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New injectors and the social context of injection initiation

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Abstract

Background—Preventing the onset of injecting drug use is an important public health objective yet there is little understanding of the process that leads to injection initiation. This paper draws extensively on narrative data to describe how injection initiation is influenced by social environment. We examine how watching other people inject can habituate non-injectors to administering drugs with a needle and consider the process by which the stigma of injecting is replaced with curiosity.

Method—In-depth interviews (n=54) were conducted as part of a two-year longitudinal study examining the behaviours of new injecting drug users.

Results—Among our sample, injection initiation was the result of a dynamic process during which administering drugs with a needle became acceptable or even appealing. Most often, this occurred as a result of spending time with current injectors in a social context and the majority of this study's participants were given their first shot by a friend or sexual partner. Initiates could be tenacious in their efforts to acquire an injection trainer and findings suggest that once injecting had been introduced to a drug-using network, it was likely to spread throughout the group.

Conclusion—Injection initiation should be viewed as a communicable process. New injectors are unlikely to have experienced the negative effects of injecting and may facilitate the initiation of their drug-using friends. Prevention messages should therefore aim to find innovative ways of targeting beginning injectors and present a realistic appraisal of the long-term consequences of injecting. Interventionists should also work with current injectors to develop strategies to refuse requests from non-injectors for their help to initiate.

Keywords

Injecting drug use; Initiation; Social setting; Narratives

Introduction

Many of the harms associated with the use of illicit drugs such as heroin depend on the route of administration. In particular, those who inject drugs are at risk of contracting blood-borne viruses via the use of contaminated equipment. Other related health problems may include bacterial infections, vein damage and overdose (Scott, 2005; Chitwood et al., 2000; Des Jarlais et al., 1999). While most people in the US who use injectable drugs are unlikely to try this route of administration, a sizeable number will, and several reports have suggested a resurgence in injecting heroin use among young, new users (NIDA, 1996; CDC 2001).

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Most literature on the transition to injecting focuses on characteristics of individuals and/or their social networks. Factors correlated with injecting drug use include low educational attainment (Crofts et al., 1996; Dunn and Lararjeira., 1999), poly-drug use (Darke., et al., 1994), sex-trading at a young age (Fuller et al., 2002) and a history of sexual abuse (Miller, 1999). The influence of social networks has also been reported (Neaigus et al., 2001; Gamella, 1994; Des Jarlais et al., 1992), as has having a sex-partner who injects (Sherman et al., 2002; Ouellet et al., 1998). Market forces may also play a part: several New York studies have noted a growing number of people using heroin intranasally (Hamid, 1997; Neaigus, 2001) linked to the availability of high purity retail-level heroin (Frank and Galea, 1998). Historically, declines in purity coupled with an increase in price have resulted in substantial numbers of drug users making the transition to injecting (Frank, 2000; Chitwood et al., 2000).

In one of the few studies to look at the circumstances surrounding injection initiation, Crofts and colleagues (1996) report that for many members of their sample, the desire to experience the intense euphoria – or ‘rush’ associated with injecting was an important factor in the decision to try it. Other studies have described the superior efficiency of injecting as a reason to initiate especially among those who have developed tolerance for a drug through use via other routes of administration (Giddings et al., 2003; Bravo et al., 2003; Van Ameijden et al., 1994; Fitzgerald et al. 1999). However, Roy et al. (2002) found that the most commonly cited motive for first injection among street youth in Canada was curiosity. Further, for almost a third of this sample, initiation into injecting was also their first experience of the drug they had injected, suggesting that factors other than economics or growing tolerance were at play.

Much of this evidence has been collected by way of epidemiological behavioural studies examining the risk of transition from one route of administration to another. What is largely missing from the literature are accounts contextualizing the process of injection initiation which consider the situational and social factors related to first injection. New initiates to injecting tend to be particularly vulnerable to HIV and hepatitis C transmission (Crofts et al., 1996; Garfein et al., 1998; Thorpe et al., 2000; Chitwood et al., 2000; Nelson, 2002). Preventing the onset of injection drug use is therefore an important public health objective, yet there are currently few interventions with this aim (Vlahov, et al., 2004; Hunt et al., 1998; Des Jarlais, et al., 1992). Broadening our understanding of the initiation process may help treatment providers and public health professionals better identify the risk factors associated with a transition to injecting drug use and enable them to frame harm reduction messages using the language and concepts of those who are vulnerable.

This paper explores the circumstances of injection initiation for a cohort of new injectors whose first injection had taken place within the previous 18 months. We concentrated on this group for several reasons: new injectors may give early warning of emergent risk behaviours; and, recent initiates are likely to recall the circumstances surrounding first injection with greater accuracy than their more experienced peers. Perhaps most importantly, our sample is illustrative of contemporary trends in drug use and injecting: as such, the motivations and experiences they describe have particular relevance for the future development of targeted prevention and harm reduction strategies.

Methods

Data was collected as part of a longitudinal ethno-epidemiological study of new injecting drug users in the New York City metropolitan area. In the first phase, a cross-sectional survey was administered to 162 respondents who had initiated injecting drug use within the previous three years. The sample was predominantly recruited by ethnographers working in and around venues where drug users were known to congregate and thereafter, through chain referrals. Street-based contact accounted for roughly a third of participants; chain referrals for another

third; and the remainder were recruited by approaching potential subjects at mobile syringe exchange programs (22%); referrals from other research studies (5%); and Internet chat rooms (3%). From this sample, a subset of participants (n=54) who had first injected within the previous 18 months were enrolled in the longitudinal phase of the research which involved in-depth bi-monthly interviews for two years as well as blood-screens for HIV, hepatitis B and hepatitis C every four months. To maintain contact with subjects we used a number of strategies including: collecting locator information; 'tracking diaries' used to note down details of all communication with subjects; field visits to locations where subjects were known to hang out; and bonus incentives of \$50 for subjects making it to key points in the study. Paid research studies, especially those seeking particular attributes for eligibility are sometimes 'hustled' by street-smart drug users (Scott, 2008). In an attempt to maintain the integrity of the sample, study ethnographers were careful not to disclose the criteria for inclusion and, where they penetrated social networks, conducted a number of masking interviews with individuals who had either never injected or whose injecting career went beyond the scope of the study. Despite these precautions, we identified 13 people who had misrepresented their injection history, and data from these subjects were excluded from the analysis.

Interviews were semi-structured and included discussion of economic resources, drug use, first use of initial injection drug, initiation into injection, current injection practices, syringe sources, sexual history, social resources, service utilization and HIV knowledge. Administering interviews in this way allowed interesting topics to be pursued and themes to develop. The topic of injection initiation was revisited several times throughout the study enabling subjects to clarify and elaborate the details of their first injection. Interviews were recorded and lasted between 30 minutes and two hours. Sections were then transcribed by ethnographers and incorporated into detailed fieldnotes which were catalogued in Atlas ti. (Muhr, 2004) using a coding framework derived from the interview guide.

The remainder of this paper draws extensively on the qualitative data collected as part of this study to describe factors that led to injection initiation. Through subjects' narratives, we give context to the post hoc rationalization for the decision to inject by examining the circumstances and social relationships which led to the first hit. All the names reported in the text are fictitious.

Results

Sample characteristics

Our cohort consisted of 54 participants whose ages at the time of first interview ranged from 16 to 42 years (median 22 years). Thirty-two (59%) were male and one identified as transgender. The majority were non-Hispanic white (30; 56%) or Hispanic (19; 35%). Levels of educational attainment were mixed: 14 (26%) had not completed high school; 12 (22%) had graduated high school or received their GED¹ and 19 (35%) had continued on to higher education. Nine (17%) respondents were still attending high school. Age at first injection ranged from 15 to 41 years (median 21 years). Most (44; 81%) initiated into injecting using heroin and the majority (49; 91%) had previously tried the drug they first injected, usually intranasally. The median time from first use to first injection was eight months. Not all of our subjects became regular injectors and by the end of the study, 12 had injected fewer than five times.

Prior to their initiation, many participants expressed negative feelings about administering drugs with a needle. For some, injecting was viewed as a stigmatized behaviour, the activity of a 'junkie' or 'low-life'. Others saw it as a potentially dangerous or dirty procedure and

¹General Educational Development is a series of tests which, if passed, certify that the taker has high-school level academic skills.

mentioned the fear of needles, overdose or concern about blood-borne disease as a reason for not injecting. As one respondent commented:

“I used to despise people who shot it. I thought it was stupid, I thought it was nasty, I thought it was a horrible thing to do. I knew what it had done to people.”

For these subjects, initiation into injecting took place when the stigma and fear of injecting had been displaced by other factors. Among our sample, this was a dynamic process during which administering drugs with a needle became at the very least acceptable and in many cases, appealing. Most often, the ‘pull’ which led to shooting drugs was associated with exposure to current injectors, often friends or lovers. The following series of case studies describe how members of our sample came to initiate into injecting and the social context in which this took place.

Injecting within friendship groups

We talked to several young drug users who reported that injecting (usually heroin) had spread through their social networks as a result of the initiation of one or two key members. These ‘pioneers’ then returned to their drug-using friends and enthused about injecting, which made it appealing for other members of the group to try. James, 26, had been sniffing heroin regularly for around nine months before he decided to try injecting: “One, I figured I could use less, and two, I knew the high would be more intense. And, three, it was just like the final frontier of the drug world”. None of his drug-using peers knew how to shoot – in fact they had collectively decided to avoid injecting as they felt it overstepped the boundary of acceptable use. As James said:

“I looked at it [injecting] as much worse than what I was doing. In my mind, at that time, I probably didn’t even admit to myself that I was a full-blown addict, whereas if I had started shooting, I would have become one.”

However, recognizing that his heroin use was becoming a problem, James planned to go to detox and decided that before he went, he wanted to try injecting so he didn’t feel that he had “missed out on anything”. No one in his immediate social sphere knew how to inject so he persuaded an acquaintance of his – an ex-heroin user who was now in a methadone program – to help him administer a shot. James acknowledged that the effect he felt from his first injection was not as powerful as he had expected. Nonetheless, when he saw his drug-using friends later that evening, he recounted his experience in glowing terms telling them, “It’s so much better”. When they heard that he had injected, James’s friends clamoured at him to introduce them to his trainer so they could also try it: “As soon as they found out that we did it, they wanted to too. And they did”. As James was not yet a competent injector (it took him over 100 injections before he could inject himself), he persuaded the same person who had initiated him to help his friends and together, injection became their main route of administration.

In this example, injecting diffused through a network of drug users who shared a common set of attitudes and interests. Their resolve not to engage in injection held as long as no one violated the decision: however, as soon as one person had overstepped the boundary, the others quickly followed. Moreover, as James pointed out, engaging in a stigmatized activity can have an attractive draw:

“If you’re feeling alienated at the time, you’re going to run with that. ‘Oh, I’m an outsider anyway, so I don’t care what anyone thinks. And I’m glad these people think that it [injecting] is dirt-baggy. Because I have no respect for them anyway: I think they’re all morons. It’s total counter-culture.”

This sentiment is consistent with previous research which suggests that engaging in a practice that is taboo or even dangerous, is part of its attraction (Dwyer, 2007; Maclean, 2005).

Another example of how drug use and injection can spread through friendship groups is Jane, 17, who started using heroin with her older boyfriend. She was the first of her friends to try heroin and despite the endemic use of cocaine and alcohol among her peers, they were shocked when they found out: "They hated us for a while and they completely ostracized us. Like 'Ohmygod, you guys are like trashy junkies.'" However, as time passed and Jane didn't turn into a "scumbag" they accepted what she was doing and stopped ignoring her. Indeed, one of her close friends, Leticia (19, also a participant in this study) became so used to her using heroin that her scorn turned to curiosity.

"I accepted her for who she was and just let her be. And then I contradicted myself and actually did what she did, just to know what she felt, just curiosity pretty much... And she looked like she was having a really good time... I got used to it. She's my friend and I'm not going to change her for anything. I can't do anything about it... So I let her be, and I followed her footsteps."

Leticia began asking questions about the effects of heroin and when she expressed an interest to try it, Jane gave her a small line to sniff. The first two times Leticia used heroin, she did so intranasally: "Because when you think about it, shooting up is hard core...you have to go from the bottom up." However, the third time she used it, she injected it explaining: "I wanted to try the real way to do it". In the nine months she had been using, Jane acknowledged that she had introduced heroin to at least eight of her friends and that because of her, it had become habitualised within her social group "Now it's just like 'dope, heroin, sure, whatever.'".

Among our sample, initiation into injecting almost always occurred in a social environment. Where most of our sample first injected with friends or sex partners, others sought out a social group to inject with. Jack, 21, first came across heroin in his home state of Tennessee around 10 months before entering the study. Brought up in what he described as a dysfunctional but devoutly Christian family, he spent his teenage years wrestling to fit into "normal" society. One summer, Jack, started hanging out with an older drug user, Gordon, 30. Gordon injected heroin, which at first bothered Jack who thought it dirty and dangerous. However, after a while, he became accustomed to seeing him use and it ceased to be an issue.

"He would shoot up dope and as soon as he was loaded, he would be in such a good mood...he would be making a public spectacle of himself being as funny as hell. He made it look really appetizing."

Seeing how Gordon behaved when he was on heroin sparked Jack's interest in how it felt. He asked Gordon if he could try it but his request was denied (Gordon said he didn't want to be responsible for turning Jack on to dope) and Jack's motivation to experience heroin was not strong enough to seek out an alternative source.

Several months later, Jack met a group of traveller kids whom he referred to as "dope-head gutter punks". Being in their company reignited his interest in heroin but having been refused once by Gordon, he decided not to admit he was a first time user as he didn't want to be turned away, or thought of as naïve. He casually bought a \$10 bag and went off by himself to try it out: "I went to a bathroom and I did the tiniest, tiniest little bit and even that tiny little bit that I snorted scared me thinking 'Oh shit! I shouldn't do too much'". Enjoying the high, he continued to sniff heroin sporadically until he arrived in New York a month or so later. While in the city he met a girl at a youth drop-in centre, their conversation turned to drugs and she offered to give him his first hit:

“We went down to this abandoned little stairwell ...I was like don’t give me a full dose, just a little bit because I’ve got a low tolerance for stuff and she was like ‘Yeah, OK’ and I trusted her to do that. I think she gave me a half dose...she shot me up for my first time. I was nervous about it. I don’t like needles; I get faintish you know, but soon as that shit hit me...she said that as soon as she shot me up, my eyes started rolling to the back of my head and I was loaded; like I had not been that fucked up in a long time...I puked all over New York City that night.”

Over a period of several months, associating with “dope-heads” acclimatized Jack to shooting drugs, and by the time of his initiation, his previously negative opinion of junkies had been transformed. Central to his narrative was his emphasis that the drug users he encountered were “super-nice” people, thus not only had he become accustomed to heroin and injecting, but he began to associate it with positive attributes. As he later said:

“Some of my favourite people that I’ve met in life – some of the most saintly, the most kind-hearted, just down-to-earth cool people that I’ve ever met have been junkies.”

A key element of Jack’s story is his decision not to reveal that he was a neophyte user: for him, spending time with other drug users enabled him to overcome his concern about the possibility of overdose which had previously been a barrier against using heroin (compare, Stillwell et al., 1999).

Experimenting with injecting

For some of the younger, less experienced members of our sample, injecting drugs had a glamorous appeal. When describing how they had become interested in injecting, several subjects spoke of “heroin chic”, usually associated with musicians and other media-related professions. As one 17-year old injector commented:

“I thought it was really glamorous because I don’t know, super models did it... and I thought it was really glamorous and pretty and I don’t know, I just thought it was really cool”

Among this group, first injection was often opportunistic and spontaneous – a “spur of the moment” event that often took place while high on alcohol or other substances. At the time of their initiation, many of these participants were experimenting with a variety of street drugs and injecting was part of this continuum. As one subject commented: “It’s not like it’s a big deal: I guess a lot [of people] are concerned with their own safety but it’s trial and error... seeing what we like and what we don’t.” George, 17, started drinking alcohol and smoking marijuana when he was around 14; a couple of years later, influenced by the music he was listening to and his desire to be a “rock star”, he tried coke, the first time: “off the top of a sleek, black record player, through a \$100 bill. It felt really cool.” Following this, he and his girlfriend became curious about heroin so they bought a bag from the only person they knew who had a connection and each sniffed a couple of lines.

“I’d always been kind of interested in heroin. It’s the worst drug. My godfather died of a heroin OD. There must be something great about it. I’d read shit about it; I’d had some guys talking at school about it, but you can’t really know about something until you’ve tried it first hand.”

Neither George nor his girlfriend particularly liked the effect of heroin (he described it as a party killer) and having sniffed it on one further occasion, he didn’t use it again until the opportunity to inject arose a few months later. Sitting around in a park with a group of kids, drinking and smoking marijuana, George became aware that a girl he knew had some heroin that she was going to shoot. Having been underwhelmed by the high he’d experienced from sniffing, George figured that injecting would be the most extreme thing to try.

“I asked her if she had any clean needles and she had a couple and I was like is there any way I could give you some money – I think I gave her \$10 – if you let me shoot up a little bit. And she’s like ‘Yeah, sure, just don’t take a lot’. So I’m like ‘You’re going to have to show me how to do this.’”

Among George and his friends, there was a casual attitude towards needle use. To them, shooting drugs was not regarded as a prohibited activity per se; however, the behaviour associated with regular injection or ‘fiending’ for drugs was viewed with derision. Zoë, 16, one of this group who occasionally injected cocaine commented that in her experience, it is not necessarily the act of injecting that is stigmatized but the type of drug administered.

“For some reason, there’s a different standard for anyone who shoots heroin...I guess it’s more of an addiction factor, like the idea that you are a junkie if you do it. There’s much bigger pressure against anyone who does that...a lot more people are against it for some reason”

The greater efficiency of injecting: getting more ‘bang for the buck’

Those subjects who were regular users before their first hit often described the pull to inject in terms of getting more ‘bang for the buck’ – an expression which included both the perceived economic benefits of injecting, as well as the promise of a better high given the available resources. In our sample, habitual users of heroin often talked about getting “straight” rather than getting high and injection was seen as a way to reduce drug expenditure while still “catching a nod”. Injection initiation among this group also tended to occur in a social setting, although the relationship between trainer and neophyte was sometimes less close than for other subjects.

Dmitri, a 28-year old Russian born immigrant, first snorted heroin after he was introduced to it by his roommates. Despite not having a particularly positive initial experience (it made his skin itch, his eyes run and he vomited repeatedly), he tried it again two or three days later when he was “sitting at home with nothing to do...” depressed about being alone for days at a time and feeling socially isolated because of his poor English. Gradually, social use turned into a daily habit and as his tolerance increased, the three bags he could afford were no longer getting him high. By now, a couple of his friends had progressed to shooting but he was afraid of needles and also believed that an injecting habit would be harder to break. However, by watching them, he came to realize that injecting was a more efficient way to administer heroin and the desire for a cheaper high prompted him to try it. Dmitri’s initiation took place in a car with three other experienced injectors. Following this event, he immediately switched to injecting as his primary route of administration although it was almost a month before he could inject himself unaided.

Dmitri’s explanation for starting to inject was his growing tolerance coupled with his limited financial situation. As it turned out, Dmitri’s anticipation of a cheaper high was misguided and although in the short term injecting reduced his daily expenditure, like other regular users in this study, his tolerance quickly built again and he was soon spending more than when he had been using intranasally.

Even if a growing tolerance wasn’t an issue, for some, seeing the physical effect of shooting a drug was a strong motivating factor for injection. Natasha, a 21-year old injector from Northern New Jersey had plenty of money to fund her growing heroin habit and was satisfied with the effect of intranasal use until she became aware of the injecting rush. Shortly before her initiation, she met Max in a gas station where she sometimes hung out after work and drawn to each other by their mutual interest in heroin, they exchanged numbers and within two days were using together and engaged in a casual sexual relationship. Max was the first person Natasha had known personally who used drugs intravenously and witnessing the increased

effect made injecting extraordinarily appealing to her. Within days of meeting him, she had asked him to shoot her up.

“I saw how much fun he was having. Are you kidding me? ...He would sit in the back [of the car] and start shooting himself. And I was watching him as he was nodding out, much more than I was, and I started getting jealous. Like ‘Get me!’”

Seeking out injection

In a number of cases, members of our cohort took an active role in their initiation. Moreover, for several subjects, first injection occurred only after a protracted campaign to find a more experienced user to assist them. Bernadette, 24, recruited her injection initiator directly via the internet through an email discussion group. Driven by the drug-related deaths of two close relatives, she felt that having personal experience of injecting heroin would help her gain closure on their deaths and set about finding someone who would administer her first shot. This led to a correspondence with Rebecca, four years her senior and already an experienced heroin injector. Concerned that she would not agree to meet her if knew she was a novice, Bernadette was careful to present herself as an experienced user even though she had never previously tried heroin. Further into their correspondence, Bernadette revealed that she was brand new to injection leaving Rebecca hesitant to take on the role of initiator. However, she was persuaded and made all the necessary preparations for Bernadette’s first shot, inviting her to her apartment, buying the heroin and injecting her in the foot (Bernadette provided her own syringe which she had purchased online). Bernadette enjoyed the high and throughout the weekend the two women injected together a total of around 10 times. Despite this, Bernadette had not used or injected heroin again by the end of her involvement in the study and reflecting on her experience nine months later said:

“I really don’t want to [do heroin again]. I mean, I have no desire really...Of course it felt great...[But] looking back at who I was, it was just terrible...I was such an idiot! Why did I feel so compelled to do that? It’s like, I see how happy I am now, and I don’t want to do anything to fuck that up...”

Marina, 17, associated her interest in heroin with exposure to the drug as a child. A recent immigrant from Mexico, Marina was living in California when she met Adolfo, an aging but attractive Mexican *cholo* (gang-member) in a local park. During one of their conversations, she noticed needle tracks on his arm and asked him to introduce her to heroin, but like Gordon, (mentioned in Jack’s case study), Adolfo was unwilling, saying that he didn’t want the responsibility of messing up her life. As their friendship developed, she continued to pester him and he continued to refuse until one day when he was dope sick and broke. Marina offered to buy him a bag of heroin on the proviso that he let her try some and reluctantly, Adolfo agreed.

“I started nodding out. You’re like so calm and so relaxed, and so good. It feels like you’re in your mother’s womb. I just like it. And it was fine because when I was a child I used to think about it. ‘When I grow up I’m gonna try heroin.’...”

Marina’s story demonstrates the persistence with which some of this study’s participants pursued their desire to inject, despite encountering resistance from more experienced users. However, the choice of injection as a route of administration may have also been governed by the type of heroin available (compare Strang et al., 1992). At the time of her initiation, Marina lived on the west coast of the United States where heroin, typically imported from Mexico, has the consistency of a sticky tar-like substance which cannot easily be consumed intranasally. Until she moved to New York, Marina was unaware that heroin was available in powder form that could be snorted.

Discussion

Preceding their initiation, many of this study's participants held negative views about injecting which included the stigma associated with being a junkie, as well as the fear of overdose, needles and the transmission of blood-borne disease. However, by the time of their first hit, these concerns had been muted enough to allow injection to occur. In describing the circumstances of first injection we have shown that for many of our subjects, initiation was a process influenced by a confluence of factors at the individual, social and interpersonal level (Neaigus et al., 2006; Roy et al., 2003; Des Jarlais et al., 1992).

We found that the pull to inject was most often the result of spending time in a drug-using milieu where injecting occurred. Among our sample, exposure to injecting within a social setting led to it becoming an acceptable, and even desirable route of drug administration. Moreover, once an interest had been expressed, association with current injectors provided the opportunity to procure the equipment and technical assistance needed to initiate. Results from this study suggest that this process happens fairly quickly and among this study's participants, the median time from first use to first injection was eight months (13 subjects had tried injecting three months or less since first use). This has important implications for prevention as the window of opportunity to divert new drug users away from injecting is likely to be small.

For many of this study's injectors, their initiation was linked to the promise of a better, cheaper high. Witnessing an injection event firsthand allowed study participants to see the amplified effect of shooting a drug and subjects with a growing tolerance saw it as a way to curtail their daily drug expenditure. Although in the short-term, spending was reduced among habitual users, the amount of drugs consumed tended to escalate to the same, or higher levels as when they had been using intranasally. However, at the time of their initiation, the negative consequences of injecting were often not visible in their drug-using group, while the positive, desirable effects were prominently on display. This reaction to the appeal of injecting is consistent with a small but growing body of literature examining the relationship between drug use and pleasure (Valentine and Fraser, 2007; Duff, 2007; Dwyer, 2007; Mclean, 2005). The positive view of injecting as a mode of drug administration has typically been neglected in interventions aimed at preventing the initiation into injection (Fitzgerald et al., 1999).

Strategies for preventing the onset of injecting tend to follow one of two approaches: the first is to identify populations who are vulnerable to injection initiation and reduce the likelihood that they will inject (Des Jarlais, 1992; Casriel, 1990). The second is to work with current injectors to minimize the influence they have on non-injecting drug users (Hunt et al., 1998). Identifying potential injectors is a challenging proposition. At the time of their initiation, many of our sample were not entrenched in drug use and may not have considered themselves 'at-risk' of injecting. In addition, few were in touch with drug services. Practitioners need to think of innovative ways of reaching this population which could include the Internet where drug users have created a forum for communication (Kobrak et al., 2008). Where prevention messages are employed, they should aim to counter the short-term benefits of injecting by providing a realistic appraisal of the potential long-term consequences using the experiences of drug users themselves.

Targeting current injectors and educating them about the influence they can have on non-injectors (Hunt et al., 1998) might be a more effective approach. Watching other people administer drugs with a needle clearly had an impact on our subjects, making injection appear pleasurable and desirable, and injectors may not always be aware of this. As demonstrated by several of this study's participants, requests for help to inject are not always welcome but potential initiates can be persistent, even offering to buy their trainer's assistance with small sums of money. As one subject said of his interaction with his trainer: "I was like 'Come on!'

What do you want me to do? Sit there and stab myself until I get it?” Interventionists should work with current injectors to develop strategies to enable them to refuse such emotional appeals.

Our findings suggest that once injecting has been introduced to a social group it is likely to spread. This is consistent with other studies which report that the probability of a neophyte user transmitting a new drug practice to their peers is greatest during the first year (Gamella, 1994; Hunt and Chambers, 1976). Previous research suggests that as a person’s injecting career progresses, they are less likely to inject in front of other non-injectors (Stillwell et al., 1999). Interventions which target current injectors to dissuade them from using a needle when a non-injector is present are therefore likely to be most effective if they are aimed at individuals who are recent initiates. Prevention programs would also be well served to investigate the possibility of utilizing peer networks to disseminate information that discourages injecting (Latkin, 1998; Witteveen et al., 2006), especially as new users are unlikely to be in touch with harm reduction services (Treloar & Abelson 2005).

Most of our subjects first injected with heroin and we do not claim that our findings are representative of the injecting drug-using population in general. Rather they add to the body of work which demonstrates that initiation into injecting is a communicable process (Grund et al., 1998; Crofts et al., 1996) and as such, should be examined as a social phenomenon. The majority of this study’s participants were initiated into injecting by a friend or sexual partner (compare Stenbacka; Sherman et al., 2002). However, despite the social context of first injection, we saw little evidence of peer pressure as a reason for initiation – rather a number of our study participants actively sought peers who could introduce them to the injecting experience. Coggans and McKellar (1994) suggest that the concept of peer pressure does not fully recognise the dynamic and reciprocal relationship between individuals and peers, and instead propose that ‘peer selection’ may be a more appropriate term. Rather than peer pressure being an important causal factor in injection initiation, we found that injecting diffused among networks of drug users who already held common beliefs, and shared similar attitudes and interests.

Several limitations of this study should be noted. First, it is important to recognize that the descriptions of first injection experiences, and the social context of these initiations included in this paper are based on the retrospective accounts of those who have become injectors. While self-reports of drug use are not ideal, studies suggest that drug users are able to accurately recall their early drug use events (Darke, 1998). Nonetheless, it is likely that the accounts are influenced by subjects’ experiences since they became injectors as well as by social desirability. Second, our sample size of 54 is relatively small, and should not suggest that the findings are representative of new injectors in general, and certainly not of new injectors outside of the New York metropolitan area. Rather, our data should be interpreted to reflect the ways in which the early phases of drug injection are often pleasurable for the user, and that the seemingly positive effects of injection are likely to have an impact on non-injectors in their social environment. Further research in this area will hopefully serve to expand our understanding of this process and develop new tools for preventing injection initiation.

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