiosity about its effects. Not all eleven women initiated heroin use with their partners, however. Four said that their partners were, in fact, reluctant to facilitate their initiation. These women initiated alone or with heroin-using acquaintances whom they had met through their partners.

Nine of the young women first became exposed to heroin through their sexual partners. They had previously used 'soft' drugs such as marijuana or ecstasy, but had not directly observed the use of heroin. Sinead, for example, met her partner, aged 20, when she was 14 years old. Although she smoked cannabis on a number of occasions from the age of 13, she explained that she had been largely "secluded" from drugs prior to meeting her partner;

> *"I'd never ever heard of it [heroin]. That was the thing. I was always secluded from drugs, so I never really heard of heroin. Obviously I heard of it before, but I didn't know what to do with it, I didn't know what it looked like or anything. So it was only when I was with [my partner] that I really started getting into drugs" — Sinead (19 years).*

Emma also said that her drug repertoire was restricted to cannabis prior to meeting her partner. She was 14 years old when she entered into a relationship with a 28-year-old heroin user/dealer and described a dramatic transition from a "rebellious teenager smoking hash" to "smoking heroin";

> *"This guy thought I was the bee's knees and he was giving me all the drugs I wanted in the world. And all of a sudden I went from this person who was like a rebellious teenager smoking hash and drinking, to sitting in a lorry with a bloke twice my age smoking heroin. And it was just completely gone off the wall" — Emma (18 years).*

Some young women reported being aware of the heroin use of significant others, for example family members or acquaintances, prior to meeting their partners. Nevertheless, they had never observed its use nor had the opportunity or motive to initiate. Four young women in the sample described parental heroin use during their childhoods, and two of these initiated when in a relationship with a heroin user. Both, therefore, had some knowledge and exposure to heroin prior to meeting their partners, yet they had not been in a social context in which they were offered the drug. Alternatively, having a heroin-using partner provided young women with the opportunity and rationale to initiate use.

Young women explained how observing their partners' heroin use changed their perceptions of the drug and increased their curiosity about its effects. Sophie, for example, said that she became curious about the positive effects of heroin shortly after she moved into her partner's home in an inner-city area;

> *"I was sitting in all the time. I didn't know nobody down there, and as I said, he was sitting there doing it in front of me. So it was going through me mind, thinking about it and thinking 'I wonder what it's like and what does he actually get out of it?'; just curious"* — *Sophie (23 years).*

Sophie believed that initiating heroin use was inevitable within this physical and social environment;

> *"With the situation that I was in, it was actually getting done in front of me 24-7. So it would have actually happened eventually"* — *Sophie (23 years).*

Regular exposure to the heroin use of their partners facilitated the young women's transition into heroin use in a number of ways. The observation of their partners' regular use, and the knowledge that they had used the drug on numerous occasions, eased their fear about the social stigma associated with it, and its potential negative consequences. Their partners were skilled in the technique of smoking heroin and could, therefore, demonstrate how to correctly use the drug. These women trusted their partners, knowing that they were experienced users of heroin. They had regular contact with them in their own, or in their partners', homes and had numerous opportunities to initiate in a private, comfortable environment. For many, these circumstances facilitated the transition to heroin use. Sinead, for example, who initiated heroin use in the private rented accommodation she shared with her partner, spoke about the technical expertise of her partner;

"[My partner] had done it in the past and he must have done it because he knew what to do; put it out on the tinfoil, put your crease in, burn your foil, make you tooter[1] *and whatever" — Sinead (19 years).*

Seven of the eleven young women initiated in the company of their sexual partners. These women generally described the event as comfortable, straightforward and unremarkable. Their partners were experienced heroin smokers, they had observed them using the drug on numerous occasions and they initiated in a comfortable environment, often their own home. The circumstance of their initiation, therefore, served to put them at ease and reduce their fears surrounding the transition to heroin use.

A number of young women who initiated in the company of their partners said that they concealed their limited drug-using experience from their partners. Sarah, for example, told her partner that she had previously used heroin and, as a consequence, he regularly offered her the drug. She explained that he was unaware that the occasion when she accepted was her initiation;

"Any time he'd smoke it he'd offer it, and this time he just put his hand [out] and I just took it off him. He didn't even say anything. I just went to do it. He had thought I'd smoked it before, 'cause I had told him I smoked it before. So that's why he didn't say anything about it; he didn't think it was my first time smoking or anything" — Sarah (18 years).

Most of the other young women's partners were aware that they had never used the drug and were reluctant to provide them with heroin to initiate. However, these young women employed a variety of strategies to overcome their partners' refusal or reluctance to facilitate their initiation. Aoife, for example, convinced her initially unwilling partner that she would initiate heroin use irrespective of his involvement or facilitation. Similar to Sarah, she suggested that she had used heroin previously in order to assuage his reluctance;

"I just kept looking at him. He goes 'No I'm not giving it to you. I'm not giving it to you'. I was like 'Well I'm going to get it somewhere else', threatening him, 'I can get this anywhere I want'. So there was no point and I really made him feel like shit. I think he'd thought I'd done it before and so I had my first smoke then. It was only two or three lines" — Aoife (17 years).

[1] The 'tooter' is a tube — usually made out of a plastic pen, straw or piece of tinfoil— that is used to inhale heroin fumes when 'chasing the dragon'. The heroin is first placed on a sheet of tinfoil and heated from underneath using a lighter. As the heroin sublimates, it is run across the tinfoil and its vapours are inhaled using the 'tooter'.

Joanna adopted an alternative strategy. When her drug-dealing partner refused to provide the heroin for her initiation, she secretly accessed his supply;

> *"I was 16. I met this bloke. He was nine years older that me...he was selling heroin and that's when me ma asked me to leave. So me and him moved into an apartment together. He'd always say 'If I catch you on heroin, I'll finish with you', but he was on methadone so it was sort of all right for him to do it, but not me. So I started robbing it from [him]. He used to have a safe. I started to rob it and when he'd come in like I'd just say, 'I'm not feeling well, I'm just really tired'. So I'd be in bed but really I'd be stoned out of me head"* — *Joanna (19 years).*

Being in a romantic relationship with a heroin user gave the young women the opportunity to initiate heroin use with someone whom they trusted, who knew the technique of smoking and could supply the drug. The young women observed their partners enjoying the positive effects of heroin use and wished to experience those effects themselves. Some young women also stated that they were motivated to participate in this activity with their partners in order to increase feelings of intimacy between them. Their partners were deeply immersed in a heroin-using lifestyle and some young women indicated that they felt excluded from their partners' heroin-using and dealing activities. By initiating heroin use, the young women felt that they could participate and share in these activities with their partners. Joanna explained that until she met her partner, she believed that she would never use heroin. In the early stages of their relationship, however, her determination not to use the drug lessened because she wanted to have "something in common" with her partner. She associated their using heroin together with a feeling of security in the relationship;

> *"I always said I would never take drugs. I was totally adamant against it, but at the time when I took it, I can't really remember why I wanted it, but I thought that if I take this, I'll have something in common with me boyfriend. [I thought] he'd really want to be with me then and we'd be together for ages. I remember thinking something like that, along those lines, but I just wanted to be cool like everyone else"* — *Joanna (19 years).*

All of the young women who initiated heroin use while in a sexual relationship with a heroin using partner said that their relationship influenced their heroin initiation. Nevertheless, this association was complex. None 'blamed' their partners for their heroin initiation, nor did they describe a simple causal pathway. Rather, the social environment of their sexual relationship contextualised their initiation rationales and facilitated their transition to heroin use. Sexual relationships, therefore, were important elements of the 'risk environment' in young women's heroin initiation. All young women initiated heroin use by 'chasing the dragon', that is smoking

the drug, but a similar process impacted upon the young women's initiation into injecting drug use. Seven of the nine young women who injected a drug initiated with a sexual partner. Pathways into injecting initiation are described in detail in chapter eight.

Emphasising Agency

The eleven young women who initiated heroin use while in a relationship with an older heroin user acknowledged that their romantic relationships facilitated their initiation into heroin use, but almost all emphasised their own agency in the process. As demonstrated earlier, their first use of heroin occurred within a social context shaped by their sexual relationships, and these circumstances influenced their motive and their opportunity to use heroin, but the young women did not depict themselves as victims of male domination or coercion. Thus, while drawing attention to the social environment, they simultaneously asserted their active role in the process of their heroin initiation. Sinead, for example, described the events preceding her heroin initiation;

> *"When we [Sinead and her partner] moved into our second flat, we moved in behind the only dealers in [commuter town] at that time... Then just one day, they said 'Would you want a bag of gear instead of hash?' I don't know what triggered it in me head to say yeah, but it was more so me than Jack that said, 'Yeah'" — Sinead (19 years).*

Sinead emphasised that she, not her partner, accepted the offer of heroin. Yet, the social context of this 'drug offer' was mediated by her partner's prior heroin use and his social connections with heroin sellers. Sinead had previously smoked cannabis, but she had never been exposed to heroin, nor had she ever been offered the drug prior to meeting her partner. It was through her romantic relationship that she began to interact with heroin users and sellers. These social interactions, therefore, created opportunities for Sinead to initiate heroin use.

In some cases, the young women drew attention to the complexity of the interaction of social and individual forces surrounding their heroin initiation. For example, Gabriella spoke about her confusion about who to 'blame' for her heroin initiation. Her mother and other family members believed that her partner was the direct cause and demonstrated animosity towards him. However, Gabriella stressed that her heroin use was her own 'choice';

> *"He [partner] goes, 'Who do you blame for getting you on the gear?' and I said 'You', straight away. And I shouldn't have, because I don't. I don't blame him because it was my choice to take it" — Gabriella (25 years).*

In her account, Gabriella highlighted the importance of the social context of her sexual relationship in her heroin initiation, but simultaneously asserted her active role in the process. She believed that she would never have been exposed to heroin if not for her partner and explained that she was "totally against it" until she first used the drug in his company. Like many others, Gabriella explained that observing her partner use the drug enhanced her curiosity about its effects and explained that she relied on her partner to administer the drug.

The narratives of these young women reveal the importance of the social environment in shaping heroin initiation but simultaneously reveal that women play an active role in the process. As reported elsewhere (Hser et al. 1987; Powis et al. 1996), many young women initiated heroin use while in an intimate relationship with a heroin user and this relationship appeared 'pivotal' (Payne, 2007). The young women described how the social context of their intimate relationship contributed towards the 'risk environment' of their initiation by exposing them to heroin use and providing them with numerous opportunities to initiate. However, as noted by previous authors (Eaves, 2004; Maher, 1997; Payne, 2007; Rosembaum, 1981; Taylor, 1993; Woods, 2008), the young women's accounts did not conform to stereotypes of women as victims of male coercion. Rather, the young women asserted their agency, explaining that they were motivated to initiate because they were curious about the positive effects of the drug.

Drug Relationships

In addition to providing a social context for the young women's heroin initiation, sexual relationships with older heroin user-dealers precipitated many of the young women's journeys into heavy or problematic use. Fifteen of the 17 young women spoke about how an escalation in their drug-using careers was mediated by one or more sexual relationships. In these cases, the women's drug use was influenced by the social circumstances of their relationship, but their relationship was also affected by their drug use. When young women felt that a sexual relationship was dominated by drug-related activities, or a 'heroin-using lifestyle', they referred to it as a "drug relationship". Young women primarily used this term to highlight the negative aspects of their former relationships; in particular, when they believed that their relationships had a negative impact on their drug use.

Emma initiated heroin use in the company of her partner and stated that their two-year relationship was dominated by heroin-using and dealing activities. She believed that this relationship was "based on drugs";

> *"It was very based on drugs. There is no denying that now. I was using him outright for drugs because he had drugs, the means to get them and he had the money, and it got very big and very heavy very quickly" —Emma (18 years).*

Although, in hindsight, Emma said that she was "using" her partner as an access route to drugs and money, it was apparent from her narrative that in the early stages of their relationship, she did not believe it to be a "drug relationship". Rather, she described the intimacy and affection that they shared during the first two years of their relationship when they were "inseparable". It was over time, and through their extensive drug use and dealing activities, that Emma felt that her partner and their relationship changed;

> *"He was very soft-hearted. He was a wimp when I met him... but as this[2] started to get bigger, I started to see a different side to him and that's what started to scare me. You can go from being soft to tough, but you can't go from being tough to soft and that was the scary bit for me. And then there was also the fear of what if he was too soft and he started messing around with these people, and he did" — Emma (18 years).*

Emma's narrative reveals the complexities of her relationship. Despite her assertion that it was "very based on drugs", there were clearly many other dynamics at work. Emma spoke about her partner's soft-hearted nature, and on another occasion, his generosity, revealing her earlier affection for him. Many of the young women highlighted the positive and negative aspects of the relationships that they described as "drug relationships". Despite stating that their relationships had a negative impact on their drug use, and that their relationships were, on occasion, dominated by their heroin-using lifestyles, these women did not feel that this was the only connection that they had with their partners. Caroline, for example, explained that when she started drug treatment, the project worker tried to convince her that her relationship was a 'drug relationship'. She strongly contested this, emphasising the love between her and her partner;

> *"When I went on to the clinic [the project worker] tried to convince me into thinking it was a drug relationship and it was just around drugs and all the rest. And that's all well and good; most of our day was spent using drugs, but I loved him. He was my first love and the more I think about it, the more I know that it's the truth" — Caroline (20 years).*

Seven young women said that they had one 'long-term' relationship with a heroin user and eight young women said that, over the course of their heroin career, they entered into relationships with more than one heroin user. The vast majority of these relationships were described in positive terms, and the young women emphasised the love and affection that they had for their partners. Acknowledging the difficulties that they faced together, including those that they associated with their mutual heroin use, the women nonetheless highlighted the intimacy that

[2] Emma is referring here to her partner's drug-dealing business. He would transport large quantities of drugs from Europe, and would sell, in bulk, to numerous clients from renowned drug-dealing gangs across Dublin.

they shared. Sinead, for example, spoke about the love that she had for her partner, both during and after their relationship, explaining that this was the reason that she remained with him through extremely difficult circumstances;

> *"I just couldn't leave. I couldn't leave him at all, that was the thing. I just loved him too much. He was the first person that understood me. It was a connection that we had, it was just love, but it wasn't always easy" — Sinead (19 years).*

Aoife also spoke about how love and attraction helped her and her partner to overcome relationship difficulties associated with their heroin use;

> *"It just helped so much more that we were absolutely mad about each other from the get-go, no matter what" — Aoife (17 years).*

In the majority of cases, the young women emphasised the positive aspects of their relationships even when they were dominated by heroin use. In addition to love and affection, they highlighted the ways in which their partners contributed positively to their lives. Charlotte spoke about how she had been sexually abused by her father when she was 11 years old and believed that, as a result, her self-esteem was very low during her childhood and early teenage years. She noted, however, that her partner was very supportive and helped her to overcome these difficulties by developing her confidence and self-esteem;

> *"From the abuse I'd no self-esteem and no confidence, and when I got with my fella that stuff all came back. I'm only like this the last about eight months, talking and all. I used to be real quiet and real shy. I wouldn't say anything to anybody, whereas [my partner] just gave me all that back" — Charlotte (17 years).*

Although highlighting the positive aspects of their relationships, the young women also acknowledged that they impacted upon their drug-using careers. All 15 young women described an escalation in their drug use from the point of their involvement with older heroin users. In addition to initiating heroin use with sexual partners, many described an escalation in poly-drug use following the commencement of their intimate relationship. Sinead, for example, spoke about how her long-term relationship with a drug user affected her poly-drug using career. When she met her partner at 14 years of age, cannabis was the only drug that she had initiated. In the early stages of their relationship, she was exposed to his extensive repertoire of drugs, including ecstasy, benzodiazepines, cocaine and heroin. She believed that meeting her partner was a key moment or 'turning point' in her poly-drug using career;

"From the boyfriend onwards, things really started to hit the shit, you know? I mean I was 14 and a half when I met him, so he was 20...moved out of home, at the age of 15, into the first flat with him, started drugs at that stage. That was literally now hash, E, that kind of stuff, very light drugs; and eventually it kind of just went on from there" — Sinead (19 years).

For some, like Emma, all their experiences with 'hard' drug use occurred solely within the social context of one long-term relationship. Sophie lived with a heroin-using partner for a total of eight years, from the age of 15 years until 23 years. She initiated heroin, powdered cocaine, crack cocaine and injecting drug use during the course of this relationship. In hindsight, Sophie believed that she and her partner "weren't good for each other" because of their extensive prior drug use, and explained that their separation made it easier for her to abstain from drug use. Sophie felt that it was difficult to separate but was uncertain about re-establishing the relationship in the future;

"Even now [it's hard] because I was with him since I was 15. It's very hard, but I suppose when the two of us [were] together just at that time, we just weren't good for each other. That's just the way I'm looking at it. God only knows, I could get back with him tomorrow, next month; I'm just taking every day as it comes" — Sophie (23 years).

The eight young women who had entered into relationships with more than one heroin user in their lifetimes also said that their drug use was shaped by their romantic relationships. These young women described how their sexual relationships created a dynamic and complex social environment which influenced their drug-using careers. Sarah, for example, entered into a number of relationships with drug-using men in her early teenage years. At 12 years of age, she met a 28-year-old cocaine dealer, Mark, and described an escalation in her cocaine use. Later, at 14, she met a heroin user, Joe, and initiated heroin and crack cocaine use in his company. Joe was dealing small quantities of heroin and Sarah described regular heroin use throughout their relationship. A year later, she met Frank, a large-scale heroin dealer. She explained that the abundant supply of heroin at her disposal led to a dramatic increase in her heroin use;

"I was strung out. I was smoking gear, I was smoking crack and that was all through Joe. And then he got locked up and then I met a fella from [Dublin area], Frank, and that's when my drug use got out of control. He was selling ounces of gear. Joe was only selling

oner bags[3] *but Frank was selling ounces. I had a lotta lotta heroin and I could smoke whatever I wanted" — Sarah (18 years).*

Gabriella believed that her relationships were fundamental in shaping her heroin and poly-drug use career;

"I find if I leave the fellas, I'm grand. I swear to God. Me ma will tell you. I do be grand. I don't need nothing; a joint yeah, but that's it. I don't know. When you're with a fella it's different, you'll try anything I suppose" — Gabriella (25 years).

The young women's narratives demonstrate the complexities of their relationships with heroin users. They emphasised the positive connection that they had with their partners but simultaneously described the negative aspects of what they perceived to be "drug relationships". All 15 young women acknowledged that being in a relationship with a heroin user influenced their heroin use and resulted in an escalation in their poly drug-using careers.

Power Dynamics

As previously discussed, in most cases, the young women highlighted the positive aspects of their relationships with heroin-using men. Nonetheless, power imbalances shaped by age, gender and drug-related experience operated in young women's relationships and impacted on their experiences of drug use and risk. Their sexual partners were older, they were more experienced heroin users and they almost invariably provided the young women with their supply of heroin. Unlike the young men in the sample, the young women did not take a lead role in high-earning activities such as drug dealing or serious acquisitive crime such as armed robbery. However, their sexual partners did participate in these activities. As one young man explained, restricted access to income-generating activities within the illicit economy ensured that in order for women to have access to a supply of heroin, intimate relationships were crucial;

"Blokes go out and rob, a bird doesn't. A bloke feeds a bird's habit. That's the way it is; you just have to accept it. That's what happens when a girl gets on drugs. They do shoplift, that's it. I don't know any bird that goes out and does robberies. No bird at all" — Jack (25 years).

Other studies have reported that due to gender inequalities in the illicit economy, female heroin users find it difficult to fund their drug use without the support of a male user (Fiddle 1967; File 1976; Hser et al. 1987; Maher & Daly, 1996), suggesting that this cultivates dependence within

[3] A 'oner bag' is a quantity of heroin with a street value of one hundred euros. As Sarah explained here, it is approximately one sixteenth of an ounce.

their relationships. When the young women in this study were in a relationship with a heroin dealer, they had an abundant supply of the drug, which precipitated an escalation in their use. Over time, the young women became physically dependent on the drug and relied on their partners to provide the heroin that they needed in order to avoid withdrawal symptoms. This became apparent to the young women when they wished to separate from their partners or when their partners decided to restrict their heroin use.

Sophie, for example, reported that her partner provided her heroin supply for the duration of their eight-year relationship;

> *"He was providing all the heroin. He was actually selling heroin to feed his own habit, so there was heroin there. If there was no heroin, there was money to go and get some" — Sophie (23 years).*

Power imbalances operated in Sophie's relationship through the provision and control of heroin; and Sophie's partner was, to a certain extent, able to manage her heroin use. This was demonstrated through his enforced restriction of her supply when she became pregnant;

> *"I had no money. I had no means of getting heroin, he would have had. It would have been him that [had the] heroin that we smoked. So when we actually found out I was pregnant, he just stopped it there and then. He wouldn't give me any more after that" — Sophie (23 years).*

As providers of heroin, the women's partners held a position of power within the relationship, and this was exemplified when the young women became physically addicted to the drug. The young women's reliance on their partners for their heroin supply created difficulties for some of these women, particularly when they were physically dependent on the drug and wished to end the relationship. One young woman, Sarah, suffered from severe withdrawal symptoms when she separated from her partner. She was unable to alleviate these symptoms alone because she had been using large quantities of the drug with her heroin-dealing partner. Sarah explained how circumstances quickly led to a second relationship with a heroin-dealing man;

> *"When I left Joe, I woke up the next morning and my stomach was at me and the backs of my legs were very sore. I told one of the girls in the hostel and she was like, 'Sarah you're strung out'. I didn't know what was going on; sweating buckets, sweating to bits and my legs were so sore I couldn't walk on them. [My friends] brought me up to [a city centre street] and I scored [purchased heroin] and I went and had a smoke, but it didn't really make me feel that much better because I was smoking so much beforehand. A couple of*

days later, that's when I met Frank, the fella from [Dublin suburban area], and he was selling. I went out to [Dublin suburban area] with him to his house and we had a smoke and I just stayed there ever since" — Sarah (18 years).

In addition to providing a heroin supply, all of the women's sexual partners were more experienced heroin users and had been using the drug for a considerably longer period. They were more familiar with the techniques of heating, rolling and inhaling the drug, and, in three cases, the young women never learned how to smoke the drug alone. These women stated that they were unable to learn the technique of smoking, or that their partners did not allow them to prepare and administer the drug themselves. Sinead, for example, said that her boyfriend did not "let" her prepare or administer her own heroin. She explained that she had to wait until he had administered his own dose before she could 'smoke[4]' the drug;

"Ian would never let me burn gear anyway; he never let me do me own thing, so I'd have to wait until he banged up to be able to have my smoke, to get my sickness, just to get my sickness gone" — Sinead (19 years).

Many young women acknowledged that power imbalances operated in their sexual relationships due to their partners' older age, greater experience, and access to heroin and money. Some attempted to address these power imbalances. Emma, for example, who was just 14 when she met her 28-year-old, heroin-dealing boyfriend noted the significant age difference between them. She also believed that she had been "used" in this relationship;

"I let myself get used for whatever I'd be, for company, for sex, whatever. You know for the sake of drugs and stuff" — Emma (18 years).

Emma attempted to redress this power imbalance in a number of ways. She made considerable financial demands from her partner, noting that she always "got what she wanted" in terms of money, drugs and gifts. She also asserted her position and shifted the power dynamics by regularly ending the relationship. She explained that she would only reconsider this decision after her partner made considerable attempts to gain her favour;

"I was always holding the strings of the relationship, and I was always the young one, and I was always real young, but I always clicked my fingers and got what I want... Me and Paddy broke up. I'd kind of get back with him, but I wouldn't officially, and he'd go and buy me gold and hand me hundreds of euro and give me bottles of phy and everything! He

[4] 'Smoke' here actually refers to inhaling the fumes of heroin while 'chasing the dragon'. The term 'smoking' heroin regularly refers to this form of administration.

let it build up and it got to the stage where he bought me a car and all, and all this kind of stuff, and then I'd get back with him and the presents would keep rolling and I was loving it" — Emma (18 years).

Emma acknowledged that she was very young at the commencement of this relationship, but asserted that she was not as innocent and naïve as she may have been perceived. Her partner was heavily involved in drug dealing and gun smuggling, which placed them both at high risk of violence and incarceration. However, Emma stated that she quickly learned how to adapt to this lifestyle and was effective in protecting herself from negative consequences;

"It was him that picked up all the charges like; there was always a part of me that was smart enough through it all. As much as they thought I was a little innocent girl who'd carry drugs for them, I never carried drugs for them. I always made sure I had my own back covered and it's mad thinking back now that I did come across quite naïve, but in a way I learned very quick how to survive in that lifestyle" — Emma (18 years).

Others also deployed a range of strategies to maintain power within their relationships. Sinead spoke about the power dynamics between her and her partner. He was six years older than she was, had more experience with heroin and poly-drug use and had many more social connections in the 'heroin world'. Sinead highlighted the positive aspects of her relationship but also admitted that there was considerable strife. She described a violent instance which occurred when she was 15 years old;

"In our first flat, we had a massive fight one night and I came out of there with a black eye, burst lip and marks around me neck... So it was just, it was just hell. For those two and a half years I was with him, it was just pure hell as well" — Sinead (19 years).

In speaking about the violence that occurred within her relationship, Sinead acknowledged her physical vulnerability and explained that, on occasion, she called the police to intervene. Yet, she also retained an influential position in her relationship, despite her young age and physical vulnerability. She took on a "mothering" role towards her partner, who suffered with schizophrenia;

"James was a paranoid schizophrenic. So from the age of 15 I had to mother him; basically, take care of him as well as being a girlfriend" — Sinead (19 years).

In this "mothering" role, Sinead felt that she exercised some authority within the relationship. Although her partner controlled the supply of heroin in their relationship, she managed to exert

some control over his drug-using behaviour, for example, by asserting certain sanctions and restrictions;

> *"He was having turn ons [injecting] at that point, but I wouldn't allow him to have an awful lot, I wouldn't let him turn on every time...I wouldn't let him bang up every time. So he'd bang up in the mornings, when he was completely dying sick, and that was it. I'd let him smoke then after it" — Sinead (19 years).*

Young women such as Sinead and Emma, therefore, managed to retain some power in their relationships by using a variety of carefully planned strategies. Their young age and inexperience in the heroin and criminal worlds placed them in a vulnerable position, but they used various means to assert themselves. These strategies were adopted as a form of defence, but both women said that they still suffered some exploitation and abuse at the hands of their partners. Emma believed that she was exploited sexually, and Sinead was a victim of domestic violence. Such experiences were not uncommon. Fifteen young women had relationships with older, more experienced heroin-using men when they were in their early teenage years. Within these contexts, gender power dynamics impacted upon their drug use and their vulnerability to exploitation and abuse. Yet, many women emphasised the positive aspects of their relationship and managed to address the power imbalances within them using a variety of strategies. As the women matured and entered early adulthood, the power dynamics within their sexual relationships began to change. They tended to instigate relationships with men closer to their own age and, as all had sought substitution treatment[5] or were abstaining from heroin use, did not rely on male partners for their heroin supply.

Sexual Exploitation, Victimisation and Abuse

The young women in this study began sexual relationships in their early teenage years. Eleven of them had their first sexual encounter with a man in his twenties when they were, on average, 13 or 14 years of age. Their young age and the substantial age difference between them and their partners placed these young women at risk of sexual victimisation or exploitation. Two young women said that their parents attempted to intervene in their early sexual relationships by contacting the police. Emma's parents attempted to prosecute her 28-year-old partner for statutory rape when she commenced a relationship with him at 14 years old;

[5] Fifteen of the 17 young women in the sample were in substitution treatment for their heroin use at the time of the interview. This included both methadone and suboxone substitution treatment. The other two young women were no longer using heroin; one had emerged from methadone treatment, and the other had never developed problematic patterns of heroin use but was currently abstaining.

"He was in a lot of trouble because of my age. My parents were trying to get him for statutory rape, trying to get me home and all this running from one place to another. I just remember using [heroin] all the time" — Emma (18 years).

All 11 young women said that their first sexual encounters with their partners were consensual, and highlighted the active role that they took in commencing the relationships. However, these women also acknowledged their vulnerability within these contexts. Sarah, for example, described her first sexual experience at 12 years old with a 28-year-old man. Her testimony demonstrates how sexual inexperience impacted upon her perception and behaviour, and enhanced her vulnerability to sexual risk;

"I was real real young. He was 28. He obviously knew what he was doing and I hadn't got a clue. But I'll never forget, it was the pain, it was real sore, and apart from that I just thought like it was going to be over within two minutes. After about five minutes, I was like, 'Is it over yet?' [I was] saying it to him when he was on top of me. He was like, 'Are ya alright?' I was like, 'No I want to stop now' and that was after about five minutes. I thought that it should be finished and over and done with by then. I didn't realise it went on for longer" — Sarah (18 years).

The young women in this study were vulnerable to sexual exploitation and victimisation both within and outside of their relationships. Seven of the 17 women had been sexually assaulted before the age of 18. Two of the young women had been sexually assaulted by a stranger, two by acquaintances within their drug-using networks, two by family members and one young woman was the victim of numerous sexual assaults perpetrated by her father, partner, strangers and acquaintances from her drug-using network. In some cases, the women's early immersion into heroin-using social networks impacted upon their vulnerability. Juliette, for example, was sexually assaulted by an older heroin-using man when she accompanied him to his home to obtain heroin;

"I was 13 and I got raped by, not them travellers [friends], but one of their friends... he was much much older than us. He's about 23 now. And [he] asked me to come out to [South Dublin area] with him to his caravan 'cause he had to collect more gear. Because I was strung out at the time I was like, "Yeah yeah, I'll go with you to get some". Then we ended up at his caravan and he locked the door and then after that he raped me and then he kicked me out of the caravan" — Juliette (17 years).

Juliette did not tell anyone about this incident for over two years, and explained the reasons for this decision;

"I didn't want to tell them because I didn't want anyone to know what I was doing out in his caravan. I didn't want anyone to know I was on drugs at the time. And I didn't tell [my female friend] because even though she's me best friend, I didn't tell her because she probably wouldn't believe it because it's me. She wouldn't believe it. Same way if she told me she got raped I'd be like 'Are ya sure?' and all. I just wouldn't believe it" — Juliette (17 years).

Juliette's immersion into heroin-using social networks at a young age contributed towards the circumstances that led to her sexual assault, and simultaneously prevented her from disclosing the event. She did not wish family members to discover her heroin use at the time and this prevented her from reporting the incident. However, as Juliette indicated, she was reluctant to discuss the sexual attack with her close female heroin-using friend because she did not think that she would be believed. Four years later, at the time of the interview, Juliette had disclosed the sexual assault to her mother, and professional health care workers, but explained that the threat of violence continued to prevent her from reporting this sexual assault to the police;

"I still don't want to go to the guards because I know what he's like. And he knows where I live and he knows people. Even if he did get locked up he knows people that would come to me house and do stuff and I wouldn't risk it now, especially because me sister has a baby and everything" — Juliette (17 years).

Another young woman, Sinead, was sexually assaulted by an acquaintance when she accompanied him to his apartment to obtain drugs for her and her partner's use. Unlike Juliette, Sinead contacted the police immediately, but she was dissuaded from prosecuting by legal representatives due to issues surrounding consent. Ultimately, she was told that the process would be emotionally distressing, and that it was unlikely that her assailant would be successfully prosecuted. Sinead highlighted the injustice that she felt at this decision;

"They thought it wasn't going to be fair on me to have to drag it up and bring up an awful lot of crap. I would have been torn apart anyway I'd say, but I just wanted that choice, you know? I wasn't going to do anything anyway but I just wanted to have that choice, you know? Do you want to bring it to court, yes or no? That's all I wanted, but I never even got that" — Sinead (19 years).

These examples highlight the young women's vulnerability to sexual violence within drug-using networks, but also reveal how disadvantaged they were in terms of seeking justice for the crimes committed against them.

Another young woman, Hannah, described numerous experiences of sexual violence which were shaped by her sexual relationship and social environment. She described the circumstances when, at 13 years of age, she met her 22-year-old partner outside a nightclub in the city centre;

> *"This young fella came along. He was 22. Call him John... I was already taking a bit of coke at the time, but he took out a crack pipe and told me I'd be on a deadly buzz if I took some of this. So I started smoking crack with him down a lane and then after we smoked the crack he started saying, 'You didn't think you were going to get this for free?' So I knew what he wanted and I had sex with him and then to come down afterwards he gave me heroin. And I loved the feeling of it. Like the crack and the heroin, I just fell in love" — Hannah (18 years).*

As evidenced by the above, Hannah met her sexual partner for the first time, initiated crack cocaine and heroin use in his company and described a sex-for-drug exchange. She was the only young woman in the sample to report exchanging sex for drugs. At 13, Hannah had already been subject to repetitive episodes of sexual abuse perpetrated by her father and a male babysitter, and was vulnerable to further sexual exploitation. She explained how this vulnerability was mediated by her belief that sex was "what men wanted";

> *"Even though I was only 13...I loved going out dancing and meeting fellas, and going off with fucking 40 different fellas in one night, you know what I mean? I loved all that. It made me feel better about meself. Because of all the abuse, I thought that that's all people wanted out of me, was sex. So I was a slut basically. I just let them all. Even if I was only meeting a young fella I'd do it. Whether I was meeting him or riding him, I'd do it and I didn't care 'cause I just thought that's the way it was supposed to be, that's all they wanted out of me" — Hannah (18 years).*

Hannah's account indicates that conventional discourses surrounding heterosexual femininity, particularly those that condemn active female sexuality (Holland et al., 1998, Jackson & Cram, 2003), impacted negatively on her sexual identity and she adopted a sub-ordinate role in her sexual encounters. There was evidence that these social dynamics powerfully contributed to her experiences of sexual risk in her early teenage years. When she was 14 years of age, her older heroin-using and criminally-involved partner facilitated her move into sex work;

> *"He started telling me that he'd give me gear and crack if I made money for him. He started telling me that I'd make money out of having sex. So, at first it was only having sex with him and he was giving me crack and gear. But then when I was 14, he turned into me*

pimp and he put me out on the game. And he'd organise all the customers and I'd go to meet them and they'd pay him instead of me and then he'd give me drugs for it" — Hannah (18 years).

Within the context of her sexual relationship, Hannah was subjected to repeated episodes of physical, emotional and sexual abuse. She was exposed to high levels of physical and sexual violence when participating in sex work and recounted numerous occasions of being beaten and raped by 'clients'. Her partner did not provide physical protection from this abuse but condoned, and was also a perpetrator of, violence and rape;

"He was supposed to be me boyfriend at the time, but he was me pimp. I just didn't realise it. We went off down a lane, I was going to have sex with him anyway, but when I walked in down the steps he pushed me down the lane, pushed me down the steps and just raped me, and then he got a few of his mates who were punters of mine, to do the same thing. I was fucking humiliated in front of all of them...and from then on, for about eight months after that, that kept happening. I kept getting gang-raped under his charge, you know. He was telling everybody to do it" — Hannah (18 years).

Hannah's partner maintained tight control over her activities and finances, and when she tried to address this power imbalance, he punished her with sexual violence, as described above. She explained that on the occasions when she threatened to leave the relationship, he would subject her to extreme violence and abuse, leading her to fear for her life. Hannah described an occasion when she resisted this violence and ended the relationship;

"One night, he had me in a room and he had petrol, a lighter and a knife, and he tied me legs to a chair like that [gestures one leg tied to each chair leg]. He said he was going to kill me, but he wanted me to fight back and all. He was jeering me and laughing at me and all. He told me he was going to kill me but in the end, it ended up that I stabbed him. He didn't die or anything but I got meself out of there" — Hannah (18 years).

Although this was the only account of violence that escalated to this level, other young women were subjected to violence within their relationships. Their accounts highlight how their vulnerability to potential abuse and victimisation were influenced by power differentials operating in their relationships with older heroin-using men.

Three other young women in the qualitative sample described episodes of physical violence within their relationships. Two of these young women immediately ended the relationship once it became violent. In both of these cases, the role of their families was crucial in facilitating this

move by providing a safe alternative living situation and offering financial and emotional support to the young women. Sarah, for example, was physically abused by her partner at 16 years of age. To facilitate her move away from this relationship, her parents organised her enrolment in a private residential drug treatment facility;

> *"I got with this fella called Eddie and he was selling tubs of tablets and heroin as well. He was 28 and I was only 16, so my family was trying to get me away from him and he used to hit me and stuff. He was hitting me so they got me and they sent me down the country [to a drug treatment centre] for a while" — Sarah (18 years).*

Social supports, such as a strong family network, or access to services such as drug treatment programmes, helped to protect the young women from sexual victimisation and violence. However, the young women only accessed these services a number of years subsequent to their heroin initiation. During this time, 11 of the young women had entered into relationships with much older heroin-using men, and seven had been raped or sexually abused. During the early stages of their heroin careers, the young women were particularly vulnerable to sexual exploitation and victimisation because they had not disclosed their heroin use to their families, nor had they accessed treatment services.

Sexual Risk Behaviour

Young women were also at risk of sexually transmitted infections in the context of their sexual relationships. Of the 17 young women, two reported using condoms during their sexual encounters, and an additional two used hormonal contraceptives. In most cases, the young women did not consider using condoms within their romantic relationships, typically explaining that they were not engaging in sexual activity with more than one partner and, therefore, did not believe that condom use was necessary. Natalie, for example, never used condoms during her sexual encounters and believed that she would not contract sexually transmitted infections because she did not "sleep around";

> *"I've never caught any hepatitis, anything like that. I've all that cleared. I didn't sleep around. I didn't sleep around. I did sleep now, but I didn't sleep around. One time I went through a phase where I was, like anyone I met that night I'd probably, but probably only like two or three people" — Natalie (19 years).*

As evidenced above, there were contradictions in Natalie's account; she acknowledged that she participated in sexual activity with a number of partners outside of intimate relationships, yet stated that she did not require condoms because she did not "sleep around". It appeared that young women believed that having a high number of sexual partners was necessary to acquire a

sexually transmitted infection. Thus, sexual activity with one partner or small numbers of sexual partners was thought to provide immunity against sexually transmitted infections. Young women regularly spoke about limited sexual encounters in their rationale for participating in unprotected sex. Their accounts also indicated that they internalised socially constructed conceptualisations of female sexuality (Holland et al., 1998) by associating high levels of female sexual activity with 'fallen identities'. Orla, for example, said that she was not the "type" of young woman to have "casual sex";

> *"I wouldn't be the type of young one that would meet a young fella for a week and go and have sex with him. I'm really not like that. I am a bit of a mad thing, like I am a bit rebellious, well I was, but I was never like that. I seen a lot of young ones that are like that; they give themselves up to young fellas at the drop of a hat. If the young fella had a few quid like they were game. I was never like that. I haven't had sex with that many people, but I've never had a one-night stand. The shortest amount of time I was with a young fella was a month before I had sex. That was the quickest like" — Orla (18 years).*

Only three young women in the qualitative sample described having sexual encounters with a number of partners in their early teenage years. One of these young women was involved in sex work and another said that she was "addicted to sex". The third young woman, Charlotte, said that she felt ashamed of her early sexual activity and was concerned about how others would perceive her;

> *"I hated it[6], like I was thinking, 'Oh God what will people be saying about me', you know? I made meself feel so little because I had no confidence, I think, and no self-esteem. I just let people take advantage of me. And I just didn't have the strength in me to say 'No, I don't want to do it' or 'Go away'. I think it was cause of growing up and being frightened and seeing me mother being bet up, and then when I got abused by me father then I was frightened then as well" — Charlotte (17 years).*

Charlotte's account reveals how elements of the social environment shaped her sexual beliefs and practices, and enhanced her vulnerability to sexual risk. She believed that experiences of sexual abuse and domestic violence in her childhood left her susceptible to sexual exploitation, and she participated in sexual activity at a young age. However, she also internalised conventional messages of female sexuality, leading her to feel ashamed of her early sexual activity.

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[6] Charlotte is referring here to her sexual history. She 'hated' that she had sex with a number of men before meeting her long-term partner.

Eight young women said that they did not engage in sexual encounters outside of intimate relationships, but described entering sexual relationships with a number of heroin-using partners during their teenage years. None of these young women reported using condoms in their relationship. They believed that if both parties were faithful, the risk of contracting a sexually transmitted infection was minimal. Sinead, for example, explained that because she "trusted" her partner to disclose any incident of infidelity to her, she believed the use of condoms was unnecessary;

> *"I just still don't [use condoms]. I mean I think he's an honest person, he lives next door, so we always trust each other to have the decency to do it [disclose infidelity]" — Sinead (19 years).*

Some young women stated openly that they did not consider the potential negative consequences of unprotected sex when they were immersed in heroin use. It has been suggested that the risks associated with unprotected sex are overshadowed by those of the heroin-using lifestyle (Rhodes, 1995), and sexually transmitted infections were not the main concerns of the young women during their early heroin use careers. However, some young women talked about the ways in which their sexual behaviour changed since accessing drug treatment. At the time of interview, five women said that they considered unprotected sex to be a 'risky' activity, and said that they almost always used condoms during recent sexual encounters. Perhaps the strongest factor influencing this behaviour change was the experience of acquiring a sexually transmitted infection. Sarah, who had sought treatment a few months prior to interview, said that contracting two sexually transmitted infections motivated her to adhere to condom use. The educational information that she received surrounding the nature of her recent sexually transmitted infection was also apparent from her narrative:

> *"I'm using condoms all the time now because A, I've had an STD before, I don't want to get another one. At the moment, I have a bacterial infection in my kidneys but that was given to me through sex. That didn't just form itself. It had been given to me from sex. So that's two, you could call that an STD. I've had two. I don't want to have any more. And I don't want to have kids. And if I have something, I sure as hell don't want to give it to someone else" — Sarah (18 years).*

These five young women changed their attitudes to condom use over time, and in their later teenage years. Treatment services appeared to play an important role in providing information surrounding the importance of contraception, and in providing affordable and accessible condoms. Yet the young women faced resistance from their sexual partners. Sarah, for example, spoke about how she had to insist on condom usage despite protests that they "break the mood":

"We get free condoms in [the clinic] so nobody has an excuse why they didn't use a johnny. We get condoms in here. They have boxes and boxes of condoms. I have loads at home. I take some everyday. I took some today. I take them every day so that I'll have them there, you know. I always use them. And I don't care if anyone says, 'Oh but it breaks the mood. You're there having sex and having foreplay and then you have to stop and run to the drawer and get a johnny'. So fucking what? So what? I always keep the box of johnnies behind my head on the shelf, and if I'm about to have sex, I put my hand up and take the condom out and I say, 'Here, put that on 'cause you're not riding bareback, now put it on! Get away, you're not!' You know what I mean? There's no excuse for anyone" — Sarah (18 years).

Sarah, quoted above, was an exceptionally confident and assertive young woman who was strongly motivated to use condoms following the acquisition of two sexually transmitted infections. However, other young women found it difficult to place demands on condom use when their sexual partners were reluctant. Charlotte, for example, did not feel empowered to insist on condom use in her early sexual encounters because she feared the consequences of her insistence;

"I was too afraid to say, 'Oh no, I'm not doing it if you haven't got this [condom]', but then like after I thought I had the STD, I didn't do it anymore after that. I made sure there was condoms. Before that, I was just like, 'Oh no, I don't want to say that, you know, because then you feel like a sap" — Charlotte (17 years).

In this account, Charlotte indicated that she insisted on condom use following the contraction of a sexually transmitted infection; however, there were contradictions in her narrative. Later in her interview, she acknowledged that she did not use condoms in her current sexual relationship.

Sixteen young women found it difficult to insist on condom use in their sexual encounters, or were not motivated to use them, and they were at risk of sexually transmitted infections. One young woman, Juliette, contracted HIV through sexual transmission when she was 15 years old. She faced extreme bullying as a result of her HIV status, and explained that erroneous beliefs surrounding the acquisition of HIV exaggerated the social stigma associated with it;

"The thing that gets me is they say that I got AIDS because I was having sex with everybody; but, to be honest, that's the first time I had sex with someone, apart from the time I got raped. So people think that when people get HIV or AIDS, sexually transmitted diseases, it's because they're having sex with everybody, but they're actually not" — Juliette (17 years).

The accusations that Juliette's peers made about her sexual behaviour, which they believed resulted in her HIV status, deeply affected Juliette's sense of well-being. She felt ashamed of her HIV status and her early sexual behaviour. She even went so far as to suggest that contracting HIV was her own "fault" for having sex at a young age;

> *"I am ashamed of it because I shouldn't have had sex with that person so young. So it is kind of my fault that I got it" — Juliette (17 years).*

Juliette's HIV status also affected her subsequent sexual relationships. She had been harshly rejected by men on a number of occasions, when they had discovered, or been told by her peers, that she was HIV positive. She described a recent relationship that ended badly, and abusively, when her partner was informed of her HIV status;

> *"There was this one fella and I was with him only there a few weeks ago and he wanted to be with me. We were friends for a while and the minute I go out, people in town saw us together and they were telling him that I had AIDS and all. So he sent me a few messages saying, 'I don't want to be with you, you're a dirty bitch and you have AIDS', and this and that" — Juliette (17 years).*

Juliette's was an isolated case in the sample as no other young woman reported an HIV positive status. Nevertheless, young women were at risk of contracting sexually transmitted infections in their sexual encounters due to the gendered power dynamics operating in their relationships which placed them in a disadvantaged position when negotiating condom use.

Conclusion

This chapter examined issues pertaining to gender, with a particular focus on the role of gender power dynamics in shaping heroin initiation and experiences of risk in the early heroin career. The quantitative data revealed that female survey participants were, on average, younger than males when they initiated heroin use, and as reported elsewhere (Hser et al. 1987; Powis et al. 1996), were more likely to report that they were introduced to heroin by a sexual partner. However, similar findings have been interpreted as implying female passivity and male coercion in drug-using environments (Anglin et al., 1987). In order to gain greater insight into heroin initiation, preceding social processes must be explored (Fiddle 1967; Rosenbaum 1981a; Stephens and McBride 1976; Waldorf 1973), and the qualitative life history narratives were examined to more fully explore the interplay of the social environment and female agency in initiation pathways.

For 11 of the 17 young women, micro-level social processes preceding their heroin initiation were dominated by their intimate relationships; they met older heroin-using men during their early teenage years, entered into sexual relationships with them, regularly observed their heroin-using episodes and were given numerous opportunities to initiate. However, as reported by previous qualitative researchers (Maher, 1995; Payne, 2007; Rosenbaum, 1981a; Sargent, 1992; Taylor, 1993; Woods, 2008), the narratives of these young women also revealed that they took an active role in their heroin initiation. The young women explained that observing their partners heroin-using episodes fuelled their curiosity about the effects of the drug, motivating them to initiate despite their partners' reluctance or refusal. These young women sought opportunities to use the drug in order to experience its positive effects, a finding that supports feminist representations of female drug users as autonomous agents actively seeking pleasure (Ettorre, 2004; Measham, 2002). This pathway into heroin use therefore, reveals the importance of intimate relationships in shaping the social 'risk environment' of heroin initiation but does not deny female agency or imply female passivity in the process.

Following heroin initiation, young women's relationships continued to shape the social environment of their drug use. Previous research has suggested that young women who are introduced to heroin by a sexual partner become more heavily immersed in the 'drug world', develop higher levels of consumption and build up a more costly habit than other young women (Gerstein et al., 1979). Similarly, the young women in this study described an escalation in poly-drug use, rapidly built up high levels of heroin consumption and became deeply immersed in a 'heroin-using lifestyle'. High levels of heroin consumption were possible when the young women had ready access to their partners' 'drug-dealing' supply but became problematic if the young women wished to end the relationship. Gender inequalities in the illicit economy are thought to restrict women's access to high-earning activities such as drug dealing or burglary (Measham 2002; Maher 1997; Marsh and Simpson 1986; File 1976) and post-initiation, the young women in this study, as has been reported elsewhere (Fiddle, 1967; File 1976; Hser et al., 1987), found it difficult to fund their drug use without the support of a male user. Gender power imbalances embedded in drug-using environments therefore, fostered dependency within the young women's intimate relationships, and heightened their vulnerability to exploitation and abuse. The survey data revealed that young women were more likely to engage in sexual risk behaviour; they were more likely to be in a relationship with a heroin or injecting drug user, but less likely to report condom use. Similar findings have been previously been reported in the Irish context (Dorman et al., 1997, Geoghegan et al., 1999, Mullen & Barry, 2001, Smyth et al., 1995). The qualitative accounts indicate that, as suggested by previous authors (Booth et al., 1995; Bourgois et al., 2004; Rhodes & Cusick, 2002), gender power dynamics within drug-using networks and sexual relationships placed young women in a disadvantaged position with regard to negotiating condom use. Furthermore, within these gendered social 'risk environments', they were vulnerable to

sexual exploitation, victimisation and violence. Many young women recounted experiences of sexual assault and exploitation within the context of their intimate relationship and/or within their drug-using networks.

Chapter Seven

Homelessness and Heroin Initiation

Introduction

This chapter, the third to document young people's pathways into heroin use, provides an account of how experiences of living 'out-of-home' and becoming immersed in social networks of homeless youth impacted upon the process of heroin initiation. The chapter begins by introducing the quantitative data, which revealed that experiences of homelessness were common among the study's participants with over 80% reporting lifetime homelessness. These data do not, however, uncover the temporal sequence of homelessness and heroin use nor do they provide insight into the lived experience of heroin use within street-based and other 'risky' environments. The life history interview data enabled an exploration of the relationship between homelessness and heroin use and of the social and relational influences on heroin use in 'out-of-home' contexts.

As noted in Chapter three, 15 of the study's young people were categorised as taking a 'homeless pathway' to heroin use. These respondents described ways in which social environments dominated by homeless or street-based drug-using networks impacted on their heroin initiation. All of these young people initiated use subsequent to becoming homeless. However, a thorough analysis of their accounts led to the identification of three sub-routes to heroin use within this 'homeless pathway'. These are identified and discussed in detail in the opening sections of this chapter. The experience of living 'out-of-home', and its impact on young people's exposure to drug-related risk and their initiation rationales, is also explored.

While the experience of homelessness and/homeless street 'scenes' impacted on the process of heroin initiation, there were others in the sample (15 in total) who had experienced homelessness in their lifetimes but who had initiated heroin use prior to becoming homelessness. These 'stories' are important since they highlight other complex dimensions of the homeless/heroin use 'nexus' and are explored in a later section of the chapter. Together, the accounts of the homeless experiences of 26 of the study's life history interview participants provide insight into what has been previously termed the 'double jeopardy' (Neale, 2001) of heroin use and homelessness. The final sections of the chapter examine the impact of heroin use on young people's housing status, demonstrating ways in which drug use and addiction act as barriers to exiting homelessness as well as ways in which homelessness hampered young people's efforts to address the matter of their heroin and/or other drug use. The impact of homelessness on young people's psychological well-being is also explored.

Quantitative Data

The quantitative instrument revealed high rates of homelessness. Of the 120 participants, 81% reported lifetime homelessness and 70% had experienced homelessness during the six months prior to interview. Almost half (47%) were living in emergency homeless accommodation at the time of interview and a further 6% were sleeping rough[1]. Periods of housing instability have previously been reported by heroin users in Canada (Corneil et al., 2006), the United States (Metraux et al., 2004), Europe (March et al., 2006), the UK (Neale, 2001) and Ireland (Crawley & Daly, 2004; Fagan et al., 2008; Woods, 2008). Nonetheless, rates of homelessness were exceptionally high among this study's population and are only comparable to those previously reported in the UK and Ireland. For example, of 200 heroin users surveyed in Scotland, 68% had experienced lifetime homelessness (Neale, 2001) and, of a sample of 86 adolescent heroin users in Dublin, 48% had a history of homelessness (Fagan et al., 2008). These research findings, along with the findings of the current study, indicate that there is a strong association between heroin use and homelessness in the Irish context. Yet, there remains a lack of concensus on the nature of this association. This study's life history interview data – based on interviews with a group of relatively young heroin users – provided an ideal opportunity to explore the relationship between heroin use and homelessness in considerable detail.

Homeless Pathways into Heroin Use

Of the 40 young people in the qualitative sample, fifteen initiated heroin use within social networks of homeless youth and were categorised as taking a homeless pathway to heroin use. Eleven of these had experienced homelessness *prior to* their heroin initiation, and described a gradual process of immersion in homeless youth networks, particularly during the period subsequent to accessing youth-oriented homeless services in the city centre. Five of the 11 reported a history of state care and their stories highlighted ways in which their care histories impacted on *both* their homeless trajectories and the process of heroin initiation. Describing a somewhat different set of experiences, an additional six experienced first homelessness during their early teenage years and subsequently accessed temporary hostel accommodation in city-centre locations where they came into contact with other homeless youth. The remaining four young people formed social connections with homeless youth despite living in their family homes and became immersed in street 'scenes' where they initiated heroin use. Thus, within the homeless pathway to heroin use, three sub-routes to heroin initiation were identified. These were associated with:

1. A history of state care (five young people);
2. Experiences of early teenage homelessness (six young people) and,

[1] Sleeping rough refers to spending the night on the street, rather than in homeless accommodation.

3. Immersion into homeless networks, despite living in the family home (four young people).

The following three sub-sections detail each of these routes to heroin use. As the narratives indicate, the three routes share similarities, particularly in terms of initiation environments, but there are differences that 'separate' their stories. The presentation of this diversity is important, particularly in light of ongoing discussion and debate about the link between 'homelessness', itself a contested term, and heroin initiation.[2]

A History of State Care

Five of the young people interviewed, three young women and two young men, reported a history of state care. All three of the young women had been removed from their family homes during childhood and placed in foster care, and all were subsequently placed in residential care homes (during later childhood or adolescence). Neither of the young men had foster care experience and both had been placed in residential care homes at the age of 14 and 11, respectively. They believed that their own problematic behaviour, coupled with their contact with the criminal justice system, had played a role in their placement in care. Following a period in residential care, all five young people reported a breakdown in their placements and they subsequently entered the official network of homeless youth through their contact with the Out of Hours Service (OHS)[3].

All three young women who were placed in foster care during early childhood stated that they did not find a stable family environment through their care placements and/or failed to 'settle' with their foster families. This led to their placement in residential care settings during later childhood. Although their accounts of the process differed, all reported that a succession of unsuccessful care placements led to their move to the city centre to access Out of Hours Service emergency accommodation. Natalie, for example, had been placed in foster care when she was three weeks

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[2] There is no single, universally accepted definition of homelessness (Jacobs et al., 1999). The most obvious definition of homelessness is "street homelessness" or "rooflessness" but this also constitutes the narrowest definition (Fitzpatrick, 2000). At the other end of the spectrum is a definition that includes all individuals who are in "inadequate accommodation" or "at risk" of homelessness. The idea of a continuum on homelessness is increasingly recognised and is evident in the European Federation of National Organisations Working with the Homeless (FEANTSA) which has adopted a definition of homelessness which that includes four distinct housing situations: rooflessness, houselessness, living in insecure accommodation and living in inadequate accommodation (see Edgar & Meert, 2006).

[3] Since the point of contact with OHS accommodation emerged as a significant 'turning point' experience for these (and other) young people, it is useful to explain the nature and purpose of this service. The OHS was established by the Eastern Health Board in 1992 to provide young people (under the age of 18) *in crisis*, with necessary services when all other options are closed. The OHS also aimed to prevent young people from becoming "encultured" into street life (Kelleher et al., 2000). The OHS is a social work service rather than a specific accommodation service but much of its remit relates to 'out of home' young people. In order to access accommodation through this service, a young person must first report to a Garda station and declare him/herself as homelessness. The out-of-hours social work service is then contacted and a social worker attends to assess the accommodation options for the child or young person. If a return home is not possible, s/he is placed in temporary 'hostel' accommodation. Essentially then the OHS provides 'out-of-home' young people with 'emergency' beds located primarily city-centre-based residential care services or 'hostels' (see Mayock & O'Sullivan, 2007 and O'Sullivan & Mayock, 2008 for a detailed overview of the emergence of this service).

old; a consequence, she believed, of her parents' problematic alcohol use. She reported that, during the subsequent thirteen years, she had been placed in twenty-three different foster homes. Natalie stated that she "ran away" from her final foster placement and refused to return and, at this juncture, entered into emergency OHS accommodation. She believed that her unstable care history was related to the sexual and physical abuse she suffered in her early foster care placements. In the following account, she described her earliest memory of foster care;

> *"The first thing I ever remember was when I was six 'cause I got sexually abused. So that's the first time I ever remember in care. I was in a foster family. It was one of the sons out of the family... It went on for ages and I tried to tell the social workers and all, but still they left me in that house while they investigated. When I told them they should have took me straight away, but they left me in that house while they investigated" — Natalie (19 years).*

Natalie was removed from this family but experienced physical abuse in two subsequent foster care placements (one in a placement with extended family members) and, over time, developed problematic patterns of behaviour in response to the trauma she suffered. She believed that her problematic behaviour contributed to the housing instability she experienced during her early teenage years;

> *"They [social workers] thought that I was wild because I kept running away from me auntie's and uncle's but they didn't understand why I kept running away... I had so much anger in me [but the] social workers wouldn't listen to me, they wouldn't get me out of this house and I'd so much anger inside me" — Natalie (19 years).*

The other two young women did not describe abuse within their foster families but highlighted alternative reasons for their unsuccessful care placements. Maeve, for example, had been taken into care when she was four years of age. She found it difficult to settle with her foster families because she felt "left out" of the family unit, got into conflict with other children in her foster homes, missed her family of origin, and found it difficult to cope with the move away from her home neighbourhood. Another young woman, Orla, who was placed in foster care when she was eight years old, highlighted her distress at being separated from her family. She reported close relationships with her six siblings and described a particularly strong bond with her older sister. Initially, their social worker tried to have her placed in a foster home along with her sister but they were separated at a later stage;

> *"We were just wild, especially when we were together. We'd kind of kick off when we were together, but then when we were on our own for a while, we were alright. But then as we got older, when we were on our own, we were like 'why the fuck aren't we together?' It*

was kind of like, 'you've taken us away from our ma and now you're taking us away from each other'" — Orla (18 years).

Orla went on to explain that she coped poorly following her separation from her siblings and responded with rebellious behaviour. She was removed from her foster family, placed in a residential care home, and later accessed emergency homeless accommodation in the city centre, having absconded from residential care on numerous occasions.

As stated earlier, the two young men had no experience of foster care. They reported involvement in minor acquisitive crime (thus indicating a degree of overlap with the criminal careers pathway outlined in Chapter Five), and believed that their social workers placed them in residential care because of their contact with the criminal justice system. Ryan explained his understanding of his placement in a residential care home at the age of fourteen;

"It was 'cause I was hanging around people that were older than me and I was getting into so much trouble. I was getting arrested so many times, nearly every day, and then the guards called social services and then me mum had to put me into their care" — Ryan (18 years).

Ryan went on to tell the 'story' of his first exposure to heroin use. He was placed in a residential care setting in a suburban area of West Dublin where he remained for a period of three years and, during the latter part of this placement, came into contact with a young occasional heroin user. This young woman was immersed in homeless heroin-using networks in the city centre at the time she was placed in the care home where Ryan was a resident. Ryan explained that he initiated heroin use in her company at the age of seventeen years;

"I was living in care in [suburban area]. There was a girl who moved in and she told me she done it [heroin] before, and I told her I done it before as well, even though I hadn't. Then we went into town one day and got some of it and went off and started smoking it. That was the first time I done it" — Ryan (18 years).

Orla also initiated heroin use with a young woman she met in a residential care home. However, she explained that the young woman with whom she initiated use was also a first-time user of the drug at the point of her initiation. Both had strong connections with homeless social networks in the city centre. Curiosity was Orla's primary stated reason for wanting to try the drug. Her account of initiation highlights her uncertainty about how to administer heroin by smoking, despite her prior exposure to use in both indoor and outdoor use settings;

"We didn't even know what we were doing. We were sitting there looking at the Q [bag of heroin] for about ten minutes trying to figure out like, 'I've seen this being done but how do we do it?'" — Orla (18 years).

Both international and Irish research has consistently noted an association between a history of state care and homelessness in the case of young people (Barth, 1990; Kelleher et al., 2000; Mallon, 1998; Mayock & Carr, 2008; Mayock & O'Sullivan, 2007; Mendes & Moslehuddin, 2006). For example, a national study of care leavers in Ireland revealed that over 30% of young people had experienced homelessness within six months of leaving care (Kelleher et al., 2000). The accounts of the five young people in the current study who had a history of state care are therefore quite consistent with the notion of a 'care pathway' to homelessness (Mayock & Carr, 2008; Mayock & O'Sullivan, 2007). Their accounts also strongly suggest that the experience of homelessness in turn played a significant role in the processes surrounding their heroin initiation.

Early Teenage Homelessness

Six young people, five young men and one young woman, reported that they first experienced homelessness during their early teenage years. These young people, like the five young people in the care history pathway, came into contact with heroin users following their contact with homeless youth services in the city centre. Unlike the young people discussed in the previous section, they did not report a history of state care prior to their homelessness. Instead, they described processes linked to difficult home situations and family conflict which contributed to their move out of the family home during their early to mid-teenage years. All emphasised their own problematic behaviour in their first episode of homelessness; however, their accounts simultaneously point to the role of family adversity and conflict in this process.

Four of the young men in this sub-group described high levels of conflict with their mothers' new partners following parental separation or divorce. Barry, for example, explained the difficulties that he and his older brother experienced following the move of his mother's partner into their family home;

"You could say (mother's partner) has 60% to do with why I'm homeless now, with all his stupid little things. Like he's a 50-something-year-old man and he goes on like a child. He'd say something to my mother that never happened and she'd take his side and it would make me look like I fucking belong in the loony bin. He knows what he's playing, that's why I won't go near him 'cause I'll just freak and lash out cause it's all mind games. He was doing it to me brother before and even when I caught him out, and me ma knew I had him caught, she still went back to him and chose him over me. So I just don't bother" — Barry (20 years).

Another young man, Christopher, also felt strongly that living in a 'blended' family along with his mother, his mother's partner and their children, created great upheaval and difficulty in his life. His account reveals his feelings of estrangement from his 'new' family and a belief that he was "treated differently" by his mother's partner;

> *"My ma used to say to me, 'The difference between you and [your brother], and [your half-brothers], is that [your half-brothers] had their father, their real father around. He was always there to support them, and you didn't have that. But you're one of his children, not that he ever treated you any different', like so she said. But obviously he did. He'd obviously have a bit more love for his own kids" — Christopher (25 years).*

Conflict between these young men and their mothers' partners and their feelings of exclusion from family life contributed to their move out of the family home. During the period subsequent to this event, they alternated between emergency homeless accommodation and sleeping rough. Both reported lengthy periods of homelessness (of periods of over two years) following their first 'out of home' experiences.

Sarah also experienced first homelessness during her early teenage years. In a somewhat different account, she highlighted the role of her own problematic behaviour in the events leading to her first homeless experience, emphasising in particular, the role of her early cocaine use and "partying" behaviour. However, Sarah also described complex family relationship and dynamics preceding her first 'out-of-home' experience at the age of fourteen years. Her parents separated when she was 11 years old, an event which had caused her considerable distress. She described a very close relationship with her father but said that her relationship with her mother was fraught. When her father moved out of the family home, levels of conflict with her mother escalated. She believed that her own 'problematic' behaviour was a factor in these difficulties but described other personal challenges which she believed, in retrospect, to have impacted on her behaviour at this time;

> *"I didn't get on well with my mam at all. I hated my mam. I hated her with a passion... I really disliked her because I thought she liked me sister more than she liked me. But that was because my sister didn't act up the way I acted. Like I was a bitch, I can admit I was a bitch to my mam. I really acted up a lot of the times. But I've also been diagnosed with ADHD* [Attention Deficit Hyperactivity Disorder] *and bipolar disorder. So that could have had a lot to do with it as well" — Sarah (18 years).*

Sarah's account of her first contact with the Out of Hours Service describes a complex configuration of issues that contributed to her leaving home;

> *"The two of the out-of-hours social workers came. They asked me what was the story with my mam and I explained the situation. I said I was after taking drugs and she's after throwing me out. At the time, I was saying it's all her fault it's not mine, but I know now it was my decision to take all the drugs. It was never their fault. It was a sad situation. It could have been handled better, but my sister never took drugs so my mam didn't know what to do. She didn't have a clue because she'd never been around drugs before" — Sarah (18 years).*

Although Sarah emphasised her own 'problem' behaviour as leading to her homelessness, her narrative simultaneously points to the role of a number of challenging experiences. During early childhood, she had experienced high levels of conflict within the family home and, following her parents' separation, these and other tensions appeared to escalate. She described a close relationship with her father, emphasised that her mother and sister shared a close bond, and reported that she felt excluded from her 'new' family unit. When she was twelve years old she began a sexual relationship with a 28-eight-year-old male who was heavily involved in drug dealing activity and she subsequently developed a 'problematic' pattern of cocaine use. Thus, while Sarah largely attributed her first episode of homelessness to her cocaine use, her life 'story' in fact suggests a complex range of experiences and events that contributed to her home-leaving.

All six of the young people who became homeless during their early teenage years subsequently accessed Out of Hours Service homeless accommodation in the city centre. Their accounts uniformly suggest that their contact with other homeless youth, and their gradual immersion in street-based social networks, produced high levels of exposure to drug use and other 'risky' behaviour. All reported that it was within these social networks that they initiated heroin use.

Not Homeless, but Immersed in Homeless Social Networks

Four young people, including two women and two men, did not experience homelessness prior to their heroin initiation but nonetheless described strong connections with street-based drug 'scenes'. Although living in their family homes at the time of initiating heroin use, they recounted spending lengthy periods of time in outdoor locations in the city centre where they formed social connections with heroin-using youth. Their accounts strongly suggest that these social environments, dominated by street-based drug-using networks, impacted upon their heroin initiation.

Two young men, both from the Traveller community, were not homeless at the time of their heroin initiation but were nonetheless exposed to the drug through their contact with street-based networks of homeless youth. They participated in a street-based lifestyle similar to that described by many who had experienced homelessness as teenagers, and socialised with homeless friends or acquaintances in public spaces (the street, alleyways) and in squats where their homeless peers lived for periods. They also described "tapping"[4] and "dipping"[5] on city centre streets. William lived in a local authority housing complex where he felt excluded because of his Traveller 'identity'. His response to the "hassle" or harassment he experienced in his home neighbourhood was to seek out alternative social settings, in the main street-based, for entertainment and solace;

> *"I didn't get on in the flats that I'm living in, with nobody. We always got a lot of hassle because we're travellers, like half travellers. Me father is a full traveller and all. So I'd go other where [places], do you know what I mean?" — William (22 years).*

William started to spend most of his days socialising in the city-centre and developed strong connections with homeless drug users over a period of several months. He explained how these social environments impacted on his 'thinking' about heroin use;

> *"I used to go back there sometimes, to the squats, and have a drink there and listen to their little radio or something. They'd start taking drugs and I couldn't socialise with a crowd that was doing something [that I was not]. I could see how there was a guy that was homeless, that had nowhere to go, that probably had a shitty life, excuse the language, and he looked very happy after [taking heroin]" — William (22 years).*

William told that he initiated heroin use in a squat a short time later with an older homeless man. Joe, another young man from the Traveller community, also became immersed in homeless social networks during his early teenage years and initiated heroin in a squat in the city centre in the company of his older cousin.

Two young women also became immersed in homeless networks despite living in their family homes and described spending vast amounts of time socialising in outdoor city centre locations during the hours after school. Juliette, for example, grew up in a socially deprived area in West Dublin and started to socialise in the city centre after her best friend, Sharon, who had moved from this suburban area to a city-centre neighbourhood during childhood. She described how they met and started to "hang around" with two young homeless men at the age of twelve;

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[4] Tapping is a colloquial term for 'begging'.
[5] Dipping is a colloquial term for 'pick-pocketing'.

"Me and Sharon used to hang around [city centre arcade], where like basically every child hangs around, and they [two young homeless men] were up there one day. Travellers are just very out-straight; they just come over to you and start talking to you. So they came over and started talking to us. The way Sharon is, she's friendly with everyone, but I think she gets too friendly with people she doesn't know. She started talking to them and that's how we basically started talking to them. They asked us to meet them the next day and we did and that's how we started hanging around with them" — Juliette (17 years).

At this juncture, neither Juliette nor her friend had any experience of illicit drug use. She went on to describe the sequence of events leading to her heroin initiation;

"We were hanging around with these travellers and they used to tell us that they were only smoking hash. They'd go into McDonalds' toilets and they'd tell us they were just rolling a spliff. We didn't have a clue what they were doing but they were actually smoking heroin. So we didn't know. Then I stopped coming into town for a few weeks 'cause me ma didn't want me in town. So I stopped coming in for a few weeks. And then when I did come back in, Sharon was like, 'I'm after trying out this thing [smoking heroin] that Jack and Kenny [the two young homeless men] were doing. So come on, just try it out'. And I was like, 'Is it ok to do it?' She was like 'yeah'. But we were only 12 or something at the time when we first tried it out. I was getting sick, and I was like why isn't she getting sick? I started getting sick and she was like, 'Oh no you have to smoke it again before ya feel it'. So I said right and I smoked it. I don't blame her for me getting on it. She gave me me first smoke, but I was the one that got addicted. I did that to meself" — Juliette (17 years).

Caroline described a similar route to heroin use. After school, she spent time with her best friend socialising in outdoor city centre locations where they came into contact with three young homeless heroin-using young men. She initiated heroin use with them in an alleyway in the city centre. Like Juliette and others, her exposure to and participation in homeless social networks shaped the course of her heroin initiation.

The research literature on homelessness and heroin use, perhaps understandably, most often highlights associations between *actual* experiences of homelessness and the initiation and/or exacerbation of heroin and/or other drug use. However, what the accounts documented here suggest is that young people who initiate heroin use in the context of homeless networks may not be homeless (at least at that juncture). Rather, the connections some may form with homeless youth, and the exposure they experience to drug use when socialising in marginal social spaces (including both indoor and outdoor locations), may frame the social processes associated with the heroin initiation of at least some. Like others whose heroin initiation was connected with

homeless networks, the process of initiation involved complex social interactions which altered their negative views of heroin and thus shaped their initiation rationales. The following two sections explore how the experience of homelessness, or of homeless others, impacted upon young people and shaped the course of their heroin initiation.

Homelessness and the Social Course of Heroin Initiation

As indicated in the previous section, the event of young people moving to emergency hostel accommodation in the city centre brought about significant change to their social worlds. Young people often referred to this process as "coming into town", a phrase that has been previously highlighted as one commonly used by homeless young people in the Irish context (Mayock & O'Sullivan, 2007 p.176). Mayock and O'Sullivan's (2007) qualitative study of youth homelessness identified the point of "coming into town" to access under-18s hostel accommodation as a significant 'turning point' experience and one which marked young people's initiation into a range of risky behaviour and activity. Similarly, the accounts of those in the current study who entered the 'official network' of homeless youth via the Out of Hours Service indicate that their contact with large numbers of homeless or street-based youth and marked the onset of their high exposure to 'hard' drug use and criminality. This experience in turn impacted on their social interactions and relationships.

Young people almost always emphasised that their 'new' social networks differed significantly from the peer networks to which they had been previously accustomed. For example, most perceived homeless youth to be more heavily involved in 'hard' drug use and criminality than youth from their home neighbourhoods and practically all emphasised the pervasiveness of heroin and other drug use within the networks of homeless youth and young adults. In the following accounts Sarah and Barry compared their former peer groups with their 'new' social networks in the city centre. Sarah framed her experience as one characterised by a move from a "sheltered" to a more "dangerous" environment while Barry drew attention to the more "extreme" behaviour to which he was exposed following his entry to OHS accommodation;

> *"The life in town was a lot different to what my life was in [suburban area]. I kinda had this sheltered life in [suburban area] and in town it was so dangerous all the time. You didn't know anyone, you were trying to get to know people and people were telling you they were on heroin and you're like, my God!" — Sarah (18 years).*

> *"They [friends from previous locale] don't smoke gear but they're not stupid, they know about drugs, they do drugs themselves. I don't know about [class] A drugs, but let's say, the people I hang around with in town are a bit more extreme. They'd be more criminal, like breaking laws every fucking minute of the day" — Barry (20 years).*

When young people "moved into town", they formed social connections with homeless youth under the age of 18, and also, with homeless adults. Emergency homeless accommodation provided access between the hours of 8pm and 9am. However, at this juncture the majority had left school, leaving them with "nothing to do" during the day. Accounts of extended periods of time spent in outdoor locations tended to dominate these narratives as young people described increased levels of contact with others in a similar situation to themselves. Most rapidly expanded their social networks over a period of months or even weeks. Young people invariably noted that the majority of (homeless) individuals with whom they formed social connections were heroin users;

> *"The difference in the drug taking in town, because nobody in [suburban locale] at that time would have ever talked to you about taking heroin, and I was hanging around with all these people that were on heroin [but] I stayed away from it for so long, I didn't touch it for a very very long time." — Sarah (18 years).*

There were other significant dimensions to their accounts. Many, for example, explained that they had few financial resources and were unable to finance conventional leisure activities such as the cinema, internet access, or the use of other recreational facilities. In the absence of alternative options, the opportunity to spend time with other homeless youth was readily grasped. Barry explained;

> *"That's the one kickback about being homeless, 'cause you might be walking around saying to yourself, 'Oh I feel like shit, I've done nothing at all today'. But you'll hopefully see somebody, one of the boys here [in the homeless drop-in centre] or something. He's going to a gaff [house] and you can buzz along with him, kill a bit of time if you're lucky" — Barry (20 years).*

Despite the positive and rewarding aspects of forming new social connections with homeless youth, a striking feature of their accounts is that they rarely described homeless 'others' as their 'friends'. Indeed, most emphasised that their relationships with street-based peers were short-lived due to the transient nature of homeless networks and 'scenes'. Furthermore, young people's homeless 'journeys' were not static or fixed and most moved in and out of homelessness at various junctures. However, young people whose homelessness preceded their heroin initiation almost always reported lengthy periods of time living 'out-of-home', with all having spent at least one period of a year or more living in emergency homeless accommodation at the time of interview. These young people regularly moved between different 'hostels' and failed to secure longer-term or more stable living situations. Their homelessness, coupled with the experience of

multiple short-term placements in emergency hostel accommodation, created profound instability and most found it difficult to form lasting or meaningful friendships. Many in fact described their peers as "acquaintances" or "associates" rather than as friends. As time passed, most began to socialise in increasingly large social networks where they came into contact with heroin users who, in most cases, were also homeless. Damien, only 18 at the time of interview, told of his extensive knowledge of individuals within homeless and/or heroin-using networks through his contact with youth emergency hostel accommodation;

> *"I can't walk through town without seeing twenty people I know. I know everyone in town, in the city centre, nearly all of them listed [on the homeless register]; there's nearly six hundred. I just know a lot of people from being in [youth emergency homeless accommodation]. I was in there for about five months and you go in there at say 10 o'clock at night and you get kicked out at 9 in the morning. So you're in town for the day"* — *Damien (18 years).*

Within these large, dynamic social networks, young people came into contact with individuals who were young, had recently become homeless and were 'experimenting' with heroin, and also with those who were older, had been homeless for extended periods, and were deeply immersed in a heroin-using lifestyle. Barry's depiction of the "homeless people" with whom he was well acquainted is instructive: he alludes to the lifestyle with which he was very familiar, dominated by drug use and other "bad qualities", but was also keen to emphasise the positive traits of individuals who were immersed in this lifestyle;

> *"Half the nicest people I've ever met in me life are homeless people. They take life for what it is and dare I say it, half of them are junkies. Half of them are strung out to bits, sell gear, fucking hate the Gardaí, use gear, all loads of bad qualities; but they're still nice people, still help blind people cross the road, d'ya know what I mean? They let women walk on the inside of a footpath and all, like they know the qualities and values in life, d'ya know what I mean? I'd look at them and sort of say, 'That's what I'd be like if I was a junkie', and then I'd look at them physically and say, 'Ughh'. That puts me off heroin, ya know?"* — *Barry (20 years).*

Most initiated heroin use in outdoor or public locations, such as alleyways (eight young people), squats (two young people), apartment stairwells (one young person), car parks (one young person) or hostels (one young person), while in the company of other homeless youth. Maeve's account of the physical environment and social context of her heroin initiation highlights both micro-level forces and situational factors that impacted upon the process;

"I was only about 14 actually. I was in [emergency homeless accommodation] at the time. I remember I ran away from [the hostel] for a week or something with another girl. We ended up staying on the street with these two travellers. I hadn't even seen heroin before, and we were down some lane one night, after being out tapping [begging]. That's what they used to do, they used to beg. Then they would come down and we'd walk up to [city centre street] and they'd get something [heroin]. They never used to tell us what it was and we went down then to some squat or something. They sat down and they were pulling out the foil and whatever and we were looking at them going, like, 'What the fuck are you doing?', you know what I mean? He told us to taste it and I took a half a line and I puked everywhere" — Maeve (19 years).

Maeve was one of five young people who reported a history of state care and, like others, she had entered the Out of Hours Service following a breakdown of her care placement. It is striking that she like others (including a number who lived at home but formed social connections with homeless youth) appeared to know very little about heroin or the 'technologies' of use at the time of her initiation. Barry also initiated heroin use in a physical and social environment shaped by his experience of homelessness. At the time of his initiation, he was accessing a homeless service through his contact with the 'night bus', a service which provides an emergency phone line and nightly hostel accommodation on a first-come-first-serve basis. However, he explained that he was often left without "a bed for the night" due to a shortage of hostel accommodation and that, in these instances, he was forced to sleep rough. He initiated heroin use in an apartment stairwell along with four other young homeless men with whom he had come into contact when accessing a homeless drop-in service in the city centre;

"Five of us from in here [homeless drop-in service] were hanging around. Three of us from the north side, two from the south side; [we] got along great. One of the boys was strung out on gear — grand, no problems. He only smoked it like, he was cool, do you know what I mean? He only went off, had a smoke and he was sick and came back. But I was seeing heroin, people injecting and smoking, everything, being curious about it. People [were] telling me you can't get hooked after a smoke and all that just built up one day. There was loads of shit going on in me head so I just said, 'Fuck it' one day. We were out in some apartment complex ... in a apartment stairwell [at] about 1 o'clock in the morning and [it was] pissing out of the heavens like all day, and me and me mate tried it for the first time. We all just didn't get accepted on the night bus so we said 'Fuck that if we're staying in', do you know what I mean?" — Barry (20 years).

Barry's account indicates that he had been exposed to the heroin use of other homeless individuals on many occasions prior to first smoking heroin. It also suggests that his social

interactions with homeless heroin users altered his fears about the drug and led him to feeling curious about its effects. Others similarly explained that their social interactions with homeless heroin users, combined with the strain of living 'out-of-home', impacted on their initiation rationales and in effect facilitated or at least encouraged their heroin initiation. These processes are explored in greater detail in the following section.

Homelessness and Initiation Rationales

Homelessness was a distressing experience for the majority of the young people, and most described how living 'out-of-home' brought physical discomfort and also generated negative emotions. Many referred to these negative experiences when attempting to articulate their rationales for heroin initiation, often explaining that they wished to use heroin to ease the negative emotional states associated with a homeless lifestyle. Others emphasised the social rewards of heroin use, stating that the shared experience of using heroin with others helped to alleviate the monotony of everyday life. Significant also is that most stated that a majority of their homeless 'associates' or friends were heroin users and that, prior to initiation, they were one of few non-users within their 'new' social networks. These dynamics provided the young people with the both the opportunity and motivation to initiate heroin use.

Typical accounts suggest that young people's regular exposure to heroin use served to increase their curiosity about the effects of the drug. Other homeless youth frequently highlighted the feelings of euphoria associated with heroin use, and these experiences or observations featured strongly in the young people's motives for initiation. Natalie, who moved into emergency homeless accommodation at age 13, remarked that youth who were using heroin and/or other illicit drugs appeared "happy all the time", leading her to aspire to a similar altered 'state';

> *"I was on no drugs, nothing, and they [social workers] put me into a hostel with young people that were on drugs and I could see them in a great buzz and happy all the time and all. So I decided to try some to get the same buzz they were on" — Natalie (19 years).*

Observations of other young heroin users also served to ease any prior fears they may have had about heroin experimentation and to challenge their negative perceptions of the drug. Some additionally remarked on the strain of continuing to refuse drug offers in the context of their socialising or "hanging around" routines. Sarah, for example, had moved into a hostel in the city centre at the age of sixteen and made social connections with numerous young heroin users. She explained that she initially held very negative perceptions of heroin, believing it to be a "dirty drug". While she resisted "the temptation" for some time, she had initiated use within one year of "moving into town";

"Then I moved into town. So while I was able to resist the temptation for a year, I didn't touch anything [heroin]. I came in here [drug treatment centre] on the 16th January one year, 2006 I think it was, and at that stage I hadn't took any heroin or anything like that. By February, I was on it and strung out" — Sarah (18 years).

Within the social contexts where young people's daily lives were played out, their perceptions of heroin (and other) drug use incrementally altered and the benefits of use increasingly came to the fore. Simultaneously, their negative perceptions of heroin use and users (described also in Chapter Four) gradually diminished. Some also explained that the potential negative repercussions of heroin use, such as the risk of others finding out about their drug use or, indeed, dependency, appeared less 'threatening' as their homelessness progressed. These young people frequently had only sporadic contact with family members and had poor connections with their home neighbourhoods. Two young people stated openly that they believed that they had "nothing else to lose" by initiating heroin use. Barry, who was accessing short-term emergency accommodation at the time of interview and was often forced to sleep on city centre streets felt that if "worse comes to worse" he might face incarceration. Significant also is that he alluded to some benefits to "getting locked up";

"I said, 'Fuck it, if I get strung out on gear, worse come to worst I could always murder someone and get locked up. At least I'll have three meals a day, a bed and a television'. I don't mean literally murder someone, but you know what I mean, commit some crime, tell them I'm homeless and get put straight into prison" — Barry (20 years).

Barry also described feelings of hopelessness and despair which he attributed to his homelessness. On the day that he initiated use, he described feelings of depression, as well as thoughts of suicide, explaining how numerous forces associated with his homelessness contributed to these negative emotions;

"It was one of them throw-yourself-in-the-Liffey days, that was it. I couldn't give a fuck what happened from here on in 'cause I've had it up to here. Everything that I've done to help this situation be as it is, and everything else outside me that's helped it be as it is, takes its toll on you, do know what I mean? You start thinking to yourself like, 'Fuck's sake, I am something else to be homeless for the second time let alone the bleedin' first time'. And there's nothing you can do about it but just go through these games of walking around wasting time 'cause you've nothing to do. It took its toll" — Barry (20 years).

Many like Barry attributed the negative emotions they experienced to their homelessness, highlighting them as a significant factor in their heroin initiation. A number also emphasised that

heroin use offered practical solutions to the hardship they endured and was an effective way of evoking feelings of safety and warmth. Natalie initiated heroin use after she had spent a cold day outdoors in the city centre. Her primary motivation was to "keep warm";

> *"Just down in the car park a young fella gave it [heroin] to me and I smoked it. It was night time and I was begging. I was sitting there and he handed me the tooter[6]...and he was saying 'it'll keep you warm' and all. I took it mainly to keep me warm" — Natalie (19 years).*

Heroin was thus portrayed as having the dual advantage of aiding physical comfort and easing emotional distress. One young man, Christopher, compared the effects of heroin to being wrapped in a "big warm blanket", depicting a strong image of comfort and security and highlighting the appeal of heroin to homeless youth;

> *"I suppose the reason I liked it was because the fact that it just numbs you out. It's like a big warm blanket around you. It's like somebody with a big warm blanket comes and it takes the pain away for a while. And it did, it really did. Heroin is a drug that when you take it, how you feel when you doing it is, it makes you feel warm and safe" — Christopher (25 years).*

Through their social interactions with other homeless youth, young people became increasingly aware of the positive effects of heroin use and became less fearful of the potential negative consequences. Previous research has documented that homeless youth are motivated to use illicit drugs to alleviate the difficulties associated with a homeless lifestyle (Klee & Reid, 1998; Neale, 2001; Rowe, 2005; Tyler & Johnson, 2006). Many in this study who experienced homelessness similarly explained a desire to ease the physical and emotional distress associated with living 'out-of-home'. Furthermore, using heroin was a sociable activity that fostered companionship within street-based heroin-using homeless networks. These positive aspects of heroin use featured in young people's rationales, and motivated their initiation within social environments shaped by their experiences of homelessness.

Homelessness Subsequent to Heroin Initiation

Those 15 young people identified as taking a 'homeless' pathway to heroin initiation have so far been the primary focus of analysis in this chapter. Eleven of these young people were homeless *prior* to initiating heroin use and the remaining four initiated use in street-based settings. There

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[6] A 'tooter' is a small tube, usually a straw or a section of a biro, used to inhale the fumes of the heroin as it sublimates off a piece of tinfoil. This is the method used when 'chasing the dragon'. The heroin is placed on the tinfoil, heated with a lighter from below and run in lines across the tinfoil.

were others in the sample, however, who reported homelessness, with an additional 15 (11 young men and four young women) stating that they had experienced homelessness in their lifetimes. All 15 first experienced homelessness *subsequent* to initiating heroin use and seven (five young men and two young women) were homeless at the time of interview.

The homeless experiences of this sub-group of young people were quite diverse. For example, the accounts of six suggested a pattern of episodic homelessness. These young people typically described conflict with a parent, usually in the form of mounting tension and/or an argument, which resulted in them leaving the family home for a period. All returned to the family home some time later – in most cases, within days – but the majority described a repeat pattern of leaving home for short periods. These experiences of homelessness could be characterised as a pattern of moving 'in and out' of home. While primarily residing in their family homes, they spent intermittent periods of time living in emergency hostel accommodation, in the homes of relatives or friends, or sleeping in outdoor locations. These young people often stressed that their homelessness was associated with their own 'problematic' behaviour and/or family conflict. Darren, for example, occasionally slept in outdoor locations close to his home neighbourhood following conflict with his mother. However, he always returned to the family home following a relatively short period.

> *"I slept rough a few times but I was never out for more than a week or something. Me ma would always take me back in, you know" —Darren (25 years).*

Another young man, Derek, explained that his father asked him to leave the family home on a number of occasions following family conflict. He rarely had to resort to sleeping in outdoor locations because he had a large number of relatives who almost always offered him a place to stay. However, he described a number of occasions when he was forced to "walk the streets" in the city centre;

> *"I never slept rough and I'm glad I didn't have to, to be honest. I have a big family, you know what I mean? But it got to the stage there about two years ago, me da fucked me out[7]... I never actually slept on the streets. I actually walked the streets a couple of times, like in and around town, just walking until it got bright" — Derek (24 years).*

The remaining nine young people (seven young men and two young women) experienced far more sustained periods of homelessness, with eight reporting at least a one-year period of consecutive homelessness during which they depended on emergency hostel accommodation or,

[7] Derek's father asked him to leave the family home.

alternatively, slept rough or lived in squats. Thus, a considerable number had experienced long-term homelessness.[8]

Whether their homelessness was episodic or longer-term, these young people often indicated that their own 'problematic' behaviour, including their drug use and/or criminal activity, contributed to their home-leaving. Similar findings have been previously reported in the Irish context (Cox & Lawless, 1999), leading some researchers to argue that problematic substance use is a major *cause* of homelessness (Lawless & Corr, 2005). However, the narratives of this study's young people point to a host of pre-existing family conflicts and hardship which played a significant role in the events leading to their homelessness. Thus, while a number stated openly that their "addiction" or "behaviour" created tensions and problems within their homes, their homelessness was shaped by a complex interplay of macro, meso and micro-level environmental forces including poverty, family breakdown, conflict and/or violence.

Derek (quoted above as having experienced episodic homelessness) believed that his drug use led to conflict in his family home. He, like others, including those who experienced longer-term homelessness, described high levels of family adversity, including poverty, familial substance use, and parental mental health problems. Home-based difficulties, tensions and/or traumas apart from those associated with young people's drug use were invariably reported. Hannah, for example, was a heroin user at the time she first experienced homelessness but it was her disclosure of sexual abuse perpetuated by a family member that triggered her home-leaving;

> *"It's just with me father and things like that. The family's kinda been broken up a bit because it was like I ratted on me da. That's just the way it is" —Hannah (18 years)*

Also significant is that all seven of the young men who reported long-term homelessness attributed the instability of their housing to a far greater extent to their criminal activity than to their drug use per se. All had taken a 'criminal career' pathway to heroin use and the majority reported home-based tensions related to their escalating involvement in criminal activity. When asked about the circumstances leading to his homelessness, Damien referred primarily to the negative impact of his criminal activity;

> *"She [mother] couldn't cope with me. I was too wild. I was on drugs and I was robbing. The police was dragging me out of the house at seven o'clock every morning and it was all too much. The guards were coming in, raiding the gaff nearly once a week to drag me in*

[8] Although 'long-term' homelessness is defined variously in the literature, there is emerging consensus that one consecutive year of homelessness is an appropriate threshold (U.S. Department of Housing and Urban Development, 2007; Chamberlain & Johnson, 2002).

for something ... Me ma said 'Look it, I can't keep you here'. This is when I was 16. So I started going to the homeless service, the underage ones, the Out-of-Hours" —Damien (18 years)

Two of the young men had experienced lengthy periods of homelessness following their incarceration. Alan, for example, experienced a period of homelessness exceeding two years in duration following his release from prison. During his time in prison his mother had moved out of the family home to another location with her new partner. Alan explained that his mother "just had enough" and did not maintain contact with him or his brother;

"She [mother] just had enough and she just moved out and didn't let us come over. When I got out of Pat's we [Alan and his brother] had nowhere to go so we moved into town. We were living on the streets in town so... we ended up starting to sell it [heroin], ended up staying in B&Bs. You know them ones up in [street in North inner-city] and all that. That's how we ended up getting strung out badly" —Alan (25 years)

Alan's life 'story' also uncovered difficult childhood experiences including poverty, family breakdown and conflict. He described how these circumstances impacted upon his family life;

"She'd [mother] be with people, but I don't know what it was, I wouldn't let them come into the house. I wouldn't let her have a partner. I don't know what it was I wouldn't let them in the house. I'd end up causing murder, smashing up the house or whatever I don't know what it was" — Alan (25 years)

Thus, the accounts of the majority who experienced homelessness subsequent to initiating heroin use strongly indicated pre-existing family adversities as well as difficult home situations (including family conflict, poverty, and parental substance use) that contributed to their homelessness. Whilst young people's heroin use and the criminal activity of young men, in particular, undoubtedly contributed to home-based tensions, their accounts do not point to their drug use as the *single reason* for their homelessness. Mallett et al's (2005) Australian research on the link between drug use and homelessness among young people similarly found that although personal or familial drug use was connected with the home-leaving of one-third of their sample of homeless youth, family conflict was also strongly implicated in the pathways taken by these young people out of home.

The Combined Impact of Homelessness and Heroin Use

The combined experiences of homelessness and heroin use impacted upon young people's well-being in a variety of ways and also shaped their experiences of risk, particularly during the early

stages of their heroin careers. These young people often emphasised the benefits of using heroin within homeless contexts and environments, highlighting its ability to temporarily alleviate negative emotions and physical discomfort. However, they simultaneously described ways in which heroin use created barriers to them exiting homelessness and, over time, impacted upon their physical and mental health. Awareness of these negative effects generally emerged as their heroin 'careers' progressed, often at the point that they realised that they were physically dependent on the drug. Several emphasised that once immersed in a homeless lifestyle it was exceptionally difficult to move out of homelessness and away from heroin use. One young man explained;

> *"You get so caught into it that you're in too deep by the time you look out" — Barry (20 years).*

It has been suggested that the move out of homelessness to stable accommodation is particularly difficult for individuals who are heavily immersed in drug use and/or drug dependent (Cox & Lawless, 1999; Garrett et al., 2008; Hutson & Liddiard, 1994; Mayock et al., 2008). Many young people in this study believed that their drug use created a strong barrier to their ability to secure even short-term secure accommodation. These young people did not have the option of returning their family homes and, due in large part to their 'status' as heroin users, were unable to secure (or sustain) private rented accommodation or medium-term accommodation such as transitional housing. Several expressed a belief that their heroin use hindered their access to social services and residential environments that could potentially provide a route out of homelessness and felt strongly that they needed to "address their addiction" before they could exit homelessness. Many felt 'trapped' in a cycle of homelessness and heroin use, as expressed by Alan;

> *"They [heroin use and homelessness] are very bad mixed together, very bad. You're thinking to yourself, you don't see any way you can get out of the situation, especially when you're homeless and you're after being on drugs. You just don't see a way out of it" — Alan (25 years).*

Those who were living in emergency accommodation at the time of interview often explained that physical exhaustion, combined with the challenge of maintaining personal hygiene, created added obstacles to securing accommodation or employment. Users of the 'night bus' service, for example, almost always referred to the level of sleep deprivation they endured;

> *"What's bleeding good about it [homelessness]? I got fucked out of me hostel at nine o'clock, about half eight in the morning, nine o'clock. And hopefully you can get a bed for the next night. You could wait for the night bus, say ten o'clock and you could be picked up*

at half two or three in the morning! And you're fucked out four, five hours later!" — Alan (25 years).

A large number expressed feelings of disillusionment and hopelessness following their repeated unsuccessful attempts to find accommodation or employment. Feelings of resignation to their situation also emerged from their accounts and affected their motivation to reduce their heroin consumption. Barry, for example, said that he continued to use heroin "out of boredom", explaining that he had been unable to secure either employment or permanent accommodation;

"[I'm] still on the night bus. I can't focus on anything until I sort that out... Today I can't be arsed; there's nothing to be doing. I can't keep coming in here[9] everyday waiting on something. There's no beds at all. I need something more permanent. So I'll just go out and try to get work. I'll stay on the night bus if I have to. I have to do something during the day 'cause that's why I'm smoking [heroin], just out of boredom" — Barry (20 years).

Barry went on to describe his predicament as a "Catch 22" situation because he was unable to secure accommodation or employment due to his drug use, but was simultaneously unable to curb his drug use because of his unemployed homeless status;

"I won't go for work looking like a scruff, like dirty clothes and all. That's why I'm here [homeless drop-in centre], to get bleeding washed and all, get changed and get out of these clothes...and getting a place is just a Catch 22 cause of me drugs charges. That's why I don't bother asking what's the story with a bed here or there" — Barry (20 years).

Others who were unable to exit homelessness and/or reduce their heroin consumption found themselves in similar circumstances. Indeed, some who had experienced homelessness over longer periods stated openly that they had reached a point of disillusionment or despair. Christopher first became homelessness at the age of 14 and subsequently experienced repeat out-of-home episodes, despite his early attempts to find employment and stable housing. He explained that he had a job at one stage but was forced to leave due to his homelessness, although had a promise of an option of returning to work when he got himself "sorted";

"I had a job at one stage. I got a job as a chef and I was sleeping in a doorway and I basically had the job for three weeks, four weeks, and the head chef came up to me one day and he said, 'I know there's something wrong with you, you look fucked!' And I just said, 'to be honest there is. I'm homeless and I'm trying to hold on to this job for a few weeks

[9] Homeless drop-in service

now and I got kicked out'. So he said, 'look, just go. It doesn't matter how long it takes. Just go and get yourself sorted. Your job will always be here'" — Christopher (25 years).

Christopher did not return to this job and remained homeless eight years later. He had returned at intervals to his mother's home but, for the majority of these years, had lived in emergency hostel accommodation or on the street. His long-term homelessness meant that he had become deeply immersed in street-based networks. Christopher stated that he found it difficult to distance himself from these physical and social environments; his social connections with street 'scenes' simultaneously made the task of maintaining a reduction in his heroin consumption extremely challenging.

Several who had experienced homelessness highlighted two main areas they felt needed to be addressed in order to facilitate the move out of a homeless/heroin use lifestyle. First, they believed that they had to find stable accommodation in order to reduce their heroin consumption. Young people also stressed their need for regular occupational activities in the form of training, education and employment, explaining that in order to maintain a regime of abstinence they needed to have alternative activities to occupy the daytime hours. Almost all expressed a desire to move towards a drug-free lifestyle but also felt strongly that this transition could only take place away from street-based networks and with a stable place to live.

As stated earlier, my relied, either in the past or currently, on emergency accommodation for either short or longer periods, leading to problems related to sleep deprivation, exhaustion and feelings of hopelessness. In these circumstances, several portrayed heroin use as a rewarding social activity and one which alleviated physical and psychological discomfort. Over time, most had developed a physical dependency on the drug and had become more deeply immersed in street-based social networks. As time progressed, this dependency strengthened the numerous barriers to their exiting homelessness. Thus, the 'double jeopardy' of homelessness and heroin use (Neale, 2001) led to extended 'out-of-home' periods, exacerbated problematic patterns of heroin use, and feelings of hopelessness and despair.

Homelessness and Psychological Distress

Although experiences of psychological distress were reported by many young people in the sample (see Chapters Five and Six), those who experienced homelessness were particularly vulnerable to negative emotional states. Of the 26 young people who experienced homelessness, all but one reported feelings of sadness, depression and anxiety and a majority also reported high levels of stress. Some attributed their feelings and emotional states directly to their homelessness, while others believed that living 'out-of-home' exacerbated pre-existing mental health problems.

Ethnographic observation in youth homeless services revealed the impact of street-based heroin use on the physical health and psychological well-being of many who participated in the study. For example, negative change in the physical appearance and demeanour of young people was regularly observed in many cases and a marked deterioration in one young man's physical and psychological was apparent over the course of the study. During the early stages of fieldwork, which coincided with the early stages of his homelessness, this young man was physically healthy and demonstrated an upbeat, humorous attitude. He was popular in the homeless drop-in centre where he was interviewed and actively engaged with the staff and the clients in a friendly manner. After a year of relying on emergency homeless accommodation, however, he developed chest complaints, physical exhaustion and became noticeably withdrawn. He revealed during interview that despite continuing to interact with others in an upbeat manner, he believed that he was depressed;

> *"I'd say I'm making a lot of people laugh lately, but I'd say now I might be depressed. [I'm] just going after the buzz and all. Buzzing off people, do you know what I mean? Like you're being in good form in front of people but like inside, do you know what I mean? Thinking about things...just like different shit" — Barry (20 years).*

Following repeated attempts to secure accommodation and employment, Barry felt powerless to influence his future;

> *"I'm just letting myself drift off again. I'm not being able to get anything [accommodation or employment]. I'm stuck in here. I've no more urge to do anything. It's just gone pear-shaped. Something's going to happen, something's going to give, whether it's getting locked up or getting sorted out. One of them is going to happen" —Barry (20 years).*

Chronic homelessness invariably led to feelings of hopelessness or distress in young people. Alan also believed that his homelessness and heroin use had led to his feelings of depression, explaining that the long periods of time he spent alone on city centre streets contributed to his feelings of despair;

> *"I got mad depressed there on the heroin and all. It was just the heroin. I was out on the street on me own. All you had to do was think. You're on your own walking about, saying to meself, 'What am I doing on this drug, man?' I used to hate the drugs" — Alan (25 years).*

Barry and Alan, unlike many others, did not experience mental health problems during their childhoods or early teenage years and identified their first intense feelings of depression or

despair as coinciding with their homelessness. Others, however, described symptoms of psychological distress prior to their first out-of-home episode and explained that their homelessness exacerbated these experiences. Sarah, for example, was diagnosed with ADHD and bipolar disorder while attending a drug treatment clinic. She believed that symptoms of agitation and hyperactivity were present in her childhood but explained that, after spending over one year homeless, she also began to experience feelings of depression and suicidal thoughts;

> *"I just wanted to kill myself constantly, you know. I was real suicidal and I just, I just felt like I couldn't believe the person I was after turning into, you know?" — Sarah (18 years).*

Young people who experienced brief episodes of homelessness also described emotional distress. Darren, for example, reported feelings of depression during periods of exclusion from his home and family life, believing that people "looked down on him" because of his homelessness and his drug use;

> *"Sometimes you'd be homeless and all, you'd be staying out of your house and all, like I slept rough a few times. So you'd be depressed, do you know what I mean? Everyone that's on heroin, you'd be depressed. Like it's a mug's game, it's horrible, it's like you're manky dirty going around, people are looking down at you and all. Like that's what I felt, like I'd be conscious of what people are looking at and saying about you" — Darren (25 years).*

Many young people in the sample experienced mental health problems such as depression, anxiety or paranoia and these have been discussed in previous chapters. However, those living 'out-of home' were particularly at risk of experiencing depression, hopelessness and despair. Previous studies have indicated a link between homelessness and mental health problems (Ayerst, 1999; MacLean et al., 1999; Whitbeck et al., 2000), suggesting that unstable living situations contribute towards experiences of psychological distress and impact upon young people's ability to cope with negative emotions (Mayock & O'Sullivan, 2007).

Conclusion

Irish research has consistently revealed a strong link between drug use and homelessness (Cox & Lawless, 1999; Crawley & Daly, 2004; Feeney et al., 2000; Lawless et al., 2004; O'Gorman, 2002; Smith et al., 2001). Indeed, it appears that there is considerable overlap between homeless and heroin-using populations. Yet, the relationship between homelessness and heroin use is complex and the direction of the relationship is uncertain. For example, one previous Irish study reported that over half of a sample of 120 homeless heroin users believed that their drug use was a direct cause of their homelessness, while two-thirds reported that experiences of homelessness exacerbated their drug use (Cox & Lawless, 1999).

Previous qualitative research on homeless youth in the Irish context has indicated that heroin initiation may be linked to experiences of great instability in a young person's life, including early episodes of homelessness (Mayock & O'Sullivan, 2007). Fifteen young people in this study were categorised as taking a 'homeless' pathway into heroin use. Eleven of these experienced homelessness prior to their heroin initiation, but four became immersed in homeless social networks in the city centre despite residing in their family homes. All 15 described a process of "coming into town", where they gradually became immersed in large social networks of street-based drug users. Micro-level processes within these physical and social contexts brought the young people into contact with heroin users, exposed them to heroin use, shaped their initiation rationales and provided them with numerous opportunities to initiate. The young people initiated heroin use in physical and social contexts shaped by their homeless trajectories or homeless social networks; they initiated in outdoor or semi-public locations with other homeless youth.

However, an additional 15 young people reported homelessness during the years *subsequent* their heroin initiation. Many of these believed that their 'problematic' behaviour, including that associated with their heroin use, contributed to their homelessness. Nevertheless, all young people who became homeless, whether before or after their heroin initiation, described complex macro, meso and micro-level environmental forces that impacted upon both their heroin and homeless trajectories. Their accounts indicate that their homelessness and heroin initiation pathways were shaped by interrelated social and economic forces (O'Gorman, 2002), including poverty, family breakdown, conflict and adversity.

Homelessness was a common experience for young heroin users in this study. Of the 120 young people who completed the interceptor survey, 81% reported lifetime homelessness. Likewise, those who were interviewed in-depth reported high rates of homelessness, with 26 of the 40 life history interviewees (that is 65%) stating that had an experienced homelessness at some time. Whether experiencing their first episode of homelessness before or after their heroin initiation, living 'out-of-home' impacted upon young people's experiences of risk during their early heroin careers. It has been suggested that using heroin while homeless creates a 'double jeopardy', placing young people at risk of a variety of physical and mental health problems (Neale, 2001), and the young people's accounts revealed that experiences of homelessness contributed towards the 'risk environment' which exacerbated their heroin use and created barriers to exiting homelessness.

Chapter Eight

Injecting Drug Use: Initiation and Risk Behaviour

Introduction

This chapter examines young people's initiation into injecting drug use as well as the extent and nature of reported risk behaviour, with a particular focus on the early stages of respondents' injecting careers. The chapter first documents the findings of the interceptor survey, which indicate high rates of injecting drug use and associated risk behaviour. It then turns to the qualitative interview data and examines young people's narratives of injecting initiation. Twenty-four of the 40 young people interviewed had transitioned to injecting drug use. Continuity was apparent between smoking and injecting initiation settings, with many young women initiating injecting drug use in the company of a sexual partner and some young men initiating within the same criminal social networks in which they first smoked the drug. However, the social course of young people's initiation into injecting drug use was predominantly shaped by their immersion into street-based and/or homeless heroin-using social networks where injecting was the dominant route of heroin administration. The analysis therefore pays particular attention to the impact of street-based risk environments on injecting initiation. Injection initiation rationales are examined and these narratives are located within a broader analysis of the social course of injection initiation.

Previous research has demonstrated that young people are more likely to engage in 'risky' injecting practices associated with negative health outcomes during the early stages of their injecting careers (Cassin et al., 1998; Fennema et al., 1997; Hahn et al., 2002; Kral et al., 2000; Ochoa et al., 2001; Smyth et al., 2001; Van Beek et al., 1998). Later sections of this chapter examine how injecting drug use contexts shaped young people's risk behaviour. These new initiates were inexperienced injectors and, during the early stages of their injecting career, were exposed to risks associated with a lack of knowledge and expertise in the techniques of injection. Some described the risks associated with injecting in outdoor locations or public spaces, highlighting the ways in which specific environmental conditions impacted upon their injection practices. Others described a complex range of social and relational forces that influenced their injecting practices. Together, these narratives highlight how a complex interaction of various dimensions of young people's 'risk environments' shaped their perceptions of risk which, in turn, impacted on their injecting risk behaviour.

Quantitative Data on Injecting Initiation and Risk Behaviour

The survey data indicated that 77% of the 120 young heroin users had injected a drug in their lifetimes. The majority of injectors had injected heroin (98%) and cocaine (63%), 44% had injected benzodiazepines and 5% had injected amphetamines. On average, participants first injected at 18.2 years (on average 2.4 years later than heroin smoking initiation). The vast majority (97%) injected heroin on their first injection occasion, with only 2% reporting cocaine as the first drug that they injected. Three quarters of injecting initiates reported that they had not planned to inject on this occasion and the majority (80%) were injected by another individual at the time of initiation. When questioned about their rationale for injecting initiation (from a list of pre-defined categories), the young people provided a variety of responses:

- 23% said that they were curious about the effects of injecting,
- 13% said that they developed a tolerance to smoking the drug,
- 11% said that they wished to experience the 'rush' of injecting,
- 11% said that they were 'dying sick',
- 10% gave economic reasons,
- 10% said that 'peer pressure' influenced their decision,
- 7% said that they could not smoke the drug on this occasion[1],
- 3% said that there was a heroin 'drought' and that they could only obtain a small quantity of the drug.

These young injectors initiated in a variety of locations: 32% injected in another heroin user's home; 17% in an outdoor space; 17% in a squat; 12% in their own home; 12% in shared indoor locations[2], 4% in prison or detention centres; and 3% in a vehicle. Therefore, a total of 52% initiated injecting drug use in outdoor, public or prison environments, settings considered to be unsafe and to increase susceptibility to blood-borne viral infection, overdose or vein damage (Small et al., 2007; Friedman et al., 1995; Bluthenthal & Watters 1995). At the time of initiation, 8% of the young people reported using a syringe after another injector, and 5% stated that they used the syringe before another injector.

A large number (58%) reported current injecting drug use: 25% injected daily; 19% once or twice a week; and 14% once or twice a month. Two-thirds of current injectors surveyed (66%) reported that they had injected alone in the past month. The vast majority (91%) stated that they obtained syringes and other drug use paraphernalia from needle exchange services, although over half (55%) reported using needles or syringes after another injector on one or more occasions.

[1] The young people said that they could not smoke the drug due to chest complaints or because they did not have the available paraphernalia.
[2] Shared indoor spaces included public bathrooms, apartment stairwells and homeless services.

Pathways to Injecting Drug Use

As documented in earlier chapters, all 40 young people in the qualitative sample initiated heroin use by smoking. Twenty-four (60%) subsequently initiated injecting drug use, a transition which took place, on average, two years after they initiated heroin use by smoking. On the first injecting occasion, 22[3] injected heroin and two young people first injected cocaine. The social contexts of injecting initiation were similar to those of initiating heroin use by smoking, with young people typically initiating in the company of sexual partners, friends or acquaintances from their social networks. Following smoking initiation, and during the early stages of the young people's heroin 'careers', the initiation pathways described in earlier chapters (the 'intimate relationship' pathway, the 'criminal network' pathway and the 'homeless' pathway) continued to shape their heroin-using environments and also influenced the social context of their injecting initiation. Nonetheless, there was an observable shift towards initiating injecting drug use within social environments dominated by homeless or street-based heroin-using networks in which injecting drug use was the dominant route of administration. The numbers of young people in each pathway into injecting drug use, and the overlap between the pathways, are depicted in Table 2.

As illustrated in Table 2, seven young women initiated injecting drug use in the company of a sexual partner, but six of these were simultaneously immersed in homeless heroin-using networks at the time of their initiation. Similarly, nine young men initiated injecting drug use with a criminally-involved acquaintance, although five were immersed in street-based heroin-using networks. The majority of injecting initiates, 18 of the 24, demonstrated a 'homeless' pathway into injecting drug use; 15 of these experienced homelessness prior to their injecting initiation, and three were immersed in street-based heroin-using networks despite living in their family homes at the time of their initiation. The three routes or pathways to heroin initiation by smoking therefore merged to a very considerable extent into a single, dominant pathway to injection initiation, one predominantly associated with street-based or homeless social networks. The account of one young woman did not 'fit' any of the three pathways into injecting initiation. She initiated injecting drug use in the company of a female friend, was living in her family home at the time of initiation, and was not immersed in a social network of street-based heroin users.

[3] Two young women first injected cocaine. Their initiation is discussed in the following section.

Table 2: Pathways to Injecting Drug Use (n=23)

Pathway	Description
Criminal Career Pathway (n=9)	➢ Four young men demonstrated *only* a criminal career pathway into injecting drug use
	➢ Five young men demonstrated *both* a criminal career and homeless pathway into injecting drug use ➢ They reported continuity in their criminal careers but also became immersed in homeless social networks prior to their injecting initiation
Homeless Pathway (n=18)	➢ Seven young people demonstrated *only* a homeless pathway into injecting drug use. ➢ They were immersed in homeless or street-based drug scenes prior to their heroin initiation
	➢ Six young women described *both* an intimate relationship and a homeless pathway into injecting drug use ➢ These young women were in a relationship with an injecting drug user at the time of their initiation but were simultaneously immersed in homeless social networks.
Intimate Relationship Pathway (n=7)	➢ One young woman described *only* an intimate relationship pathway into injecting drug use

The following three sub-sections discuss the 'intimate relationship', 'criminal career', and 'homeless' pathways to injecting drug use, demonstrating the degree of overlap between them and highlighting the significance of homeless social networks in the process of injecting initiation.

Intimate Partners and Injecting Initiation

Nine of the 17 young women interviewed (just over half) reported injecting a drug in their lifetimes. The majority transitioned rapidly to injecting drug use: seven reported that they injected within a year of initiating heroin use by smoking, one two years subsequent to first smoking heroin and, the final participant, four years after her first heroin use. Seven of these young women initiated injecting drug use in the company of a male intimate partner: four reported that initiation occurred in the company of the same sexual partner with whom they had previously initiated use by smoking, and the remaining three initiated with a sexual partner whom they met at a later stage in their heroin-using careers. Two initiated in the company of a female friend. Grace, for example, initiated in the home of a female friend within one year of first smoking heroin;

"She [friend] was saying, 'Ah it's great, you'd want to see the buzz you get out of this'. So I said, 'Right, don't put it into me vein because I'm afraid, put it in me arm or something'. So she put it into me arm, skin-popped[4], and I liked it. So one of the next days I just said 'Go on. Put it into me vein' and she said, 'Yeah great, you'll get a great buzz off it', and then I just started doing it since" — Grace (17 years).

The more commonly reported context of initiation for women, however, was in the company of a male drug user who was an intimate partner, a finding which has been reported elsewhere (Bryant & Treloar, 2007; Gerstein et al., 1979; Hser et al., 1987; Payne, 2007; Powis et al., 1996). Sophie, for example, initiated both smoking and injecting heroin use in the company of her long-term[5] sexual partner. These events occurred four years apart, but within a similar physical and social environment. Sophie initiated heroin use by smoking in the company of her partner and subsequently first injected cocaine in the local authority home that they shared. She described the events and circumstances surrounding her initiation to injecting drug use;

"I had seen him using needles for a month before I had ever touched it. So I knew exactly what to do... When I realised that it [cocaine] wouldn't wash up[6], he was in the bathroom doing his [injection]. So I went and took a clean syringe and a clean spike. I was saying to him, 'Will you do it?' but no, he wouldn't. He was going mad 'cause I was after finding the things [injecting paraphernalia] before he actually got out [of the bathroom]. He didn't want me using [injecting], but because I was after been watching what he was doing I knew how to do it" — Sophie (23 years).

Sophie's account suggests that she had become familiar with the techniques of injecting by observing her partner's drug use and was also aware, at the time of her initiation, that sterile injecting paraphernalia was available to her. Her account also emphasises her own agency in this drug transition, particularly in her rejection of her partner's refusal to assist her, and in her use of his drug use paraphernalia without his knowledge or consent. Unlike most young women in the sample, Sophie had never become immersed in heroin-using social networks. She gave birth at the age of 17 years, within a year of initiating heroin use by smoking, and spent most of her time at home caring for her daughter. She also refused to allow friends or acquaintances to use drugs in her home. Sophie's story is unusual among those who transitioned to injecting drug use in that many more reported extensive involvement in heroin-using networks during the months (and, indeed, years) following their heroin initiation. These women formed strong social connections with other heroin users in the context of purchasing or using heroin, or when accessing homeless

[4] Skin-popping refers to injecting underneath the skin or into the muscle rather than intravenously.
[5] Sophie was in this relationship for six years
[6] To 'wash up' is to convert powdered cocaine into its freebase form 'crack' by mixing it with baking soda and heating the mixture until it crystalises.

or drug treatment services. This social contact with other heroin users gradually led to their immersion into street-based or homeless social networks. The six other young women who initiated in the company of an intimate partner, therefore, also demonstrated a 'homeless' pathway into injecting drug use.

Emma, for example, began to socialise with her partner's friends and acquaintances following her initiation into heroin use by smoking and also formed social connections with homeless heroin-using youth through the city centre drug treatment clinic she attended. She initiated injecting drug use in the company of her partner and her female friends;

> *"There was a few of the girls from the clinic in an apartment I had. [My partner] was there and his friends, they were all banging up. I don't know, we were just sitting around watching TV and we just tried it, just literally tried it" — Emma (18 years).*

Four young women, including Sophie and Emma, described a long-term[7] relationship with a heroin-using partner with whom they initiated both smoking and injecting heroin use. Three others, however, did not describe long-term or stable relationships with the men with whom they initiated smoking, with all three stating that this relationship ended shortly after the occasion of their first heroin use. These young women had developed regular patterns of heroin consumption and, following the break-up of their relationships, experienced difficulty financing their heroin use alone. All three subsequently entered into new relationships with injecting drug users.

Joanna, for example, first smoked heroin with a sexual partner who was subsequently apprehended and incarcerated for drug dealing. She explained that, following this event, the burden of independently financing her drug consumption quickly became a challenge. Joanna was, at this stage, deeply immersed in street-based heroin-using networks and entered into a relationship with an injecting drug user who she met during a period of profound housing instability. She initiated injecting drug use with this man at the age of 17 years;

> *"He was big into injecting coke. That's when I started to inject cocaine and heroin and take valium all the time. It was just horrible. I was actually in a stable place at the time, in a hostel, and I left this hostel to move in with him, to his flat. But in the two days when I moved into his flat, he got kicked out 'cause he didn't pay the rent last month. So we were back homeless again. I was going through the emergency hostels and we just started then [injecting] the coke. So it wasn't a nice time" — Joanna (19 years).*

[7] Sophie was in a relationship with her heroin-using partner for six years and Emma, for three years. Both of these relationships ended prior to interview.

Although accompanied by a male romantic partner, Joanna's homelessness simultaneously shaped the social context of her injecting initiation. A similar pattern was identifiable in the heroin 'careers' of other young women who had experienced homelessness. Six of the seven young women who reported that they initiated injecting drug use in the company of a male intimate partner had developed strong connections with street-based or homeless heroin-using social networks and four were living 'out-of-home' at the time of their injecting initiation. Over time, these women had gradually become immersed in a heroin-using lifestyle which brought them into contact with larger networks of heroin users, usually in the context of socialising in outdoor locations, or when accessing city centre treatment or homeless services. For the majority of young women, therefore, injecting initiation was strongly influenced by their homelessness and/or immersion in social networks dominated by homeless heroin users.

Criminal Careers and Injecting Initiation

There was strong evidence to suggest that, like young women, the routes taken by young men to first heroin use by smoking also impacted on their subsequent initiation into injecting drug use. Those who started to smoke heroin in the company of friends or acquaintances from criminal social networks often initiated injecting drug use within similar social environments. Similar to the young women was an evident increase in the extent of their social interactions with street-based or homeless heroin users. As illustrated on Table 2 (above), nine of the 15 male injectors initiated in the company of a criminally-involved friend or acquaintance, but five were simultaneously immersed in street-based drug-using networks at the time of initiation.

Adam initiated smoking and injecting heroin use within the same criminal social network within a six-month period. He came into contact with three older men through his participation in acquisitive criminal activity and, over time, formed social connections with them. All of these men were injecting drug users and he was regularly exposed to intravenous drug use;

> *"They [friends] injected, but I smoked and they wanted me to inject... say I was using heroin, I was watching people injecting" — Adam (18 years).*

Other young men became immersed in street-based or homeless heroin-using networks following their initiation to heroin by smoking and initiated injecting drug use in contexts shaped by these new social connections. Early heroin use was often depicted as a social activity, and most young people in the sample came into contact with increasing numbers of injecting drug users as their heroin 'careers' progressed. The young men who were involved in criminal activity formed social connections with street-based injecting drug users through various means, including their involvement in drug-using and dealing activities, acquisitive crime and also during periods of incarceration. Many also experienced homelessness and came into contact with large numbers of

heroin users when accessing homeless services. A gradual and deeper immersion into heroin-using social networks, particularly in the context of street-based or homeless networks, exposed these young men to injecting drug use.

Damien had participated in drug-dealing activities prior to his heroin initiation and first smoked heroin in the company of one of his 'clients'. Following this, he began to socialise and use heroin with many other clients and, over time, became immersed in a social network of heroin injectors. He also lived in emergency hostel accommodation in the city centre for a period and formed numerous social connections with street-based heroin users. He told that he initiated injecting drug use in the company of one of his injecting 'clients' in a public toilet in the city centre;

> *"I'd seen him getting himself perfect and all, always clean, clean needles. So I said 'Look it, will you get me with a clean works and all?' and he says, 'Yeah'" — Damien (18 years).*

As evidenced by Damien's account, his immersion in social networks of injecting drug use played an important role in his injection initiation. Indeed, all of the young people who initiated injecting drug use were exposed to the injecting behaviour of other heroin users prior to their initiation (these social processes are discussed in detail in a later section). For Damien, and eight other young men in the sample, involvement in criminal or drug-dealing activities brought them into contact with injecting drug users. However, five of these young men had experienced homelessness prior to their injecting initiation and were also immersed in street-based drug 'scenes'. Their accounts therefore indicate that drug-using environments shaped by their 'criminal careers' continued to impact upon their drug use but that their homeless experiences and the connections they formed with street-based networks of drug users, also played an important role in their injecting initiation.

Homeless Pathways into Injecting Drug Use

Previous research has indicated that homeless youth are at high risk of initiating injecting drug use (Clatts et al., 1998; Crofts et al., 1996; Gleghorn et al., 1998; Kral et al., 1997; Pfeifer and Oliver, 1997; Roy et al., 2003, 2007). As previously stated, 18 of the 24 young people in this study were immersed in street-based or homeless heroin-using networks prior to their injecting initiation and, therefore, demonstrated a 'homeless' pathway into injecting drug use. There was considerable diversity in these young people's routes to injecting drug use. However, their injecting initiation occurred primarily within physical and social environments shaped by their experiences of homelessness or their social connections with homeless injecting drug users. Fifteen young people in this pathway had experienced homelessness prior to their injecting initiation while the remaining three lived in their family homes but had become immersed in

social networks of street-based heroin users. The settings in which they first injected heroin varied, but most reported either an outdoor space (alleyway, back of building etc.) or emergency homeless accommodation as first injection locations.

For some young people, a continuation of the circumstances and environments associated with their initiation to heroin by smoking was observable. Eric, for example, had started to smoke heroin when accessing a homeless drop-in service in the city centre. He reported that he initiated injecting drug use in very similar circumstances;

> *"The first time I had a turn-on [injection] was [when] I was over in a hostel in [commuter town]. There was a fella over there and he was in [the hostel], he had works and he had gear and all that and he banged it into me arm and he says 'Now that's better than smoking it, isn't it?" — Eric (25 years).*

Other young people did not take a 'homeless pathway' to heroin smoking but experienced homelessness some time subsequent to their heroin initiation. Alan, for example, who took a 'criminal career' pathway into heroin use, had initiated heroin smoking in the company of a criminally-involved acquaintance. He explained that he initiated injecting drug use following his first episode of homelessness when living in a squat in the city centre;

> *"It was after I got out of [Dublin prison]. I was injecting when I got out, started injecting... When I got out of [prison] and when me ma moved out of the house, we [Alan and his brother] had nowhere to go, so we moved into town. We were living on the streets in town" — Alan (25 years).*

The impact of contact with or immersion in homeless or street 'scenes', often through their contace with services, was evident in the accounts of many others. Sarah, who had initiated heroin use by smoking in the company of a male sexual partner, initiated injecting drug use in the company of a male drug user who she met during visits to city centre homeless and drug treatment services;

> *"It was Paddy's weekend. I met this guy who I knew from over here [drug treatment centre] and we went off, took a load of tablets and I was out of my head and he gave me a T.O. [injection]. I asked him for it now but I was out of my head on a load of tablets... That whole weekend I met him[8]. I was meeting him because I was out of my head but I wasn't*

[8] She had an intimate relationship with this young man for the weekend.

seeing him before that or anything. I just knew him from being around town, from around [the hostel] or on the boardwalk or over here" — Sarah (18 years).

While the majority of young people who were included in the 'homeless' pathway to injecting drug use were living 'out-of-home' at the time of their injecting initiation, three were living in their family homes. However, they were included in this pathway because of their immersion in homeless social networks. William for example, who was living in his family home, initiated injecting use in a squat along with a homeless acquaintance he had met while 'begging' in the city centre;

"I was really really sick and I was out trying to get a few bob tapping [begging] and a guy comes along that I knew from seeing around the town tapping and he said, 'How are ya doing?' and I said, 'Oh I'm dying sick. I haven't got none [heroin], I can't get a penny, the people are walking by'. He said, 'I've a bag here, I'll share it with ya" — William (22 years).

As documented in this and the previous sections, both continuity and change were observed in the pathways taken by young people into smoking and injecting heroin use, respectively. However, despite evidence of continuity, pathways to injecting drug use were strongly associated with the experience of homelessness and/or their connections with street-based networks of drug uses. Nonetheless, there was considerable diversity and overlap within these young people's stories of initiation; some followed a 'homelessness' pathway into both heroin smoking and injecting drug use but for many, a 'criminal career' or 'intimate relationship' pathway to heroin smoking was followed by a 'homeless' pathway into injecting drug use. Nevertheless, all 18 young people within this pathway were immersed in social networks of homeless or street-based heroin users at the time of their injection initiation. The following section documents how homeless trajectories and social interactions with homeless heroin users impacted on young people's initiation contexts and rationales.

Injecting Initiation Contexts and Rationales

As documented in the previous three sub-sections, the majority of young men and women interviewed reported some level of immersion into street-based or homeless heroin-using networks during the period subsequent to initiating heroin use. Social contact and interactions with homeless or street-based heroin users typically occurred in contexts in which young people were purchasing and/or using heroin, when accessing drug treatment services, and/or, in the case of those who experienced homelessness, through their interaction with others who were also accessing homeless services. Within these social networks, the young people became increasingly exposed to injecting drug use and were given numerous opportunities to initiate.

Many of the young people stressed that injecting was the dominant route of administration within street-based heroin-using networks and that the majority of their homeless heroin-using acquaintances were administering the drug by injecting. Over time, as they became more fully immersed in heroin use, injecting drug users were increasingly present in the settings where they consumed heroin. Sarah, for example, a young woman who became homeless prior to her heroin and injecting initiation, explained that she tried to limit her social contact with heroin users to "smokers", and also stated a preference for smoking the drug during the earlier stages of her heroin career. However, the majority of her homeless friends and acquaintances were administering the drug by injection;

> *"When I was smoking, I was trying to just hang around with smokers. See there's so much more people who use [inject] than there is people who smoke, and no matter where you go there'll always be somebody using, you know?" — Sarah (18 years).*

Even when young people did not wish to smoke heroin in the company of injectors, the social dynamics of their heroin-using environments meant that there was frequently no alternative since injecting was the more common mode of administration within street-based heroin 'scenes'. A number of young people also believed that expressing reluctance or refusing to join, or be joined by, injecting drug users was a response that would attract negative attention. One young man, Tom, described this dynamic;

> *"I'd be having me smoke and a fella would come in and say, 'You don't mind if I have a turn on?' I'd say, 'God no, work away'. I'd be afraid to say to them no. They'd say 'What do you mean you saying no, ya cunt!' You know what I mean? Stick the needle into your fucking... So that's why I'd say 'No, no problem, work away'" — Tom (17 years).*

Some young people explained that, after a period of time, they were the only heroin 'smokers' within their networks of friends or acquaintances. In these contexts, situations arose when it was more convenient for young people to inject rather than smoke the drug. Four young people described occasions when they did not have the paraphernalia (tinfoil or 'tooter'[9]) they needed to smoke the drug and were offered the option to initiate injecting drug use rather than abstain. Four others described circumstances in which heroin users within their social networks assumed that they wanted to inject and prepared the drug for them for that purpose. William, for example, described an occasion on which he met an acquaintance from "around town" and they travelled to

[9] The 'tooter' is the tube, usually constructed from tinfoil, a biro or a straw, used to inhale the fumes of heroin as it sublimates.

a squat over a mile away to use heroin together. His acquaintance assumed that he was an injecting drug user and offered him heroin in a form suitable for injection;

> *"I walked with him back to where he was doing it and not knowing anything he whips out a needle. I said, 'Ah Jaysus, you're after bringing me the whole way back here for that?' and he says 'Yeah I have a few clean ones [syringes] there. As soon as I was going to get meself, I was going to put half into one for you" —William (22 years).*

Seven other young people reported that, at the time of initiation, they did not have a personal supply of heroin, or the necessary paraphernalia to 'smoke' the drug. Critically, these young people were offered the opportunity to inject by an experienced injector who, in some cases, assumed that they had injected previously or that injecting was their preferred route of administration.

Previous studies have demonstrated the importance of social connections with injecting drug users in the move to injecting drug use (Clatts et al., 2003; Doherty et al., 2000b; Roy et al., 2003). Almost all of the study's drug injectors had a close social connection with an injecting drug user prior to their initiation. Seven said that they had family member[10] who was an injecting drug user, eight had partners who were injecting drug users, and 23 reported that they had a number of friends or acquaintances who were injecting drugs at the time of their injecting initiation. Earlier analyses strongly suggest that homeless trajectories, coupled with a close social relationship to an injecting drug user, shaped the social course of many young people's initiation into injecting drug use. Christopher, for example, first initiated injecting drug use while homeless, with the help of his brother who was also accessing homeless services in the city centre;

> *"I asked my brother to give me a turn on. He gave me my first turn on. I trusted him. I wanted him to do it for me. I didn't want anyone else to do it so he done it. So then I got a taste for the needle and I started using" —Christopher (25 years).*

Christopher's first injection was facilitated by his brother who was an experienced injecting drug user. Previous research has suggested that trustworthy injection partners are an important pre-condition for some young people in making the transition to injecting drug use (Lankenau et al., 2007). The "trust" that Christopher placed in his brother was in fact a significant dimension of his account. The narratives of others similarly revealed the role of close social bonds in the process of injection initiation. Observing their family members, partners or friends injecting cultivated

[10] In all but one of these cases, the family member was a brother. In the remaining case, it was the young man's cousin who was an injecting drug user.

the young people's curiosity about the effects of injecting and also served to diminish their fears about potential negative consequences. Joanna's narrative, for example, indicates how her intimate relationship with an injecting drug user impacted on her injecting initiation rationale;

> *"I always wanted to inject to see what it was like, you know? I was always terrified to do it, but I just wanted to know what it was like. And so he was doing it. I was snorting coke and he was injecting and it just looked as though it was great by looking at him" — Joanna (19 years).*

Almost all of the 24 young injecting initiates acknowledged that they were afraid to inject during the early stages of their heroin-using careers. However, regular exposure to the injecting drug use of their friends, partners or acquaintances served to diminish their fears as time progressed. Their observations of friends', family members' or their partners' injecting drug use challenged their belief that injecting was necessarily hazardous and unsanitary. They deduced that injecting could be conducted safely if clean injecting paraphernalia was used, the correct dose was administered and a knowledgeable individual carried out the injection. Having a close social bond with an injecting drug user also provided the young people with a 'safe' opportunity to inject; they generally perceived a partner or relative to be trustworthy and to have access to sterile injecting paraphernalia. These beliefs eased young people's fears about injecting drug use and led them to feel protected against potential negative consequences, certainly in the short term. Sophie, for example, explained that regularly observing her partner's injecting drug use in their home eased her fears surrounding potential negative outcomes such as blood-borne viral infection. She initiated injecting drug use with her partner's sterile injecting paraphernalia;

> *"There was clean needles there, clean syringes everything. So it was just kind of, I don't know...because I thought everything was clean, you know? I'll just try it this once" — Sophie (23 years).*

Damien also highlighted how his negative perceptions of injecting drug use were challenged when his friend, Chris, began to administer heroin by injection. Similarly to Sophie, he emphasised how injecting with sterile injecting paraphernalia assuaged his fear of potential negative outcomes;

> *"I knew that [Chris] could inject and he wasn't like the junkie Anthony; he wasn't dirty. Like Anthony was in his 30s and he had hepatitis C and he was real skinny looking. Chris just looked like anyone else, do you know what I mean? He was young, he was healthy, so I got him to get me with a clean needle. Like I hated needles at that time; I was terrified. But once after that then I just lost me fear of it" — Damien (18 years).*

Observing family members, partners or acquaintances inject safely with sterile injecting paraphernalia eased the young people's fears about the potential negative consequences of injecting drug use. They began to perceive the process as one which could be controlled by their behaviour, or the behaviour of their family member, partner or friend. With precautions in place, the young people also began to perceive injecting as an acceptable route of administration, and one which brought the potential rewards of enhanced or more pleasurable effects.

Previous research has documented that the desire to experience the euphoria associated with injecting drug use is an important factor in initiation (Crofts et al., 1996). Many young people in this study explained that they wanted to try injecting to experience the 'buzz', having been present in injecting settings and observed the effects on others. Kenneth, a young man involved in drug-dealing activities prior to his heroin initiation, regularly 'smoked' heroin with his injecting drug-using 'clients'. Kenneth explained that he had been reluctant to initiate injecting drug use and had 'chased the dragon' for four years. Kenneth, like others, was in the company of injectors at the time that he initiated;

> *"The gear was bad; like I don't mean bad, but there was no strength in it. I remember buying a bit and I had it on the tinfoil and it was nothing. But seeing other people banging it and they were getting a good bit out of it, so I was going to let them do it for me" — Kenneth (24 years).*

Dialogue surrounding injecting drug use within the young people's social networks often focused on its pleasurable effects and the young people became curious about 'the buzz' and wished to experience the sensations about which they heard. A small number described instances in which others communicated the positive effects of injection drug use directly. Grace's friend, for example, told her that she would experience "a great buzz" from injecting heroin. However, the majority of the young people explained that their *observations* of injecting drug users cultivated their curiosity about its enhanced effects, motivating them to initiate. Charlotte, for example, said that she wished to experience the effects of injecting after observing her older female friend's injecting drug use. When she met her sexual partner, a former injecting drug user, she requested that he facilitate her first injection;

> *"I met him and I said I tried heroin before. He says, 'Oh did ya? I've done things like that as well. I was in prison as well before, but I want to put all them behind us'. So I was stupid enough to say I always wanted to try injecting, like to inject meself. I wanted to see what the buzz was like so the two of us got it anyway. The next day, he brought me up to Dublin" — Charlotte (17 years).*

On average, young people had been smoking heroin for a period of two years prior to their injecting initiation and most said that they had developed an increased tolerance to the effects. They explained that they no longer "got a buzz" or a 'high' from smoking the drug. Orla, for example, explained that, following initiation, she had become "obsessed with the buzz" of heroin use. Over time she had developed an increased tolerance to smoking and could not reproduce the effects of her earlier heroin experiences. She became aware that heroin-using friends and acquaintances experienced enhanced effects when injecting the drug and described how this impacted upon her initiation rationale;

> *"I was well introduced to the gear at this stage. I knew the buzz that I got off it. But I noticed that people who were banging up really got it, and it was like their first time ever smoking it. They got it really strong and I thought, 'Jesus, I'd love that'. 'Cause you do like, you get obsessed with the buzz. You really just want that, the real, just can't move, stoned. It sounds mad like but you just want it" — Orla (18 years).*

Regular heroin smoking led to increased tolerance to the effects of the drug and also led to financial strain for many young people. Indeed, some highlighted the economic pressures of regular heroin smoking in their injecting initiation rationales. Echoing findings of previous research (Bravo et al., 2003; Fitzgerald, 2009; Giddings et al., 2003; Van Ameijden et al., 1994), they explained that injecting was a more efficient and economic route of administration. Adam, for example, highlighted the economic advantages of injecting drug use;

> *"If I bought 25 euros worth to smoke and I bought 25 euros worth to inject, the 25 worth to smoke would do me for about 12 hours; but if I injected it, it would do me for 24 hours so it done me for twice as long" — Adam (18 years).*

In their injection initiation rationales, young people most often referred to economic benefits in combination with other reasons such as their increased tolerance to smoking, enhanced curiosity about the effects of injecting, and diminished fear of negative outcomes. However, these perspectives were shaped by their social environments and their experiences within those environments, with evidence to suggest that, in response to social interactions and experiences, young people's perceptions of risk changed as their drug-using careers progressed. Over time, many began to perceive 'harder' forms of drug use, or routes of administration, as more advantageous and less 'risky'. Damien, for example, spoke directly about this process, highlighting change in his risk perception and behaviour over time;

"First, it was methadone, right? I'll never use heroin. Then when it was heroin, it was, right I'm never going to get strung out. Then when I was strung out I'd say, right, I'll never be like them junkies with no teeth that using needles, do you know what I mean? So it just kind of worked its way up till I was using needles, but that was a while later" — Damien (18 years).

As Damien's accounts suggests, drug-related beliefs were fluid and changeable, a finding previously been documented in the Irish context (Mayock, 2005). Young people modified their perceptions of risk in response to their changing social environment and this process was critical to the transition to injecting drug use. Through their social interactions with injecting drug users, young people were exposed to 'messages' that increased the acceptability, and simultaneously diminished the stigma, associated with injecting drug use. These social processes played an important role in their injecting initiation rationales.

As suggested by others (Clatts et al., 2003; Harocopos et al., 2009; Lankenau et al., 2007; Nasir and Rosenthal, 2009; Sherman et al., 2002), the motives associated with the decision to inject were strongly connected with the environments or settings that dominated the young people's daily routines and social interactions. Even when the young people cited explanations such as the enhanced physical effects or economic benefits of injecting, there was evidence that their social environment impacted on their (changed or changing) perspectives on injecting drug use. Assertions about the effects of the drug and experiences of injecting were highly subjective and relative, and the young people often relied on their observations of others and/or the 'words' or advice of more experienced injectors. Most said that they were curious about the effects of injecting, a finding that has been documented previously (Roy et al., 2002, 2003), but this curiosity was cultivated by the information they accumulated over time in the context of observing and interacting with other heroin users. Repeated exposure to successful injection events within these contexts also served to ameliorate the young people's fears about the potential negative consequences of injection.

Experiences of Risk during the Early Injecting Career

On average, young people in the qualitative sample initiated injecting drug use at 17.5 years of age[11], and approximately 2.5 years prior to participating in the interview. The majority, therefore, were recent injecting initiates. Research has consistently found that young people are particularly susceptible to engaging in high-risk behaviours associated with negative outcomes, such as blood-borne viral transmission and overdose, during the early stages of their injecting careers (Cassin et al., 1998; Crofts et al., 1996; Fennema et al., 1997; Garfein et al., 1998; Hahn et al.,

[11] On average survey participants initiated injecting drug use at a slightly older age (18.2 years).

2002; Kral et al., 2000; Nelson et al., 2002; Ochoa et al., 2001; Smyth et al., 2001; Thorpe et al., 2000). This study's recent injecting initiates described injecting environments and circumstances which increased their vulnerability to 'risky' injecting practices and techniques.

At the point of initiation, and during the early stages of their injecting careers, many young people indicated inexperience and a lack of knowledge about 'safe' injecting techniques. Researchers have previously noted the importance of young people's injecting social networks in providing information regarding injecting practices and behaviours (Lankenau et al., 2007). The young people in this study had observed injecting drug users, often on many occasions, prior to their initiation, but they were nonetheless often unaware of the complexities of safe injecting procedures. Most, for example, lacked the skill required to administer their own injections and, on such occasions, asked a sexual partner, family member or friend to assist them. A significant minority, however, five of the 24, administered their own injection either at initiation or shortly afterwards, and reported mishaps or mistakes in the preparation and administration of the drug. These young people spoke about the difficulties involved in injecting oneself without guidance or facilitation, as well as confusion about how to safely prepare and administer the drug.

The Risks of Self-Administration

Typical accounts indicated that self-administration during the early stages of injecting careers was associated with risk related to a number of possible mishaps including the faulty preparation of the drug, miscalculations in dosage and failure to safely locate a vein for the purpose of injecting. These risks were noted by a majority of new initiates who, during first and early injecting episodes, indicated awareness of their lack of experience in the techniques of injecting. Consequently, most were reluctant to self-administer until they developed their knowledge and skill. However, all five who self-administered first injections explained that they were unwilling to ask others to help them, or that their partners or friends had refused to facilitate their initiation. A smaller number believed that they had the skills to safely administer their own injections because of their regular observations of the injecting behaviour of others.

David described his initiation into injecting drug use, highlighting the social circumstances that contributed to his self-administration on this occasion. He explained that during his mid-teenage years (both prior to and following his heroin initiation) he had experienced social isolation which was related to what he described as feelings of anxiety and 'paranoia'. While he had heroin-using 'acquaintances' who informed him of the advantages and techniques of injecting drug use, he was reluctant to ask them to facilitate his injecting initiation. David's account of his injecting initiation depicts the risk associated with self-administering injections in the early stage of a heroin career;

"I did it completely wrong. I did it with a can and all, but I just didn't put anything in it [the heroin solution], a filter or anything. I just took it up through it [the syringe] and 'cause I had big veins, I just put it [the needle] in and pulled it back. Someone told me about it, like I was told how to do it, but I didn't really get it, you know what I mean? Just a little bit, and then me whole hand swelled out" — David (19 years).

David's social circumstances, and his relative isolation from other users, shaped his initial injecting environment, leading him to inject alone. His lack of social contact with other injecting drug users also restricted his access to information regarding safe injecting techniques, thus contributing to his exposure to risk during the early stages of his career.

William also injected in solitary environments during the early stages of his injecting career. A member of the travelling community, he lived in a local authority housing complex in the inner city, but became socially isolated during his teenage years, having been victimised by the "settled people" due to his minority status. During his early teenage years, he spent his leisure time with his older brother, also a heroin user, but when William was 15 years old, his brother died following a chronic illness. William suffered from feelings of anxiety which, he explained, often prevented him from leaving his home. Although he initiated injecting drug use in the company of an acquaintance who was also a member of the travelling community, he did not describe a close connection with this man. On his second injecting occasion, he self-administered heroin alone in his home and described fearing that he had overdosed during this injecting episode;

"I thought I was going to drop. It was bringing me down to the ground and it was trying to pull me into a deep sleep of some sort, and I've heard of people overdosing off it, off that much, going asleep and not waking up. So when I felt that way after that second time of injecting, at that moment the way I felt, I thought that was going to happen to me. I really did. So I left it after that" — William (22 years).

William's inexperience and lack of knowledge about injecting practices was influenced by his limited social connections with other heroin users and contributed to his exposure to the risk of overdose. His social isolation from other injecting drug users influenced the physical and social context of his injecting environment, and self-administering his injection alone in his local authority home carried a higher risk of fatal overdose due to the lower chances of discovery and medical intervention.

The social isolation described by William and David were not widely repoted experiences. Indeed, as described in earlier sections, the vast majority of young people had strong social bonds with injecting drug users prior to their initiation and many were deeply immersed in street-based

heroin-using networks. The availability of the knowledge and skills of other users, coupled with the awareness that their inexperience made them susceptible to risk, appeared to motivate most to ask others to administer their first injections.

The Risks Associated with Facilitated Injections

The majority of the study's injecting drug users, 19 of the 24, asked a sex partner, family member or friend to administer their injections during the early stages of their injecting careers. By asking another drug user to facilitate early injections, they avoided the potential negative outcomes associated with self-administration, but this arrangement carried its own risks. For example, injection by another heroin user limited the recipient's ability to control the process and/or to manage specific injecting risks. For these young people, the expertise of the individual who facilitated injection and the nature of their relationship, were important dimensions of their injecting 'risk environment'.

Joanna, a young woman who initiated injecting drug use with her sexual partner shortly after becoming homeless at 16 years of age, highlighted some of the risks associated with being injected by another heroin user. She described her relationship with her partner as fraught, stating that he was not committed to their relationship and was often physically abusive. At the time of initiating heroin injecting, and during many subsequent injection episodes, Joanna's partner administered the drug. She believed that the dynamics of their relationship impacted upon the process, claiming that her partner's lack of concern for her well-being resulted in 'careless' practices on his part;

> *"Me arms were in bits then. He never injected me properly. He didn't really care, you know? He did get me properly, but me arms used to be in bits, bruises all over and lumps and everything, you know?" — Joanna (19 years).*

The social and relational context of Joanna's injecting drug use shaped her exposure to and experience of risk. There were also aspects of the physical environment which impacted on her injecting practices. During the early stages of her injecting career, Joanna was homeless and had limited access to private spaces for the purpose of drug injection. She consequently resorted to the use of outdoor public locations, including public toilets or squats, where her partner prepared and administered heroin. A sense of urgency frequently surrounded these drug-taking episodes, due in part to the fact that both she and her partner were frequently in an early stage of withdrawal by the time they accessed both the drug and a location suitable for injecting. This led to hasty and haphazard preparation and administration practices. Joanna's account describes the dynamics that typically surrounded these drug-taking episodes;

"He always used to want to get himself first and I used to be like, 'No get me first, get me first', but because he wanted to get his into him real quick, sometimes he wouldn't even get it in the right vein. He'd just push it real quick into me and it'd hurt me and me arm would blow out, you know? 'Cause he'd want to get his into him real quick" — Joanna (19 years).

In the early stages of her injecting career, Joanna was injected on numerous occasions by her sexual partner, an arrangement which diminished her capacity to avoid risk. Five other young women reported that their sexual partners administered their injections during the early stages of their injecting careers; however, they described different contextual factors that influenced their injecting environments. For example, Charlotte initiated injecting drug use with her partner who continued to prepare and administer her injections on many subsequent occasions. Unlike Joanna, Charlotte described a caring relationship with her partner and was anxious to highlight the ways in which he had been supportive throughout her drug career and also, more recently, in the context of her efforts to engage in a drug treatment programme. She explained that her partner was reluctant to administer her injections but agreed to do so out of concern that she would attempt to self-administer or ask another injecting drug user to facilitate. Nevertheless, Charlotte's description of injecting initiation reveals several dimensions of risk despite her partner's 'careful' injecting practices;

"I blacked out for a while and my boyfriend was saying 'I was hitting your face and all, I was shaking you and all!' I says, 'No you weren't'. I didn't feel anyone touching me, you know what I mean? But I just didn't feel it 'cause I blacked out for a little while. But he says, 'Oh no, you really frightened me and all, I don't think we should do that again, I thought you were dead!'" — Charlotte (17 years).

Charlotte's partner was thirty-one years old, had a lengthy injecting history and had injected her with caution in a private location. However, even for an experienced injector, the task of calculating a safe dose of heroin for a less experienced drug injector is complex. Numerous variables are relevant to this calculation, including the potency of the heroin, the individual's body weight, gender and his/her tolerance to the drug (Moallem et al., 2004). Following this occasion, Charlotte's partner was reluctant to continue this practice but Charlotte persuaded him to continue to administer her injections.

Within the context of a facilitated injection, some young people pointed out that their partner, friend or family member was careful to maintain separate injecting paraphernalia. However, the nature of the injecting initiation environment, as well as the social dynamics operating between the individuals, heightened the risk of needle sharing in many cases. Ryan, a young man from a

West Dublin suburban area, described social and relational aspects of his early injecting behaviour that produced an environment conducive to risk. Ryan was deeply immersed in a social network of street-based heroin users at the time of his injecting initiation and asked an individual from his social network to facilitate his first injection. Ryan emphasised that this man was not a 'friend' but an 'acquaintance';

> *"I was just in town. Like no one's friends with people, you just go off with people you don't know and do it with them and those people were injecting. I just got someone to do it for me" — Ryan (18 years).*

During the early stages of his injecting career, Ryan asked a number of older injecting drug users to facilitate his injections. Being injected by others in outdoor locations or squats restricted his ability to control the injecting procedure and brought a sense of urgency to his injection episodes. Ryan acknowledged that he was uncertain whether sterile equipment was used to prepare and administer all his early injections; although he believed that his injecting partners used sterile needles and syringes, he was unsure if they kept the other injecting paraphernalia, such as spoons and flush water[12], separate during the injecting procedure. Ryan contracted hepatitis C in the early stages of his injecting career, a consequence, he believed, of risky injecting practices employed by his injecting partners.

The young people's accounts revealed that they asked other, more experienced injecting drug users to facilitate their injections in order to avoid the risks associated with self-administering in the early injection career. However, this arrangement limited their ability to control the injection procedure and the young people were vulnerable to the risks associated with the sharing of injecting paraphernalia and other unsafe injection practices. Elements of the social environment, such as the expertise of their injection partner and the nature of their relationship, were important determinants of their risk exposure.

Power Dynamics and Injecting Risk

There was evidence of power imbalance between injection initiates and those individuals who facilitated their injections in the early stages of their injecting careers. Power imbalances between individuals were associated with the age and relative inexperience of young people who were usually injected by older males with considerable experience of street-based heroin 'scenes'. These power dynamics operated irrespective of gender but compared to their male counterparts, young women were far more likely to report continued facilitated injection, often for an extended period following their initiation into injecting drug use. Seven of the nine female injectors in the

[12] In the preparation of heroin for injecting, the heroin is mixed with water and citric acid in a spoon or 'cooker' and heated using an open flame. The mixture is drawn up through a filter into the syringe and then administered.

qualitative sample stated that their drug-using intimate partner continued to administer their injections in the early stages of their careers.

In general, there were more males than females in the young people's heroin-using networks and the males invariably occupied higher roles in the illicit drug economy. Women were less visible within street-based heroin-using networks[13], and were often younger and less experienced drug users than their male counterparts. As discussed in chapter six, the young women had limited access to high-earning activities within the drug economy and, as a result, found it difficult to independently fund their heroin use. Gender power imbalances impacted upon the young women's injecting environments, and their younger age, relatively limited experience and dependency on men to fund and facilitate their injecting drug use, produced environments which exposed them to risk.

When she was 13 years old, Hannah initiated heroin smoking and crack cocaine use in an alleyway in the company of an older man, John. Within a number of weeks, this man had introduced her to street-based sex work and quickly adopted a management role in this work (by informing potential clients of her services, organising a suitable time and place for her to meet with them and taking cash payments in advance). In exchange, he provided her with a supply of heroin and crack cocaine. Within a short period of time, she was consuming large quantities of heroin on a daily basis as her tolerance levels increased. She initiated injecting drug use, facilitated by her partner, within six months;

> *"I was out with John and I was complaining that the gear wasn't working as well anymore and blah blah blah. He went and got works and cooked it up for me, and then he got a hit. I could feel it going through me body, the rush of it, and you get pins and needles going up you and all. You just feel, I felt a bit dizzy at first and then, it was like what I explained with smoking but ten times better" — Hannah (18 years).*

John continued to facilitate Hannah's injections in the early stages of her injecting career which meant that she had only limited control over the process of preparing the drug and very little say in the matter of using sterile injecting paraphernalia. Hannah reported that, on many occasions, her partner used the same needles and other equipment to administer both of their injections and always injected himself first. Hannah contracted hepatitis C during the early stages of her injecting career.

[13] Participant observation revealed that men were more visible in various street-based settings in the city centre where heroin users are known to congregate.

Hannah's story demonstrates ways in which gender power dynamics can impact on injecting environments and place young women at risk during the early stages of their injecting careers. However, power imbalances were not restricted to the stories of young women. Young men who were injected by older, more experienced male drug users were also subjected to risks associated with their lower social positions within injecting drug-using networks. Adam, who was 17 years of age at the time of his initiation to injection, for example, described injecting within a social network of older (mostly aged thirty or over), more experienced drug users. He was unable to self-administer his injections during the early stages of his injecting career and always requested the assistance of another individual. He believed that the dynamics surrounding these facilitated injecting scenarios, which invariably resulted in him having to forfeit a proportion of the heroin that he had purchased, left him vulnerable to exploitation. Over time, Adam became reluctant to inject in the company of others, a development which pushed him towards self-administration in a solitary environment;

> *"He got me*[14]*. A couple of weeks after [injecting initiation], I went home and done it myself. I couldn't get myself so he told me not to do it on me own. He told me not to do it in me own house in case something happened to me [because] I'd lock meself in the bathroom but I don't think he was worried about me, it was because he wanted me to bring it over to him so he'd get half of it" — Adam (18 years).*

Adam was aware of the power imbalances that characterised his relationship with older drug users in his social network and claimed to have been victimised by them on a number of occasions. The power dynamics that operated between him and older, criminally-involved men in this social network also extended to the injecting risk environment;

> *"One day, David tried to sell me a bag of heroin. He said, 'That stuff's from China. China White it's called. It's not mixed, it's white. That's proper stuff, you can't smoke that stuff now, inject it'. So I injected it at nine o'clock in the morning. I went home and me mother told me the next day I sat on the settee looking at the telly from half nine in the morning till twelve o'clock that night and never moved once. It was a D10*[15] *he was after injecting into me and I thought it was great stuff. I went back the next day. He was making a fortune out of me for about a week. So, in other words, for a week I wasn't using heroin. There are these tablets you can buy. You can buy them for three euro each. He was breaking it up and selling it to me for 25 euro. I was buying one every day and I'd go home then and watch telly for the day" — Adam (18 years).*

[14] Adam's acquaintance administered his first injection.
[15] A tablet containing 10mg of diazepam (first marketed as valium)

Adam's youth and inexperience left him vulnerable to exploitation within his social network of injecting drug users, limiting his ability to protect himself against 'risky' injecting practices.

The power dynamics at work in Adam's account were apparent, albeit from an opposing perspective, in the accounts of other young men. These dynamics were particularly apparent in the accounts of young men who participated in drug-dealing activities and who occupied higher social positions within drug-using hierarchies. These young men managed to exert a greater degree of control over their injection episodes. Controlling the supply of heroin for one's own use as well as that of others shifted the power dynamics in their favour and placed them in positions of authority, irrespective of their age or experience. Their easy access to heroin also provided them with a bargaining tool for the acquisition of sterile injecting paraphernalia. One young man, Kenneth, had participated in heroin-dealing activities for a number of years prior to his injecting initiation and was deeply immersed in injecting drug-using networks. His account describes his role as providing heroin for others' use which, in turn, placed him in a position of power and ensured his access to, or first use of, clean injecting equipment;

> *"No, I never shared. I always made sure, no matter what, because I always had the stuff [heroin] when I was doing it. So when I had it, in other words, if you want a bit of this, you'll get what I say. You know what I mean? So I want this or that" — Kenneth (24 years).*

Kenneth used his ability to supply heroin as an effective bargaining tool within injecting contexts, particularly in accessing sterile injecting paraphernalia from his 'clients'. He also described trading small quantities of cocaine or heroin in exchange for sterile syringes or needles. Kenneth was not the only young man to describe these power dynamics. A number of others who occupied stable positions within drug-dealing hierarchies described similar circumstances. However, as described in chapter six, high positions in drug-dealing hierarchies were not available to all young people, and those who did not have the requisite social connections, or were restricted by their gender, were unable to occupy or command these positions of power which would have enabled them to exert a greater degree of control over injecting events.

The Physical Environment

There were both macro and micro-level dimensions of the physical environment that shaped the injecting risk behaviour of young people. For example, at the macro-level, young people had different levels of access to services such as needle exchange facilities within their home neighbourhoods. Indeed, a number felt that the limited availability of sterile injecting paraphernalia increased their propensity to share needles and other paraphernalia with others. These accounts are discussed in a later section. Micro-level dimensions of the physical

environment also shaped the young people's injecting risk behaviour. For example, injecting in public or outdoor locations heightened the sense of urgency surrounding injecting episodes and complicated critical elements of the injecting procedure such as filtering the heroin solution and locating a vein. Thus, many inter-related dimensions of the physical and social environment shaped the injecting behaviour of young people. This section will focus primarily on micro-level physical environments that heightened injecting risk.

Outdoor or Public Environments

Fifteen of the 24 injecting initiates had experienced homelessness, and many others were immersed in street-based or homeless injecting social networks. During periods of homelessness, the young people reported a whole range of challenges and difficulties which carried negative implications for their health and well-being. Homelessness also impacted on their drug use practices and behaviour, particularly in terms of their access to a 'safe', appropriate and private injecting environment, and most had no option but to resort to the use of public settings such as public toilets, car parks, squats and alleyways.

Recent studies have indicated that outdoor locations and public settings are associated with high-risk injecting practices, blood-borne viral transmission and overdose (Carlson, 2000; Dovey et al., 2001; Rhodes et al., 2003, 2005; Small et al., 2007; Singer et al., 2000; Weeks et al., 2001). Injecting in outdoor locations was most often depicted as a 'last resort' for the young people in this study due to the lack of privacy and difficulty involved in controlling environmental conditions. The young people feared interruption by members of the public and this brought a sense of urgency to these injecting episodes. Cold weather and unsanitary conditions also rendered safe injecting more difficult. One young woman, Joanna, who regularly injected in outdoor locations, explained how the physical environment impacted upon her injecting risk behaviour;

> *"Well I always, mostly, I injected outdoors... It's very hard to get a vein because it's cold out and you're doing it quick so no one notices, you know?" — Joanna (19 years).*

As Joanna explained, outdoor environments impacted on safe injecting practices, creating a sense of urgency and increasing the likelihood of error in the preparation and administration of the drug. The unsanitary conditions of alleyways, and other physical locations such as squats, car parks or public toilets, also made it difficult to inject hygienically, placing young people at risk of abscesses or swelling. David, a recent injecting initiate who had only injected on four of five occasions, had always injected in public toilets. Following a recent injecting episode, he felt unwell and, as with others who had limited social connections beyond drug-using networks, he relied on the views and advice of more experienced drug users after the event;

"I did [inject] once and I got very sick. I didn't know what it was. This was like after a few days. Someone said 'Oh it must have been a dirty hit', but I didn't know what that was at the time" — David (19 years).

Many young people used squats during periods of homelessness, both for shelter and as sites for injecting drug use. These settings were often unsanitary and littered with used injecting paraphernalia. One young man, Alan, who described a lengthy injecting and homeless career, spoke about the impact of these environments on the injecting experience;

"It'd be a lot more harder using [injecting] in a squat. There's all used yokes [needles] all over the place. You could get stuck with one easily 'cause most of the squats, that's where everyone goes to use and they leave their yokes lying around. If you're in a house, you wouldn't have anything like that. You can relax, you know what I mean?" — Alan (25 years).

The young people's residential status, their immersion into street-based injecting networks and the physical context of injecting episodes interacted to produce risk. Young homeless injecting drug users who injected within street-based social networks in unsanitary environments were vulnerable to negative outcomes such as viral transmission, abscesses and vein damage.

Injecting in Prison

Previous studies have indicated that sharing injecting paraphernalia is common among prisoners in the UK and Ireland (Allwright et al., 2000; Long et al., 2001, 2004; Turnbull & Stimson, 1994). Moreover, rates of blood-borne viral infection among prison populations are high (Butler et al., 1997; Crofts et al., 1995; Hutchinson et al., 1998; Vlahov et al., 1993). In Ireland, 81% of a sample of 509 incarcerated injecting drug users were found to test positive for hepatitis C infection (Allwright et al., 2000). A qualitative study of 29 male and female Irish prisoners revealed that injecting was the dominant and preferred route of administration in the prison context and that sharing injecting paraphernalia was necessary due to restricted access to sterile injecting equipment (Dillon, 2001). These studies indicate that prison is a high-risk environment associated with the sharing of injecting paraphernalia and the transmission of blood-borne viral infection.

Eight of the young men interviewed had been incarcerated in adult prisons during their lifetime and four of these reported injecting in the prison environment. Kenneth described a history of incarceration and had spent time in three Dublin-based prisons. He explained that he was reluctant to inject in the prison environment due to reports of widespread needle sharing;

"In prison I heard that they go around with the one syringe, using everything. I never did drugs in prison though" — Kenneth (24 years).

Similar to Kenneth's account, reports of widespread sharing of drug paraphernalia in prisons were commonplace and emerged from a range of data sources including the life history interviews, the findings of the quantitative survey, as well as information obtained during the conduct of ethnographic fieldwork. Many young people believed that large numbers of inmates shared needles and syringes and that HIV and HCV infection was widespread in prisons. The young men who injected in prison acknowledged that the absence of needle exchange facilities in prison, coupled with challenges of prison life, created environments in which 'risky' behaviours occurred.

The four young men who had injected in prison confirmed that it was a high-risk environment, and all reported that they had participated in the sharing of injecting paraphernalia while incarcerated. Derek, a young man who spent an extended period of time in a Dublin prison, described how the absence of needle exchange services impacted upon the injecting risk behaviour of inmates. High rates of injecting drug use, coupled with low availability of sterile injecting equipment, placed heroin users at high risk of blood-borne viral transmission;

"I'd a few [syringes] going in with me but now it's actually worse I heard for it. They're putting in an exchange now in the prison they are, in [Dublin prison] 'cause there's so much [injecting] going on in there... Fellas used after me anyway but I would never, I never have used a needle after anybody. Like I have the hepatitis and that ..." — Derek (24 years).

Derek claimed not to have shared needles or syringes during this injecting career but believed that he had contracted hepatitis C during his incarceration through the sharing of other injecting paraphernalia such as water, spoons or filters. He was reluctant to discuss his injecting risk behaviour but gave accounts of the injecting episodes of others when recounting his experiences of the risks associated with injecting in the prison environment;

"In the rec [recreational area] in [prison], I seen a fella watching the door, for the officers like. This fella, he was actually going into his groin. He was banging it into his groin. The other fella actually went up and stuck it out and used it straight away after him, do you know what I mean? These wouldn't have known each other from Adam, only known [each other] from prison like" — Derek (24 years).

Other young men were more explicit when discussing their injecting risk behaviour during a period or periods of incarceration. Alan reported that he had shared needles with his cellmate and brother and acknowledged that this placed him at risk of contracting HIV;

> *"In [Dublin prison] you can't get no drugs in there unless someone comes in, that's only after getting locked up, if they have anything on them. So a bloke then had used [injected] and we used the needle after and I'm sure he had the virus, but thank God I didn't catch it off him. Me and me brother were in the same cell and when your man came in he had gear on him so we ended up using it after him" — Alan (25 years).*

Heroin was depicted as a precious commodity within the prison environment and when young men had the opportunity to use the drug, they were reluctant to decline the opportunity, even if sterile injecting equipment was unavailable. Alan (above) was willing to inject with previously used paraphernalia because that was the only option available to him. Others similarly emphasised that sterile needles and syringes were difficult to access in the prison environment and that, as a result, the sharing of injecting paraphernalia was a common occurrence.

The Perceived Risks of Blood-borne Viral Transmission

The young people were generally aware of, and wished to minimise, the risks of blood-borne viral transmission. Nonetheless, the context of their injecting episodes shaped risk perception and behaviour and, in many cases, led to practices which created susceptibility to HCV or HIV transmission. Perceptions of 'acceptable' or 'necessary' injecting behaviour also changed over time in response to specific social environments and interactions. As their injecting careers progressed, many became exposed to social 'risk environments' in which sharing injecting paraphernalia was considered 'acceptable'. Within these contexts, some young people participated in the sharing of needles or other injecting equipment.

Sexual Relationships and Risk Perception

Although the young people communicated knowledge and awareness that sharing injecting paraphernalia carried the risk of viral transmission, under certain conditions they considered this behaviour to be 'acceptable' or 'appropriate'. Many young women shared injecting equipment with their long-term sexual partners and their narratives indicated that most did not perceive this to be a 'high-risk' activity. Charlotte, for example, shared injecting paraphernalia in the social context of her sexual relationship. She explained that she did not consider the sharing of needles or syringes to be 'acceptable' under other social circumstances, and emphasised that her partner was the only person with whom she shared injecting equipment. Nonetheless, in the early stages of her relationship, she did not share injecting equipment, or have unprotected sex, with her

sexual partner. She said that she did not "know him" and, therefore, was unsure of his injecting and sexual history;

> *"At the start, it was definitely always clean needles and protection and all. Even when we were having sex we had protection and that, you know? Even though we got on so great, we still didn't know each other, like where he had been and where I had been" — Charlotte (17 years).*

Charlotte did not believe that sharing injecting paraphernalia or engaging in unprotected sex with her partner were 'acceptable' behaviours in the early stages of their relationship. However, over time, and as the relationship evolved, Charlotte's attitude towards sharing injecting equipment and engaging in unprotected sex with her partner changed. She explained that she "only" participated in these behaviours with her partner because she believed that he did not have a sexually transmitted infection or blood-borne viral infection. In her account, she emphasised a growing feeling of "trust" in her partner which, in turn, changed her perception of sexual risk;

> *"I think I only did it with Ian because I was going out with him and the odd time we didn't have protection having sex and I knew I didn't have any STD. So I believed him, I trusted him, so that's why I shared with him and I didn't share with anybody else" — Charlotte (17 years).*

Charlotte's narrative highlights an association between sexual and injecting risk behaviour within the context of a sexual relationship. The feeling of social proximity to her partner influenced her risk perceptions and, over time, she believed engaging in unprotected sex and the sharing of injecting paraphernalia to be an 'acceptable' risk. Other young women described a similar dynamic, highlighting how the nature of their relationships with other injectors shaped their injecting and sexual risk behaviours.

As described in chapter six, the majority of young women entered into intimate relationships with heroin and/or injecting drug users and reported low adherence to condom use in their sexual encounters. A number of young men entered into relationships with female heroin users in their early heroin careers; however, in the majority of cases, their partners administered the drug by smoking. None of the young men reported sharing injecting paraphernalia with an injecting drug-using partner. Nevertheless, they described participating in sexual risk behaviours and most said that they rarely used condoms in their sexual encounters. Only one young man said that he always adhered to condom use;

"[I use condoms] all the time because that's a mad fear I'd have. Like I'd never ever want to be standing in an STD clinic, walking up to some bleeding doctor or nurse, 'What have I got? Let's go'. So it's either be careful and use them or not and then it's your own fault when your dick falls off, or whatever happens to you" — Barry (20 years).

Most young men reported only occasional condom use, explaining that they would use condoms if they were available, if they did not have to pay for them or if their sexual partners insisted on their use.

Darren described entering into a number of sexual relationships with young heroin-using women during his early heroin career. His account reveals that his adherence to condom use largely depended on female insistence;

"If they [condoms] were there I would [use them] but if they're not there like, you know what I mean? If the young one [woman] said that you have to wear a condom, like I would, but if she doesn't mind, it's...you know what I mean?" — Darren (25 years).

Similarly, other young men highlighted that they only used condoms if their partners insisted on their use because they perceived sexual activity to be more enjoyable without them;

"I prefer it [having sex] without a condom because you wouldn't really be able to feel things, anything, with a condom on. I prefer it without, but sometimes a young one [woman] would say to you, 'I'm not doing it. I'm not having sex with you if you're not going to use a condom'" — Tom (17 years).

The majority of young men were aware that unprotected sexual activity was associated with blood-borne viral transmission, but their narratives indicated that they did not perceive this to be a high risk in their sexual encounters. As previously observed by Rhodes (1997), their accounts indicated that the perceived risks associated with unprotected sex did not outweigh the perceived benefits of enhanced sexual pleasure. Young men generally perceived the risk of blood-borne viral transmission to be low when engaging in unprotected sexual activity with young women they perceived to be "clean";

"I'd only be with a clean girl...I'd only be with a girl that I know washes herself properly, nice looking, you know?" — Kieran (17 years)

"I didn't sleep around with loads of dirty birds or anything, just one or two or something. And I went out with a few birds for a while. Just had probably one, two dirty birds or something that I got wary about" — Ian (25 years).

In general, young men believed the risk of blood-borne viral transmission to be higher if their sexual partner was an injecting drug user. Three young men reported unprotected sex with female injecting drug users and two described negative experiences following these sexual encounters. They were subsequently informed by acquaintances within their heroin-using social networks that their sexual partners had tested positive for HIV and became fearful that they may have contracted the viral infection through sexual transmission. Keith described seeking medical attention shortly after engaging in unprotected sex with an injecting drug user;

"That's why I got tested [for blood-borne viral infections] because I was having sex with a girl that I didn't know she was using [injecting]. She said she wasn't using, but I found out she had the virus and hepatitis and what have you. So that's why I went into the doctor straight away. I got blood tests. That was a few weeks ago" — Keith (24 years).

Keith explained that he did not use condoms in the context of his sexual relationship because, at the time, he did not perceive it to be a 'risky' activity. His narrative also uncovered an association between "trusting" his partner and participating in sexual risk behaviour;

"I just wasn't thinking about [using condoms] at the time. I was trusting her as well. She said she hadn't got it. I won't be that stupid again" — Keith (24 years).

Previous studies have reported how feelings of trust and social proximity impact on sexual and injecting risk behaviour (Davies et al., 1996; Klee et al., 1990; Payne, 2007; Rhodes & Cusick, 2002). Similarly, in this study, the social context of sexual relationships impacted upon young people's risk perception and behaviour and many described how feelings of "trust" influenced their risk boundaries. Most of the young women reported an intimate relationships with an injecting drug user with whom they shared injecting paraphernalia and engaged in unprotected sex. Young men were less likely to enter into relationships with injecting drug users and none reported sharing injecting paraphernalia with their partners. Nevertheless, during the early stages of their heroin careers, some entered into relationships with an injecting drug user and engaged in unprotected sexual activity. Their narratives indicated that many did not perceive unprotected sex to be a high-risk activity, particularly in the context of an intimate relationship with a non-injection drug user.

Needle Sharing, Needle Exchange and Opiate Withdrawal

Young people described other factors which influenced the sharing of injecting paraphernalia. For instance, a number explained that their access to clean injecting equipment was limited during periods when syringe exchange services were closed, or because the nearest service was some distance away. Adam, for example, lived in commuter town approximately 45 kilometres from Dublin city. He reported sharing and re-using needles with his friend, Adam, explaining that the distance to the nearest needle exchange service created barriers to his ability to access sterile paraphernalia;

> *"We [Adam and his friend] were using the one needle. You're only supposed to use it once but we used the same needle 54 times. We used it 4 times a day each, that's 8 times right? For 8 days and then it broke so that's 64 times, [because] you have to come up to Dublin for them" — Adam (18 years)*

In circumstances in which clean injecting paraphernalia was not available, sharing injecting paraphernalia was understood as a 'necessary' or 'acceptable' strategy to alleviate the 'sickness' associated with heroin withdrawal. Joanna explained that accessibility to injecting paraphernalia during periods when syringe exchange services were closed contributed to her sharing behaviour;

> *"I always made sure I had clean spikes and barrels from [the needle exchange]. I used to go there probably two or three times a week and get 20 of them. So I always had clean stuff. It was just when you were desperate, cause it closes at 4 o'clock, so if it was after 4 o'clock and you didn't have one I'd use after me boyfriend"— Joanna*

Unlike Joanna, Sarah initiated injecting drug use only three months prior to interview and did not report sharing injecting paraphernalia. She was fearful that her perception of risk would change in the later stages of her injecting career. She believed that her determination not to share injecting paraphernalia would be affected by symptoms of opiate withdrawal;

> *"[Other injectors] use the same spoon as somebody else or do dodgy things. Even using the same barrel and all is big. I would never do that. But that's not to say if I got strung out on it I wouldn't do it. I might do it when I get strung out on it, but I just hope that I'll never get strung out on it that I'll have to do that, you know?" — Sarah (18 years).*

Other young people, who were in the later stages of their injecting careers, reported sharing injecting paraphernalia under these circumstances, explaining that the need to alleviate heroin withdrawal symptoms superseded concerns associated with needle sharing. Dylan, a young man

who had initiated injecting drug use four years prior to interview, described a typical occasion on which he participated in the sharing of injecting paraphernalia;

> *"See how you're after meeting someone, you're dying sick, you say, 'Right come on, I have a Q[16] here, I'll bleeding half it with you' or whatever. Then you go up and they've only got their own works or something, you know? You're sitting there dying sick. I thought I'd never share needles with anyone but then when you're in that situation, you're dying sick and all, you don't give a fuck, do you know what I mean? You're just sort of saying, right well I'll think of the consequences later, I just need to get it into me now. That's all it is, you know? That sort of thing just takes over. You don't care" — Dylan (20 years).*

Symptoms of opiate withdrawal impacted on the young people's perception of the risks associated with the sharing of injecting equipment. In these circumstances, some young people highlighted that they prioritised their immediate distress over the potential or long-term consequences of blood-borne viral transmission. William, a recent injecting initiate, described circumstances in which heroin withdrawal caused considerable distress and demanded action. He explained that the potential negative consequences of sharing injecting paraphernalia did not pose an immediate risk, and were, therefore, not given priority in this instance;

> *"The pain I was in was happening then at the moment. So you get what I mean? I wasn't worried about the consequences. I was worried about the way I was feeling at the moment" — William (22 years).*

Although experiences of opiate withdrawal directly impacted on the young people's risk behaviour, the social context of their injecting episodes also played a vital role. The young people *only* shared injecting equipment when they were in social environments in which they were offered equipment by other heroin users. Furthermore, most *believed* sharing injecting paraphernalia to be 'acceptable' or 'understandable' when experiencing withdrawal symptoms, and there was evidence that this belief was socially organised. They observed others sharing injecting paraphernalia within their injecting drug-using networks and received messages that this was 'acceptable' when experiencing opiate withdrawal.

The Social Risks of Refusing to Share

Many young people described a complex mix of forces as impacting upon their injecting risk behaviour. Sarah, for example, provided a description of an occasion on which she agreed to share a needle with an acquaintance from her social network of homeless injecting drug users;

[16] A 'Q' bag is the standard street retail unit and costs approximately 15 euro.

"I was going for a T.O. [turn on/ injection] with this fella and he was like, 'Oh I've two barrels but I've one spike'. So I said, 'Right, fair enough, most of the blood will be left in the barrel anyways. At least it's a clean barrel and there won't be much blood in the spike'. He had a T.O. and he got himself and I was talking to somebody. We were down in the underground, down in Temple Bar. It's like this place where everyone puts all their bins out, underneath the ground, and we get in and we sit under there. As soon as he was finished, he took off the spike and threw the spike in the bin, like that, but that was the only spike. I turned around and I said, 'What the fuck are you after doing?' He said, 'Ah shit', and he went rooting around in the bin for the spike. I said, 'I'm not putting that thing near my arm after you throwing it in the bin'" — Sarah (18 years).

Sarah did not share injecting paraphernalia on this occasion due to the accidental disposal of the needle, but she highlighted that her intention was to inject with the same needle as her acquaintance. Sarah outlined her thought processes surrounding this incident, explaining that they were contextualised within the social environment. However, she also challenged the rationale that she employed at the time, emphasising that she no longer believed her intention to share injecting paraphernalia was an 'acceptable' risk;

"At the time I was thinking, oh he doesn't have anything, he's a nice bloke. A, I only knew him one day. B, how do I know he has anything? C, just because he doesn't look like he has AIDS doesn't mean he hasn't got AIDS. Just 'cause he doesn't look like...what does a person that has AIDS look like? What's a person that has hepatitis look like? You know what I mean? But you think, ah he looks grand. So what if he looks grand, what if he's not grand? And you don't think about that. You think, ah he's dead sound[17]. He'd tell me if he had anything. No he wouldn't. He doesn't give a bollox 'cause if he already has it, he doesn't care about getting it and he doesn't care if anybody else gets it" — Sarah (18 years).

In hindsight, Sarah believed that her rationale for sharing injecting paraphernalia was flawed, and explained how this behaviour could have exposed her to viral infection. This example illustrates how the young people's perception of risk was fluid and dynamic, and shaped by the social context of injecting environments. However, there were other social forces at work that contributed to Sarah's acquiescence to share injecting paraphernalia. In addition to the immediate social environment, previous interactions with other drug users impacted upon her risk perception and behaviour. Sarah said that she assumed that her acquaintance did not have a viral infection

[17] 'Sound' is a colloquial term for amiable

based on his appearance and demeanour; she reassured herself because he was healthy and attractive in appearance. The belief that individuals with HCV or HIV would appear 'unhealthy' or 'dirty' was commonly reported by the young people, and was a message that permeated their social networks. The young people also explained that refusing an offer to share injecting equipment indicated suspicion that the other person had a blood-borne viral infection. This was considered an insult due to the social stigma surrounding a positive HCV or HIV status. Sarah explained how these social dynamics contributed to the sharing of injecting paraphernalia;

> *"It's a rude thing for someone to imply... 'cause he's saying, 'Oh I don't have anything', and you're saying, 'Sure I know you don't have anything'. Like you don't want to say, 'Oh well do you have hepatitis or anything?' 'cause that's a really rude thing to say to someone. For someone to imply that you might think they have hepatitis! You're going to say, 'No sure, it's grand, I'll use after you, you don't have anything'. You know what I mean? It's like that" — Sarah (18 years).*

Refusing to share injecting equipment, therefore, held a particular meaning within drug-using networks. When offered, reluctance or hesitation to participate indicated uncertainty surrounding the viral status of the other injector and was perceived as insulting or shaming. As a result, refusing to share injecting paraphernalia in some contexts carried social risks for the young people. In addition, the young people were more likely to share injecting paraphernalia when they perceived another injector to be healthy or physically attractive.

Conclusion

This chapter has documented the social course of injecting initiation among the study's young people and has examined risk perceptions and behaviour during the early stages of their injecting careers. Injecting initiation is a significant drug transition and one which places young people at heightened risk of drug dependency and exposure to blood-borne viral transmission and overdose (Chitwood et al., 1998; Des Jarlais et al., 1992; Friedman et al., 1999). As reported elsewhere (Clatts et al., 2003; Harocopos et al., 2009; Nasir and Rosenthal, 2009), social dimensions of the 'risk environment' played a crucial role in the young people's transition to injecting drug use. The study's quantitative findings revealed that the majority of young injecting initiates were injected by another person and did not plan to inject on their first occasion. Initiation to injection emerged therefore as a spontaneous event which was facilitated by more experienced injecting drug users (Lankenau et al., 2007; Harocopos et al., 2009; Sherman et al., 2002).

Twenty-four of the 40 young people in the qualitative sample had transitioned to injecting drug use. Continuity was observed in their heroin-using trajectories and there was evidence to suggest

that the social course of their 'smoking' initiation[18] impacted on their subsequent initiation to injecting drug use. Many young women initiated injecting drug use in the company of an older sexual partner and some young men initiated within criminally-involved drug-using social networks. Simultaneously, however, most became more deeply immersed in street-based drug-using networks, a process strongly associated with escalating heroin use and the experience of homelessness in some cases. Injecting has been reported as a common route of administration with homeless drug-using networks (Gleghorn et al., 1998; Nyamathi et al., 2002; Rhodes, 2006; Susser et al., 1996). Young people in this study were regularly exposed to the injecting behaviour of their homeless heroin using friends and acquaintances within their social networks.

The survey data revealed that young people's injecting initiation rationales included the following motives: curiosity about its effects, the wish to experience the "buzz", developing a tolerance to smoking, the economic benefits of injecting, experiences of opiate withdrawal and peer influence. Similar motives have been reported in previous studies (Bravo et al., 2003; Crofts et al., 1996; Fitzgerald et al., 1999; Giddings et al., 2003; Roy et al., 2002; Van Ameijden et al., 1994; Witteveen et al., 2006) and also featured in the rationales of young people in the qualitative sample. While emphasising agency, the young people's accounts simultaneously pointed to the importance of the social environment in shaping their initiation opportunities and rationales. Most young people in this study had a close social bond with an injecting drug user and were immersed in street-based heroin-using networks at the time of their injecting initiation. Within these social environments, they were exposed to injecting drug use, which cultivated their curiosity about the effects and ameliorated their fears of potential negative outcomes. They also received messages, either through direct verbal communication or through their observations of others', that injecting produced enhanced effects, had economic benefits, and could be carried out safely if sterile injecting paraphernalia was used.

Previous studies have suggested that young recent injecting initiates are at higher risk of negative outcomes associated with injecting risk behaviour (Cassin et al., 1998; Crofts et al., 1996; Fennema et al., 1997; Fuller et al., 2003; Garfein et al., 1998; Hahn et al., 2002; Kral et al., 2000; Nelson et al., 2002; Ochoa et al., 2001; Smyth et al., 2001; Thorpe et al., 2000; 2002; Van Ameijden et al., 1994; Van Beek et al., 1998; Welp et al., 2002). Many of this study's young people were exposed to risks associated with overdose, blood-borne viral transmission and vein damage. Furthermore, most acknowledged that they lacked the knowledge and experience required to inject safely, particularly during the early stages of their injecting careers. A large number therefore asked other, more experienced injectors, to administer their injections. A number of studies have indicated that receiving injections from others is associated with needle

[18] The social course of their 'smoking' initiation is described in chapters five, six and seven and relates to their sexual relationships, criminal careers and homeless trajectories.

sharing and blood-borne viral transmission (Doherty et al., 2000a; Kral et al., 1999; Spittal et al., 2002). The nineteen young people in this study who asked other individuals to administer their injections described a lack of control over the injecting procedure as well as an inability to maintain separation between their own, and the injecting paraphernalia of injecting partners. Some also felt that they were at risk of overdose because their more experienced injecting partner was unable to calculate a suitable dose for a recent initiate.

Authors have suggested that risk perception is relative and a product of the interplay between social environments and experiences (Mayock, 2005; Rhodes, 1997). In this study, young people's accounts revealed that their perception of risk was fluid, dynamic and influenced the context of their injecting environments. As young people's injecting careers progressed, most were exposed to a variety of physical and social environments which challenged their beliefs about what could be deemed 'acceptable' risk behaviour. Physical and social elements of the environment intersected, creating injecting contexts in which the young people participated in injecting risk behaviours. The nature of their social relationships with other injectors shaped their injecting practices and, as noted by previous researchers (Bailey et al., 2007; Barnard, 1993; Dear, 1995; Gossop et al., 1997; Loxley and Ovenden, 1995; Unger et al., 2006; Valente and Vlahov, 2001), young people were more likely to share injecting paraphernalia with individuals with whom they felt 'close', or perceived as 'healthy' and 'attractive'.

Previous studies have indicated that certain physical environments, such as prison or outdoor locations, are associated with high-risk injecting practices (Edwards et al., 1999; Ford et al., 1999; Rhodes et al., 2005, 2007; Sarang et al., 2006; Small et al., 2007). This study's findings similarly demonstrate that, the limited availability of injecting paraphernalia in prison, coupled with the high rates of sharing amongst inmates, influenced the risk perception and behaviour of those who had experienced incarceration. A number of young men reported sharing injecting paraphernalia on numerous occasions in prison contexts. Physical environments such as outdoor locations and public settings are also associated with injecting risk behaviour and associated negative outcomes (Carlson, 2000; Dovey et al., 2001; Rhodes et al., 2005, 2006; Singer et al., 2000; Small et al., 2007; Weeks et al., 2001). These environments also proved to be high-risk for this study's injecting drug users. The urgency surrounding injecting events in these setting, their fear of interruption, as well as unsanitary conditions and unfavourable weather conditions, complicated the injecting process and made it more difficult to inject carefully and safely. Overall, the young people's accounts of injecting episodes revealed physical and social aspects of the environments as shaping both their risk perception and behaviour, rending them vulnerable to a range of negative outcomes.

Chapter Nine
Discussion and Conclusion

This study set out to investigate heroin initiation and risk behaviour among young recent initiates. The research adopted a 'risk environment' framework and explored the macro-, meso- and micro-level environmental forces shaping the process of heroin and injecting initiation, as well as young people's risk perceptions and behaviour in the early stages of their heroin and injecting careers. Both epidemiological and ethnographic research methods were incorporated into the study design. However, in order to place drug-related behaviours in their social context, gain insight into the lived experience of heroin initiation and explore subjective experiences of risk, qualitative life history interviewing was adopted as the primary data collection technique.

As discussed in chapter two, research on heroin use in Ireland and elsewhere has been dominated by individualistic perspectives that neglect the lived experience and social construction of risk (Connors, 1992; Duff, 2003, 2007; Rhodes, 1995), and fail to place heroin use in its broader social and economic context (Davis & Rhodes, 2004; Davis et al., 2004; Moore, 1990; Rhodes, 1997). As a result, understandings of the role of social and environmental forces in the transition to heroin use are poorly understood. Furthermore, the bulk of the Irish literature on heroin use dates back to the 1980s and 1990s, when available indicators revealed "a startling increase" in the number of youth initiating heroin use (Dean et al., 1985, p. 108). During the past decade, fewer research studies have focussed specifically on heroin use, particularly among younger groups. A period coinciding with a decrease in the number of 'new' heroin users seeking treatment, on the one hand, and one of unprecedented economic growth on the other, has, therefore, seen little research attention given to the lives and experiences of young heroin users. This period of economic prosperity, colloquially known as the 'Celtic Tiger' years, saw a dramatic transformation of the Irish economy. Nevertheless, the Combat Poverty Agency (CPA) forewarned that "a booming economy does not guarantee an end to poverty" (CPA, 1999, p. 9). Indeed, social and economic inequality continued to be a strong feature of the economic landscape (Allen, 2000; Callan et al., 2004; Fahey et al., 2007). The fieldwork for this study was conducted between 2007 and 2009, a period during which the heroin 'epidemics' had abated, although figures from the National Drug Treatment Reporting System indicated a steady stream of new cases, the majority of whom nominated heroin as their primary drug of misuse, entering treatment (Carew et al., 2009; Reynolds et al., 2008). Studying heroin initiation within this social and economic context is arguably important, not simply because of the relative dearth of research on heroin use during this period, but also because such a study can provide important knowledge and insight into recent or contemporary initiation patterns.

Previous Irish studies documenting heroin initiation contexts have uncovered several important insights. For example, young people often first use heroin within peer social networks (Woods, 2008), they typically initiate in the company of recent heroin initiates (Dean et al., 1983) and often initiate in physical environments that are close to home (Mayock, 2003). However, somewhat in contrast, this study's findings reveal that heroin use was predominantly rejected and stigmatised within the local peer networks of the study's recent initiates. It was an activity that was primarily associated with older injecting drug users and was considered to bring about physical deterioration and dependency. As a result, the majority of young people did not report initiating heroin use in the company of peers from their locales. Alternatively, they described a process of coming into contact with, and forming social connections with, older, more experienced heroin users. Those who initiated heroin use in the company of youth of the same or similar age only did so following their immersion into street-based or homeless social networks in the city centre, where attitudes towards heroin use were more favourable. These findings indicate that contemporary heroin initiation processes are less open and, thus, more hidden than previously. Recent initiates to heroin, certainly those encountered during the fieldwork phase of this study when 'epidemic' numbers of youth were *not* initiating heroin use, are arguably more 'at risk' due to the more stigmatised nature of heroin use and the greater likelihood of their drug use remaining hidden from their peer groups, communities and the wider society.

Research has shown that political and economic transition can increase drug-related risk (Rhodes & Simic, 2005). Macro-level forces, such as social and economic marginalisation, interact with meso-level forces, influencing historical trends in drug preferences within social networks of drug users (Agar, 2003; Agar & Reisinger, 2002; Bourgois, 2003). In Ireland, 'heavy-end' drug users within socially deprived neighbourhoods have traditionally demonstrated a preference for heroin use, administered through intravenous injection (Dean et al., 1983; 1987). Recent figures from the National Drug Treatment Reporting System indicate that the majority of drug users seeking treatment in Ireland continue to report heroin as their main problem drug (Reynolds et al., 2009), and that over 40% report intravenous injection as their preferred route of administration (Carew et al., 2009). Furthermore, there has been a recent increase in the number of new heroin users seeking drug treatment (Carew, 2010). Insights gleaned from this study can serve to enhance understandings of initiation and risk among these new heroin initiates and inform future prevention and harm reduction efforts. These are discussed in more detail in a later section.

This final chapter is primarily concerned with discussing the main findings arising from the research. It begins by discussing the merits of the study's ethno-epidemiological approach, highlighting how the ethnographic research methods used, and in particular the life history interviews, helped to unravel the epidemiological complexity arising from the survey data. The

chapter goes on to discuss the main findings of the thesis, highlighting the macro-, meso- and micro-level environmental forces that impacted on heroin and injecting initiation. Injecting risk perception and behaviour is then discussed is some detail, with particular emphasis on the role of social and physical environments in producing risk during the early stages of the injecting career. The chapter concludes by highlighting themes that may serve to inform future drug policy and practice in Ireland, and making suggestions for further research.

Using Ethnography to Explain Epidemiological Complexity

Methodologically, this study adopted an ethno-epidemiological research design, combining ethnographic and epidemiological data collection techniques. Ethno-epidemiology is in its early stages of development but has recently been used to explore drug-related risk in Canada (Small et al., 2009), Australia (Moore et al., 2009), and the US (Bourgois et al., 2004; Clatts et al., 2001, 2002; Reisinger, 2004). These studies have predominantly used ethnographic research methods to contextualise and explore statistical information gleaned from large-scale epidemiological datasets. For example, Small and others (2009) conducted qualitative in-depth interviews with 26 young people from a sample of over 500 street-involved drug users from the At-Risk Youth Study (ARYS) in order to explore the social context of injecting initiation. Similarly, Bourgois and others (2004) used ethnographic observation to explore emerging gender differences in rates of hepatitis C seroconversion among over 800 young injecting drug users in San Francisco (Evans et al., 2003; Hahn et al., 2002). The current study is a comparatively small-scale ethno-epidemiology; an epidemiological sample of 120 young drug users, ethnographic observation, and life history interviews with 40 recent heroin initiates are incorporated into the analysis. However, it has provided a valuable opportunity to apply this innovative methodological approach in the Irish context, within which a large body of epidemiological research has developed over the past 30 years in the relative absence of strong qualitative insight (Mayock et al., 2009; White & Comiskey, 2007). Primarily interpreting epidemiological data within a positivist individualistic framework neglects the importance of context and meaning, and the subjective experience of heroin users. As argued elsewhere (Rhodes et al., 1999b; Stimson et al., 1999), there is a need for a 'paradigm shift' in the Irish research context, as an over-reliance on 'risk factor' epidemiology has led to inadequate understandings of the social and environmental determinants of heroin initiation and risk behaviour.

As an efficient means of acquiring data on current drug-using trends and practices, epidemiological research methods are likely to remain a dominant approach within the Irish context. Nevertheless, data gleaned from these studies need not be interpreted solely within a positivist individualistic framework. As previously suggested by Agar (1994), there is a need to bridge existing research methods rather than increasing the methodological and epistemological divide between them. Epidemiology is often conducted in the absence of social theory, yet the

origins of epidemiology are rooted in an approach that draws attention to social and environmental forces (Susser & Susser, 1996b). It has been argued that in order for the discipline to progress, it must return to its public health origins by readdressing the role of the environment in the spread of disease (Krieger & Zierler, 1996; Susser & Susser 1996b). Ethnography seeks to explore the interplay of context and meaning (Agar, 1997; Denzin & Lincoln, 1994; Guba & Lincoln, 1998; Long & Long, 1992; Marshall & Rossman, 2006) and can bring insight to the interpretation of epidemiological findings in the drug field. By revealing how environments and social interactions shape individuals' perception and behaviour, it can enhance understandings of the statistics obtained from large-scale quantitative studies, and can uncover how subjective experiences and interpretations bring meaning to drug-using trends and practices. To this end, there is a need for qualitative research methods in general, and ethnography in particular, to explore, inform, compliment and interpret epidemiological descriptions of drug-related environments and behaviour (Agar, 1995; Rhodes & Moore, 2001; Stimson et al., 1999).

As described in chapter three, this study incorporated both qualitative and quantitative research methods and adopted four main data collection techniques: a community assessment process, ethnographic observation, an epidemiological instrument or interceptor survey, and life history interviewing. Lengthy periods were spent in locations where heroin users congregate, although the degree of immersion described in the ethnographic fieldwork of drug researchers such as Bourgois (1995, 1998) or Agar (1973, 1977) was less prolonged and intense. Nevertheless, an ethnographic epistemological framework appropriately describes the study's methodological and theoretical approach. The analytic focus was on integrating the study's quantitative and qualitative data in an approach that valued the subjective experiences of young heroin users and the social construction of risk. The benefits of combining epidemiological and ethnographic research methods within this framework emerged in the dissemination of findings. The two data collection techniques complemented and strengthened each other; quantitative data obtained from statistical analysis of the interceptor survey served to highlight emerging themes for qualitative analysis, and the qualitative data brought meaning to these data, highlighting how social interactions shaped risk perception and behaviour, and providing insight into the subjective experience of risk environments. For example, in chapter five, the quantitative data indicated high rates of criminal behaviour, particularly among the men in the sample, while the qualitative analysis revealed that criminal activity shaped the 'risk environment' of their heroin initiation. Similarly, in chapter six, the quantitative data indicated that a high proportion of young women initiated in the company of a sexual partner. The qualitative data analysis revealed that while young women were active participants in their initiation, their intimate relationships with older male heroin users shaped their (micro-level) social interactions and impacted on both their heroin-using opportunities and rationales. As demonstrated throughout each of the findings chapters, the study's survey data provided evidence of important associations between variables

but could not unravel or unpack the nature of these connections. The study's life history interview data permitted an exploration of the interaction between macro-, meso- and micro-level forces, revealing ways in which environments shaped young people's subjective experiences and perceptions. These ethnographic interviews highlighted the inseparability of context and meaning, revealing, as suggested by Rhodes (2005), that the risk environment was a product of the interplay between individuals and their environment.

This study has highlighted the value of bridging the gap between ethnographic and epidemiological research methods in the Irish context by demonstrating how qualitative research methods can bring deeper insight and understanding to existing epidemiological data. Nevertheless, the epistemological framework of ethnographic research, which questions the existence of an objective social reality and acknowledges the social construction of knowledge, should not be undermined when undergoing such research endeavours. Risk is socially and locally produced (Rhodes, 2005) and the findings of this study reflect both the subjective perception and social construction of risk. For the successful interpretation of epidemiological findings, and to develop understandings of risk perception and behaviour, the lived experience and subjective interpretations of heroin and other drug users must be incorporated into future Irish research.

Heroin Initiation as a Process

Positivist approaches to understanding illicit drug use tend to depict drug initiation as an isolated event in a young person's life, and seek to locate 'risk factors' within the individual. The findings of this study have challenged this perspective on heroin initiation, arguing instead for a need to locate heroin initiation within the social situations, processes and structures in which individuals are immersed. Rather than an isolated event, heroin initiation was found to be strongly linked to social processes and shaped by a myriad of influences that came into play long before the individual's first use of the drug. Thus, macro-, meso- and micro-level environmental forces intersected to create 'risk environments' in which young people became exposed to heroin use and heroin users. Within these environments, social interactions with heroin users shaped young people's risk perceptions, fuelling their curiosity about the drug and simultaneously diminishing their prior fears about the drug's potential negative effects.

Previous research has consistently revealed that heroin users in Ireland (Dean et al., 1983, 1985; Reynolds et al., 2008), the UK (Parker et al., 1986, 1988; Pearson, 1987a; 1987b) and elsewhere (Bourgois 1998; Dai, 1937) come from socially and economically deprived areas. As described in chapter four, the young heroin users in this study were no exception; they grew up in neighbourhoods characterised by high rates of unemployment, early school leaving, problematic

drug use and criminal activity. Parker (2001) has suggested that macro-level environmental forces, such as poverty and social deprivation, impact on meso-level environments in ways that enhance vulnerability to experiences of family adversity. Young people in this study experienced numerous forms of hardship during their childhood years, including family breakdown, familial substance use, domestic violence and abuse. As observed by others (Rhodes, 2005; Vimpani, 2005), multiple features of adversity and inequality intersected to create vulnerability to drug-related risk. However, rather than pointing to a direct causal relationship between macro-level environmental forces and heroin initiation, the accounts of young people highlighted the impact of both macro and meso environmental contexts on micro-level social processes, thus bringing them into contact with older heroin users and shaping their pathways into heroin use.

Parker (1998a) argued that high concentrations of heroin users in poor quality, overcrowded, local authority housing brought young people into social contact with older heroin users, influencing the process of 'micro-diffusion', or the spread of heroin use from one heroin user to the next. The findings of this study similarly indicate that macro- and meso-level forces associated with poverty and relative deprivation shaped young people's micro-level 'risk environments', bringing them into contact with older heroin users. Thus, in keeping with the claims advanced by career theorists (Becker, 1953; Gould et al., 1974; Waldorf, 1973), social interaction with other heroin users was crucial in explaining the process of heroin initiation, and this social contact also impacted on young people's initiation opportunities and rationales. Young people's observations of the heroin use of friends, family members, romantic partners or acquaintances cultivated their curiosity about its effects, and provided them with numerous opportunities to initiate, findings that have previously been alluded to in the Irish context (Mayock, 2003; McElrath, 2001; Woods, 2008). These data strongly suggest that macro-level forces *alone* cannot adequately or fully explain heroin initiation. Both meso- and micro-level elements of the risk environment featured crucially in young people's pathways to heroin use and also mediated the relationship between the macro-level environment and heroin initiation risk.

Previous authors have noted the role of micro-level factors in the process of heroin initiation (Feldman, 1968; Gould et al., 1974; Rosenbaum, 1981a; Waldorf, 1973) and this study extends this literature through a strong focus on the social and situational contexts of heroin and injecting initiation. Detailed analysis of respondents' biographic narratives led to the identification of three main routes or pathways into heroin use: a 'criminal career' pathway; an 'intimate relationship' pathway; and a 'homeless' pathway. The key features of these three distinct typologies emerged from the young people's descriptions of the social interactions and relationships that immediately preceded heroin initiation and shaped initiation contexts. The majority of young men were extensively involved in criminal activity (either acquisitive crime such as burglary and/or robbery, or drug-dealing activities) or were incarcerated prior to their heroin initiation.

Conversely, most young women entered into relationships with older heroin users/dealers in the period preceding their first use of the drug. Other young people (both men and women) experienced living 'out-of-home' and/or described becoming immersed in homeless social networks when accessing homeless services or spending time in outdoor locations in the city centre. These micro-level social processes played a crucial role in bringing young people into contact with heroin use and users, providing them with opportunities and motives to initiate use.

The three pathways identified in this study indicate that contextual forces and social interactions preceding heroin initiation are influenced by gender, criminal activity and/or experiences of homelessness. Similar themes have frequently been identified and explored within the literature on heroin initiation. For example, researchers have noted that criminal activity often precedes initiation into heroin use (Chambers, 1974; Chein et al., 1964; Greenberg & Adler, 1974; Robbins & Murphy, 1967; Vaillant, 1966), that many female drug users are introduced to heroin by a partner and initiate use in their company (Bourgois et al., 2004; Hser et al., 1987; Rosenbaum, 1981a), and that heroin initiation often occurs during periods of housing instability (Mayock & O'Sullivan, 2007). This study provided insight into the subjective experience of these distinct journeys into heroin use and provided a detailed description of how young people's perceptions of heroin use were moulded by their social interactions and experiences.

During their early heroin use careers, young people continued to use heroin within micro-level environments shaped by their initiation. 'Risk environments' which impacted on heroin initiation, therefore, continued to shape drug-related risk perception and behaviour. These 'risk environments' also impacted more broadly on young people's experiences of risk and enhanced their vulnerability to violence, victimisation and intimidation. The following three subsections discuss the findings pertaining to gender, criminal careers, and homeless or street-based heroin-using networks, highlighting ways in which each impacted on the social course of heroin initiation and also influenced young people's subsequent exposure to and experience of risk, particularly during the early stage of their heroin careers.

Gender and Heroin Initiation

In this study, two of the main pathways to heroin use that were identified, the 'criminal career' pathway and 'intimate relationship' pathway, were shaped by gender; only young men took the former pathway and only women the latter. Nevertheless, young men's and women's social pathways into heroin use demonstrated a number of important similarities. Neither young men nor young women used heroin within peer social networks in their home neighbourhoods, but the majority were introduced by an older, experienced male heroin user. They came into contact with these older heroin users, formed social connections with them, were exposed to their heroin use, became curious about its effects and initiated use in their company. Similar micro-level social

processes, therefore, impacted on the heroin initiation pathways of young men and young women. However, in keeping with Rhodes' (2005) claims, gender emerged as an important element of the social 'risk environment'. In particular, the nature of young people's relationships with the older male heroin users with whom they initiated differed according to gender. Young women were more likely to enter into an intimate relationship with an older male heroin user, while young men frequently came into contact with heroin users through their criminal activity, adopting them, in some cases, as 'role models'. In both cases, power dynamics operated within these relationships and impacted upon young people's experiences of risk.

The majority of young men in this study took a 'criminal career' pathway to heroin use. Simpson (2003) has argued that the relationship between drug use and crime is mediated by local social contexts and environments, and the drug-crime relationship, therefore, is likely to vary according to different physical, social, cultural and historical contexts (Parker & Newcomb, 1987). Within the context of this study, young men were often heavily involved in criminal activity prior to their heroin initiation, and they formed social connections with criminally-involved heroin users. Three main criminal trajectories were observed to bring young men into contact with older male heroin users: extensive acquisitive crime, drug-dealing activity and incarceration. The 'risk environment' of their heroin initiation was thereby shaped by their escalating involvement in criminal activity. Power dynamics were identified as operating within their social relationships with older criminally-involved men; the study's young men looked up to these men, tended to depict them as 'role models', described them as offering 'protection' or increased opportunities within criminal networks, and often explained that they 'taught' them the techniques of more lucrative criminal activities. Within micro-level social environments shaped by these power differentials, the young men observed their older, criminally-involved peers using heroin, and were provided with both motive and opportunity to initiate. Micro-level social interactions shaped by their criminal careers and their relationships with older, criminally-involved men shaped these young men's pathways into heroin use.

Unlike young men, a significant proportion of young women in this study were introduced to heroin by older heroin users who were their sexual partners, and initiated heroin use in their company. Similar findings have been reported elsewhere (Gerstein et al., 1979; Hser et al., 1987; Maher, 1995, 1997; Powis et al., 1996; Rosenbaum, 1981a; Taylor, 1993) but acknowledgement of male presence in female initiation has often been interpreted as male coercion and dominance. Theoretical representations of female drug users have traditionally been dichotomised into two extremes, with women perceived as either passive victims or emancipated drug consumers (Maher, 1997). Studies that report the presence of male partners in female initiation contexts have been associated with the former, and those that report that women often initiate with female friends have been associated with the latter. The findings of this study strongly contest these

dichotomies of agency within initiation environments, demonstrating that neither perspective accurately reflects the complexities of young women's journeys into heroin use. Whether young women initiated with their partners, or initiated with friends or acquaintances (within homeless, heroin-using networks), their social environments and interactions shaped their initiation pathways and rationales. All of the young women emphasised their agency in the process of their heroin initiation, but their accounts simultaneously highlighted the ways in which environmental forces impacted on their experiences and behaviours.

Social relationships play an important role in shaping the 'risk environment' of heroin initiation and, for many young women in this study, the social course of their heroin initiation was influenced by their sexual relationships with older, male heroin users and/or dealers. Nevertheless, young women exercised agency at each stage of the process; for example, they willingly entered into a relationship with them, they observed their partners using heroin and wished to initiate with them, they actively sought out opportunities to initiate, and used a variety of strategies to convince reluctant partners to facilitate them. These young women might, therefore, be viewed as active participants in their own heroin initiation. However, the interaction of the individual and the environment is crucial in producing drug-related risk (Rhodes, 2009), and sexual relationships have previously been identified as a 'site of risk management' (Rhodes & Quirk, 1998). In the context of an intimate relationship with a heroin user/dealer, young women were provided with a rationale for making the transition to heroin use; heroin was readily available, they were curious about its effects, their fears surrounding initiation were ameliorated, and they were provided with the opportunity to initiate in a comfortable social environment with an experienced administrator of the drug. Furthermore, as observed in a recent qualitative study of women's heroin initiation, some "linked their heroin use with the trust implicit in close, often sexual, relationships and an associated desire to share the experience of euphoria" (Payne, 2007, p. 647).

Gender and Risk in the Early Heroin Career

During young people's early heroin career, those micro-level social environments which impacted on their heroin initiation continued to shape the risk experiences of both young men and women. Young men who were involved in criminal activity prior to their initiation described becoming more deeply immersed in criminal social networks in which they were at risk of violence and intimidation. Alternatively, young women's accounts pointed strongly to the risk of sexual victimisation and exploitation within gendered drug-using social networks and relationships. Bourgois and others (2004) have argued that macro-level social, economic and political forces related to social, economic and gender inequality manifest in micro-level social environments through everyday violence. Within macro-level environments shaped by social and economic disadvantage and meso-level criminal social networks or sexual relationships, violence,

victimisation and exploitation were common experiences for young men and young women in this study. As described in chapter five, many young men were threatened with violence or were physically assaulted by acquaintances or 'superiors' within their criminal networks. Alternatively, as highlighted in chapter six, many young women recounted experiences of sexual exploitation and assault within the context of their intimate relationships and/or drug-using networks.

The findings of this study suggest that macro-level gender norms and power dynamics operated within drug-using micro-level environments, producing differential experiences of risk for males and females. As their criminal careers evolved, young men became more deeply entrenched in criminal networks in which violence was endemic, and they became both the victims and perpetrators of violence. The 'risk environment' simultaneously shaped their experiences of violence and their violent behaviour, placing them at risk of psychological distress, physical harm, and even death. For young women, gender power imbalances operated in their relationships and drug-using activities (Bourgois, 2004; Rhodes, 2005) shaping their experiences of risk. There was often a significant age gap between the young women and their intimate partners, they were less experienced in drug use and criminal activity and they occupied lower positions in drug-using social networks. Within their relationships, young women initiated heroin and injecting drug use, and developed heavy patterns of consumption but, as noted by previous authors (Bourgois, 1989; File, 1976; Hser et al., 1987; Maher, 1997; Marsh & Simpson, 1986; Measham, 2002), young women did not have equal opportunities within the illicit economy, making it difficult for them to fund their drug use alone. These gender inequalities fostered dependency in young women's sexual relationships, exacerbating their susceptibility to risk within them.

It has been argued that macro-level gender power imbalances manifest in micro-level environments, rendering women who are immersed in street-based drug cultures vulnerable to oppression, domination and violence (Bourgois, 1989; Maher, 1997; Rhodes & Cusick, 2002; Rosenbaum, 1981a, 1981b). Young women in this study were subject to abuse, victimisation and exploitation within the context of their sexual relationships and drug-using social networks. As observed elsewhere (Holland et al., 1998), the conventions of heterosexual masculinity and femininity impacted on these young women and powerfully contributed to their experiences of sexual risk. Young women predominantly adhered to beliefs of conventionally feminine behaviour; for example, they predominantly held negative views of women participating in non-monogamous sexual activity, and asserted that they were "not the type" to participate in sexual activity with numerous partners. As a result, they perceived the risk of sexually transmitted infection to be low in their sexual encounters and believed that condom use was unnecessary in the context of their intimate relationships. Women's subordinate positions within drug-using

social networks also heightened their risk of sexually transmitted infection due to their disadvantaged position in negotiating condom use. These micro-level social dynamics placed young women at risk of contracting sexually transmitted and blood-borne viral infections.

The findings of this study, similarly to others (Bourgois, 2002), indicated dramatically different experiences of risk across gender. This is not to suggest that young men or women were more or less vulnerable to risk; only that young women and men were exposed to differential risks shaped by their gendered risk environments. Young women were more likely to initiate heroin use in the company of an older sexual partner, and were more likely to experience risks associated with sexual exploitation, victimisation and abuse within their relationships and heroin-using social networks. Alternatively, young men were 'at risk' within social environments shaped by their criminal activity and criminally-involved others. They were more likely to initiate with an older man who they perceived to be a 'role model', and who occupied a higher position with their criminal social network. Within these micro-level 'risk environments', they were also 'at risk' of physical violence and intimidation.

Street-based Heroin-using Networks

Homelessness is strongly linked to macro-level processes of social and economic inequality and is thought to impact on drug-related risk (Galea & Vlahov, 2002; Rhodes, 2005). However, Irish research examining the relationship between homelessness and heroin use has predominantly focused on heroin use as a cause of homelessness (Cox & Lawless, 1999; Houghton & Hickey, 2000; Lawless & Corr, 2005; Seymour & Costello, 2005). This is despite findings indicating that, prior to their heroin initiation, young people are often deeply immersed in street-based drug scenes, where a variety of illicit substances are available and their use accepted (Mayock, 2000; Mayock & O'Sullivan, 2007). In this study, the experience of homelessness was identified as a key process that brought young people into environments in which they were at risk of heroin and injecting initiation. Heroin and injecting drug use were described as highly prevalent within homeless or street-based drug-using networks in the city centre, a finding previously reported by others in the Irish context (Cox & Lawless, 1999; Lawless & Corr, 2005). As a result, young people's initial point of contact with homeless services and social networks in the city centre, a process to which they frequently referred as "coming into town", emerged as an important 'turning point' in their drug careers. Within a short period of time, they rapidly expanded their social networks and were exposed to the heroin and/or injecting drug use of their homeless acquaintances. Many young people initiated both heroin smoking and injecting within homeless social networks and in 'high-risk' physical environments (Bourgois, 1998; Latkin et al., 1996; Maher & Dixon, 1999; Rhodes et al., 2007; Small et al., 2007), such as outdoor or public locations, associated with their homeless status.

A small number of young people in this study described a 'homeless' pathway into heroin use despite living in their family homes at the time of their initiation. As described in chapter seven, these young people spent long periods of time in outdoor locations in the city centre, and formed numerous social connections with heroin users. This finding is significant as it highlights the importance of social interactions and experiences in young people's journeys into heroin use. Social interactions with heroin-using homeless youth impacted on young people's perception of the risks associated with heroin and injecting drug use. The young people regularly observed others' drug-using episodes and received messages surrounding the advantages of the drug or injecting as a route of administration. Within these contexts, young people became less fearful of the potential negative consequences of use and more curious about the positive effects. Similarly to other studies (Klee & Reid, 1998; Neale, 2001; Rowe, 2005; Tyler & Johnson, 2006), young people who were living 'out-of-home' also emphasised that they were motivated to use heroin to ease the physical and emotional distress associated with a homeless lifestyle. These young people's homeless status led them into specific and often unfamiliar settings (including indoor and outdoor social spaces), but it was the micro-level characteristics of these environments, in particular their social interactions, that shaped their initiation to heroin.

Injecting initiation is a 'critical moment' in the drug careers of individuals since it places young people on a trajectory along which they become exposed to heightened risks such as blood-borne viral transmission and drug overdose (Chitwood et al., 2000; Des Jarlais et al., 1992a; Friedman et al., 1999). In this study, injecting was reported to be the dominant route of administration within street-based heroin-using networks, a finding that has previously been documented in the Irish context (Cox & Lawless, 1999; Lawless & Corr, 2005; O'Brien et al., 2002). Subsequent to the process of "coming into town", young people formed social connections with injecting drug users by means of which they were exposed to their injection episodes, often in social environments (for example, outdoor locations, squats or hostels) that were themselves characterised by risk. The initiation rationales of these young people were shaped by their interactions with homeless injecting drug users and, similarly to other studies (Witteveen et al., 2006), many developed a heightened curiosity about the effects and wished to experience the "buzz" of injecting.

In this study, the 'homeless' pathway emerged as the dominant pathway into injecting drug use. This finding is significant and concurs with previous research indicating that homeless youth are at high risk of injecting initiation (Clatts et al., 1998; Gleghorn et al., 1998; Kral et al., 1997; Pfeifer & Oliver, 1997; Roy et al., 2003). The vast majority of young people initiated during a period of homelessness and in the company of homeless injecting drug users[1]. Indeed, previous

[1] As discussed in chapter three, a significant number of young people were recruited from homeless services. As a result, the dominance of the 'homeless pathway' into injecting drug use may reflect the recruitment strategy adopted by

studies have highlighted the importance of individuals' participation in social networks that include injecting drug users in the process of injecting initiation (Kipke et al., 1997; Lankenau & Clatts, 2004; Lankenau et al., 2007; Rhodes, 2005; Roy et al., 2003; Small et al., 2009). This study's young people often described their observations of experienced injecting drug users, sometimes over periods of weeks or months, as an experience that gradually altered their risk perceptions. As reported by Harocopos and others (2009), exposure to the injecting behaviour of friends or acquaintances increased their curiosity about its effects, and diminished many of their fears concerning stigmatisation or danger. They began to believe that safe injection was possible, particularly if clean paraphernalia were used and the injection was administered by an experienced injector. Simultaneously, young people received messages that injecting produced greatly enhanced drug effects. As noted by Small and others (2009), social interactions with other injecting drug users served to emphasise the benefits of injecting compared to smoking heroin, thus encouraging injecting initiation. Within street-based heroin-using social networks, young people also had access to injecting paraphernalia and were able to obtain the technical assistance required to initiate. All of these social forces and dynamics played a vital role in injecting initiation in this study.

The 'Risk Environment' of Injecting Drug Use

As previously described, the 'risk environment' has been defined as the space, whether social or physical, in which a variety of factors exogenous to the individual interact to produce drug-related risk (Rhodes et al., 2005). Understandings of how macro-, meso- and micro-level environmental forces impact upon injecting risk behaviour and the spread of blood-borne viral infections have greatly expanded in recent years, leading to an acknowledgement that environmental determinants are among the most important in the spread of HIV and Hepatitis C (Barnett & Whiteside, 1999; Burris et al., 2004; Rhodes, 2002; Rhodes et al., 2005; Friedman & Reid, 2002). Yet, few Irish studies have incorporated consideration of the 'risk environment' into studies of injecting risk behaviour and blood-borne viral infection[2]. Young injectors in Ireland and elsewhere are particularly susceptible to engaging in high-risk behaviours associated with blood-borne viral infection, particularly during the early stages of their injecting careers (Cassin et al., 1998; Chitwood et al., 2000; Cox & Lawless, 1999; Crofts et al., 1996, Fennema et al., 1997; Fuller et al., 2003; Garfein et al., 1998, Hahn et al., 2002, Kral et al., 2000; Nelson et al., 2002; Ochoa et al., 2001; Smyth et al., 2001; Thorpe et al., 2000; Van Ameijden et al., 1994; Van Beek et al., 1998; Vlahov et al., 1990). Although not focused solely on injecting drug use, this study sought to explore how the social and physical contexts of injecting episodes shaped the production of risk among young recent injection initiates.

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this study. Therefore, this finding, although important, may not apply to populations of injecting drug users recruited by alternative strategies.

[2] Only one known Irish study by Cox and Whitaker (2009) has used the 'risk environment' framework to investigate sexual and drug-related risk behaviour among sex workers.

Previous researchers have suggested that macro-level political, social, economic and cultural environments 'structure' the micro-level environments in which risk is produced and reproduced (Rhodes et al., 2005; Sumartojo, 2000). Poverty and relative deprivation, for example, have been shown to influence drug-related risk behaviour, with disproportionate levels of drug and injecting drug use among the urban poor (Galea & Vlahov, 2002; Galea et al., 2004; Latkin et al., 2003; Rhodes et al., 2003a, 2005; Waterston, 1993). The young people in this study predominantly came from deprived social and economic backgrounds, and pathways to injecting drug use were strongly mediated by experiences of homelessness. Despite occurring during the 'Celtic Tiger' economy, a macro-level environment of great economic prosperity, their injecting initiation and risk behaviour was shaped by political, social and economic forces that cultivated inequality of access to resources and services (Allen, 2000). These young people were 'at risk' of initiating injecting drug use and also of associated negative outcomes such as overdose, blood-borne viral transmission, vein damage and abscesses.

Research has shown that social and economic disadvantage are key factors influencing injecting risk behaviour and blood-borne viral transmission among injecting drug users (Bourgois, 1998; Bourgois et al., 1997; Fee & Krieger, 1993; Friedman et al., 1998; Parker et al., 2000; Sikkema et al., 1996; Singer, 1994; Singer & Clair, 2003; Zierler et al., 2000). For example, a study conducted in urban areas of the United Stated indicated that higher levels of social and economic inequality were associated with higher numbers of injecting drug users per capita, higher rates of HIV prevalence, and higher rates of HIV transmission (Friedman et al., 1998). Similarly, in Ireland, a number of studies have suggested that structural disadvantage is associated with the spread of blood-borne viral infection, as higher rates of HIV have been reported amongst injecting drug users living in socially deprived areas (Clarke et al., 2001; Long et al., 2006; O'Gorman, 1998). Moreover, homeless injecting drug users in Ireland and elsewhere are considered to be at elevated risk due to poor living conditions and a lack of social and economic resources (Cox & Whitaker, 2009; Magura et al., 2000; Schechter et al., 1999; Song et al., 2000; Susser et al., 1996). The majority of injectors in this study suffered from poverty and marginalisation, experienced homelessness, and were subject to risks associated with injecting in outdoor or public locations where they feared discovery and had limited control over environmental conditions. These findings strongly suggest that young people's injection contexts and behaviour cannot be dislocated from the macro-level risk environment.

There is also evidence in the literature to suggest that macro-level gender inequality impacts upon the micro-level drug-using environments and experiences of injecting risk. For example, a recent large-scale epidemiological study in San Francisco demonstrated that rates of HCV sero-conversion were 50% higher among women. The strongest predictors of HCV infection were

having an injecting sexual partner and sharing injecting paraphernalia with a sexual partner (Evans et al., 2003). Similarly, epidemiological research in the Irish context has indicated that female injection drug users are more likely to have an injecting drug-using sexual partner, to share injecting paraphernalia with their partner and to be at higher risk of contracting HIV and hepatitis C (Dorman et al., 1997; Geoghegan et al., 1999; Mullen & Barry, 2001; Smyth et al., 1995). Elsewhere, qualitative research has demonstrated how macro-, meso- and micro-level environmental factors interact in complex ways to compound risk for young women within injecting drug-using networks and contexts (Bourgois, 1998; Farmer et al., 1993, 1996; Rhodes et al., 2005; Singer et al., 1992; Weeks et al., 1998). For example, macro-level gender power imbalances are expressed in meso-level injecting drug-using social networks, manifesting in gender inequalities in income-generating strategies and placing women in a disadvantaged position in drug-using hierarchies (Bourgois et al., 2004; Maher, 1997). These macro- and meso-level gender inequalities shape micro-level injecting contexts, with men often taking control of the injecting procedure and administering their partners' injection after their own, using the same injecting paraphernalia (Bourgois et al., 2004; Harvey et al., 1998). Similarly, the findings of this study strongly suggest that macro-level gender inequalities shaped the interactions between individuals in injecting environments. For example, the majority of young women entered into relationships with older, more experienced heroin users, initiated smoking and injecting drug use with their sexual partners, and received injections from them during the early stages of their injecting careers. Facilitated injections from their partners meant that young women had limited or no control over their own injection episodes and simultaneously created barriers to the use of safe injecting techniques. Young women also emphasised that growing feelings of "trust" and "intimacy" in their relationships impacted on their sexual and injecting risk behaviour, and most reported engaging in unprotected sex and/or the sharing of injecting paraphernalia with their partners. Previous research on heroin use in Northern Ireland has suggested that injecting drug users may not consider "sharing" to include using the same injecting paraphernalia within an intimate relationship (McElrath, 2001). In this study, many young women used needles or syringes after their sexual partners and explained that they did not believe this to be a 'high-risk' activity because they "trusted" that their partners were not carriers of a blood-borne viral infection. Moreover, their narratives indicated that power imbalances operating within their relationships placed them in a disadvantaged position when negotiating condom use and safer injecting practices. Thus, micro-level social interactions, shaped in large part by gender inequality, ultimately placed young women at risk of negative outcomes associated with injecting and sexual risk behaviour, including blood-borne viral infection, overdose and sexually transmitted diseases.

To understand the role of the macro-level environment in producing risk, meso- and micro-level forces must be explored. Socio-economic and gender inequalities manifest in young people's

social networks and injecting contexts in complex ways and the meso- and micro-level forces that shape risk perception and behaviour also require attention. It has been suggested that meso-level social networks influence patterns of injecting risk behaviour through shared social and group norms (Broadhead et al., 1998; Davey-Rothwell & Latkin, 2007; Friedman et al., 1999; Hawkins et al., 1999). For example, a recent study has provided evidence that risky injecting practices, including groin injection, have become 'normalised' within street-based injecting drug-using networks (Rhodes, 2006). In this study, those practices and behaviours considered to be 'acceptable' by young people were strongly influenced by the social norms within their street-based, injecting drug-using networks. For example, sharing injecting paraphernalia under conditions of opiate withdrawal was considered 'understandable' by many in the early stages of their injecting careers, and commonly reported by those who had been injecting for a number of years. It appeared that deeper immersion into street-based, injecting drug-using networks, in which this behaviour often occurred, gradually shaped young people's risk perception and behaviour. As a result, the *perceived* risks associated with the sharing of injecting paraphernalia with friends or acquaintances did not outweigh the *perceived* risk of intense opiate withdrawal.

Social network norms and practices impacted upon risk behaviour in other ways. For example, within some injecting drug-using networks, refusing an offer to share injecting equipment was considered to be an insult and thus carried social risks. Young people often explained that demonstrating aversion or fear towards syringe sharing in these contexts implied a belief that the donor had a blood-borne viral infection which, in turn, implied that the individual was considered by the potential recipient to be "dirty". The perceived risks of refusing to share, such as loss of friendship, being unable to avail of their injecting paraphernalia, or creating an altercation, thus overshadowed the perceived risks of potential blood-borne viral transmission through acquiescing to share. These findings demonstrate that, as suggested by Rhodes (1995; 1997), risk perception is socially constructed and organised rather than individually determined.

A number of authors have suggested that the structure of injecting drug-using networks also impacts upon injecting risk behaviour and negative outcomes (Friedman et al., 1999; Galea & Vlahov, 2002; Latkin et al., 1996, 2003; Neaigus et al., 1994). In this study, there was evidence to suggest that social hierarchies within injecting social networks influenced young people's susceptibility to injecting risk. Power dynamics operated between young recent initiates and their older, more experienced counterparts, and, as reported elsewhere (Lankenau et al., 2007), young men and women often received injections from those occupying higher positions within drug-using hierarchies. Within these contexts, young people had limited control over the injecting process and were in a disadvantaged position with respect to negotiating safer injecting techniques. As a consequence, they were positioned at high risk of blood-borne viral infection during the early stages of their injecting careers. Fuller and others (2003) reported similar

findings, arguing that the inability to administer one's own injections often results in young recent initiates injecting within high-risk social settings, making them vulnerable to blood-borne viral transmission.

Rhodes (2005) has argued that in addition to exploring macro and meso-level determinants, there is a need to focus on micro-level social situations and places in which risk is produced. As previously stated, young recent initiates have been identified as particularly vulnerable to engaging in high-risk injecting behaviour, placing them at risk of blood-borne viral infection or overdose (Cassin et al., 1998; Fennema et al., 1997; Fuller et al., 2003; Garfein et al., 1998; Hahn et al., 2002; Kral et al., 2000; Nelson et al., 2002; Ochoa et al., 2001, Smyth et al., 2001; Thorpe et al., 2000; Van Beek et al., 1998). In this study, the early injecting careers were replete with accounts of exposure to risks associated, in many cases, with their lack of injecting experience and expertise. Micro-level processes and contextual forces intersected to shape risk as these young people self-administered their injections, often in solitary contexts, or requested older, more experienced injectors to administer their injections. Both of these injecting contexts placed them at risk, and they were susceptible to overdose, damaged veins, and blood-borne viral infection.

As stated earlier, most of this study's young injectors experienced homelessness in their lifetimes. Living 'out-of-home' has been associated with injecting in outdoor, public or semi-public environments (Bourgois, 1998; Fuller et al., 2003; Maher & Dixon, 1999; Roy et al., 2002) and many young people in this study reported injecting in alleyways, squats, public toilets, car parks or apartment stairwells. These micro-level environments reduce the individual's capacity to employ safe injecting practices and techniques (Carlson, 2000; Latkin et al., 1996; Rhodes et al., 2003, 2005; Singer et al., 2000) and have been associated with blood-borne viral transmission and overdose (Dovey et al., 2001; Friedman et al., 1995; Weeks et al., 2001). Within high-risk physical injecting contexts, young people in this study described how fear of interruption, the inability to control external forces (such as weather and sanitary conditions), and the desire to complete injections rapidly, impacted on injecting procedures and techniques. Within such circumstances, mistakes were made in the preparation and administration of the drug, leading to negative outcomes such as near overdose and vein damage.

The findings on injecting drug use among young people clearly demonstrate that environmental forces create barriers to the employment of safe injecting practices and techniques (Rhodes, 2005). The accounts of young recent injecting initiates in this study identify the impact of macro-level forces, including gender and socio-economic inequality. They equally highlight the influence of meso-level social network norms and interactions and micro-level interpersonal and contextual forces in shaping their risk perceptions and risk behaviour. These young people

reported unsafe injecting practices such as the faulty preparation and administration of heroin, as well as the sharing of injecting paraphernalia. These practices, as well as the conditions and characteristics of their injecting environments, placed them at potential risk of overdose, vein damage and blood-borne viral infection.

Implications for Policy and Intervention

One of the main objectives of empirical drug use research is to enhance knowledge and understanding of drug-related issues in order to deal more effectively with the harms inflicted on individuals, families, communities and society (Mayock, 2003). Heroin and injecting drug use continue to be a major public health concern in Ireland (Carew et al., 2009; EMCDDA, 2008; Mayock et al., 2009; Reynolds et al., 2008) and injecting drug use, in particular, is associated with high rates of morbidity and mortality (Frischer et al., 2002; Tarabar & Nelson, 2003; Van Beek et al., 1998). This section considers the implications of this study for education, prevention, and harm reduction strategies that seek to reduce drug-related harm among young Irish heroin users.

Numerous authors have called for a paradigm shift, from individualistic to ecological approaches, in public health policy (Diez-Roux, 1998; Friedman et al., 1999; Rhodes et al., 1999b; Susser & Susser 1996a, 1996b), thereby moving the focus away from individual responsibility towards approaches that recognise that risk is a product of social situations and structures (Ezard, 2001; Rhodes 2002, 2005). Risk is best understood within its social and cultural context (Douglas, 1992), and individualistic approaches to education, prevention or harm reduction strategies are limited in their ability to bring about behavioural change. The Minister of State argues that the National Drugs Strategy 2009-2016 aims to "maintain the focus on individuals, their families and communities" (National Drugs Strategy, 2009, p. 3), but harm reduction, education and prevention strategies in Ireland continue to be dominated by individualistic approaches. For example, needle exchange programmes are primarily individual-centred and rarely target the social networks of injecting drug users (Cox & Robinson, 2008). This study indicates that young people's risk perception and behaviour are strongly mediated by interactions within their social networks, and that pathways into heroin use are shaped by environmental forces rather than individual decision-making processes. Therefore, the transfer of understandings of the 'risk environment' into policy and practice could go a long way towards improving the effectiveness of prevention and harm reduction measures targeting young heroin initiates or those 'at risk' of initiation.

The current drug strategy has developed around the five pillars of supply reduction, prevention, treatment, rehabilitation and research (National Drugs Strategy, 2009). This study's focus on heroin initiation and risk behaviour means that its findings relate most strongly to the pillars of

prevention (which include education campaigns) and treatment (which encompasses harm reduction strategies). The next two sub-sections discuss the relevance of the study's framework, as well as that of the 'risk environment', to these two pillars of the National Drug Strategy.

Prevention of Heroin and Injecting Initiation

One of the key objectives of drug prevention in the Irish context is to "prioritise prevention interventions on those in communities who are at particular risk of problem drug/alcohol use" (National Drug Strategy, 2009, p. 7). This study's findings indicate that the perceptions of heroin users and their motives for initiation are situated within complex macro-, meso- and micro-level environments. Macro-level structural interventions recognise that vulnerability to drug-related harm is associated with social and economic inequality (Bourgois, 1989, 1995, 1998, 2003), and seek to bring about policy changes that will address social disadvantage and deprivation in communities that are 'at risk' (Blankenship et al., 2000; Heimer et al., 2002; Sweat & Denison, 1995). Such macro-level changes are essential in addressing drug-related harm as well as health inequalities more generally (Rhodes et al., 2005). The findings of this study highlight the importance of macro-level interventions, supporting recent recognition that drug prevention efforts must be located within broader social inclusion policy (National Action Plan, 2007; National Development Plan, 2007; Pike, 2007). However micro-level social processes also shape pathways into heroin use and these findings can inform meso- and micro-level prevention and education programmes targeting populations 'at risk' of heroin and injecting initiation.

Many young people in this study demonstrated early school leaving, extensive criminal activity and/or homelessness prior to their heroin initiation. Although the current National Drugs Strategy recognises these young people as 'vulnerable', it acknowledges that "prevention measures are not seen to be making sufficient impact" (National Drugs Strategy, 2009). Prevention efforts must focus on those accessing homeless services and entering the criminal justice system while recognising those micro-level social processes operating within criminal and homeless networks bringing young people into contact with heroin use and heroin users. Physical environments such as emergency homeless accommodation and prisons, for example, foster social interactions between young people and other heroin users, shaping the process of heroin and injecting initiation. Law enforcement and housing strategies need to reduce the level of harm to individuals rather than focusing solely on eliminating drug distribution or visible homelessness. Therefore, the way in which homeless services and criminal justice interventions can foster 'risk environments' for heroin initiation must be recognised and addressed.

This study revealed that experiences of homelessness, in particular, contributed towards the 'risk environment' of injecting initiation. It has been observed that strategies for preventing initiation into injecting drug use follow two main approaches; targeting vulnerable populations to reduce

the likelihood that they will inject, and working with injecting drug users to minimise the influence that they have on non-injectors (Harocopos et al., 2009). Homeless youth in this study were primarily recruited through homeless services, including drop-in services, outreach and emergency hostel accommodation. Therefore, this population of 'at risk' youth was 'visible' and accessible, unlike 'hidden' populations of young heroin users living in stable accommodation (Egginton & Parker, 2000). These young people can be targeted for education and prevention work aimed at reducing their likelihood of initiating injecting drug use. However, this study revealed that social connections with injecting drug users played an important role in the process of initiation. As suggested by others (Harocopos et al., 2009; Latkin, 1998; Small et al., 2009; Witteveen et al., 2006), working with existing injecting drug users to dissuade non-injectors from initiating may be a more effective strategy than targeting individuals who are 'at risk' of initiation.

Treatment and Harm Reduction

A shift towards harm reduction practices has been observed in Irish drug policy over the past 20 years, and abstinence is no longer considered the only acceptable goal (Butler, 1991, 2002). The main harm reduction strategies introduced since the identification of intravenous drug use as a major route of HIV transmission in the mid-1980s include needle exchange, methadone maintenance programmes, and the creation of outreach and locally-based services (Butler & Mayock, 2005). Harm reduction policies that focus on individual behaviour change, however, are likely to result in limited success (Rhodes et al., 2005) because macro-, meso- and micro-level physical, social and cultural contexts mediate risk behaviour (Rhodes, 2000, 2005; Rhodes et al., 1999b). The results of this study strongly suggest that structural intervention strategies, in which the unit of analysis and change is the environmental system rather than the individual (Rhodes et al., 2005), are necessary if initiation into heroin use and risk behaviour are to be significantly reduced in young people.

Young injecting drug users are more likely to engage in 'risky' injecting practices associated with blood-borne viral transmission (Cassin et al., 1998; Fennema et al., 1997; Hahn et al., 2002; Kral et al., 2000; Ochoa et al., 2001; Smyth et al., 2001; Van Beek et al., 1998). Indeed, many in this study reported the sharing of injecting paraphernalia. As noted by Rhodes (1999), injecting risk behaviour is contextually determined by laws and policies that influence the availability of injecting equipment. The first needle exchange programme in Ireland was introduced in 1989, and there are now a number of statutory and voluntary services in the Dublin city area that aim to meet demand (Cox & Whitaker, 2009). However, the opening hours of needle exchange services vary; only one service in the city centre opens five days a week (between 10am and 4.30pm) and others open for between one and five hours, on just one day of the week (Cox & Robinson,

2008). Furthermore, provision is primarily restricted to urban areas and coverage at the national level is inadequate (Cox & Robinson, 2008).

Restrictions on needle exchange coverage can limit the effectiveness of harm reduction strategies in reducing rates of injecting risk behaviour and the spread of blood-borne viral infection (Bluthenthal et al., 2007; Islam & Conigrave, 2007; Loxley & Davidson, 1998; Sharma et al., 2003). Young people in this study explained that the limited availability of injecting paraphernalia, due to an absence of needle exchange services in their locales, or restrictions on needle exchange opening hours, contributed to the sharing of injecting paraphernalia. Previous researchers in Ireland have recommended extending needle exchange coverage to areas outside of Dublin, and have suggested the provision of 24-hour access to sterile injecting equipment (Cox & Lawless, 2000; Moore et al., 2004). The findings of this study indicate that such implementations may be effective at reducing injecting risk among young recent initiates.

National laws regulating syringe distribution are structural determinants of HIV transmission (Des Jarlais et al., 2000; Friedman et al., 2001; Hurley et al., 1997; Rhodes, 2005) and higher levels of syringe sharing have been reported among injecting drug users with no access to needle exchange services (Friedman et al., 2001; Hurley et al., 19978). At present, needle exchange services in Ireland do not extend to incarcerated populations of injecting drug users, despite concerns surrounding high rates of blood-borne viral transmission (Long et al., 2001). Similarly to the findings of previous studies (Edwards et al., 1999; Galea & Vlahov, 2002; Rothon et al., 1994), young men were more likely to participate in needle sharing while incarcerated due to the limited availability of injecting paraphernalia. This study, therefore, confirms that the sharing of injecting equipment in prisons is a major health concern (Allwright et al., 2000; Long et al., 2001, 2004). As suggested elsewhere (Cox & Robinson, 2008), the introduction of needle exchange services to prison settings requires urgent consideration.

Safer injection or consumption rooms have been a recent topic of interest and discussion among researchers, service providers and policy makers in the Irish context (Cox & Robinson, 2008; Moore et al., 2004; O'Shea, 2007; O'Sullivan, 2008). It has been argued that the introduction of these services would meet with considerable public resistance and would require too extreme a shift in drug policy to be considered feasible (Moore et al., 2004; O'Shea, 2007). Nevertheless, safer injecting rooms have been successfully introduced in Germany, the Netherlands, Switzerland, Australia and Canada (Dolan et al., 2000; Kimber et al., 2003; Wood et al., 2003, 2005; Zurhold et al., 2003). This study's findings indicated that finding suitable and safe injection locations presented major difficulties for young people, particularly for those who were living 'out-of-home'. Moreover, injecting in public outdoor locations, as reported elsewhere (Small et al., 2007), was associated with risky injection practices, placing young people at risk of

negative outcomes. As previously recommended by O'Sullivan (2008), the introduction of a safer injection facility in Dublin's inner city may serve to reduce the risk of blood-borne viral transmission among high-risk populations including young, homeless, recent injecting initiates.

The results of this study indicate that, in addition to the risks posed by injecting risk behaviour, sexual risk behaviour is a significant health concern among this population, particularly among young women. These findings strongly suggest that drug services must identify and address sexual risk within their clients' relationships, recognising individual constraints as well as the role of micro-level social and cultural norms. They also highlight a need to develop gender-sensitive approaches to both injecting and sexual risk behaviour. Drug treatment and harm reduction programmes must acknowledge the importance of gender (McElrath, 2001), and recognise that gender power dynamics operate to constrain safer sexual and injecting practices.

Concluding Comments

This study has provided valuable insights into the process of heroin and injection initiation among young people in Ireland, uncovering their pathways to heroin use and enhancing understanding of the role of macro-, meso- and micro-level 'risk environments' in shaping drug-related perceptions and behaviour. The findings also contribute to a more rounded and detailed understanding of the risks to which young people are exposed during their early heroin careers. Within 'risk environments', influenced by criminal involvement, gender power dynamics and experiences of homelessness, young people were vulnerable to violence, victimisation and exploitation, as well as to negative health outcomes such as mental health problems and blood-borne viral infection. Macro-level social, economic and gender inequalities shaped meso- and micro-level environments and young people described how social interactions with other drug users shaped their drug, injecting and sexual risk perception and behaviour. The majority participated in 'high-risk' activities such as sharing of injecting paraphernalia and engaging in unprotected sexual activity. Their narratives highlight how subjective experiences of risk were socially organised and shaped by social networks and relationships.

The findings of this study also have important implications for future drug research. It is strongly recommended that future studies of heroin and injecting drug use in Ireland account for the social and environmental determinants of risk perception and behaviour, and aim to explore how these forces interact to shape drug users' vulnerability to negative outcomes.

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APPENDICES

Appendix One: Information Sheet for Young People

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Information Sheet: Young People's Heroin Use

The purpose of this study is to look at early heroin use in young people. It will be focusing on young people between the age of 16 and 25 years and will be investigating their first experiences of heroin use. The study will examine:

- Where young people first use heroin
- How and why they use heroin
- If they are aware of the risks; and
- If they look for treatment for their heroin use

To answer these questions, 120 young people will be asked to complete a short 10-minute survey. Then, **40 young people will be asked to do an interview.** The interview will last about an hour and will look at many different things including the person's life experiences, their drug use and their sexual behaviour.

Taking part in this study is **voluntary**, therefore young people should not feel that they have to participate; they should only get involved if they want to. If at any stage during the survey or interview the young person feels uncomfortable with a question, they do not have to answer and if they change their mind about participating, they can leave.

Anything that is discussed during the survey or interview is **confidential**. Therefore, the researcher cannot tell anyone else what the young person said. The only exception is if the young person is in danger or distress and someone else needs to be told so that they can help him or her.

For Further Information Please Contact:

Dr. Paula Mayock, Senior Researcher, Children's Research Centre, Trinity College Dublin.
pmayock@tcd.ie (01) 896 2636

Jennifer Cronly, Children's Research Centre, Trinity College Dublin.
jcronly@tcd.ie (01) 896 3658

Appendix Two: Information Sheet for Service Providers

The aim of this study is to investigate young people's initiation into 'hard' drugs with a specific focus on heroin use. The study will examine young people's drug initiation environments, their drug use practices, their smoking/injecting rationale, risk behaviour and drug-related help seeking. Young people between the age of 16 and 25 years will be targeted for participation and the data collection methods include ethnographic observation, interceptor interviews and life history interviewing.

Background

Problematic heroin use has been identified in Ireland with an estimated 13,640 opiate users and a constant stream of new initiates. Injecting is a common route of administration with higher rates than in other European countries. Although a range of harm reduction strategies were introduced as a result of the public health crisis of HIV, unsafe injecting practices still persist in Ireland. Intravenous drug use is the largest risk category for HIV and it has been estimated that 68% of users have hepatitis C. Despite this, there has been no detailed investigation of injecting environments, practices and risk behaviour in the Irish opiate population. This is essential for developing effective prevention and intervention strategies.

Research Aims

[1] To describe the context in which high risk youth initiate the use of heroin.

[2] To describe the different practices that youth employ in the early course of heroin use

[3] To clarify youths' rationale for engaging in one or more types of heroin practices.

[4] To assess youths' experiences in help-seeking, including perceived barriers and obstacles.

Methods

Ethnographic observations will be made in a variety of public and semi-public settings in which young drug users are known to congregate. In these settings, 120 interceptor interviews will be conducted to assess background variables and risk behaviour. Based on this information, forty individuals between the ages of 16 and 25 will be targeted to complete an ethnographic interview. This interview will seek to explore the general life history of the youth and to uncover their initial involvement in drug and sexual risk behaviour. The emphasis is to obtain a narrative, depicting the youths' interpretation of events in his/her life. From this data, a descriptive summary will be obtained, followed by an analysis of the themes that emerge.

Contact: Paula Mayock or Jennifer Cronly, Children's Research Centre, Trinity College, Dublin 2.

Tel: 608 2636. E-mail: pmayock@tcd.ie or jcronly@tcd.ie

Appendix Three: Young Person's Consent Form

Consent to Participate In a Research Study entitled
PROJECT H

Life History Interview

The purpose of this consent form is to provide you with the information you need to consider in deciding whether to participate in this research study.

Study Purpose

You are invited to participate in a research study of young heroin users. The objective of the study is to examine how young people get involved in heroin use and how heroin use impacts on their lives. We are doing this study in the hope that we can recommend ways to prevent young people from becoming involved in serious drug use. We also hope to be able to recommend ways to help young people to reduce the harms and risks associated with heroin use.

Study Procedures

The purpose of the interview is to gather information about the lives and experiences of young people who use heroin. If you decide to take part in the study, we will ask you to participate in what we call a 'life history interview'. This interview may require up to an hour of your time. During the interview we will ask you to discuss the major events of your life. We will also ask you about your drug use history, about how you use heroin (and other drugs), about your friendships, social and family relationships, your romantic relationships, your daily life, and about your education and your health.

Depending on your preferences, the interview may be conducted in the setting where the researcher met you, such as on the street or at a needle exchange, or at another nearby location, such as a coffee shop or at a research office.

Audiotaping and Transcription

With your permission, we will audiotape the interview to help us to record your 'story' accurately. The researcher will turn off the recorder if at any time you wish that some part of the interview not be recorded. Following the interview, the audiotape or sections of the tape will be transcribed. We will remove all identifying information from the transcript, including your name and any other names, as well as any information that could be used to identify you or anyone else you mention. When the transcript is completed– which should occur by the project's end date of September, 2007– the audiotape will be destroyed.

Study Risks

Some of the questions that are included in the study are personal and may seem intrusive. You may refuse any question that you are not comfortable answering. If you become upset during the interview, the researcher will stop the interview and assist you in securing any kind of services or supports that you may need.

Study Benefits

The knowledge that you and others in the study provide may eventually lead to more effective methods of prevention. Because of the uncertainties and the time involved in research, it is not likely that any individual study participant can benefit personally from the study. However, results of this study may contribute to our understanding of how and why young people start and continue to use heroin. This information may contribute to the development of improved outreach, prevention, and treatment programmes.

Costs

The only cost to you is the time that will be required to complete this interview which we estimate to take one hour.

Compensation

For your participation in this study you will receive a 20 Euro Dunnes Stores Voucher.

Confidentiality

It is important that you understand that what you say during this interview will not be communicated to any other adult (social worker, the police, drugs worker, drug treatment personnel, outreach worker etc) or to any young person. The only exception is if you tell us that you or somebody you know is in danger.

To minimize any risk of someone else seeing your personal information, all of the information that you provide is kept secure in a locked file and is considered confidential. Code numbers will be used to protect your identity within the research project. When we write about the study, we will not use your name or anyone else's name, or anything about you that could be used to identify you.

Questions

If you have any questions, please ask and we will do our best to answer them. If you have additional questions in the future, you can reach the director of the study, Dr. Paula Mayock, at (01) 896-2636.

I, _____ (print name) give permission to participate in the study described above.

Signed: _____

Date: _____

Signed: _____ (Researcher)

Date: _____

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Parental Consent Form

Research Project on Young People's Drug Use

The purpose of this consent form is to provide you with the information you need to consider in deciding whether your son/daughter can participate in this research study.

Your son/daughter has been invited to participate in a research study of young heroin users. This research is being carried out at the Children's Research Centre, Trinity College Dublin. The objective of the study is to examine how young people get involved in heroin use and how heroin use impacts on their lives. We are doing this study in the hope that we can recommend ways to prevent young people from becoming involved in serious drug use. We also hope to be able to recommend ways to help young people to reduce the harms and risks associated with drug use.

We would like your son/daughter to take part in an interview. The purpose of the interview is to gather information about young people's lives and experiences and about their drug use.

Everything that is discussed in the interview is **confidential** and will not be communicated to any other adult or young person. The only exception is if your child tells us that they are in danger. All of the information gathered will be kept secure in a locked file and code numbers will be used to protect your child's identity within the research project. When we write about the study, all identifying information will be removed.

If you have any questions, please ask and we will do our best to answer them. If you have additional questions in the future, you can reach the Director of the study, **Dr. Paula Mayock**, at (01) 896-2636 or the researcher on the study, **Jennifer Cronly**, at (01) 896- 3658.

I, _____ (print name) give permission for my son/daughter to participate in the study described above.

Signed: _____ (Parent)

Date: _____

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Social Worker Consent Form

Research Project on Young People's Drug Use

The purpose of this consent form is to provide you with the information you need to consider in deciding whether your client can participate in this research study.

Your client has been invited to participate in a research study of young heroin users. The objective of the study is to examine how young people get involved in heroin use and how heroin use impacts on their lives. We are doing this study in the hope that we can recommend ways to prevent young people from becoming involved in serious drug use. We also hope to be able to recommend ways to help young people to reduce the harms and risks associated with heroin use.

The purpose of the interview is to gather information about the lives and experiences of young people who use heroin. If you decide your client can take part in the study, we will ask them to participate in what we call a 'life history interview'.

Anything that is discussed in the interview is confidential, therefore will not be communicated to anyone. The only exception is if the young person tells us that they are in danger. All of the information is kept secure in a locked file and is considered confidential. Code numbers will be used to protect the young person's identity within the research project. When we write about the study, all identifying information will be removed.

If you have any questions, please ask and we will do our best to answer them. If you have additional questions in the future, you can reach the director of the study, Dr. Paula Mayock, at (01) 896-2636.

I, _____ (print name) give permission for my client _____(clients name) to participate in the study described above.

Signed: _____ (Social Worker)

Date: _____

Appendix Six: Community Assessment Process (CAP)

Interview Protocol

Introduction

- This study is being conducted by the Children's Research Centre and is funded by the National Institute on Drug Abuse, USA.
- The information obtained will help build knowledge about a group of young people who are at risk of heroin use.
- We hope to;
  a) Build knowledge of factors that place young people at risk
  b) Have a better understanding of risk behaviours
  c) Make policy and practice recommendations
- The focus of the study is heroin use among young people (18-25) who have initiated within the past 4 years.
- The goal is to better understand the process of initiation including the initiation environment, risk behaviours and knowledge of harm reduction strategies.
- We wish to interview service providers because they are in the best position to know about these issues and can help us recruit.
- We really appreciate your knowledge and expertise and hope you can help us better understand the scene
- The information obtained may be used but the agency and individual will (of course) NOT be identified.
- Can I record the interview?

Description of Agency

Name of Service _____

Role in Organisation _____

- Can you just give me an overview of the service you work for?
- What does the service offer and how is it structured?
- Where do you get most of your referrals?
- What other agencies or services do you liase with?
- What population to you serve?
- What percentage of your clients are under 25?
- What is your role within the service?
- What clients do you have the most success with?
- What clients do you have the least success with?

The Drug Scene

- What drugs are most available in this area?
- What is young people's drug of choice at the moment?

- Do you think this has changed in the last 5 years?
- There is less talk about heroin (in the media), do you think that this is because there's less of it around?
- What is the typical heroin user like today?
- Do you think this has changed in the last 5 or 10 years?
- Which young people are most at risk of heroin initiation?

Service Provision

- Are there unique challenges dealing with young drug users?
- What is the greatest challenge in addressing their needs?
- Is there interaction between the drug and youth services?
- Do you think the provision of services for young users has improved?
- What are the gaps in service provision?

Addressing Young People's Needs

- What are the young people's most immediate needs?
- What is the most difficult thing about engaging this group?
- Who are the most difficult young people to engage?
- Which young people are easier to deal with?

Advising the Study

- We need help recruiting young people, where do you think we could find them?
- What difficulties do you think we might face?
- Do you think young people are reluctant to admit heroin use during the early stages?
- What about after 1 or 2 years?
- Are there other services or agencies we should contact?
- Is there anything else you'd like to add?
- THANKS A MILLION!!!!

Appendix Seven: Questionnaire

Subject ID: _____

Interviewer ID: _____

Date: _____

Place of interview: _____

Demographics (DM)

DM1. Gender

_____ Male
_____ Female

DM2. Age

___ ___

DM3. Do you identify with any of the following cultural/ethnic backgrounds?

____ Traveller
____ Roma (Gypsy)
____ Eastern European
____ African
____ None

DM4. Date of Birth

_____/_____/_____

DM5. Education

_____ Completed primary school
_____ Completed Junior Certificate
_____ Completed Leaving Certificate
_____ FAS/Youthreach Training
_____ Apprenticeship
_____ Diploma/College
_____ None of the above

DM6. What type of place do you live? (*multiple responses okay*)

_____ Family home
_____ LA Home (council)
_____ Flat (private rented)
_____ Friend's home
_____ Partner's home
_____ Hostel
_____ Squat
_____ Other

DM7. Have you ever experienced homelessness?

_____ Yes
_____ No

DM8. If yes (to DM7), was this:
_____ in the past two years
_____ in the past year
_____ in the past six months

DM9. What are your current sources of income? (please tick all that apply)
_____ Social Welfare
_____ Family
_____ Partner
_____ Full/Part time employment
_____ Theft/ Robbery/ Burglary
_____ Selling drugs
_____ Other

Drug use history (DH)

DH1. How old were you the first time you used heroin?
_____ years

DH2. (If ever used) How often have you used heroin in the past month?
_____everyday
_____once/twice a week
_____once/twice a month
_____not at all

DH3. Drug that you have EVER used, used in the PAST YEAR, used in the PAST MONTH

Drug	Ever Used	Used in past year	Used in past month
Alcohol			
Cannabis (Hash)			
Cocaine Powder			
Crack (Rock) Cocaine			
Heroin			
Methadone			
Speed			
Ecstasy			
Benzo's			

Cocaine Use

CU1. How old were you the first time you used cocaine?
_____ years

CU2. The first time you used cocaine, how did you take it?
____ Snort
____ Smoke
____ Inject
____ Other (Specify: _____)

CU3. Have you ever washed up (cooked or 'rocked') cocaine powder yourself?

____ Yes
____ No

CU4. At the moment, how often are you using cocaine?
_____ daily
_____ once or twice a week
_____ once or twice a month
_____ not at all

CU5. How are you using cocaine at the moment (tick all that apply)?
_____ Snort
_____ Smoke
_____ Inject
_____ Other (Specify: _____)

CU6. On an average day when you use cocaine, how much would you usually take?
_____ grams

OR _____(*verbatim*)

First Use of Heroin

FU1. Was there a specific person who introduced you to heroin?
_____ Yes
_____ No

FU2. Approximately how old was this person?
_____ Age

FU3. What was your relationship with this person?
_____ Parent
_____ Sibling
_____ Other relative
_____ Friend
_____ Acquaintance
_____ Boyfriend/girlfriend/husband/wife/partner
_____ Other

FU4. Have any members of your family ever used heroin?
____ Yes
____ No

FU5. The first time you used heroin, how did you take it?
____ Smoked
____ Skin popped
____ Other (Specify: _____)
____ Injected at first use

FU6. Where did this first heroin use take place? _____(*location*)

_____ Your home
_____ Other user's home

_____ Hostel
_____ Indoor venue (bathroom, pub etc)
_____ Outdoor space
_____ Squat
_____ Jail/Prison
_____ Other

FU7. Besides yourself, how many others also used heroin at that time?
_____ Number

Initiation into injection (IN)

IN1. Have you ever injected?
_____Yes
_____No

IN2. What drugs have you ever injected? (*check all that apply*)
_____ Heroin
_____ Cocaine/Crack
_____ Speed
_____ Pills (Benzo's)
_____ Other

IN3. How old were you when you first injected?
_____

IN4. Did you plan this first injection event?
____ Yes
____ No

IN5. What was the first drug that you injected? (*check all that apply*)
_____ Heroin
_____ Cocaine/Crack
_____ Speed
_____ Pills (Benzo's)
_____ Other

IN6. Why did you decide to inject at that time, instead of taking the drug in some other way?
(*verbatium*)_____
_____ Curiosity
_____ Wanted better high/instantaneous rush
_____ Economics
_____ Peer pressure
_____ Problem with other mode of administration
_____ Developed a tolerance to other mode of administration
_____ Dying Sick
_____ Other

IN7. Can you remember where you were at the time?
(*verbatium*)_____

_____ Your home
_____ Other user's home
_____ Hostel
_____ Indoor venue (bathroom, pub etc)
_____ Outdoor space
_____ Squat
_____ Jail/Prison
_____ Other

IN8. Did you inject yourself on the first occasion?
_____ Yes
_____ No

IN9. Did you have your own syringe?
_____ Yes
_____ No

IN10. Did anyone else use the syringe before you did?
_____ Yes
_____ No
_____ Don't know

IN11. Did anyone else use the syringe after you did?
_____ Yes
_____ No
_____ Don't know

Current injection practices (CI)

CI1. At the moment how often do you inject?
_____ everyday
_____ once/twice a week
_____ once/twice a month
_____ not at all

CI2. In the past month, have you injected on your own?
_____ Yes
_____ No
_____ N/A

CI3. When did you last inject?
_____today
_____yesterday
_____in the past week
_____ in the past month
_____ in the past year
_____ never

CI4. What drug(s) did you inject? (*check all that apply*)
_____ Heroin
_____ Cocaine/Crack
_____ Speed

_____ Benzo's
_____ Other

CI5. Did anyone else use the syringe before you did?
_____ Yes
_____ No
_____ Don't know

CI6. Did anyone else use the syringe after you did?
_____ Yes
_____ No
_____ Don't know

Syringe sources (SS)

SS1. From which of the following sources have you obtained syringes during the past month? (*check all that apply*)
_____ Syringe exchange
_____ Pharmacy
_____ Syringe dealer
_____ Injection partner
_____ Friend/relative
_____ Other
_____ None/not applicable

SS2. Has there ever been a situation where you've had to use someone else's syringe?
_____Yes
_____No

Sexual history (SH)

SH1. How old were you the first time you had sexual intercourse?
_____ Age (***if never, enter "99" and skip to question SU1***)

SH2. Approximately how old was this other person?
_____ Age of other person

SH3. Did you use a condom the first time you had sexual intercourse?
_____ Yes
_____ No
_____ Don't remember

Current sexual practices (CS)

CS1. When was the last time you had sexual intercourse? ***(If never, go to question SU1)***
_____ a few days ago
_____ a few weeks ago
_____ a few months ago
_____ a few years ago
_____ Never

CS2. Approximately how old was your sexual partner?
_____ Age

CS3. Has your sexual partner ever injected drugs?

_____ Yes
_____ No

CS4. Did you use a condom the last time you had sex?

_____ Yes
_____ No

CS5. In the past two months, have you used condoms for sexual intercourse…

_____ All of the time
_____ Some of the time
_____ None of the time

Service Utilization (SU)

SU1. Have you ever been tested for any of the following?

_____ HIV
_____ HBV
_____ HCV
_____ Any STD
_____ None

SU2. Have you tested positive for HCV?

_____ Yes
_____ No

SU3. Have you tested positive for HIV?

_____ Yes
_____ No

SU4. Have you tested positive for HBV?

_____ Yes
_____ No

SU5. Have you ever received any type treatment for your drug use?

_____ Yes
_____ No

SU6. What type of drug treatment(s) have you received? (check all that apply)

_____ Detox
_____ Residential
_____ Methadone Maintenance
_____ Other

SU7. Are you currently in a methadone maintenance program?

_____ Yes
_____ No

SU8. What is your current methadone dose?

_____ Milligrams

SU9. Have you ever overdosed on any drug?

_____ Yes
_____ No
_____ Not sure

SU10. Have you ever been charged with a crime?

_____ Yes
_____ No

SU11. What crimes have you ever been charged with? (*check all that apply*)

_____ Drug possession
_____ Drug dealing
_____ Theft/ Larceny/ Shoplifting
_____ Burglary/ Forcible Entry
_____ Robbery of Establishment/Person
_____ Armed Robbery
_____ Assault
_____Public Order Offence
_____Other

SU12. Where you ever convicted?

_____ Yes
_____ No

SU13. Have you been in prison?

_____ Yes
_____ No

SU13a. Did you use heroin in prison?

_____ Yes
_____ No

SU13b. Did you inject in prison?

_____ Yes
_____ No

SU14. Are you currently on probation?

_____ Yes
_____ No

Appendix Eight: Life History Interview Protocol

LIFE HISTORY

1. As I have explained, this study is interested in young people who use heroin. You might remember that the last time we met I asked you some questions about your heroin use. Today I want to talk to you in a bit more detail about your life in general and about your drug use. This interview will take about 1 hour. To help us to get started, it would be good if you could tell me a bit about your life. We often call this our **'LIFE STORY'** ...

We all have a life story (elaborate, if necessary) – could you tell me yours? You can start anywhere you want and tell me whatever parts you want. Take your time. You can start whenever you feel comfortable.

[*Let the young person tell his/her story without questioning or probing*].

EARLY LIFE HISTORY

2. What would you say is your **earliest memory** of your home or family?
3. Can you tell me a little more about your **family** when you were a child?
   - parents, other guardians/caregivers
   - significant others (e.g. grandparents, aunts/uncles and other extended family members)
   - siblings (how many brothers and sisters)
   - current family relationships
4. Did you or your family **move house or area** at all when you were a child or as a teenager?
   - experience of living in different parts of the city?
   - experience living away from Mum/Dad/parents?
   - what was it like moving around a lot?
5. Can you tell me about what **school** was like when you were younger?
   5a. When did you stop attending school? Can you remember why?
   5b. Did you do a FAS/Youthreach course at any time?
   5c. What about work? Have you ever had a job? (explore)

DRUG HISTORY

I'd like ask you some questions now about your drug history if that's ok.

6. Can you remember the first time you EVER tried a drug?
   6a. Age/which drug?
   6b. Can you tell me how this came about (who was present; situation/setting; what was 'going on')?
7. Can you tell me where your drug use went from there?
   [Focus here on drug use chronology]
8. Explore the respondent's use of the individual drugs s/he mentions, focusing on (see attached questions on each area):
   8a. Drug use settings/contexts of use
   8b. Drug transitions

8c. Drug use motives

9. What about drinking during this time? As a teenager did you go drinking with your friends? Explore alcohol use frequency and use settings.

HEROIN INITIATION

10. I want to talk to you now about the first time you took heroin: Could you go back in your mind and try and picture where you were and what happened?
    10a. Can you remember who was there?

    10b. What was your relationship to these people?

    10c. Where were you at the time? [Probe for information on use setting]

    10d. Had you thought about taking heroin before this?

    10e. Were you curious about what it would be like?

    10f. Did you know a lot of people who had used heroin?

    10g. What did other people tell you about heroin?

    10h. Did you plan on taking heroin this time or was it unexpected?

    10i. Can you remember what it felt like the first time? Was it different to other drugs?

11. How did you use heroin the first time? Did you smoke or inject?
    11a. Did you know what to do or did somebody help you?

    11b. Can you describe the process of how you smoked (or injected) this first time. What did you do?

12. Did you have your own supply?
    If yes, did you score earlier that day?

    If no, who provided the drug?

    Can you remember how much you used that first time?

13. Can you remember how you felt the next day?
14. How long was it before you used heroin again?
15. Thinking back, what do you think about that first time you used heroin? Does anything spring to mind about that time in your life?
16. What did you think about heroin at that time? Since then have you changed your opinion about heroin? Why has your opinion changed since then?

FRIENDS & FAMILY

I'm going to switch now and talk to you about your friends and family.

17. Can you tell me a little bit about your friends, about the people you hang around with now? What do you do together?
18. Would you say that your friends/friendships have changed over the past years?
19. Do you have a girl/boyfriend? Are you close to them? Have you had a close relationship in the past?
20. Do you get on well with your parent(s)?

Did your drug use affect your relationship with your parent(s)?

21. What about your brothers & sisters? Do you see them? Do you get on well with them?

DAILY LIFE

22. How do you usually spend your day?
23. Is it hard to manage on your welfare money?Have you ever had to steal or do other things to make money? If yes, probe for further detail.
24. Have you ever been **in trouble with the police**?
    - How old were you when you first got into trouble with the police?
    - Did you attend a special school for young offenders?
    - Have you ever been *arrested*?
25. Have you ever been charged with a crime?
    If YES, what was the charge(s)?

    have you gone to court yet?

    do you have outstanding warrants or charges?
26. Have you ever been in prison? If YES, can you tell me more about that?

IF the young person has experienced homelessness:

27. You mentioned earlier that you are/have been homeless. Can you tell me how that came about?
    31a. How old were you?

    31b. What places have you slept/stayed after leaving home?
28. What is you situation now? Where are you living?Are you happy with your living situation or are there things you would like to change? If yes, what might help you?

DRUG/HEROIN 'CAREER'

We talked a good bit earlier about the first time you used heroin. I just want to talk to you about how your heroin use went from there.

29. Is there anything that comes to mind right now the time in your life when you first took heroin? Anything, that strikes you looking back?
    Probe:

    Like, do you think looking back that there were things in your life that influenced your drug use?

    Were your friends important to you at this time?

    What would you say were the important things to you as a teenager?
30. At what point would you say you started to use heroin regularly?
31. At what stage did your heroin use become a problem? Can you remember the point/stage when you felt you were strung out?
32. What changes did your heroin use bring about in your life? Did things change for you? If yes, what?
33. Did using heroin have an impact on your health? Has it affected your teeth, lungs?

34. Did you ever get any treatment for your drug use? Did it help? Why/Why not?

INJECTING DRUG USE

35. **Have you ever injected a drug?**
IF NO,

Have you ever considered injecting a drug? Why/Why not?

What do you think about injecting drugs?

Why do you think other people inject drugs?

Have you ever been around other people injecting drugs?

IF YES,

36. Can you remember the **first time** you injected a drug? If you could try go back in time and remember where you were and who was with you.
35a. Which drug?

35b. Who was with you? What was your relationship to this person?

35c. Where were you?

35d. Did you have your own needle/syringe?

35e. Did you inject yourself or did somebody help you? Who was that? What was you relationship with him/her? Why did they inject you/ How did you know how to inject yourself?

35f. Can you describe the process of what you (or they) did? What equipment did you use? How and what part of your body did you inject into?

37. Which drugs have you **ever** injected? [heroin/cocaine/other drugs]
What are the different experiences in injecting these drugs?

38. Which drug(s) have you injected **recently** (in the past month)?
39. Can you tell me about the **last time** you injected heroin?
38a. Where were you? Can you describe what it's like there?

38b. Were there other people with you/injecting at the time?

38c. What part of your body did you inject into?

38d. Can you describe the process of how went about injecting?

38e. Did you have a clean needle? If yes, where did you get it?

38f. Did you all use the same injecting equipment (spoon/filter/water)?

38g. What did you (or your friend) do with the needle afterwards?

40. What drug(s) do you **usually** inject? What quantities do you inject at a time? How many times would you inject in a day?
41. Is injecting the way you prefer to use drugs? Why do you prefer to inject?
42. What do you think are the negative aspects of injecting drugs? Do you worry that anything bad might happen as a result of injecting?
43. How do you try to make sure that you inject as safely as you can? What do you try to do to minimise the dangers of injecting?
44. Have you ever had health problems as a result of injecting (such as collapsed veins, abscesses, septacemia)?
45. Have you ever overdosed on any drug? Can you tell me a little bit about what happened?

46. Have you ever had any blood tests for HIV, Hep C or Hep B? What was the outcome?
47. (If tested positive) Have you received any information or treatment about your HIV/Hep C or Hep B?

INJECTING RISK BEHAVIOUR

48. Can you remember a time when you shared a syringe/needle?

    If yes,

    - Can you tell me about how that happened (setting, individuals present etc.)?
    - When did it happen for the first time?
    - Who was the person you shared with?
    - Did you use/inject before or after you?

    If no,

    - Do you think it's difficult for people to keep to the 'rule' of not sharing?
    - Have you ever been in a situation where you thought you might have to share?
    - Have you ever given somebody your syringe after you finished injecting?
    - Have you ever used injecting equipment (a spoon, swab) after somebody else?

ALCOHOL/POLYDRUG USE

49. What about alcohol? Do you drink now at all?

    49a. Do you drink every day? What time(s) of the day do you usually drink?

    49b. How many days a week do you usually you drink?

    49c. Do you usually take drugs when you drink?

50. Which drug would you say you have used the most? Which one is your favourite drug?
51. Do you usually drink when you are taking drugs?
    - Which drug(s) do you usually mix with alcohol?
    - What are the effects like?
52. Have you ever used Benzodiazepines? (eg. valium, xanax, Zimmovane, D5's, D10's, sleepers)
53. Do you use Benzo's regularly? How often would you take them and how much would you take at one time?
54. Do you take Benzo's in combination with alcohol or other drugs?

SEXUAL BEHAVIOUR/RISK BEHAVIOUR

55. You mentioned earlier that you are/have been in a relationship ... can I ask you if you are sexually active?
56. Can you remember if you used a condom the last time you had sex?

    If YES Do you usually use a condom?

    Are there times when you have not used a condom?

    If NO Do you usually use a condom?

57. Do you ever/usually carry condoms? (probe)
58. Have there been times when you didn't use a condom?

DRUG ACQUISITION

59. Where do you usually 'score' (buy) drugs?
    - Do you usually 'score' from the same person?
    - Have you ever bought drugs from your friends? (probe)
    - Have you ever been caught buying or selling drugs by the police? If yes, can you tell me about that and what happened?

HEALTH

60. Do you have any physical health problems at the moment? EXPLORE, particularly in relation to problems related to drug use.
61. Have you had (or do you have) any problems with your mental health?
62. Do you have worries or concerns about your health?
63. Do you ever feel depressed?
    - What makes you feel depressed? How often etc?
    - What do you do when you feel depressed? Is there anything that helps?
    - Have you spoken to a doctor about depression?
    - Have you taken medication for depression at any time?

      (if yes to the above question – explore:

      - What drug(s) was prescribed?
      - How long did you take this medication for?
64. If you feel upset about something, is there somebody you can talk to?

SERVICE ACCESS & UTILISATION

65. Are there places have you gone to get help at any time? If yes, where did you go?
66. Where is the most recent place you have gone to for help or advice?
67. Have you ever talked to a **counsellor**? If yes, when & where? Was it helpful?
68. Has an **outreach worker** ever talked to you on the street? What kind of advice did s/he give?
69. Is there a service that you have found to be good? Are there others that didn't help you?
70. What kind of service would be a help to you now?

FUTURE

71. Everyone has their own ideas about the future. Where would you like to see yourself in the future, say in a couple of year's time?
72. Are there things about the future that worry you? If yes, EXPLORE.
73. Is there anything that would help you to have a better future?

ADVISE THE STUDY

Over the next few months we will be talking to other young people about their lives and about their heroin use:

74. Do you think there are other questions we should ask?
75. Do you know anyone who would be interested in talking to us?

I THINK WE'RE FINISHED. THANKS A MILLION FOR YOUR HELP.

Counselling Services in Dublin

Merchant's Quay Ireland: The Failtu Counselling Service is provided by the Failtu Resource Centre, a drop-in and crisis support service for homeless people. It was established to help homeless people cope with the stresses of life on the streets.

Failtu Resource Centre,
4 Merchant's Quay, Dublin 8.
Drop-in Service.

Dublin Rape Crisis Centre: The Dublin Rape Crisis Centre offers a range of services to women and men who are affected by rape, sexual assault, sexual harassment or child sexual abuse. Services include a 24 hour Helpline, one-to-one counselling, group counselling, medical and court accompaniment.

Dublin Rape Crisis Centre
70 Lower Leeson Street, Dublin 2.
FREEPHONE: 1800 77 88 88.

Teen Counselling: A counselling service for a young people under 18 and their families. Issues covered include alcohol and drug problems, relationship difficulties, domestic violence and emotional problems.

Ballygall,
19 Glasilawn Avenue, Dublin 11.
(01) 864 6014

Clondalkin,
Quarryvale Community & Leisure Centre, Dublin 22.
(01) 623 1398

Mater Dei,
Clonliffe Road, Dublin 3.
(01) 837 1892

Tallaght,
Raheen Park, Springfield, Dublin 24.
(01) 462 3083

Northside Counselling Service: A free service for people over 18 that provides individual counselling and group therapy covering issues such as suicide, bereavement and life-management skills.

Coolock Development Centre, Bunratty Drive, Bonnybrook, Dublin 17,
(01) 848 4789

Elah Voluntary Counselling Service: A counselling service covering issues such as families in crisis, drug addiction, marital and relationship conflict, gender identity issues, eating disorders, depression and abuse.

48 Hamilton Street, Dublin 8.
(01) 454 1278.

Hesed House: A community based counselling service for individuals, families and groups, particularly for those on low income or social welfare. Issues include separation, bereavement and domestic violence.

74 Tyreconnell Road, Inchicore, Dublin 8.
(01) 454 9474

New Day Counselling Service: Low cost counselling service for those living in the inner city, particularly the south west inner city. Issues include relationship difficulties, HIV/AIDS, depression, eating disorders, sexual abuse, rape, bereavement and adolescent difficulties.

11 Meath Street, Dublin 8.
(01) 454 7050

The National Counselling Service: A free community based service provided by the Health Service Executive for adults who experienced childhood abuse in Ireland.

Northern Area Health Board,
Laragh Counselling Service,
140 St. Laurence's Road, Clontarf.
FREEPHONE: 1800 234 110

East Coast Area Health Board,
Baggot Street Community Hospital,
18 Upper Baggot Street, Dublin 4.
FREEPHONE: 1800 234 111

South Western Area Health Board,
Adult Counselling Service,
66 Old Bawn Road, Dublin 24.
FREEPHONE: 1800 234 112

Helplines & Support Groups

Samaritans: A 24-hour Helpline and one-to-one listening service providing emotional support for people who are experiencing feelings of distress or despair, including those which may lead to suicide.

112 Marlborough Street, Dublin 1.
(01) 872 7700
HELPLINE: 1850 60 90 90

Aware: A service offering a Helpline and support groups for those who are affected directly by depression.

72 Lower Leeson Street, Dublin 2.
(01) 661 7211
HELPLINE: 1890 303 302

OANDA: A national self-help organisation for people suffering from panic attacks and anxiety disorders. OANDA offers information packs and support groups.

140 St. Lawrence's Road,
Clontarf, Dublin 3.
(01) 833 8252

Schizophrenia Ireland: A national service for those affected by schizophrenia offering a Helpline, support goups, counselling and an employment service.

38 Blessington Street, Dublin 7,
(01) 860 1620
HELPLINE: 1890 621 631

Narcotics Anonymous: Meetings provided by a group of recovering addicts for drug users who wish to stop using.

4-5 Eustace Street, Dublin 1.
(01) 672 8000
086 862 9308