University of
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”It’s like dancing with the Devil.” Exploring perspectives on risk, pleasure and overdose among people who inject drugs

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Abstract

Drug use is a significant health problem worldwide, and people who use drugs often suffer from impairments in daily life in terms of loss of healthy years, and premature deaths. This also affects the person's family, as well as communities and societies. In Europe, drug overdose is the main cause of death among high-risk drug users, for whom drug injection is one of the main risk factors. Despite the implementation of several preventive measures, Norway is one of the countries in Europe with a high and stable overdose-related mortality rate. However, little is known about the views and opinions of the people themselves who inject drugs. In this thesis, I study injecting drug use and the risk of overdose from the perspective of people who inject drugs (PWID). The aim is to increase our understanding of injecting drug use, and the social meanings of risk and overdose, within the contexts of PWID's everyday lives.

Based on qualitative interviews with 80 PWID, this thesis helps to provide understandings of PWID's complex, and even contradictory perceptions and experiences of injecting drug use, risk, pleasure and overdose. In the three published articles, I show how PWID's perceptions of their drug use practices entail multiple social meanings and experiences developed in social interaction and in the context of their everyday lives in the risk environment. The study shows a complex range of attractions towards injecting drug use and how participants' experiences evolved from a fear of the needle, to embracing it as a meaningful practice. This highlights how perceptions of injecting and risk are relational and socially contingent. The thesis also demonstrates that PWID participate in risk environments which involve high levels of distress, fear and stigma. Despite the elevated risk of overdose death, these contextual factors made them prefer solitary injecting, involving a perceived notion of safety from an unpredictable environment, as well as contextual pleasures that were maximised by injecting alone. This highlights the competing priorities among PWID, and that solitary injection should be understood as an adaptive strategy. The thesis also highlights the complexity of overdoses, and challenges assumptions about the relationship between knowledge of risk and risk avoidance. PWID did not always personalise the risk, or they considered it to be part of their high-risk lifestyle. They also expressed an indifference towards survival whereby avoiding death, the main rationale of overdose interventions, was viewed with indifference. This is important for understanding the complexity of overdose mortality and should be reflected in future harm-reduction initiatives.

Overall, I have offered a contribution to the field of harm reduction regarding the need for increased knowledge about PWID's own experiences and perceptions of injecting drug use. The key arguments are that contexts and the individual's overall life situation need to be addressed in the overdose prevention work. PWID live their everyday lives in social environments that influence their perceptions of risk and survival. This illustrates the

importance of a person-in-context understanding, and of addressing the reasons behind the interviewees' ambivalence towards survival, and not only individual behavioural change, which may further contribute to the marginalisation of PWID.

Keywords: injecting drug use, overdose, high-risk drug use, pleasure, qualitative methods.

List of publications

Article 1

Hanoa, K., Bilgrei, O. R., Buvik, K., & Gjersing, L. (2021). “Hooked on the needle”: Exploring the paradoxical attractions towards injecting drug use. *Drugs: Education, Prevention and Policy*, 1-8. DOI: 10.1080/09687637.2021.1955829

Article 2

Hanoa, K., Bilgrei, O. R., & Buvik, K. (2023). Injecting Alone. The Importance of Perceived Safety, Stigma and Pleasure for Solitary Injecting. *Journal of Drug Issues*, DOI: 00220426231151377.

Article 3

Hanoa, K., Buvik, K., & Karlsson, B. (2023). Death Holds No Fear: Overdose Risk Perceptions Among People Who Inject Drugs. *Contemporary Drug Problems*, DOI: 00914509231164764.

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1 Introduction and background

> Sometimes I've been thinking: 'You know you'll get an overdose now', that I'm taking a dose that's too strong. Then you just push it in. That's how the drugs fuck with your mind. I don't give a shit if I die. For normal people, that's so sick to think about.
>
> (Oscar, participant)

Risks associated with injecting drug use, including the risk of overdose death, are well-documented. Several overdose prevention measures have been implemented. Yet the overdose mortality rate remains stable (Gjersing, 2023; Norwegian Directorate of Health, 2019). A relevant question may be: How do people who inject drugs (PWID) perceive their injecting practices and the risk of overdose? Oscar may shed some light on this issue. At least he highlights the complexity of overdoses, and challenges assumptions about the relationship between knowledge of risk and risk avoidance (Rhodes, 1997; Winiker et al., 2020). This emphasises the importance of analysing injecting drug use and overdoses from the perspective of PWID themselves, which is the topic of this thesis.

Drug use is a significant health problem worldwide, and people who use drugs often suffer from impairments in daily life in terms of loss of healthy years, and premature deaths. This also affects the person's family, as well as communities and societies (Lander et al., 2013; Rhodes & Hedrich, 2010; UNODC, 2021). How the drugs are consumed is important, and injecting drug use is one of the leading risk factors for overdose-related deaths. There have been an alarming number of overdose deaths during the last decade in many countries. In Europe, drug overdose is the main cause of death among high-risk drug users, for whom drug injection is one of the main risk factors (Degenhardt et al., 2011; EMCDDA, 2018; Mathers et al., 2013; UNODC, 2019). People who inject drugs both experience and are aware of these risks (Winiker et al., 2020). Yet, injection is the preferred mode of use among many opioid and stimulant users, with an estimate of 11.2 million PWID worldwide (Degenhardt et al., 2017; EMCDDA, 2020; UNODC, 2022). There is therefore a need for more knowledge of how to prevent overdose deaths, and to understand overdoses on the basis of how PWID perceive and experience them. Little is known about the actual views and opinions of PWID themselves – how they perceive their injection practices and construct them as meaningful – despite their awareness of risks (Rhodes et al., 2001). This thesis seeks to fill this knowledge gap.

Norway is one of the countries in Europe with a high and stable overdose-related mortality rate (EMCDDA, 2020; Gjersing, 2021). This is partly due to a persistent culture of injecting and poly-drug use, and may also be related to the fact that many people inject drugs alone

(Gjerde et al., 2021; Gjersing, 2023; Gjersing & Bretteville-Jensen, 2018; Gjersing & Helle, 2021). Norway is among the countries in Europe with a high number of overdose deaths per capita (Gjersing, 2023). This emphasises the need for knowledge about the perceptions, meanings and considerations surrounding injecting drug use from the perspective of PWID. This knowledge may contribute to informing decision-makers and future harm reduction interventions, as well as enhanced services for PWID.

The aim of this thesis is to increase our understanding of injecting drug use from the perspective of PWID, and how they experience the meanings the injection practices have to them. The study seeks to explore PWID's complex, and even contradictory perceptions and experiences of injecting drug use, risk and overdose. An overarching research question is: How can we understand injecting drug use and the social meanings of risk and overdose? An underlying research question is how PWID's perceptions and experiences may be understood within the contexts of their everyday lives. Such a qualitative approach is sensitive towards the participants' lived experiences and may provide new understandings of injecting drug use and overdose deaths, highlighting multiple realities, constructed through subjective experiences and interactions with others (Creswell & Poth, 2017).

1.1 Previous research

As a phenomenon, drug injecting spread quickly in many countries in the 1970s and 1980s, including central and eastern Europe (Bridge, 2010; EMCDDA, 2018). The emergence of HIV focused attention on injecting drug use (Rhodes et al., 2001), with research approaches varying over time and across disciplines. In the following, I will elaborate on research topics that are relevant to the research questions.

1.1.1 Injecting drug use and health risks

The body of research on injecting drug use is largely made up of quantitative studies and associated risks. While some studies focus on drug use in general, others focus specifically on injecting. Overall, these studies highlight injection as one of the most central risk factors for illness and drug-related deaths; a high-risk drug use (Bretteville-Jensen & Skretting, 2010; Gjersing & Bretteville-Jensen, 2014). Drug injection dramatically increases the risk of health damage such as contracting blood-borne diseases, resulting in infections and abscesses (Degenhardt et al., 2011; Mathers et al., 2013). Injecting also causes huge problems economically and socially, and involves a high degree of stigma (Flåto & Johansen, 2008; Lloyd, 2013; Simmonds & Coomber, 2009). This includes difficulty in obtaining employment, reduced access to housing, or interpersonal rejection and social exclusion (Amundsen & Bretteville-Jensen, 2010; Luoma et al., 2007).

In psychological research, injecting is discussed as a behavioural addiction related to mental health, examining orientations towards injecting by understanding them as internal psychological/psychiatric conditions (Hinton et al., 2013; Pates et al., 2009; Pates et al., 2001; Powell, 1995). In this literature, PWID report that various factors influence their choice of injecting over other intake methods, such as pleasure, economy, a perceived lack of alternatives, self-harm, sensation-seeking and the social aspects of a self-image as an "injecting drug user". Some of these studies describe injecting as a personal ritual (Giddings et al., 2003; Hinton et al., 2015; McBride et al., 2001; Pates et al., 2001). However, the studies have small samples, and their main emphasis is on the individual psychologically conditioned response to drug use, and less on the influence of cultural (for example, norms, attitudes) and ecological (for example, drug market, drug policy) factors, which may provide a more contextual and holistic understanding of injecting (Giddings et al., 2003; Pates et al., 2001; Rhodes et al., 2007; Van Ameijden & Coutinho, 2001).

1.1.2 Drug-related deaths

Quantitative studies show a strong association between injecting drugs and fatal overdoses, where factors such as opioid and poly-drug use, and lower tolerance due to periods of drug-use absence increase the overdose risk (Darke et al., 1996; EMCDDA, 2018; Rossow & Lauritzen, 1999; UNODC, 2019). Experiences of non-fatal overdoses are common (Kerr et al., 2007; Ochoa et al., 2001; Pollini et al., 2006). This is associated with health damage which may partly explain a higher risk of future overdoses (Coffin et al., 2007; Kerr et al., 2007; Madah-Amiri et al., 2017). There is also an association between overdose and depression, suicide attempts and feelings of exhaustion (Darke et al., 2007; Gjersing et al., 2011; Miller, 2009). PWID are between six and 20 times more likely to die than their non-injecting peers, and death due to suicide among heroin users occurs at 14 times the rate of matched peers (Darke & Zador, 1996; Harris & Barraclough, 1994; Miller, 2009). Many of the factors known to predispose individuals to suicide are also associated with drug use (Klee, 1995; Range et al., 1997), such as mental and physical health problems, poor family relationships, social isolation, and stressful life events (e.g. physical and sexual abuse) (Neale, 2000). In a mixed methods study (Gjersing et al., 2011), participants from healthcare services linked overdose deaths to e.g. accidents or "exhaustion overdoses" (Gjersing et al., 2011, p. 59). The latter entailed long-term problems related to physical, mental and existential problems. Overdoses were also viewed as suicides based on the person's feelings of hopelessness and exhaustion. Additionally, overdose deaths were understood as accidents due to periods of abstinence or drugs with a stronger potency than expected. Some interviewees who used drugs believed that overdoses were suicides, and others described overdoses as "judas doses" – murder due to drug debt (Gjersing et al., 2011, p. 58). Similar findings are described in qualitative studies by Biong (2008; 2013), which e.g. show that the time previous to an overdose is characterised by ongoing crisis, negative physical changes affecting existential and intimate relationships, and increased ambivalence towards the future. This may be related to structural, cultural and individual factors, such as a

discrepancy between needs and supply of services, and that people who use drugs may have problems living up to cultural ideals of abstinence, work and close relationships (Biong, 2013; Rossow & Lauritzen, 1999). However, these latter studies have small samples, and focus mainly on men, young of age, from a migrant background or in treatment (Biong, 2008, 2013; Biong & Ravndal, 2007, 2009). This thesis will contribute a larger and more varied sample.

1.1.3 Social meanings of injecting drug use

Epidemiological studies have provided a valuable overview of the practice of injecting drug use, and the degree of associated risks. Yet a growing body of qualitative literature shows that injecting drug use, perceptions of risk, and behaviour that may lead to an overdose involve distinct meanings, shaped by social and structural factors (Bartoszko, 2018; Guise et al., 2017; Rhodes et al., 2007). These perspectives offer more in-depth explorations of PWID's perceptions, e.g. how injection is experienced, the meanings and identities it can bring, and how initiation is shaped by social and contextual factors. For example, in a Canadian study, young people said that they wanted to avoid injecting as an intake method and the associated identification with "junkie" behaviour. Yet their negative perceptions were often replaced with the view that injection was an acceptable intake method (Small et al., 2009). Studies highlight the "normalisation" of drug injecting within social networks, which, over time, leads to new social roles and identities bound to injecting (Fitzgerald et al., 1999; Rhodes et al., 2011; Roy et al., 2008). Studies thereby emphasise the importance of understanding the perceptions of people who use drugs within sociocultural norms and interaction, which influence preferences (Olsen et al., 2012; Sherman et al., 2002). These studies also highlight the multiple perceptions of, and attitudes towards, injecting from the perspective of PWID.

Although overdoses are associated with the aforementioned risk factors, a growing body of studies highlights the importance of understanding overdoses not only as a result of isolated risk factors (Nesvåg et al., 2019). Rather, overdoses may also be understood based on how PWID perceive and experience risk. For instance, despite recognition of peer risk and experiences of overdose, PWID often do not perceive themselves to be at risk of overdose (Darke & Ross, 1997; Horan et al., 2015; McGregor et al., 1998). It is therefore important to understand injecting and overdoses in the light of the marginalised lifestyle and the social dynamics of risk behaviour. This may also be related to the setting where drugs are injected, which represents an important dimension in the production of drug-related harm (Small et al., 2012). For example, solitary injection entails increased risk of overdose death, due to the lack of opportunity for others to intervene. Yet PWID may experience solitary injection as a protective factor in their social environment, which further emphasises the need to understand risk in a wider sociocultural context (Rhodes et al., 2007; Tsang et al., 2019). Subjective meanings of drug use also involve pleasure emerging through social, environmental and emotional transformations enabled through consumption routines (Duff,

2007; MacLean et al., 2022). As such, pleasure is also an essential part of understanding injecting and overdoses.

The complex, multiple and even conflicting experiences of risk and pleasure from the perspective of PWID are fundamental issues that need to be understood in order to guide effective harm-reduction interventions. This entails more detailed knowledge to provide diverse and meaningful information about PWID's understandings and interpretations of a situation as it is experienced by people in the context of their everyday lives (Flick et al., 2004; Svartdal, 2009). This study contributes to filling this knowledge gap based on 80 qualitative interviews with PWID themselves.

1.2 Terminology

The purpose of this project is to explore PWID's experiences of injecting drug use, risk, pleasure and overdose. Before moving to the substantive theoretical perspectives, I will explain and discuss three main concepts underlying the study: overdose, risk, and the background and meaning of the term "harm reduction".

1.2.1 Overdose

When opioids are consumed, the breathing centre in the brain is affected, sometimes to such an extent that the individual has impaired consciousness and a reduced breathing rate. When an individual breathes as rarely as 8-10 breaths per minute, this is considered an overdose (Bramness & Madah-Amiri, 2017). The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) has prepared a coding of overdose deaths based on diagnoses in the ICD international diagnostic system: "People who die directly due to use of illegal substances" (EMCDDA, 2022, p. 9). Death generally occurs shortly after the consumption of the substance and is commonly referred to as overdose or poisoning (EMCDDA, 2022). The Norwegian Directorate of Health uses this coding in all work with overdose issues, as well as Norway's National Overdose Strategy: "Deaths happening shortly after consumption of one or more drugs and/or medications, and directly related to this consumption" (Norwegian Directorate of Health, 2020, paragraph 2). The strategy also uses the terms *drug deaths* and *overdose deaths* interchangeably because the terms are used in that way both in everyday speech and in the public professional debate.

In this thesis, these definitions of overdose are applied when I discuss statistics and the more overall scientific overdose discussions. However, during the interviews with participants, as well as in the analysis, the focus is on how the interviewees themselves perceive and describe overdoses. This does not mean that the medical definition is of less importance. Rather, one aim of the project is to increase our knowledge of the participants' own

perceptions of overdoses. Some studies show that there may be ambiguities and varied perceptions surrounding the term overdose (Frank et al., 2015). Overdose events may be difficult to categorise, and it can be difficult to define the border between a maximum high and an overdose with the risk of dying. Some may therefore be uncertain whether they have actually had an overdose and be ambiguous about whether their experience qualifies as an overdose (Monico et al., 2021). Consequently, in order to emphasise the PWID's experiences, using the participant's interpretations will best serve the purpose of the study, giving these persons a central position (Borg & Karlsson, 2017).

1.2.2 Risk

Notions of risk behaviour in the field of drug use are largely derived from epidemiological categorisations. These have played a central role in constructing understandings of injecting drug use, and contributed to a limited understanding of risk as it is perceived and experienced by PWID themselves (Rhodes, 1997). While objective risks exist, some risks are also designated objects of attention due to socially constructed responses and interpretation (Bartoszko, 2018), such as the understanding of "the drug problem" which is "contingent on time, place, and scholarly positions" (Sandøy, 2022, p. 72).

The understanding and narrative of risk dominates the health discourse, and minimising risk is fundamental in the harm reduction programmes. However, in order to minimise a discrepancy between public health and PWID understandings, it is important to include PWID's own perceptions of injecting and risk, including the meaning of life and death (Bartoszko, 2018; Small et al., 2012). This also concerns the context in which individuals take risks and negotiate to avoid risk. Although risk perception is partly based on knowledge, other factors also influence the comprehension, such as perceived probability of harm, level of pleasure involved, and the ease or difficulty of carrying out actions to reduce risk (Aven et al., 2011; Connors, 1992; Nesvåg et al., 2019). Rhodes (1997) therefore emphasises the importance of qualitative research in both questioning and complementing dominant scientific constructions of risk, in which this understanding of risk speaks more to the notion of experienced and socially constructed risks (Connors, 1992; Douglas, 1985; Gifford, 1986). The "insider perspective" approach is therefore relevant for the concept of risk, which may vary depending on what individuals perceive as a risk, what is at risk and to whom. This perspective also aligns with the starting point of this thesis; exploring the multiple perspectives of PWID in the context of their everyday lives. In this thesis, I will therefore use the term "risk" in this experiential sense. That is, the interviewees' perspectives on what they perceive and experience as risky. This entails perceptions of risk from the perspective of the actors, which may be complex, changing and perhaps also contradictory, emphasising a holistic approach (Borg & Karlsson, 2017).

1.2.3 Harm reduction

Harm reduction refers to a variety of policies and practices that aim to minimise unnecessary harm associated with illicit drug use, including the negative health, social and legal impacts associated with drug use, and drug policies (Harm Reduction International, 2023). This also include interventions that seek to reduce the burdens of drug use for individuals, communities and societies (Rhodes & Hedrich, 2010). The philosophy of harm reduction has guided the design and implementation of many policies and overdose prevention strategies (Winiker et al., 2020). Harm reduction may be viewed as a social movement that respects the rights of people who use drugs and seeks to empower them to engage in ways to reduce harm. This entails providing help and services on the users' terms, with few conditions, a focus on how to reduce injury related to health, sexual conduct and finances, and a focus on an anti-stigmatising attitude (Ådnanes et al., 2008). The services may reach people outside formal treatment and can also be used as an entry point into formal treatment at a later stage (Van den Brink & Haasen, 2006). Examples of harm reduction include education on safe injection techniques, and overdose prevention programmes entailing the distribution of the naloxone antidote nasal spray. Low-threshold services are a part of the harm reduction approach, and often include health services, needle exchange programmes, shelters, food delivery and drug consumption rooms. The services are characterised by easy access to help and care, free of charge and free of regular appointments (Edland-Gryt & Skatvedt, 2013; Madah-Amiri, 2017). I will elaborate on harm reduction in the Norwegian context in section 2.2.

1.3 Content of the dissertation

This thesis is based on three accepted papers exploring injecting, risk and overdose from the perspective of PWID. The three articles are included in their entirety in the Appendix section. In Chapter one, I have introduced the background of the study and previous research, as well as aims, research questions and relevant terminology. In Chapter 2, I elaborate on the Norwegian context in terms of injecting drug use, overdoses, and how overdose prevention interventions have been implemented as a part of the national harm reduction work. I introduce an overview of the development of injecting drug use and overdoses, and describe the main trends in the field of harm reduction in Norway. In Chapter 3, I outline and discuss the theoretical and conceptual contributions that have inspired the work on this dissertation. This draws on contributions from sociology, psychology and health research, as well as empirical work from various contributions within the field of drug-related research. In Chapter 4, I elaborate on the study's underpinning theory of science, and the methodological and analytical work involved in the dissertation. I present and discuss the choice of research method, as well as the data collection and analysis. Strengths and limitations will be discussed, followed by reflexivity and a presentation of challenges of an ethical nature. In contrast to the published articles, this introduction allows for extended elaboration and discussion of the methodologies involved. Chapter 5 consists of a summary of the findings

that appear in the three journal articles that together form the dissertation; exploring the paradoxical attractions towards injecting drug use, the importance of perceived safety, stigma and pleasure for solitary injecting, and overdose risk perceptions among people who inject drugs. Finally, in Chapter 6, I discuss some plausible explanations for the complexity of drug use practices and ambivalence towards survival, as well as reflecting upon possible recommendations for future perspectives.

2 The Norwegian context

In this chapter, I will elaborate on the Norwegian context in terms of injecting drug use, overdoses, and how overdose prevention interventions have been implemented as part of the national harm reduction work. I will first briefly introduce an overview of the development of injecting drug use and overdoses, and then describe the main content and trends in the field of harm reduction in Norway.

2.1 Injecting drug use and overdoses

Norway is a sparsely populated Nordic country with a population of 5.3 million (Statistics Norway, 2023), and the capital city, Oslo, is the largest city with 709,037 inhabitants (Oslo Municipality, 2023). The next largest city is Bergen with 289,330 inhabitants (Bergen Municipality, 2023). Possession, use, and supply of any illegal psychoactive substances remain criminal offences (the Ministry of Justice and Public Security, 2019).

The first overdose deaths in Norway were registered in the last half of the 1970s, as a consequence of the availability of heroin (Amundsen, 2015). Alongside heroin availability, the prevalence of PWID increased steadily in the 1980s, peaked in 2001, decreased until 2003 and then stabilised. At the same time, the number of overdose deaths increased during the 1970s and 1980s, with an even higher increase in the 1990s until 2001. From 2001 to 2003, the number decreased. Amundsen (2015) indicates that this may be related to an increase in the number of patients in Substitution Opioid Treatment (SOT). However, a continued increase in SOT patients has not to the same extent contributed to a further reduction of overdoses (Amundsen, 2015). Rather, after this period, the number of overdose deaths has been relatively stable with an annual average of 280 since 2002 (Gjersing, 2023).

In 2022, the number of overdose deaths was 321. This was 74 more than in 2021, but 10 less than in 2020, which saw the highest number since 2002. In 2022, 32% of the deaths were women, aligning with a stable trend of around 30% (Gjersing, 2020, 2021). The mean age was 43 for men, and 49 for women (Gjersing, 2023). In most overdose deaths, on average four types of drugs and medicines are found in the persons autopsied (Amundsen, 2015; Gjersing et al., 2011). It can therefore be difficult to determine whether an overdose is caused by one single drug or a combination of several drugs. Yet, in 2022, it is assumed that 69 persons died of heroin, and 84 died of other opioids such as morphine, codeine and oxycodone in addition to heroin (Gjersing, 2023). Most overdose-related deaths in Norway are categorised as accidents, while 10-20% of overdose deaths between 2012 and 2021 were considered to be suicides. Yet there has been an increase in overdose deaths registered as suicide using illegal substances from 2008 to 2020 (Myhre et al., 2022).

Overall, the overdose trends have prompted various efforts to prevent drug use and drug-related harm in Norway.

A high prevalence of injecting drug use has been reported in studies of high-risk drug use populations in Norway in 2013 and 2017 (Gjersing, 2017; Gjersing & Sandøy, 2014). In the 2017 study, seven out of ten participants reported injecting, keeping the risk of overdose deaths at a high level (Amundsen et al., 2023; Gjersing, 2017). In a study from 2011, a majority (six out of ten) had been in contact with three or more services during the year before they died, and many had been in contact shortly before their death (Gjersing et al., 2011). Today, there are an estimated 8,500 PWID in Norway, with a confidence interval of 7,100-10,000 persons (Burdzovic, 2022). The estimate was stable in the period from 2004 to 2019. Heroin is the main substance of choice for injection, although amphetamines are also injected or consumed in other ways (Amundsen & Bretteville-Jensen, 2010; EMCDDA, 2017).

2.2 Harm reduction in Norway

There have been several phases in the Norwegian authorities' understanding of the "drug problem" and how it should be handled. These phases have varied across legal, medical and social understandings of drug use and how to meet people who use drugs (Olsen, 2020). I will briefly describe three main phases, although mainly focus on the most relevant phase of harm reduction.

2.2.1 Historical background

The years from 1913 to the mid-sixties is described as a period where the societal understanding of drug use was mainly perceived as a medical problem confined to health care personell and patients with access to morphine – i.e. a health problem. The period from the mid-sixties to the mid-eighties was characterised by a mobilisation against drug use, where punishment was a key tool in the war against drugs. Concepts such as "moral panic" have been used to characterise the dominating attitudes in this period (Christie & Bruun, 1985; Olsen, 2020; Skretting, 2014). From the early and mid-1980s, HIV spread among PWID, which led to a drug policy focused more on health and less on punishment. This included a focus on harm reduction, although the principles behind harm reduction stood in stark contrast to the previous restrictive and repressive interventions (Skretting, 2014). Thus, in order to prevent the high number of fatalities, as well as the harms associated with high-risk drug use, for several decades Norway has promoted evidence-based harm reduction measures.

2.2.2 The implementation of harm reduction programmes

Several harm reduction interventions have been introduced (Norwegian Directorate of Health, 2014; 2019). A needle exchange programme was established in the capital, Oslo, in 1988 (Norwegian Institute of Public Health, 2020; Olsen, 2020). Other interventions followed, such as SOT in 1998. A low-threshold healthcare station opened in Oslo in 1999, aiming to improve health, quality of life and ability for self-care, and to connect people who use drugs with the public healthcare system (the Association Against Drugs, 2023). In 2005, a supervised drug consumption room (DCR) opened in Oslo, which in 2020 also included an inhalation room (Prindsen reception centre, 2021). A DCR opened in Bergen in 2016 (Gjersing & Amundsen, 2018). Many municipalities and non-governmental organisations have social arenas for people who use drugs, such as designated cafes. In 2017, 22% of Norwegian municipalities had a needle exchange facility (Amundsen et al., 2023; EMCDDA, 2019).

In 2010, the harm reduction goals within Norway's alcohol and drug policy were defined in a 2011-2012 white paper, which included the prevention of harms such as overdoses (Ministry of Health and Care Services, 2011). In 2014, a national strategy towards drug overdose death was established by the Norwegian Directorate of Health, working with the 14 municipalities most affected by overdose deaths (Amundsen et al., 2023; Norwegian Directorate of Health, 2014). The strategy included several interventions such as continued expansion of SOT, and the distribution of naloxone nasal spray. Naloxone was also made available in prisons, police cars, and to security guards (Madah-Amiri et al., 2019). The strategy also included a patient safety campaign for the prevention of overdose after discharge from drug treatment and release from prison (Norwegian Directorate of Health, 2014). A new national strategy was launched in 2019, emphasising the importance of the enhancement of already existing services. The strategy added an increased focus on physical health and nutritional programmes, and a warning system encouraging PWID to avoid potent drugs. The use of harm reduction services was also expanded, as well as the establishment of heroin assisted treatment in 2022 (Edland-Gryt, 2018; Norwegian Directorate of Health, 2019). Low-threshold facilities exist in many of the Norwegian municipalities, which are publicly funded facilities that offer a variety of health and social services for PWID at no cost to the client (Madah-Amiri, 2017). Hence, Norway is a welfare state which provides various rights for its inhabitants, such as the Norwegian national insurance scheme that is based on automatic and universal enrolment and provides access to healthcare for all residents in Norway (Madah-Amiri, 2017). Opioid maintenance treatment is offered by the national system, and today there are next-day start-up as well as drop-in centres that do not require a referral (Clausen et al., 2008).

Several harm reduction-based overdose prevention strategies focus on individual-level interventions that seek to educate PWID about risks and promote behavioural change (Bardwell et al., 2019; Papamihali et al., 2020; Winiker et al., 2020). These include e.g.

avoiding mixing drugs, awareness of risk when the heroin is pure (and therefore stronger) or after periods of abstinence, to always carry naloxone and general advice to reduce risky behaviour. Researchers are interested in measuring associated behavioural change (Amundsen et al., 2023; Norwegian Directorate of Health, 2019). As such, this study contributes to understand injecting and overdoses in contexts where harm reduction efforts exist (Lovell, 2002). However, some criticism has been levied against the harm reduction methodology due to concerns that the model places too much emphasis on individual change, failing to account for the wider sociocultural factors that influence injecting behaviours (Bardwell et al., 2019; Hagan et al., 2007; Winiker et al., 2020). This includes a lack of addressing the circumstances of people's lives that make it difficult for them to avoid risk factors, or "risking risk" (Lovell, 2002, p. 804). For instance, while encouraging people not to use drugs alone has become a widespread overdose prevention strategy, less research has been conducted to understand the reasons why PWID use alone, or to assess the feasibility, acceptability and barriers to adoption of the practice of always injecting drugs around others (Bardwell et al., 2019; Winiker et al., 2020).

While the implementation of drug prevention interventions remains low worldwide, especially in middle- and low-income countries (UNODC, 2022), Norway has a relatively expanded system of harm reduction services and overdose prevention measures. Yet a survey of 487 opioid and/or stimulant users showed that most of them injected whilst alone (Gjersing, 2017, 2023). Although there is no evidence that these measures have had any effects (Gjersing, 2017), the interventions have been found be relevant for the risk groups, and potentially effective in preventing an increase in drug overdose trends (Amundsen et al., 2023). Norway has also recently been ranked as having favourable drug policies, based on UN recommendations on human rights and health. Here, recommendations such as harm reduction and access to medicine are central, as well as law enforcement alongside efforts to promote health (Clausen, 2022; Thornton, 2021). It is nonetheless always an important goal to reduce overdose mortality, where an improved understanding of PWID is necessary to guide the development of effective prevention and intervention approaches (Norwegian Directorate of Health, 2019). Although harm reduction is crucial in overdose prevention, various measures may seem more relevant if we have a thorough understanding of the perspectives of PWID and the contexts in which they live their everyday lives. In that way, we can provide insights into how interventions "translate into the lives of the people they aim to address" (Bartoszko, 2018, p. 260). This entails exploring the various accounts of injecting, as well as possible meanings and explanations for why such behaviours are preferred – despite the elevated risks.

3 Theoretical inspirations and concepts

In this chapter, I outline and discuss the theoretical and conceptual contributions that have inspired the work on this dissertation. This draws on several contributions from sociology, psychology and health research, as well as empirical work from various of contributions within the field of drug-related research. In what follows, I will first introduce the concept of risk environment, which is the overarching theoretical approach of the thesis. I will then describe the theoretical inspirations and concepts and how they are applied in the three journal articles: a social interaction perspective, stigma theory, risk neutralization, symbolic boundaries, and the concept of pleasure. Throughout the chapter, I discuss how employing several perspectives can help acquire new understandings of injecting drug use and overdoses, and how these different theoretical lenses can be employed to capture different aspects of injecting drug use and the risk of overdose.

3.1 Risk environment

A 'risk environment' framework promotes an understanding of harm as contingent upon social contexts, "comprising interactions between individuals and environments" (Rhodes, 2009, p. 1). Central to this concept is that, alongside a focus on the individualisation of risk, several researchers stress the importance of socio-structural factors influencing decision-making regarding how, where and with whom injecting occurs (Winiker et al., 2020). This encourages us to think about the social situations and places in which injecting drug use and harm are both produced and reproduced, and where various factors interact (Rhodes, 2002). Such an approach emphasises social and environmental factors, and how they may shape individual, community and policy responses to drug use behaviour, risk and the reduction thereof. It also highlights how various social contexts are incorporated into experiences, in which manifold social forces combine to undermine public health risk rationality (Rhodes, 2009). Risk is experienced and lived by PWID in different ways, shaping their practices, perceptions of risk and their choice of milieu for injecting drugs (Moore & Fraser, 2006; Rhodes et al., 2007). In this thesis, the concept of risk environment is applied as an overarching framework in order to understand the participants' perceptions and experiences of their injecting drug use and the risk of overdose death.

Using objective conceptualisations of risk, scientists may be able to estimate actual and potential risk to a population independently of an individual's consciousness of risk taking (Rhodes et al., 2007). However, to understand injecting drug use in a broader social context of risk among PWID, it is important to examine the PWID's individual perceptions of their injecting drug use and overdose risk. Such knowledge may also shed light on subculture, social interaction, and the larger picture of how social policies may affect individual choice (Connors, 1992). This entails socially constructed meanings in various contexts, where risk is

continuously negotiated in social interactions, both at the individual and societal levels (Lupton, 2005). Drug use behaviour and associated harms are thus shaped by various factors such as physical, social and structural forces operating within the broader risk environment surrounding people who use drugs (Kerr et al., 2013). As such, the concept of risk environment shifts focus from individualistic modes of self-survival to the social and environmental conditions that influence health (Koester et al., 2005).

Rhodes et al. (2004) argue that an epidemiological understanding of drug-related risk alone might undermine the understanding of how people who use drugs experience risk in their day-to-day lives. Therefore, exploring PWID's own perspectives and understanding them in the context of their environment may provide insights into how the experiences of PWID can shape their practices, as well as their choice of environment for injecting drugs (Moore & Fraser, 2006; Rhodes et al., 2007). For example, although solitary injection is associated with a greater risk of overdose death, it may also be subject to perceptions of greater personal control and a sense of safety (Hagan et al., 2007). In this way, the lived experiences of PWID influence their drug use practices, and also their perceptions of risk and safety (Rhodes et al., 2004). This implicates a social constructivist take on risk, where the focus is on the social and cultural aspects of our perception of risk, as well as the contexts in which risk is understood and communicated (Lupton, 2005). Following this perspective, an overarching lens of understanding in this thesis draws on this concept of risk environment, highlighting how the PWID's own perceptions of their drug use practices, and associated risks, may be understood in relation to specific drug use settings and social contexts (Rhodes, 2009). It also highlights how PWID's high-risk drug use practices may be viewed as adaptive strategies employed by highly marginalised individuals to manage multiple and also competing forms of risk (Bourgois, 1998; Connors, 1992; Moore, 2004).

3.2 A social interaction perspective

A social interaction perspective emphasises how perceptions of injecting are structured by group norms and the influence of peers and social networks (Harocopos et al., 2009; Roy et al., 2008; Small et al., 2009). Sherman et al. (2002) argue that social influence occurs through social interaction with an environment in which these norms are established, and plays a central role in behaviour such as injecting. In this way, the individual's perceptions, and the meanings they attach to their actions and identities, are developed through social interaction and network values (Rhodes et al., 2011). Social interactions and environments influence injection initiation, which entails exposure, social influence and the learning of norms and rules in the drug-using environment (Sherman et al., 2002; Stillwell et al., 1999; Witteveen et al., 2006). As such, perceptions of injection and associated risks and benefits are socially constructed through "the interplay between individuals, and the ways in which these are organised through the process of social interaction itself" (Rhodes, 1997, p. 211).

The initiation of the self into drug use is also a process influenced and derived from social interactions (Rhodes et al., 2011; Stillwell et al., 1999). Injecting drugs may involve an identity transition in terms of a process of becoming and may constitute a transition to a new social identity (Järvinen & Ravn, 2011; Martin, 2010; Rhodes et al., 2011). Lalander (2011) describes heroin as the heaviest drug, "closer to the total absence of boundaries and subject dissolution than anything that gives rise to anxiety to the modern human" (Lalander, 2011, p. 74). Although he mainly focuses on the drug and not injecting, there are similarities with this study, where the act of injecting may feel like a "risk boundary" (Rhodes, 1997, p. 220) – a fear of an onward transition towards "junkie behaviour" entailing symbolic and social meaning as well as harms – a deterioration or serious addiction. Initiation may thus be "navigating the self through a moral boundary (…) to a practice popularly determined as a social bad" (Rhodes et al., 2011, p. 449).

In this thesis, I draw on this social and processual perspective to understand the participants' paradoxical attractions towards injecting as an intake method – despite their awareness of associated harms. This entails the PWID's perceptions of risks associated with injecting, where their "social interaction presumably does a large part of the perceptual coding of risks" (Douglas, 1985, p. 66), in which our realities are continuously constructed in social processes (Justesen & Mik-Meyer, 2010). Yet studies of injecting drug use and health behaviour are to a high degree associated with the concept of "individual rationality" (Rhodes, 1997, p. 213), viewing risk behaviour as a product of individual cognitive decision-making. A solid body of epidemiological research emphasises individual-level factors in explaining transitions into injecting drug use, such as childhood experience and early initiation to non-injecting drug use (Rhodes, 1997; Rhodes et al., 2011). Studies show, however, that individuals' decision-making does not occur in a context-free vacuum. Rather, PWID's perception of injecting and its initiation is a process bound to social interactions (Rhodes, 1997, 2009; Rhodes et al., 2001; Sherman, Smith, Laney, & Strathdee, 2002), and a socially situated nature of individual action. This entails various meanings, experiences and practices that persons produce when they do things together (Denzin, 1992; Hunt et al., 2007). Such meanings are derived from social interaction within social networks which influence drug-use behaviours (Blumer, 1969; Kirst, 2009, Small, 2009). Hence, collective norms and social interactions may encourage protective drug-use behaviour, but also risk (Kirst, 2009). Small et al. (2009) thereby indicate that injecting is influenced by social interaction with drug-using peers and evolving perceptions of injecting.

The processes by which individual behaviour is shaped through socialisation are therefore the analytical focus of a social interaction perspective. As such, shared perspectives and social norms contribute to perceptions on how drug effects are valued, expressed and interpreted among PWID (Becker, 1953; Svensson, 2007). In this way, individuals learn important norms and rules through interaction with PWID. They also acquire technical and practical knowledge, as well as more emotionally anchored or embodied experiences (Lalander, 2012; Richert, 2014). Hence, spending a lot of time in environments where drug

use and drug-related activities are a central aspect of everyday life, may influence the person's worldview in terms of drug-use behaviour (Rhodes et al., 2011; Richert, 2014; Richert & Svensson, 2008). In this process, risks and benefits of injecting may produce new meanings, where injecting is encouraged through learning opportunities from drug-using peers (Kirst, 2009). As such, the social interaction perspective seeks to understand the social meanings, experiences and contexts of risk and drug-use behaviour (Rhodes et al., 2001). This illustrates the complex social environments that influence and even promote injecting drug use, and where the meanings associated with injection and identity evolve through social interaction (Guise et al., 2017; Mayock, 2005; Sherman et al., 2002). Injecting – which was once seen as risky or "departures from the norm" (Rhodes, 1997, p. 220) – may through social interaction, become habitualised as normal over time and a part of the PWID's everyday routine and lived experience. Hence, injecting involves socialised habituation because its benefits become inextricably bound to everyday life (Rhodes, 1997).

3.3 Stigma

The concept of stigma refers to feelings of shame and negative self-evaluative thoughts that emerge from identification with a stigmatised group and their behavioural impact (Rivera et al., 2014). Goffman (1963) relates stigma to an attribute that is discrediting to the individual. He describes how those stigmatised tend to internalise aspects of a 'spoiled identity'. In this way, stigma signals discrediting attributes to the individual in terms of deviation from what society defines as "normal". Those marked by stigma, such as PWID, may seem to behave in irrational ways (Moore & Fraser, 2006). Stigma exists in various forms: enacted, perceived and self-stigma. Enacted stigma refers to experienced stigma, such as difficulty finding employment or interpersonal rejection. Perceived stigma entails the beliefs that members of a stigmatised group have about the prevalence of stigmatising attitudes and actions in society (Luoma et al., 2007). Feelings of stigma may lead to an internalisation of these feelings, also known as self-stigma (Fulton, 1999; Rivera et al., 2014; Simmonds & Coomber, 2009). This involves negative thoughts and feelings, such as negative self-evaluative thoughts or fears that emerge from identification with a stigmatised group and their resulting behavioural impact. It also entails feelings of being "excluded from ordinary society" (Grønnestad & Lalander, 2014, p. 177). For many PWID, drug use has become a central feature of their lives and they are aware of what this means to others; "they feel different and largely accept the judgements of others" (Lloyd, 2013, p. 91).

Although stigma has an individual component in terms of self-stigma, it also has a public one, as the reaction of the general population (Corrigan & Watson, 2002). The study of stigma has been criticised for focusing too heavily on the individual psychological approaches, and neglecting the understanding of stigmatised individuals as embedded in local moral contexts, including problems that may arise in the social interaction between the stigmatised and "normal" people (Lloyd, 2013). This has contributed to a broader understanding of stigma

and highlights the importance of social processes that occur within the sociocultural environment, which in turn affect the individual. In this way, social, economic and political factors shape the distribution of stigma within a social milieu (Kleinman & Hall-Clifford, 2009). Following this perspective, stigma is also understood as a social construction whereby a distinguishing mark of social disgrace is attached to others, in order to identify and devalue them (Arboleda-Flórez, 2002). This is relevant to this project in several ways; in a practical sense in terms of understanding the participants' feelings of shame through the lens of stigma theory. It is also relevant in terms of the social constructionist worldview of the thesis, where social reality is created through social interaction (Creswell & Poth, 2017). In this perspective, realities are constructed through our lived experiences and interaction with others, emphasising not only persons and individual feelings of stigma, but also the importance of contexts. This may also be relevant to the other theoretical lenses of the thesis, where the social, interactional and environmental aspects are applied to understand the participants' stories.

3.4 Neutralization theory

Neutralization theory describes neutralizations as forms of techniques that may verbally resolve differences between action and expectation, specifically when responding to questions about behaviour that is inconsistent with normative expectations (Copes & Deitzer, 2015; Maruna & Copes, 2005; Peretti-Watel & Moatti, 2006; Sykes & Matza, 1957). This is particularly relevant in this thesis, because studies show that PWID are heavily stigmatised by the public and by healthcare professionals, as well as within populations of people who use drugs (Fulton, 1999; Luoma et al., 2007; Simmonds & Coomber, 2009). This may be related to perceptions of injection as an undesirable mode of use and its associations with HIV (Rivera et al., 2014).

In line with the concept of risk environment, adjustment to risk is central to the theory of neutralization techniques (Miller, 2005; Nesvåg et al., 2019). The theory is primarily associated with Sykes & Matza (1957), who suggested that individuals who are considering committing a crime, must "first find a way to avoid the consequences of guilt of their actions. For most people, the inability to overcome this guilt leads to avoidance of committing deviant acts altogether" (Copes & Deitzer, 2015, p. 1). The authors argue that the techniques, such as denial of responsibility or injury, or claiming that one's behaviour is consistent with the obligations of a group, may reduce barriers to committing crime (Copes & Deitzer, 2015; Sykes & Matza, 1957). Maruna & Copes (2005) emphasise that there is nothing pathological about neutralizing. Rather, the challenge we all face is "to integrate negative life events into our self-narratives without making the self out to be a bad person" (Maruna & Copes, 2005, p. 293). The need to protect oneself from stigma seems universal and is particularly potent when a person's self-concept is at risk. Thus, "naturalization techniques are as common as breathing" (Maruna & Copes, 2005, p. 285).

In this study, I lean on this perspective in order to understand the PWID's stories about their injecting drug use and risk of overdose death. Peretti-Wattel & Moatti (2006) suggest that people engaged in risky behaviour, such as PWID, often wish to neutralize the 'risky' label. Neutralizations may thus be understood as dynamic cognitive processes. These are of specific importance where there are conflicts between one's self-concept as a responsible person and behaviour that may be considered morally questionable by the general public, such as injecting (Aronson, 1968; Lloyd, 2013; Maruna & Copes, 2005; Trang et al., 2022). Neutralizations may also serve as adaptive mechanisms for coping with stress. For example, it may modify intrinsic conflicts when faced with serious risks (Maruna & Copes, 2005), such as the risk of overdose. Miller (2005) suggests that people who use drugs take risks within the context of risk management. When the hazardous nature of injecting is exposed by a drug-using peer, such as an overdose, "they will focus on their own personality characteristics (e.g. experience) in an effort to differentiate themselves from the other person" (Miller, 2005, p. 250). In this sense, neutralizations have similarities with the theory of symbolic boundaries in terms of distancing oneself from others. I will elaborate on this theory in the next section.

Alongside a focus on the individualisation of neutralization techniques, scholars emphasise the importance of sociocultural factors influencing constructs surrounding the perceptions of risk (Miller, 2005). PWID inhabit drug-using environments, often characterised by various risks. This may create a subculture which incorporates the dangers of drug use as behaviours which must be justified. Consequently, being faced with these risks, neutralization may be a rational and functional reaction to the drug-using environment they live in (Maruna & Copes, 2005; Miller, 2005). Miller (2005) argues that neutralizations such as self-confidence may be a rational response to the risk environment. He argues that behaviours that may be difficult to understand when viewed at an individual level, may be rational within particular contexts. Similarly, Maruna & Copes (2005) refer to Aronson (1992) who suggests that neutralization is not only about identity construction, but also making sense of the individual's environment, where the individual seeks to live a life perceived as sensible and meaningful. They stress the social nature of these techniques, understood in the wider culture, highlighting the social rather than the individual aspects of neutralization (Maruna & Copes, 2005).

3.5 Symbolic boundaries

The concept of symbolic boundaries places emphasis on how human interactions revolve around storytelling, and how we talk about ourselves in order to create identity, which "may be the way through which human beings make sense of their own lives and the lives of others" (McAdams, 1995, p. 207). These stories create boundaries which we can use to separate ourselves from those we find less desirable (Copes, 2016; Copes et al., 2008). Although all people engage in boundary work, it is especially important for members of

stigmatised groups, such as PWID (Lloyd, 2013; Simmonds & Coomber, 2009). Bruner (2003) writes:

> We constantly construct and reconstruct ourselves to meet the needs of the situations we encounter, and we do so with the guidance of our memories of the past and our hopes and fears for the future. Telling oneself about oneself is like making up a story about who and what we are, and why we do what we're doing (Bruner, 2003, p. 64).

Copes (2016) argues that people in marginalised positions realise that there are powerful prevailing narratives directing condemnation against them. For example, people who use drugs, and particularly PWID, are often subject to evaluative enquiry about their actions; "decisions that begins with assumptions that their behaviour is unusual (possibly harmful) and demands explanation" (Copes, 2016, p. 194). Consequently, people who use drugs must take care to avoid such labels. They therefore construct symbolic boundaries which serve several functions, such as to form social identities, and to create feelings of self-worth to gain a sense of agency in individuals' lives:

> Typically, people using drugs portray their own behavior as appropriate and the behaviors of other categories of users as inappropriate. They do this by constructing symbolic boundaries that outline the essential characteristics of each group and place people in broad categories accordingly (Copes, 2016, p. 194).

Copes (2008) describes e.g. PWID (referred to as "junkies") as persons that many people who use drugs want to distance themselves from. As a response, PWID narratively create symbolic boundaries in order to differentiate between different types of people who use drugs. This may be a key component in developing social and personal identities (Copes, 2016). Western societies place a high value on moderation free from excess and hedonism, encouraging individuals to develop self-discipline – characteristics that shape the symbolic boundaries related to drug use. Copes (2016) suggests that stories told by people who use drugs may be useful devices to show that their behaviour is rational when viewed in the appropriate cultural context. This entails the construction of symbolic boundaries towards others in the drug-using group. For example, being able to exhibit self-control while using drugs is key to separating the functional from the dysfunctional (Gashi et al., 2021). Stories emphasising rationality and control – which reflect wider cultural goals in most Western countries (Zajdow, 2010) – may in this way show how some PWID are not like other PWID (without skills and moderation). Similar to neutralization, this may reduce feelings of shame and guilt (Copes, 2016). These boundaries are not rigid or objective, but flexible and challenged (Gashi et al., 2021). Hence, boundary work may be complex and nuanced, e.g. related to what kind of drugs to use and how to use them. Creating boundaries between those who inject in public or in "dirty" places, and those who inject in private spaces, may also be a technique to preserve one's presentation of self as "clean" (Rhodes et al., 2007).

This aligns with Goffman's perspectives, where interaction is viewed as a performance controlled by impression management, based on the pressure of normal conduct (Goffman, 1967; Sandberg, 2009).

3.6 Pleasure

Pleasure associated with drug use receives less attention in contemporary drug policy discourses. Harm reduction interventions have been criticised for 'pleasure oversight' – thereby hindering their capacity to respond to drug use in more innovative ways (Duff, 2008; Duncan et al., 2017). Although the response of present drug policies focuses on harm minimisation, scholars suggest that it has elements of self-governance where people seek moderation (Duncan et al., 2017; Zajdow, 2010). Zajdow (2010) refers to Foucault (1996), who suggests that "pleasure, excitement and intoxication therefore seem to be the antithesis of modern governance" (Zajdow, 2010, p. 219). Considering the risks associated with injecting drug use, I believe that opening a space for the participants' multiple experiences and perceptions of injecting, including feelings of pleasure, is an important aspect of this study. The concept of pleasure is therefore applied as a lens in understanding the participants' various rationales behind their drug-use practices.

Although pleasure may stand as one of the most obvious explanations for drug use (Duff, 2008), it may also be associated with hedonism, and not a 'warrant motive' for high-risk behaviour. This may lead to stigmatisation of people who use drugs (Bartoszko, 2018; Malins, 2017; O'Malley & Valverde, 2004; Zajdow, 2010). Nevertheless, scholars suggest that pleasure is important for understanding drug-use practices, and an essential aspect of a coherent response (Moore, 2008; O'Malley & Valverde, 2004; Zajdow, 2010). Moore (2008) argues that pleasure is key to understanding the subjective motives for drug use, including "a desirable bodily experience arising from the interaction of pharmacology, subjectivity, culture and history" (Moore, 2008, p. 354). This also includes the specific activities related to the drug use (Tsang et al., 2019). As such, pleasure extends beyond the purely physiological experience, illustrating how there is rationality not only in the drug use, but also in the techniques used for preparing drugs and how they influence the experience of pleasure (Zajdow, 2010). It is "the things one does whilst using illicit drugs that are the key" to understanding drug-related pleasure (Duff, 2008, p. 387). Pleasure should be considered as more than a product of intoxication, since it also includes pleasure that emerges in the consumption events through contexts, practices and bodies, which may extend beyond the pharmacological effects of the drugs (Duncan et al., 2017; MacLean et al., 2022). This perspective includes a more holistic understanding of drug use, highlighting complexity and context, and reflecting the lived experiences of people who use drugs (Duff, 2008).

3.7 Implications for the thesis

The theoretical level of ambition of this project is to apply theory as a window to illuminate the issues at hand (Malterud, 2016). The focus of the dissertation is actor-oriented, and the theoretical frameworks are contributions to understanding data based on the actor's perspectives. Participants have been explicitly conceived of as subjects, not objects, necessitating a qualitative exploration of the perceptions and experiences of the PWID themselves, yet understood in the contexts of the interactions and environments they live in. While illicit drug use may open up theoretical frameworks focusing on individual pathology, often understood as addiction, pain or disease, others focus more on social understandings of how drug use can be perceived and understood (McGovern & McGovern, 2011). Rhodes (1997) argues that a common distinction in approaches to health is between paradigms focusing on risk behaviour as a product of individual cognitions and decisions, and those who view the unit of analysis to be "social" in terms of an interplay between individuals, "their communities and social environments" (Rhodes, 1997, p. 210). In this thesis, I lean to the latter. This aligns with the person-centred influence (see section 4.3), giving the person a central position, as various ways of "being in the world", but also to understand their stories and value the whole person in the context of their everyday lives, emphasising a holistic and contextual approach (Borg & Karlsson, 2017). This entails exploring the rationales and meanings from the actors themselves, as a more holistic understanding, and to "affirm them as active and creative agents of their lives" (Titchen et al., 2017, p. 35).

4 Methodology

In this chapter, I will elaborate on the study's underpinning theory of science, related to the methodological aspects of the thesis. The thesis consists of a qualitative data source presented in the three articles. The guiding aim of this section is to elaborate on some of the methodological aspects and challenges not covered in the three journal articles. I will clarify my background and role in the project, and elaborate on my researcher positionality, as well as the person-centred inspiration in the thesis. I also present and discuss the choice of research method, as well as the data collection and analysis. Strengths and limitations will be discussed, followed by an elaboration of reflexivity and a presentation of challenges of an ethical nature. The focus of the dissertation is actor-oriented, which means that persons who inject drugs are at the centre of the study, highlighting *their* perspectives and experiences. The data consists of 80 qualitative interviews with persons who inject drugs.

4.1 Clarifying my background and role in the project

Responding to the need for more knowledge about injecting drug use and overdoses from the perspective of PWID, the Norwegian Institute of Public Health (NIPH) initiated a project that was granted funding. At the time I was invited to participate in the project, I had been working at the drug consumption room in Oslo for about four years. I also had 15 years of experience from low-threshold services, mainly at a needle exchange programme, and partly at an outreach service for people with drug and mental health challenges. Additionally, I had participated in several projects at the NIPH, mainly in various data collection process. I therefore had experience from both the field of harm reduction and with people who inject drugs, as well as research projects at NIPH. Furthermore, I am a criminologist with quite extensive experience in interviewing people in vulnerable life situations, such as people in prison and/or who use legal and illegal substances. There are essential questions that need to be clarified related to my research process, both in terms of conducting the interviews, my understanding of the data material and questions of pre-understanding. These aspects will be elaborated on and discussed below.

4.2 Researcher positionality

How we view the world has significance for what we see, and how we understand and interpret what we see. What we consider as truth and how to gain knowledge about this truth is at the core of ontological and epistemological questions. Ontology is related to the nature of reality and its characteristics – "our view of reality and being" (Dewing et al., 2017, p. 20). Epistemological issues relate to how knowledge is gained and the researcher's role in the research process (Colonna et al., 2022; Creswell & Poth, 2017).

In theory of science, it is common to distinguish between realism and constructivism. In realism, the world is perceived as an existing, objective reality, independent of our cognition, experience and the conditions that give us access to them. The goal is to describe phenomena as precisely and objectively as possible, and to reveal cause-and-effect. Constructivism, on the other hand, is an epistemological position stating that knowledge is subjectively constructed, rather than objectively perceived through senses (Delanty, 2005; Justesen & Mik-Meyer, 2010). This thesis is grounded in constructivism, albeit not a radical constructionism whereby each of us has our own completely private truth and perception of the world, and where an objective world does not exist independently of social aspects (Justesen & Mik-Meyer, 2010). Nor does it promote the perception of interview data as not "saying anything about any other reality than the interview itself" (Silverman, 2014, p. 187). Rather, this thesis is based on a social constructionist worldview which Delanty (2005) defines as an intermediate position between weak and radical constructivism.

The starting point of social constructionism is that social reality is created through social interaction, action patterns and how they are perceived, and not only through objective dimensions. This also includes language as a significant contributor in shaping realities, establishing qualitative research as a linguistic and communicative construction of reality (Justesen & Mik-Meyer, 2010; Kvale, 1995; Silverman, 2014). In this way, knowledge is a matter of interaction and co-construction of knowledge between the researcher and participants through conversation (Justesen & Mik-Meyer, 2010; Karnieli-Miller et al., 2009). This involves the language of participants and their efforts to convey something about their subjective experiences. It also involves my conversational skills as a researcher and how I interpret their stories at a later stage in order to capture meaning (Braun & Clarke, 2006; Kvale & Brinkmann, 2009; Silverman, 2014).

It is possible to combine "concern with both form (how?) and content (what?)" (Silverman, 2014, p. 187) within a social constructionist perspective. Also, the study of subjective experience is considered a valid focus of research, although several possible interpretations are available (Finlay, 2009). As such, the ontology of social constructivism is understood as multiple realities, constructed through our lived experiences and interaction with others, emphasising persons and contexts (Creswell & Poth, 2017). If the world is perceived as something that "is" out there, the main aim of the researcher is to reveal this hidden world. Understanding the reality as "made" and multiple is related to a perception of acquiring knowledge as becoming, creating and multiple (Braun & Clarke, 2019; Klevan, 2017). Applying Kvale's metaphor of the researcher as a miner or as a traveller (Kvale & Brinkmann, 2009), my position during this project has mainly been closer to the latter.

There are not always clear distinctions between approaches that view reality as made or found, and the perspectives may intertwine or overlap. For instance, in all varieties of phenomenology, subjectivity and interpretation play a central role at both the ontological and

the epistemological level (Flick et al., 2004). As such, Benton & Carib (2011) argue that it is not necessary to choose strictly between the approaches of social constructionism and phenomenology. Rather, each can be seen as appropriate to some level of analysis or particular object of meaningful social action. Yet the social constructionist way of conducting research is mainly based on an assumption that there are various ways to view reality. Thus, common meanings and understanding are created within social interaction and communities, which the researcher is also a part of in the research process (Gergen, 2015).

Initially, in a research process, the researcher needs to reflect upon and make choices which will guide how data is generated, analysed and understood (Creswell & Poth, 2017; Justesen & Mik-Meyer, 2010). However, when I was included in this project, researchers at NIPH had made choices in terms of aims and methods – although explicit justifications for the reasoning of the choices had not yet been made. Nor did I know that the study would lead to a PhD – an opportunity the project leader positively encouraged, and which led to several applications and a patchwork of fundings along the way. Several questions came to mind: How can I choose the most relevant theoretical framework later in the project, and would this impair my project in terms of well-founded and conscious choices? I also contemplated my background and how it would influence the project. Additionally, I felt a responsibility for pinpointing and finding useful answers for researchers, colleagues and decision makers in the field – a feeling of responsibility for "cracking the nut" of overdoses in Norway, as a clear answer to how it could be prevented. This latter perspective has similarities with an ontology and epistemology of revealing an objective truth, independent of the researcher's influence on the research process.

However, based on my background as a criminologist and knowledge from literature, as well as my clinical practice, I perceived the phenomenon of drug use as complex, multiple and changing. Also, although the project was not planned with explicit pre-defined onto-epistemological assumptions, the aim was to explore *various* perceptions, thoughts and experiences of injecting from the perspective of the actors. This points to my ontological stance: By exploring the actor's perspectives, I did not expect to find "the truth", but rather multiple perceptions and realities which "are constructed through lived experience and interactions with others" (Creswell & Poth, 2017, p. 35). This entails exploring not only "what" they experience, but also "how" (Silverman, 2014), and an awareness that my role as a researcher was a contributor of knowledge together with the participants. It also entails an assumption that the way we understand the world is a product of a historical process of social interaction between individuals and groups of people. That is, meanings are formed through interactions with others, rather than solely being inherent or intrinsic (Creswell & Poth, 2017). Moreover, a growing body of research emphasises the importance of understanding drug use not only at an individual level, but also as social and contextual, changing over time between groups and in communicative processes (Lalander, 2011; Rhodes, 2002; Richert, 2014). Martin & Félix-Bortolotti (2014) describe how individuals are complex and must be understood as intertwined and contextualised, and not just as cause-

and-effect. This embraces studies with “the intent of reporting these multiple realities” (Creswell & Poth, 2017, p. 20), for example in terms of how individuals participating in this study have different perceptions of their injecting experiences.

In this thesis, I have operated at different levels of interpretation, by interpreting meanings and how they are required in social interaction with others. This requires that I both acknowledge the participants’ various subjective understandings, and that I look for complexity in their views (Creswell et al., 2007). That is, to explore and understand the meanings of social phenomena as they are experienced by people in light of their social context (Kvale & Brinkmann, 2009), as well as reflection on how the interpretations came about, and an interest in how we make sense of our lives. Overall, I have sought a balance between closeness to the experiential world of the participants and constant consideration of my own influence as a researcher, in which reflexivity has been an ongoing process (Braun & Clarke, 2006).

4.3 Person-centred influences

The concept of person-centredness is often associated with Carl Roger’s humanistic psychology from the 1940s (Borg & Karlsson, 2017), focusing on “(…) a desire to know and be known by other persons” (Dewing et al., 2017, p. 27). Rogers describes person-centredness as an attempt to give the person a central position. This involves challenging hierarchies, and to promote egalitarian ideals of humans relating as equal persons, whatever their roles, status or positions (Borg & Karlsson, 2017). The philosophy of person-centredness also points to a more constructivist paradigm emphasising that knowledge cannot be understood as purely objective, independent of human minds (Joranger, 2019). Consequently, knowledge needs to be considered as a human and social construct (Martin & Félix-Bortolotti, 2014). A central aspect of person-centredness is also the importance of a holistic approach, valuing the whole person in context, rather than merely the health problems (Borg & Karlsson, 2017).

The starting point of this thesis is that in order to understand actions, they need to be studied from the perspective of the actors (Blumer, 1969). This aligns with the person-centred philosophy of giving the person a central position – whatever their role or status (Borg & Karlsson, 2017). People who engage in high-risk drug consumption are often diagnosed with a drug-use disorder (UNODC, 2021), and substance use and mental health disorders show a high degree of co-occurrence (Brekke, 2019; Mueser et al., 2000). However, in this thesis, the intention is not to explore these aspects of drug use, but rather to explore PWID’s subjective experiences of injecting drug use, as well as their social contexts (Entwistle & Watt, 2013). In order to understand what is going on in people’s lives, we need to be curious about the persons, because they have useful knowledge (Borg & Karlsson, 2017) – not only regarding their drug use or mental health problems, but also their social contexts. The

participants' own perspectives and rationales may hold multiple experiences and valuations of drug use. Such a person-centred approach is sensitive towards lived experiences and may help provide new understandings of drug-use behaviour.

The focus on persons is also reflected in the term PWID, which I use in order to emphasise that the interviewees are *people* who inject drugs, and not "drug users". Hence, they are persons, not their drug use (Kinderman & Cooke, 2018). This does not mean that disorders, health problems, or the pharmacology of the drugs are ignored (Dalgarno & Shewan, 2005; Zinberg, 1984). Rather, "because the 'whole truth' needs to be attended to, (…) in general trying to understand the person's place in the world" (Borg & Karlsson, 2017, p. 219), the focus is on the person's subjective experiences as well as their environments (Entwistle & Watt, 2013). Consequently, it is important to explore how injecting drug use and overdoses appear to the participants and how this may be intertwined with their day-to-day lives. Martin & Félix-Bortoletti (2014) argue that such a paradigm holds the importance of qualitative inquiry in order to highlight insider perspectives and patient perceptions. These aspects of giving persons a central position and situating them in context align with my focus in the study. In this thesis, I therefore consider person-centredness to be a relevant influence at a methodological level.

4.4 Qualitative research

Research from various approaches serves complementary purposes in knowledge development and in answering different research questions (Creswell & Poth, 2017). Rhodes et al. (2001) emphasise the importance of qualitative knowledge in order to develop relevant interventions in the field of drug use: "Qualitative understandings of risk behaviour are important, not only for identifying and describing how specific injecting practices relate to the risk of ill-health, but also (…) for developing appropriate risk-reduction interventions" (Rhodes et al., 2001, p. 12).

As such, qualitative interviews hold the opportunity for gaining detailed knowledge of the phenomenon being studied, of which the usefulness can be attributed to the diversity of information that can be generated (Silverman, 2014). Such data may hold meaningful information about the interviewees' perceptions, understandings and interpretations of a situation and not what necessarily entails correctness in an objective or chronological sense (Svartdal, 2009). Qualitative research is generally well-suited to explore broad questions and provide insights into the social contexts in which individuals and their practices develop (Creswell et al., 2007). Therefore, qualitative research has become increasingly popular within the field of drug use, and has contributed to deeper understandings of drug use, including reasons for use, preventive interventions and harm reduction strategies (Colonna et al., 2022; Neale et al., 2005).

Several aspects of this study point to the relevance of qualitative interviews, such as increased insight and "the world seen from the perspective of the actors" (Tjora, 2017, p. 114). This approach may facilitate a deeper understanding of meaning than could be achieved using a standardised questionnaire (Flick et al., 2004; Silverman, 2014; Titchen et al., 2017). Qualitative approaches hold the potential of discovering new issues, providing awareness of preconceptions and prejudice, and addressing existing structural phenomena. That is, to describe, explore and understand meanings of social phenomena as they are experienced by people in relation to context (Kvale & Brinkmann, 2009). Qualitative interviews allow the voices of otherwise marginalised people to be heard, such as PWID, and accessing as well as communicating experiential and emotional aspects of social reality (Binder et al., 2016). Kvale writes: "In qualitative interviews, social scientists investigate varieties of human experience. They attempt to understand the world from the subject's points of view (…)" (Kvale, 2006, p. 481). In this sense, qualitative research is a means of interpreting behaviours which might otherwise seem inexplicable. The qualitative approach explores "the subjective and social constructs of their world" (Flick et al., 2004, pp. 4-5), which aligns with my onto-epistemological starting point of this project.

Drug health problems are compounded by various factors such as properties of the substances, the intake method, individual vulnerability as well as the social context in which drugs are consumed (EMCDDA, 2019). However, drug use may also include pleasure, which is one of several aspects that should be highlighted in order to better understand the complexity and rationale behind injecting (Duff, 2008; Duncan et al., 2017; Zajdow, 2010). This aligns with Goffman (1968), who argues that actions or ways of living that from the outside may seem irrational often become meaningful and reasonable when you get closer to them. I believe that this perspective also points to an ethical aspect; to gain knowledge in order to improve understanding:

> From a conventional research perspective, and from the perspective of the ´man in the street´, drug injecting is a risky practice and one which is difficult to understand. (…) It is necessary to understand why and how people decide to engage in such dangerous behaviour (Rhodes et al., 2001, pp. 5-6).

The study of human experience therefore implies a qualitative research approach which may contribute to a better understanding of social realities and explore processes, meanings and structural features (Flick et al., 2004). As such, qualitative research often shares the underlying theoretical foundations of social constructionism, recognising that knowledge is contingent, situated, emergent and subject to alternative interpretations. Here, there is a basic assumption that social reality may be understood as the result of meanings and contexts jointly created in social interaction (Creswell & Poth, 2017). For example, as described in section 1.2.2, perceptions of what is considered a "drug problem" varies over time, place and scholarly positions (Moore & Fraser, 2013; Sandøy, 2022). This not only

implies a methodological focus on the subjective views of the actors, but also that injecting drug use may be experienced in various ways, and the need to explore the actor's motives in order to understand both action and interaction (Benton & Craib, 2011). Accordingly, Rhodes (2001) emphasises the importance of analysing "the perceptions and purposes of the injectors themselves, how they perceive risk and if, or how, they try to avoid them" (Rhodes et al., 2001, pp. 5-6), which may also capture meanings that different individuals attach to injecting and risk. This corresponds with the ontological and epistemological assumptions in this project; the importance of understanding persons and their actions in the context of environmental conditions (Creswell & Poth, 2017).

Although there can be no final conclusion about what injecting drug use means for the participants, I believe some possible meanings can be illuminated, and that these meanings may have relevance in the overdose prevention work in Norway. Thus, the purpose of this study is to contribute to a more nuanced, thoughtful and in-depth understanding of the participants' perceptions of injecting drug use and the contexts in which this occurs. This also entails an understanding that it is important to identify and promote reflexivity in the research process. Reflexivity recognises that both the participant and the interviewer produce the data. This points to the ontological and epistemological stance of this thesis in terms of seeing the world as consisting of multiple realities, constructed through our lived experiences and interaction with others – including the researcher (Creswell & Poth, 2017). Borg & Karlsson (2017) argue that the exploration of first-person experiences is a key contribution to focusing on and valuing the lives of individuals, and not seeing them as being 'too ill' to have a voice or say. This is an essential starting point of my study. I also believe that first-person accounts are essential to gain insider perspectives and identify how their perceptions are intertwined with their day-to-day lives (Buckley, 2017). Such a paradigm holds the importance of qualitative inquiry in order to increase knowledge on insider perspectives which make "the person and their story central of the event" (Buckley, 2017, p. 133). This entails probing for "more details and reflections about their daily lives" through qualitative first-person interviews (Titchen et al., 2017, p. 35).

4.5 Procedure

4.5.1 Recruitment

In order to achieve breadth in the sample of participants, substances and contexts, participants were recruited from low-threshold services in five Norwegian cities: 22 participants in Bergen, 20 in Oslo, 20 in Trondheim, ten in Sandnes and eight in Stavanger. Two of the low-threshold services included a drug consumption room (Oslo and Bergen), while the remaining sites covered services such as health and social care, needle exchange programmes, shelters and serving of food. The services were selected based on

geographical and cultural closeness to the interviewees (Watters & Biernacki, 1989). They were also selected based on the researchers' pre-existing contacts with the services related to previous research projects in the drug-use field. This may be considered a convenience sample (Tjora, 2017). Creswell & Poth (2007) describe how gaining access to sites and individuals may be challenging in terms of convincing individuals to participate, building trust and credibility at the field site, and getting people to respond. In this project, the project leader's pre-existing contacts may have been of significance in terms of a door-opening function. In this way, I believe it may be easier to let someone "back in" than to welcome a researcher for the first time (Sandøy, 2022). Initial connections with organisers at the low-threshold services were established through email and subsequent phone calls to the low-threshold services. The email contained information about the project, as well as an information sheet aimed at potential interviewees describing the aim of the study, and issues related to consent, confidentiality and reimbursement.

All services were positive towards the project and wanted to contribute. From my clinical practice in low-threshold services, I also had pre-existing contacts in the field which facilitated the practical arrangements for some of our visits. For example, I knew that the number of people visiting the low-threshold services varied. This may depend on e.g. appointments they had at the services, or welfare benefit payment day, which might lead to more visits due to an increased ability to buy/sell drugs and hang out in the area where this is done. I therefore called the services, and in order to facilitate recruitment, we scheduled some of our appointments according to times when the services were more crowded. These conversations were also beneficial in another sense; the staff were concerned that they were not able to recruit interviewees beforehand, or that people they made appointments with would not show up on the day of the interview. They wanted to explain that their clients had stressful lives and therefore did not always turn up for appointments. I told them that I had experience from clinical practice in this field, and that I understood these aspects of the recruitment. One said: *"Oh, thankfully. I was worried that we would not be able to help, but then you know how it works."*

The recruitment and the interviews were conducted by two researchers from NIPH, two research assistants and myself. All researchers except one had experience from conducting interviews with people who use drugs. The research assistants received training related to the topics in the interview guide. I visited all the sites and interviewed 26 of the participants, while the other researchers and research assistants visited some of the sites and divided the remaining interviews between them.

The recruitment process was similar at the various services. Some sites provided lists for potential interviewees to sign up. Some signed up, but only a few came. Other sites had made verbal appointments with potential interviewees, and most of them came as agreed upon. Yet most interviewees were recruited while the researchers were present at the

services – to a high degree by the staff, but also by the researchers and by participants who recruited each other by snowballing sampling (Tjora, 2017). Interviewees were thus often waiting for us when we finished one interview and were leaving the room to recruit another interviewee. In other instances, we spent some time at the premises in between interviews, talking to the staff and their visitors. We walked around a little while we asked potential participants, or they approached us in order to participate. Each interviewee was informed about the overall goal of the project, issues related to anonymity, that the interview would be audio recorded, and how we would treat the data after the interviews. We also emphasised that we did not represent the health services, but rather that we were researchers, curious to learn about their drug-using practices.

Considering that most individuals were intoxicated to various degrees, it was important to assess levels of intoxication. Since substance use and mental health disorders show a high degree of co-occurrence (Brekke, 2019), an ethical aspect was also to be aware of these challenges. Although this is not always easy to assess, it was an aspect to be sensitive about and part of the overall assessment during recruitment. The inclusion criteria were to be over the age of 18 and to have injected during the last four weeks. Almost all interviewees met the criteria. Two participants said that they had switched to other intake methods than injecting, such as smoking, sniffing or orally. Yet they had injecting experience, and we therefore considered their perspectives as relevant.

Upon inclusion, each participant received an envelope with information about the project, and a note with a randomly generated code number. If they at some point after the interview had further questions or wished to withdraw from the study, the code could be provided if they contacted the project leader. At the beginning of each interview, the code was read into the audio recorder instead of the participant's name. If a participant provided identifiable information during the interview, this was anonymised during transcription. All identifiable information other than gender, age and city was removed from the data material. Further confidentiality was ensured by excluding interviewees' potentially identifiable descriptions from the articles. In the data material, the code number is used instead of the participant's name. We use pseudonyms, and all identifying factors have been removed. The audio recordings were deleted once the interviews had been transcribed.

4.5.2 Sample

The final sample consisted of 80 interviewees, which provided the opportunity for a great breadth of perspectives in order to illuminate the research questions. The mean age of the interviewees was 45 (range 23-63), and 23% were female, reflecting the overall composition of people who inject drugs in Norway (Gjersing & Bretteville-Jensen, 2018). A total of 71% of the sample used multiple substances (mainly combinations of heroin, amphetamines and benzodiazepines). 19% mainly used amphetamines, and heroin was the main drug of choice

for 10% of the interviewees. This also reflects the population of PWID, where 72% inject multiple drugs (Gjersing, 2017). Most participants were involved in street-level drug scenes, characterised by injecting poly-drug use, drug dealing and low-level petty crime. They also had a long history of illicit drug use and the majority injected on a daily basis.

Almost all participants received financial support such as work assessment allowance or regular social benefits provided by the Norwegian welfare system. Although we did not ask for a specification of the sum, most interviewees described tight finances. In Norway, a person is considered homeless if they have no privately owned or rented accommodation, or have unstable positions in the housing market such as shelters for homeless people (Dyb, 2017). In this study, six participants owned their own apartment, and almost one out of three had an unstable housing situation such as living in a shelter. Half of the participants were provided with a municipal rental apartment, and the remainder had other living arrangements such as living with a partner. The information about income and housing status does, however, have limitations because the information provided was specified in most, but not all, interviews due to unclear answers. Yet the sample to a great extent reflects the overall socio-demographic background of the PWID population in Norway (Gjersing, 2017). A Norwegian study shows that 17% have an unstable housing situation, and 91% receive financial support such as work assessment allowance or regular social benefits provided by the Norwegian welfare system (Gjersing, 2017).

Although we could have collected more socio-demographic data such as marital status, educational background, and whether they supplemented their income with illegal income, we concentrated on the data that we considered most relevant to the study in order to preserve the anonymity of the participants. This included age, gender, housing status and work/income. Data on how long participants had been injecting could also have been relevant. However, although participants told us about their first injection, these stories were somewhat fragmented because all interviewees had had breaks in their drug use due to treatment, prison sentences or periods where they tried other intake methods.

4.5.3 Conducting the interviews

As the interviews were conducted with people who inject drugs, an interview could potentially activate sensitive topics related to, for instance, overdoses, the law, family, stigma or health challenges. We therefore deemed it important to create an atmosphere in which the interviewees could talk freely and undisturbed in private spaces. We were provided with individual rooms with as little disruption as possible in the low-threshold services, including staff rooms, offices or healthcare rooms.

The interviews were semi-structured, and we used an interview guide to ensure that key topics were covered. This entailed topics such as thoughts on injection before injection

initiation, positive and negative experiences with injecting drug use, experiences with other intake methods, risks and risk-prevention strategies, and narratives about their participation in street-based drug scenes and use of low-threshold services. There was also room for the interviewee's free narration within the scope of the study and to elaborate on subjects they considered important. This open approach may have revealed thoughts and information about, for example, indifference towards death that might not otherwise have been discovered in the study.

We emphasised open-ended questions and encouraged the participants to speak freely. Rather than introducing strictly specific questions or pre-defined concepts about drug-related risks, we asked participants to reflect on issues they themselves considered relevant for the main focus of the study. This allowed for increased emphasis on the thoughts and experiences of the interviewees, and how they perceived drug-related risks and whether, or how, they sought to avoid them. The interviewer also asked questions for elaboration along the way, such as "How do you experience …" or "Could you describe …". This often led to descriptions and meaningful stories, and also conversations with joint reflection, where together we sought a greater understanding of various topics. This also felt more natural in the setting, rather than a more mechanical question-answer dynamic. However, recent discussions about qualitative interviewing highlight the relationship that exists between the researcher and the participant, e.g. whether the phrasing of our interview questions leads to subtle persuasive questions, responses or explanations (Creswell & Poth, 2017; Kvale & Brinkmann, 2009). This may be related to issues such as power asymmetry in research interviews, which is also an ethical question (Brinkmann & Kvale, 2015). I will discuss this more fully in section 4.5.7.

In the first city, two researchers from NIPH and I conducted the interviews, and we considered them as pilot interviews. We were, for example, wondering about the relevance of the questions or whether the interview guide was too comprehensive. After the sessions, we met at nearby cafés to discuss our impressions of the interviews. This process helped facilitate discussion of the quality of the interviews and assessment of whether any changes should be implemented during the data collection. It also helped to systematising the initial interpretation of the data and thereby informing the subsequent analysis. The interview guide was thus not a set procedure, but was adapted and slightly changed in order to increase the relevance or just the phrasing of some of the questions.

Factors such as level of intoxication, type of drugs, physical and mental health, and various experiences in the interviewees' everyday lives influenced the participants' concentration and energy to engage in the interview. This contributed to some interviews being both shorter and longer than planned. For example, one interviewee said that he was in a rush due to withdrawal symptoms. Another stated that he had injected heroin and therefore felt slower than usual, but that he wanted to participate. Consequently, we considered it important that

the interviews should not last too long so as not to wear the interviewees out (Kvale & Brinkmann, 2009). Yet in some incidences, the level of intoxication increased during the interview. This is also my experience from clinical practice; a person appears awake while they are up and active, but the intoxication increases or becomes more visible when the person sits down or is not active. For example, one interviewee approached me and wanted to participate. He appeared clear and sat down on a bed in the interview room. I sat on a chair in front of him. A few minutes into the interview he lay down on the bed and closed his eyes, yet actively answered the questions. Gradually, his response slowed down and I asked if he could sit up because then I would know that he was reasonably clear. He sat up in a second and described how drugs work when you sit down. I explained that this was also my experience from low-threshold services. He laughed and said that he wanted to continue the interview, because he felt present, although he liked to sit with his eyes closed. Hence, it may be argued that different levels of intoxication, and simply having used a psychoactive substance, do not compromise someone's ability to participate in an interview. Rather, visual signs of intoxication, as indicated by, for example, slurred words, glazed-over eyes, or moving in and out of sleep, are potential reasons not to proceed with an interview, rather than the simple fact of having used a substance.

4.5.4 Data analysis

After the interviews were conducted, the audio-recordings were transcribed verbatim into the Word format. The transcripts were made by me and the two research assistants who had conducted interviews. They were also made by two research assistants who had not conducted interviews, but who had previous experience from interviewing and transcribing from other research projects at NIPH. I transcribed almost half, i.e. 37 of the interviews – interviews that both other researchers and I had conducted. The rest were transcribed by NIPH research assistants.

On conducting and listening to the interviews, I heard the participants' humoristic, enthusiastic and deeply serious reflections on these topics, including laughter and tears (Klevan, 2017). Although some of these atmosphere elements may have been lost on transcribing the interviews, we stayed as true to the content of the recordings as possible. All transcribers were given guidance in how to make the transcripts, involving a rich and orthographic transcription with all verbal and non-verbal – such a cry or laughter – utterances (Braun & Clarke, 2006). The material thus consisted of rich and nuanced descriptions. This information was helpful in the later reading of the interviews, in order to remember and/or get an impression of context and atmosphere during the interviews. Braun & Clark (2006) suggest that the time spent on transcription contributes to informing the early stages of analysis. They argue that transcriptions contribute to developing a more thorough understanding of the data, and that the close attention needed to transcribe data may facilitate the close reading of the interview material. I also believe that in this phase, the impressions constituted part of my pre-understanding, because my process of understanding

and interpretation had already begun. To ensure the credibility of the study results, authentic illustrative quotes are included in the presentation in the articles, and the original terminology used by the participants is retained as far as possible. Interviews, transcription and analysis were conducted in Norwegian, but translated into English when articles were written. Articles and the thesis were proofread by a professional translator from a company that NIPH uses for language editing.

The transcripts were then imported into the qualitative analysis software HyperRESEARCH (version 3.7.3). This gave me a good overview of the data and enabled me to analyse the interview material in a more rigorous way. It has been suggested that such methodological tools may enhance the validity and reliability of qualitative data analysis (Hesse-Biber et al., 1991; Silverman, 2014). Although this may be an important point, the strength of qualitative data does not necessarily lie in the ability to generalise. Yet computer-based software programs such as HyperRESEARCH may be an effective tool for conducting analysis in a transparent way, as well as making it easier to manage the large amounts of data this project had generated, based on the 80 interviews. Transcribed into Word, the total amount of text consisted of about 1,007 pages, and where I assessed it particularly important to code the data systematically. I coded all the interviews. Also, to enhance the probability of a sound interpretation and shared understanding of the data, 25% of the interviews were coded by two researchers (co-authors and myself).

The data was analysed through thematic coding inspired by Braun & Clark (2006, 2019). Thematical analysis is a method for “identifying, analysing, and reporting patterns (themes) within data. It minimally organises and describes your data set in (rich) detail” (Braun & Clarke, 2006, p. 6), and involves searching across a data set in order to find repeated patterns of meaning. The authors argue that thematical analysis is a method independent of theory and epistemology. Yet they do not subscribe to a naïve realist view of qualitative research, but emphasise the active role the researcher plays in identifying themes. As such, they argue, in thematic analysis there needs to be an ongoing reflexive dialogue throughout the analytical process which aligns with the methodology in this project.

Inspired by Braun & Clark (2006), the interviews were coded in several stages. The thematic coding was based on the interview guide and included a wide range of codes, such as thoughts and reflections about injection initiation, injecting and other intake methods, how and what they perceived as risks and how to avoid them, attendance at low-threshold services, and descriptions of their everyday lives – that is, an average day in terms of e.g. when, where and with whom they used drugs. Topics that were introduced by the interviewees, such as indifference towards death, were added to the code list during the process of fine reading and coding of the interviews. The list finally consisted of 34 codes. In order to retain context for further thematisation, relevant surrounding data was retained in the text extracts.

I printed out the coded interviews and re-read them for thematisation. From the broad code structure, I developed themes in more detail. This involved an emphasis on stories that contained information about the overarching aim of the project and were geared towards the interviewees' thoughts, reflections and perceptions of injecting, risk, pleasure and overdose. I made notes in the margin throughout and used colour pens to highlight key themes. Through these passes over the coded material, I noted several differences, patterns and similarities in the participants' stories. Rather than a linear process where I just moved from one phase to another, this was more of a recursive process, where I moved "back and forth as needed" (Braun & Clarke, 2006, p. 16), in order to consider the validity of individual themes in relation to the overall data material (Braun & Clarke, 2006). Throughout the project, I also discussed preliminary possible topics with the co-authors. I believe this contributed to a more complex and nuanced understanding, which also influenced which topics to explore further in the analysis. They also contributed to seeing how various topics were connected. However, the final sorting and priorities were made by me.

Further, I developed the specific topics for the research articles, based on the overall aim of the project, but also topics that emerged (or that I noticed, see p. 37) through the interviews. In this study, we did not rely on predefined concepts or theoretical lenses that guided our analysis. In this way, we based the analysis on an inductive epistemology, rather than a deductive one, in which the narratives presented by the participants were our initial starting point. An inductive coding was thus chosen, where the analysis is primarily data-driven, or from below and up, as opposed to theory-driven or from above and down (Braun & Clarke, 2006; Tjora, 2017). For example, one quote in the "pleasure" code contained the term "hooked on the needle", which later became the starting point for Article 1. This was an expression used by several interviewees. Although they to a great extent acknowledged the risks of injecting, they also described paradoxical attractions towards injecting drug use. This sparked our interest and also informed one of our research questions related to the choice of injection rather than less risky intake-methods such as smoking heroin.

Based on an emphasis on the data generated through the interviews, we also learned that many participants had solitary injecting as their preferred setting for use (Article 2). Given the heightened risk of fatal overdose, we saw this as an avenue for further exploration. Based on this initial analysis, we developed analytical codes related to the physical settings in which they injected. This involved focusing on narratives that highlighted their rationale for such a choice of setting, and different codes were combined to form an overarching theme. Subsequently, I re-read all the interviews in which solitary injection was described, and marked various themes related to this topic with different colours, such as yellow for "injecting alone", orange for "feelings of safety" and pink for "stigma". Primary and secondary topics were thus identified with categories and concepts described by the interviewees, and I made documents with main headings based on these. Braun & Clarke (2006) describe well how categories and themes in the analysis may turn out to overlap. This had similarities with my analysis, where I merged themes or categories that led into each other along the way.

Through such an inductive process, I systematised the data and searched for patterns and recurring themes across the material. Hence, the theories used in the manuscript were introduced at a later stage and used in an effort to broaden the analytical discussion of our findings. Overall, I believe that the strength of this qualitative study is to inductively reach an understanding of the phenomenon being studied, for example the reasons for solitary injection, as expressed by PWID themselves, without an a priori theoretical framework to guide my initial coding and analysis.

During the analysis, I sometimes felt that themes emerged. However, according to Braun & Clark (2006, 2019), and in line with my ontological stance in this project, the term “emerged” reflects a passive description of the analysis process because it does not acknowledge the active role of the researcher. Thus, it may be more suitable to describe the themes as topics I found interesting based on my analytical interest, and which also sprung from the research questions. It may therefore be more correct to describe it as what initially began as a single broad code, I developed into several sub-themes through an inductive process. In this way, my understanding, concepts and associated theory were developed on the basis of the themes I noticed and the empirical material (Järvinen, 2005; Järvinen & Mik-Meyer, 2017).

As described in section 4.2, all three articles entail various levels of interpretation in order to organize participants’ experiences and relate the themes to previous research. Article 3, though, may be considered to entail a greater degree of interpretation in terms of not only understanding the participants’ perspectives and their life situation, but also understanding how people talk about themselves. Overall, thematic analysis was a suitable method as it allows for a social constructivist epistemology in terms of not only examining individual perspectives, but also how experiences and meanings are influenced by various contexts, such as social interaction and “discourses operating within society” (Braun & Clarke, 2006, p. 81). Hence, thematic analysis conducted within a constructionist framework does not solely focus on motivation or individual psychologies. It also seeks to theorise the sociocultural contexts and structural conditions that enable the individual accounts that are provided, such as various sources of stigma and feelings of unsafety due to their everyday lives in risk environments.

4.5.5 Strengths and limitations – reflections on methodological quality

Various perspectives exist regarding how to maintain scientific quality (Justesen & Mik-Meyer, 2010). Validity refers to whether a method investigates what it is intended to investigate and an awareness throughout the research process in terms of method and reflexivity. Reliability refers to quality in terms of data collection, transcription and elaboration of the choices made in the research process. The concept of generalisability refers to the extent to which the researcher may argue that the findings are valid for both the field and other fields (Kvale & Brinkmann, 2009). In this thesis, remarks about validity, reliability and

credibility are presented throughout, in order to make choices and procedures visible. Yet, in order to avoid the pitfalls of traditional quantitative studies, some scholars argue that there is a need for a reconceptualisation with a postmodern sensibility for defining trustworthy data in qualitative studies (Creswell & Poth, 2017; Justesen & Mik-Meyer, 2010). Kvale (1995) emphasises validity as the quality of craftsmanship in an investigation. He relates this to the "close personal interaction in qualitative interviews" (Kvale & Brinkmann, 2009, p. 497). This requires reflexivity and ethics, and also reflects the social constructionism underpinning the project. In the following, I will therefore present additional examples from the research process to illustrate the importance of continually checking and questioning as a quality control throughout the research process (Kvale, 1995), followed by a discussion of reflexivity and ethics.

A strength of the qualitative interview data is an open and exploratory approach to the topics, where the participants can describe their thoughts and reflections. This provides an opportunity for variation in the perspectives and experiences to be expressed. However, the method had its limitations with regard to the information the participants chose to give us. For example, whether they wanted to give us information they assumed we wanted to get, or how they wanted to present themselves. For instance, as previously described, injecting is often associated with shame and stigma. This may have contributed to "social desirability", where participants' awareness of self-presentation may contribute to underreporting and/or responses they assume are less stigmatising or most desirable on the part of the researcher (Krumpal, 2013; Latkin et al., 2016). How we present ourselves may also be related to the theoretical inspirations in Chapter 3, where neutralizations and symbolic boundaries contribute to avoiding labels and meeting the needs of the situations we encounter (Bruner, 2003; Maruna & Copes, 2005).

In studies of marginalised groups, this can be a particular challenge (Friberg, 2019). Scholars therefore argue that interviews are a form of social interaction whereby people contribute to the presentation of self and the impression you give others (Goffman, 1967; Järvinen, 2005). It was therefore essential to show openness, sensitivity and acceptance of the interviewees' perspectives (Bogdan et al., 1975; Krumpal, 2013). This may contribute to rich data and getting closer to the subjective experiences which enhance the quality of the study (Holstein & Gubrium, 1995; Titchen et al., 2017). These aspects of interviewing are, however, also an ethical aspect, which I will return to in section 4.5.7.

Another strength of the project may be that the interviews were conducted in low-threshold services, instead of the researcher's offices. This may have felt like a safer environment for the participants and contributed to more open dialogue, which may increase the credibility of the project (Esbensen et al., 2008). Gubrium & Holstein (2001) emphasise the importance of awareness of how narratives are shaped and what types of narratives are told, and in which circumstances. A limitation may be, however, that several of the participants received

treatment for, among other things, Hepatitis C. This often requires a reduction in drug use, which may have contributed to holding back information about the interviewee's drug use at the time of the interview. Yet the main impression was that the participants generally brought up various and sensitive topics, also beyond the interview guide. People within marginalised groups may also appreciate being heard and having their views communicated (Friberg, 2019), which the majority of participants expressed. Additionally, from my clinical experience, it is often easier to talk to PWID after they have injected their dose rather than before ["*friskmelding*" as PWID call it in Norwegian], due to withdrawal symptoms. Although it was not possible to use this strategy fully, we sought as far as possible to interview people after they had injected, in order to reduce factors such as time pressure and physical discomfort during the interviews.

The participant-based interpretation of events considered to be "overdoses" used in this study could be seen as a limitation (Frank et al., 2015). For example, what did we mean when we talked about overdoses? Was it a too large dose where you fall into deep sleep, or with a deadly outcome? As described in section 1.2.1 - although we could have applied the medical definition of overdose, I believe that using participants' interpretations could best inform the purpose of the study.

Further, this study is based on a substantial number of qualitative interviews with PWID. However, although the sample reflects the overall population of people who inject drugs in Norway (Gjersing & Bretteville-Jensen, 2018), the data could be analysed according to several factors such as age, gender, social background or geographical location. For example, could it be that women feel more vulnerable in the drug-using environment and therefore feel safer in solitary injection settings? Do the younger participants to a greater degree prefer social contexts and injecting around others? Does the participants' housing affect their perceptions of solitary injection? And what about geographical differences between the cities which had a DCR and those which did not? Studies show variations in types or drugs used in various cities (e.g. most heroin in Oslo) (Gjersing & Sandøy, 2014). In our analysis, these factors did not appear crucial to illuminating the issues at hand, and we had to make some choices about how to approach the various topics. Yet it could be argued that such factors may have positioned the findings differently.

The findings reflect the Norwegian context alone and may not be generalisable to other contexts. A limitation may also be that the sample consists of people who to a certain extent were known to the low-threshold services. Consequently, we may have missed the views and experiences of people in less contact with the services and/or the drug-use environment – participants who may have different views and experiences of risk and overdose.

4.5.6 Reflexivity on my role as a researcher

All research requires reflexivity and an awareness of the researcher's role (Malterud, 2001; Nyström & Dahlberg, 2001). This means that the researcher's understanding of a phenomenon is influenced by the researcher's existing knowledge and experiences (Braun & Clarke, 2006; Tjora, 2017). Whether we are aware of it or not, we always bring certain beliefs and philosophical assumptions to our research, but "the difficulty lies first in becoming aware of these assumptions and beliefs" (Creswell & Poth, 2017, p. 15). This aligns with social constructionism in that researchers "position themselves" in the research in order to acknowledge how their interpretation drifts from their own personal, cultural and historical experiences. Researchers make interpretations of what they find, "an interpretation shaped by their own experiences and background" (Creswell & Poth, 2017, p. 24). Hence, it is important for me as a researcher to be reflexive and aware that research to some degree is a result of interpretation (Guillemin & Heggen, 2009; Justesen & Mik-Meyer, 2010; Kvale, 1995). This also aligns with a person-centred influence, recognising both participants and the researcher as persons, and how participants are subjects who interact with the researcher, rather than as passive objects and suppliers of an objective reality (Klevan, 2017). This requires reflexivity in order to make the research process transparent in terms of incorporating the reader in the reasoning and understanding of the researcher. Attempts to achieve transparency can be argued to enhance the validity of the project (Kvale, 1995). Thus, although researcher subjectivity may be understood as a resource (Braun & Clarke, 2019), the researcher's ability for self-reflexivity is of significance to meeting questions about validity, and to what degree the researcher may argue that the findings are reliable. In this project, this was particularly relevant due to my clinical practice in low-threshold services, such as needle exchange programmes and a DCR. There, I have observed overdoses, preparation and injection of drugs, and training in the use of take-home naloxone (antidote). Although a researcher's experience, competence and interest in a field can be a valuable resource, this requires an awareness of one's own role and pre-understanding in all phases of the research process (Malterud, 2001; Tjora, 2017).

It could be argued that due to my clinical experience from the field, I already had knowledge about injecting drug use, how PWID perceive injecting, overdoses, or how to prepare and inject drugs. To some extent, I did have knowledge about some of these issues. An advantage may be that this enabled me to ask relevant and perhaps more pointed follow-up questions during the interviews. It may also have allowed me to understand the participant's descriptions more quickly, for instance of the technical aspects of preparing and injecting drugs. This may facilitate my understanding of the interviewee's stories because I had witnessed them many times. However, a challenge might be that you do not wonder and ask questions in the same way, because you assume you already know or take things for granted (Thagaard, 2013). Consequently, a disadvantage might be that I miss out on knowledge or the participants' perspectives. It was therefore essential to be aware of being open to new and unexpected perspectives as far as possible (Kvale & Brinkmann, 2009). At

the same time, although I have observed injections and overdoses, I did not have any systematic knowledge of the rationale behind their choices, how this was experienced, where they had learned to do this, or other topics in the study. Thus, during the interviews my background knowledge was put in a new light. This involved surprising findings and topics, where I was conscious of asking further questions about thoughts and reflections.

Further, I have had many conversations with people under the influence of drugs and in vulnerable life situations. I was therefore used to conversations where attentive listening, connectivity, and an awareness of persons' mental and physical health challenges were important. This may have been an advantage in interviewing about sensitive topics, as well as staying flexible during the interviews. At the same time, in this project I was not a helper, but a researcher (Tjora, 2017). Yet I considered it important to be aware of the imbalance in the power relation between myself as researcher and the participants (Karnieli-Miller et al., 2009; Kvale, 2006). In my view, though, the participants *were* the experts in this field, and I was explicit on this. My impression is that this may have empowered the participants, which also ensured greater patience as well as humour when I asked follow-up questions.

In order to enhance my own awareness, I also discussed possible topics and ways of understanding with both co-authors, a leader at a DCR and a peer support worker. One example is discussion of the themes in Article 1, which explores the participants' experiences of injecting. During the interviews, coding and analysis, I noted several topics I found interesting and relevant for the overall aim of the project. I noticed the pleasure they described from injecting, yet found myself to be more occupied with the harm. I discussed it with my co-authors who found it important to also investigate the pleasures. We had all noticed the phrase "hooked on the needle" and the joy the interviewees expressed when they described the expectations and feelings of calm related to the preparation of drugs. I also talked to the peer support worker, and she described exactly that topic of the pleasure, and not just the harm. She said that there should be less shame and more room for talking about the pleasure, not only the harm. This aligned with the themes and sub-themes I had as a draft for an article. Yet I realised that my experience from the field of harm reduction may have influenced my initial perspective, focusing more on harm than pleasure. Reading literature also made me more conscious of how the focus on harm may contribute to overlooking the aspects of pleasure associated with injecting. I also sent drafts of various topics in the study to the leader of the DCR and the peer support worker in order to get their thoughts and reflections on the relevance of topics and my understanding of them.

An additional and valuable source of understanding in this project was my co-supervisor, who started to take shifts at the DCR during the study. She said that this gave her insights in other ways and with more depth than from just interviewing and coding. For example, she believed it may have facilitated her understanding of the interviewees' emphasis on the importance of the technicalities related to the preparation of drugs, as well as topics about

indifference towards survival (Article 3). This led to many conversations about how to understand the data material. Awareness and reflection were therefore an ongoing process in the study, also by discussing interviews and interpretations in various fora, and reading previous research.

4.6 Ethical considerations

In Norway, researchers are obliged to follow the guidelines outlined by the National Committee for Research Ethics in the Social Sciences and the Humanities (NESH, 2021). Central aspects include e.g. principles of anonymity and informed consent, which have been emphasised in this study. Studies collecting information about health and illness must also be approved by the Regional Committees for Medical and Health Research Ethics in Norway (REK). This project was assessed to fall outside the scope of REK on 23.9.2019 / ref.no.1206091. The project is also DPIA (data protection impact assessment) approved at NIPH, 11.19.2019, ref.no. 19/11466. Still, there are ethical challenges associated with this project that need to be discussed. For example, in order to minimise the interviewees' burdens on participating in the research, ethical principles such as consent, confidentiality and trust are central (McLeod, 2003; Silverman, 2014). McLeod (2003) also describes the importance of assessing ethical challenges in all phases of a study, and of procedures for how to counter potential challenges. This is particularly relevant for participants in this project, who may be rendered vulnerable due to personal, social or legal stigmatisation associated with their activity or identity (Bracken-Roche et al., 2017).

The question is whether one should avoid research concerning people who are considered vulnerable, in order to avoid distress to the participants. This requires research that is responsive to their needs, and where several considerations must be taken into account. In this project, the interviewees had access to the professional staff for conversations after the interviews, if this was needed. Yet it may be considered whether the study may contribute to enhancing the life situation of the participants, or groups they represent. It may also be contemplated whether the risks of participating are weighed against society's need for knowledge about important social issues (Bredal et al., 2022; Kvale & Brinkmann, 2009).

Interviewing people who are under the influence of drugs places a great ethical responsibility on the researcher because the participants were often in a vulnerable life situation with reduced physical and mental health, broken social relationships and homelessness. Being interviewed about challenges related to injecting may also activate sensitive topics and stressful feelings. It was therefore essential to emphasise a non-judgmental attitude (as described in section 4.5.5). This aligns with a person-centred approach which emphasises values such as connectivity, focusing on the co-action of researcher and participants (van Dulmen et al., 2017). It is, for example, important not to rush on with the interview questions,

but to dwell a bit when we talk about sensitive topics and acknowledge the participant's difficulties, while maintaining an awareness of the interviewee's boundaries and private life (Kvale & Brinkmann, 2009).

Another ethical challenge was informed consent when the interviewees were intoxicated. Informed consent requires the interviewees to have been presented with the research purpose and procedure, to be free to choose whether they want to participate or not, as well as an understanding of what participation entails (Kvale & Brinkmann, 2009). It could be argued that people under the influence of drugs might be compromised. However, as described in section 4.5.3 - rather than considering the fact of having used a substance as a reason not to recruit or proceed with an interview, we assessed visual signs of intoxication. This involved e.g. slurred speech, glazed-over eyes or moving in and out of sleep.

A third ethical challenge was that the participants received NOK 200 to participate as compensation for their time. This can be considered a strong incentive to participate. It was therefore important to emphasise that they would receive the compensation even if they wanted to cancel the interview at any time. The compensation may have contributed to recruiting participants who needed the compensation the most (Watters & Biernacki, 1989). Participants described tight finances. At the same time, they expressed other motivations for participating, such as finding it useful to talk about their experiences. Some said that they did not know about the compensation beforehand. Rather, they found it meaningful to contribute, in order to reflect on the questions related to themselves and their lives. They also found it meaningful to elaborate on stereotypes and prejudices about PWID, and provide more nuanced knowledge in order to help others.

Kvale (2006) suggests that although interviewing may be a sensitive method for investigating subjects' lives, it is vital to recognise that research interviews are not necessarily an open and dominance-free dialogue between egalitarian partners. Rather, interviews are a "specific hierarchical and instrumental form of conversation, where the interviewer sets the stage and scripts in accord with his or her research interest" (Kvale, 2006, p. 485). A growing body of literature, though, suggests that participation in qualitative research may involve agency and positive gains for the interviewees. This may involve e.g. interest, the ability to help, informing "change" or an opportunity for participant reflexivity (Clark, 2010; Perera, 2020; Wolgemuth et al., 2015).

Based on an implicit underlying assumption that a research interview may be harmful, Bredal et al. (2022) express a general unease about the increasingly narrow understanding of consent in ethical reviews of research. They argue that interviewees often welcome the opportunity to participate and use the interviews for their own purposes, such as telling their story for themselves, for others and for the researcher. Telling their story for themselves concerns the participant's personal development in terms of being listened to – taking

ownership of one's experiences in a culture where invalidation may be a risk. This may be especially relevant in this project because many PWID have experiences of not being believed, inadequate services or being confronted with stereotypical ideas of "drug users" (Paquette et al., 2018). Telling one's story to others implies a need and a responsibility to do good and improve general understanding, agencies and the system. On telling their story to the researcher, participants appear to come to the interview with no other agenda than being interviewed, although a lack of elaboration on motivation does not mean that they were not motivated. However, Bredal et al. (2022) suggest that the way interviewees were recruited was of significance to the participants' motives for participation. For example, self-recruitment was associated with telling one's story for oneself and others.

As described in section 4.5.1, recruitment in this study took place as self-recruitment and recruitment by the staff and researchers. Still, the overall impression was that, whoever conducted the recruitment, participants expressed interest and an eagerness to be interviewed. When the interview was over, some said: *"Is it over already?", "Are you sure you don't have any more questions?"* or *"Just ask if you wonder about anything more. It's important to enhance an understanding of our situation, you know".* However, some also expressed feelings of sadness in telling their story, yet in a constructive sense so as to give them an overview and "sum up" in a way. Bracken-Roche et al. (2017) argue that how vulnerability is defined may reinforce stereotypes and stigma about categories of individuals, focusing overwhelmingly on a lack of ability to consent. Instead, the authors highlight the importance of contextual factors and individual characteristics beyond their membership of a group.

Here, it is ethically important how the researcher meets the interviewees and potential unpredictable situations during research practice – "everyday ethical practice of research" (Guillemin & Heggen, 2009, p. 294). Such "field issues" may contribute to strengthening and/or weakening the quality of a study (Creswell & Poth, 2017, p. 149). For example, in this study, one participant said that he had never been asked such questions before. He said that he experienced them as meaningful, for example topics related to thoughts and reflections about risks. He started to cry and said: *"That was a deep question. I haven't been asked that before, and I'm sorry for [crying], but I welcome the question. Do you really want the sincere answer to that? I don't care [about risks]."* We both dwelled a bit, and I found it important to pause and not rush on with further questions. Rather, it felt natural and ethical to acknowledge his feelings, and to show support.

This example also emphasises the importance of researcher reflexivity and how to make a safe space for the participants. However, how to be a good listener is not often spelt out (Bredal et al., 2022; Lavee & Itzchakov, 2021). Jacobs et al. (2017) argue that although there is no easy way out of relational barriers, there is a need for the researcher to be sensitive to the setting and various challenges that may arise on the way. This includes having a

repertoire of conversational approaches and being able to be “flexible in the organization of the research” (van Dulmen et al., 2017, p. 211). The flexible approach aligns with my clinical practice, which may have had a transference value for the interviews; I tried to tune in so as to connect with the participants in the best possible way. For example, I interviewed a 30-year-old woman. She appeared tired and chaotic, yet said that she wanted to participate. I was occupied with creating a calm and safe atmosphere, and a mild conversational approach. I also focused on ensuring informed consent and that she could discontinue the interview at any time. During the first part of the interview, she was sceptical, looked down, answered briefly, and often in terms of negative views of herself and her peers. It was a priority for me to answer in an understanding manner and to acknowledge her feelings. After a few minutes, she seemed less chaotic, looked me in the eyes and answered my questions with more presence. However, she suddenly remembered that she had misplaced a dose of heroin on the way to the interview. She said that she wanted to continue the interview, yet appeared distracted and unable to focus on the interview. Eventually, she said that she had to search for the 0.2 gramme bag of heroin, and asked if I could help.

From my clinical experience, I was used to this. However, in this situation I was not a helper in a clinic, but a researcher. We searched for the drugs for quite some time in various floors and rooms, but could not find them. I asked if she wanted to discontinue the interview, but she said no. Yet she appeared distracted and despairing. Then I saw the little bag of heroin under her chair. She lighted up, smiled, thanked me and said: *“You see what heroin does to you?”.* I interpreted this as an expression of frustration, relief and also discomfort at the fact that she had thought about the heroin – unable to focus on the interview she had actively asked to participate in. The interview atmosphere changed back to being calm, and the participant was more present, talkative and engaged. Yet central questions are: Could I have resolved the situation differently? Was it unethical to help her search for her drugs? Was it too “natural” for me to assist, considering my clinical experience? Could that have contributed to strengthening or weakening the data, and should I have decided to stop the interview? In this context, it is important to reflect on what it means to me to be an ethical researcher, and that ending her interview in this situation might also have contributed to feelings of shame on the part of the participant. This highlights that although my clinical experience may be a resource, it has also required critical reflexivity.

5 Summary of the research articles

This section provides a summary of the study findings as they appear in the three published articles. It highlights the interconnectedness of the individual works in the thesis, which is a comprehensive methodological and theoretical exploration of injecting drug use and associated risks and pleasures from the perspective of an extensive number of PWID. Article 1 offers insight into how people who inject drugs have lived through the shifting perceptions and status of injecting, and how they perceive and give meaning to their injecting drugs use. It also offers insight into possible explanations for why such behaviours are maintained over time, despite the associated negative consequences. Article 2 contributes knowledge about the complex practices of solitary injecting, and explores the meanings, perceptions and possible rationales associated with such a drug-using practice. Article 3 provides insights into the meanings and various ways of relating to the risk of overdose death by exploring the lived experiences and perceptions of overdose. In sum, these article findings shed light on how PWID perceive and give various meanings to injecting drug use and the associated risks, as well as pleasures. They also show the social processes involved in these experiences and contribute a multifaceted understanding of risk, pleasure and ambivalence towards overdose death in the social context of drug-using environments and living conditions.

5.1 Article 1

Hanoa, K., Bilgrei, O. R., Buvik, K., & Gjersing, L. (2021). “Hooked on the needle”: Exploring the paradoxical attractions towards injecting drug use. *Drugs: Education, Prevention and Policy*, 1-8. DOI: 10.1080/09687637.2021.1955829

Injecting drug use is one of the leading risk factors for harmful health effects such as infections and drug-related deaths. Yet many PWID continue to inject, despite access to less damaging intake methods. In Article 1, we explore this seemingly paradoxical attraction towards injecting drug use. Based on data from 80 qualitative interviews with PWID recruited from low-threshold settings in five cities in Norway, we focus on the process of injection initiation and why PWID maintain such behaviour over time, despite associated harmful health effects and other negative consequences. Inspired by a social interaction perspective, the study shows a complex range of attractions towards injecting drug use. It also shows how participants’ experiences evolved from a fear of the needle, to embracing it as a meaningful practice. This involved social interaction and learning from other PWID, as well as appreciating the intensity and speed of the intoxication. It also involved the ritual aspect of injecting entailing positive feelings, described as an addiction of its own. Perceptions of injecting also entailed a devaluation of other modes of use. Participants accounted for various harmful effects related to injecting. Yet analyses show how the attractions involved

social interaction and learning from other PWID, highlighting how social influence occurs through social interaction in an environment where drug-use norms are established. This shows how perceptions of injecting and risks are relational and socially contingent, fuelled by subjective logic that rationalises injecting drug use. The study thus highlights how injecting is not only an individual project. Rather, it is influenced by socially constructed perceptions developed through social relationships and interactions. This entails a process whereby experience and knowledge are internalised through social influence and learning in drug-using networks, and embodied experiences which emphasise the importance of a common habitus. The paradoxical attractions towards injecting are thus embedded in the social and physical environments of drug scenes. This also entails an identity transition associated with injecting – a process of becoming, in which the perspective of social interaction seeks to understand the social meanings, experiences and contexts of risk behaviour. The study thereby helps expand upon understandings of the interactional process and cultural context of drug use, in which the interplay of social factors influences individual actions and promotes injecting over other and less risky intake methods. Hence, future interventions aimed at reducing the number of PWID need to consider how various contexts and social negotiations impinge on, or even encourage, such risky practices among PWID.

5.2 Article 2

Hanoa, K., Bilgrei, O. R., & Buvik, K. (2023). Injecting Alone. The Importance of Perceived Safety, Stigma and Pleasure for Solitary Injecting. *Journal of Drug Issues*, DOI: 00220426231151377.

Many PWID inject when they are alone, which increases the risk of overdose death. In Article 2, we explore the complex practices of solitary injection based on the same qualitative data as in Article 1; interviews with 80 Norwegian PWID. Leaning on the concepts of risk environment, stigma and pleasure, the analyses show that the interviewees construct several rational and positive meanings of injecting alone. First, the analysis illustrates that the risk environments in which they participated involved high levels of fear and stigma, which made them prefer solitary injecting. This involved a perceived notion of safety from an environment where they experienced theft and feelings of unpredictability. In this way, some considered the relative risks stemming from these environments as more pronounced than those of a potential overdose. Second, stigma was described as causing feelings of otherness. The interviewees therefore wanted to hide their drug-using practices. Their identities as injecting drug users and feelings of shame and societal discrediting were felt and enacted from both drug-using peers and wider society. This transformed the interviewees' drug use towards a potentially riskier practice by hiding their injections. Finally, injecting drug use involved contextual pleasure, maximised by injecting alone due to peace and concentration. Despite the participants' awareness of the overdose risk when injecting alone, injecting with others or in public places were perceived as less hygienic. Additionally, they experienced barriers such

as noise or discomfort in DCRs. In this way, the participants' contextual experiences go beyond the physiological drug effects, to also include the physical space in which they inject. In sum, the study illustrates how the risk environment in which PWID lived their everyday lives caused additional harm, by which solitary injections were rationalised, despite an increased mortality risk. Rather, they considered the potential harm from the sociocultural factors embedded in their drug-using environment as more salient than solitary injection. This highlights the competing priorities among PWID, and that solitary injection should be understood as an adaptive strategy employed by marginalised individuals to manage various considerations and risks in their everyday lives. This invites further discussion of how solitary injections are influenced by social and environmental factors, and how they may contribute to an understanding of such drug-using behaviour. Future harm-reduction initiatives should reflect this important aspect.

5.3 Article 3

Hanoa, K., Buvik, K., & Karlsson, B. (2022): Death holds no fear. Perceptions of the risk of overdose among people who inject drugs. *Contemporary Drug Problems.* DOI: 00914509231164764.

Over the past decade, the overdose mortality rate has increased in several countries worldwide – despite various preventive measures. In Article 3, we highlight the need to understand overdoses on the basis of how PWID perceive and experience risk. Based on the same qualitative source of data as Articles 1 and 2, we explore the complex lived experiences and perceptions of overdose among 80 PWID in Norway. We lean on the concepts of neutralization and symbolic boundaries. Both theories are often used in self-presentation, which may serve several functions, such as downplaying intrinsic stress related to risk, or avoiding stigma by distancing oneself from those we find less desirable. The analysis presents three types of accounts concerning the participants' perceptions of overdose risk. First, interviewees described death as natural and universal, and therefore giving nothing to fear. This was related to the participants' perceptions of death as part of their high-risk lifestyle, and to previous overdose experiences described as pleasurable. The participants' stories of death as natural might neutralize intrinsic stress, or the risk of being perceived as irresponsible risk takers, avoiding feelings of otherness. Second, they presented accounts of how they perceived others to be at greater risk of overdose than themselves. They believed they had control based on experience and a perceived high tolerance of drugs, which created boundaries between themselves and PWID they described as less rational or skilful. These boundaries may contribute to forming social identities and creating positive perceptions of self, which is particularly important for people who are stigmatised. In this way, the participants may gain a sense of agency and feelings of self-worth. Finally, interviewees described an ambivalence or indifference towards life and death. This was related to various life challenges such as physical and mental health, feelings of

stigma and hopelessness, or living in a high-risk environment. The participants' indifference towards death highlights a grey area on a continuum between the wish to live and death as relief from life. This reflects the blurred lines between intentional and unintentional overdoses.

In sum, the study illustrates how PWID inhabit drug-using environments characterised by a high-risk lifestyle. Faced with these risks, participants presented stories which may serve several functions. For instance, they may contribute to neutralize feelings of risk and stigma and gaining a sense of control in an otherwise overwhelmingly stressful environment. Participants also created symbolic boundaries by distancing themselves from other stereotypical people who use drugs, describing rationality in their drug use – despite associated risks. The participants additionally expressed an indifference towards overdose death, which is key to understanding the complexity of overdose mortality. This suggests that avoiding death, the main rationale of overdose interventions, is viewed with indifference by some PWID and is not always the most important priority in many people's lives. In order to understand the complexity of overdose mortality, these aspects should be reflected in future harm-reduction initiatives.

6 Discussion and concluding remarks

In my dissertation, I have offered a contribution to the field of harm reduction regarding the need for increased knowledge about PWID's own experiences and perceptions of injecting drug use. Applying a focus on PWID themselves – a person-centred focus – I have provided new empirical knowledge about their experiences and perceptions in the context of their day-to-day lives. The overarching research question has been: How can we understand injecting drug use and the social meanings of risk and overdose? An underlying research question has been how PWID's perceptions may be understood within the contexts of their everyday lives. Against the previous chapters and the three articles, the simplified answer is that we can understand injecting drug use and the risk of overdose death as complex and changing, contingent on social contexts. The phenomena entails multiple social meanings and experiences developed in social interaction and in the context of the risk environment in which PWID live their everyday lives. In this concluding chapter, I discuss some plausible explanations for the complexity of this drug-use practice and the ambivalence towards life and death. Moreover, I reflect upon possible implications from my observations and offer some recommendations for future research.

As described in Chapter 1, various harm reduction strategies focus on individual behavioural change, such as switching to safer intake methods (Bardwell et al., 2019; Edland-Gryt, 2018). This perspective is based on individual risk knowledge and the wish or ability of PWID to avoid risks (Small et al., 2012). However, individuals also act within social contexts that influence experience, expectations and perceptions (Olsen et al., 2012; Richert, 2014). A better understanding of risk perceptions from the vantage point of PWID themselves may allow the development of a range of preventive strategies adapted to a variety of realities.

In addition to contributing on the field of drug use, this study has also allowed me to increase my knowledge and understanding of injecting drug use. It highlights how PWID's perspectives on injecting, practices and perceptions of overdose death are intertwined with socio-structural factors, social interaction and living conditions. I have leaned on the concept of risk environment (Rhodes, 2002, 2009; Rhodes et al., 2001) as an overarching lens through which to view the findings. The important aspect here is that the study shows that risk in the PWID's environment encompasses multiple and changing meanings. It involves the risk of harmful health effects and overdose death, which is well-documented (Colledge et al., 2020; Degenhardt et al., 2017; Gjersing, 2020). The participants also describe the risk of stigma, arrest, and theft, and hence also their money situation in an otherwise financially restrained life. Risk also involves feelings of otherness, stress and a lack of opportunity to alleviate withdrawal symptoms, or to feel safe, comfortable and able enjoy the kick – risk factors which influence the participants' navigation in their drug-using environments, their

perceptions of injecting and how, where and when to consume drugs – as well as their perspectives on survival.

6.1 The social process of injecting

Prior to injection initiation, participants in this study expressed an awareness of risks associated with injecting. Yet spending a lot of time in an environment where drug use and drug-related activities are central contributed to influencing their perceptions, paving the way for injecting as an increasingly valued mode of use. This highlights how injecting is not only an individual project, but also encompasses interactional processes between experienced and novice PWID (Harocopos et al., 2009; Khobzi et al., 2009). Lalander (2012) describes drug use as a social process where experience and knowledge are internalised through social networks and embodied experiences, emphasising the importance of a common habitus. This also includes positive feelings about the ritual aspects of injecting. Although Lalander (2011) describes drug use rituals as something friends do together, it has similarities with this study, highlighting the pleasurable feelings related to rituals – secluded from the outside world. Thus, despite awareness of the harmful effects associated with injecting, participants learned about its functions and pleasures, as well as a devaluation of other intake methods (Hanoa et al., 2021). This thesis thereby illustrates how the paradoxical attractions of injecting drug use are embedded in the social interaction processes, habituated in PWID's lives, which contribute to shaping risk perceptions. In this way, even though injecting and opioid use cause a large proportion of the illness and death resulting from drug use, health problems are also compounded by other factors, e.g. "properties of the substances, the route of administration, individual vulnerability and the social context in which drugs are consumed" (EMCDDA, 2023, p. 1). Such ecological perspectives shift the emphasis from an individual to a social focus, such as social interactions, relationships or situations, aiming to understand how risky behaviour is socially organised. This also involves political and economic factors, as well as the importance of physical environments, and how they interact with the person and their characteristics to determine health outcomes (Burris et al., 2004; Rhodes, 1997; Rhodes et al., 2005). This is not to ignore the significance of choice and responsibility, but rather to emphasise how drug-use behaviours are also shaped by social and contextual factors (Duff, 2007).

6.2 The solitary process of injecting

Drug use may be viewed as a social behaviour related to the setting where drugs are injected, which represents a crucial dimension in the production of drug-related harm (Rhodes et al., 2007; Small et al., 2012). Injecting in public places is associated with elevated risk behaviour and health harms. This is related to hasty injections, increasing the risk of 'missed hits' and disruptions to hygiene routines due to e.g. the risk of arrest (Rhodes et al.,

2007). Against this backdrop, private settings are often preferred for injecting drugs (Hanoa, et al., 2023; Winiker et al., 2020).

As described in Chapter 1, encouraging PWID not to inject alone and to carry naloxone are widespread harm reduction interventions (Norwegian Directorate of Health, 2019; Winiker et al., 2020). For naloxone to be effective, the person who has overdosed depends on another person to administer it. However, in line with other studies showing that most PWID often inject alone (Gjersing, 2017; Gjersing & Helle, 2021), participants in this study described complex reasons for solitary injections, as well as barriers to adopting the practice of injecting around others. This was mainly related to contextual factors such as the risk of theft. Trust was also highlighted as crucial, with many interviewees saying that they did not have anyone they could trust or feel close to.

Grønnestad & Lalander (2014) describe how being part of a social environment with other people who use drugs produces feelings of belonging, solidarity and care for others. They describe open drug scenes and sceptical glances from people passing by. Here, “decay stories” (Grønnestad & Lalander, 2014, p. 177) are highly valued, connecting the people who use drugs to the past, each other and a humoristic perspective on life. Yet, in line with this study, they also describe a lack of trust towards drug-using peers, and the need to be on guard. Additionally, although participants in this study emphasised the benefits of the presence of healthcare personnel at the DCRs, these environments were also perceived as stressful, due to e.g. noise and crowded environments. Hence, although PWID might wish to prioritise health and safety, solitary injections were perceived to alleviate risks in their social environment. This aligns with other studies, describing solitary injection as both protection and risk (Papamihali et al., 2020; Winiker et al., 2020). Solitary injections must therefore be understood within the context of worldviews that deviate from that of the “expert” risk assessments (Fox, 1999). While experts in the drug field tend to focus on a causal relationship between knowledge and behavioural modification (Connors, 1992), this thesis illustrates a grey area between what the individual knows and how that person applies that knowledge in various contexts.

Harm reduction initiatives are intertwined with the responsibility of risk-averse citizens, in which discourses of pleasure have been rather absent (Duncan et al., 2017; Rhodes et al., 2007). As shown in this thesis, pleasures related to injecting, as well as the consumption events and environments where PWID were able to “chill out” and feel autonomy, are of crucial importance. This also relates to the positive ritual aspect of injecting drug use, as described in Article 1. Article 2 shows how solitary injection facilitated the performance and enjoyment of these consumptions routines. Duff (2008) argues that pleasure is an essential part of understanding drug use, which also extends beyond physiological experiences to include contextual elements. Pleasure facilitates feelings or ways of being in the world that are otherwise unthinkable while sober (Bartoszko, 2018; Duff, 2008; Titchen et al., 2017). As

participant Lukas described in the title of this dissertation, risk does not exclude pleasure: *"Because that kick… It's like dancing with the Devil."*

In this way, the study illustrates how risks may be mediated by social norms about what risk is and through the interplay of social factors exogenous to individuals themselves. Rhodes (1997) describes this as a hierarchy of risk priorities. This is reflected in the interviewees' perceptions of the risk of overdose, which was related to several factors, such as perceiving risk as "an everyday thing", and not necessarily perceiving overdose death as the worst outcome relative to other challenging life factors.

6.3 The ambivalence of overdose mortality

The interviewees' perceptions of the risk of overdose challenge the assumption about the relationship between knowledge of risk and risk avoidance in various ways. Some did not personalise the risk of overdose based on feelings of control. Although they had strategies for preventing overdoses, these were deployed sporadically. This is reflected in other studies showing that PWID are often unrealistically optimistic regarding their own risk of overdose (Darke & Ross, 1997; McGregor et al., 1998). Others perceived death as natural and universal for all human beings, and therefore nothing to fear. This may contribute to neutralizing feelings of otherness by comparing the risk of overdose death with death as pertinent for all people, not just them. Perceiving death as natural was also linked to living in an environment where death and disability were common occurrences. Some described how they had already experienced death – had been "on the other side" as they described it – and experienced it as pleasurable.

Living in a risk environment, these stories may contribute to neutralizing the risk of death – a highly adaptive mechanism for coping with intrinsic stress (Maruna & Copes, 2005). Stigma is also crucial. The participants inhabit drug-using environments which incorporate the harms of drug use as behaviour that needs to be justified, either to wider society, but also to me as a researcher. Participants may wish to construct themselves as moral agents in interviews which highlight how talk is also action, and the importance of interaction between the interviewer and the interviewed (Atkinson & Coffey, 2003; Kvale, 1997; Silverman, 2014; Sandberg, 2009). It could also be mentioned, though, that Lalander (2011) describes how death gives rise to anxiety for most people. Yet death is both taboo and fascinating, and gives drug use and associated rituals an aura of autonomy and energy, and a fascination with death being just nearby. This may also be related to Oscar's words at the beginning of this thesis, when describing how he balanced on the edge of the risk of death, which he perceived as almost impossible to think about for "normal people".

Importantly, participants expressed an indifference towards overdoses, involving a lack of concern for death or even a wish to die. This was often not described as a clear wish for either life or death. Rather, they expressed shifting perspectives on a continuum between the wish to live and death as relief. They related these shifts to various life factors, such as physical and mental health, feelings of frustration, stigma, hopelessness and long-term emotional suffering (Hanoa, et al., 2023). Bartoszko (2018) describes how this entails living in a chronic survival mode which may create barriers for their ability to aim for new social roles – and survival. This reflects the blurred lines between intentional and unintentional overdoses, and how perceptions of risk and feelings towards survival are complex and changing. As Miller (2009) describes – although they engage in hazardous behaviour that carries a risk of death, they perceive the likelihood of their death with indifference or resignation.

As described in Chapter 1, a narrative of survival has dominated the harm reduction movement (Bartoszko, 2018). A question is, though, if this focus may contribute to overlooking other important perspectives on the meaning of life and death for PWID. In a study of persons with heroin addiction, Bartoszko (2018) describes how the dichotomy between “life” and “survival” often emerged in the conversations during her fieldwork. She describes how staying alive and living longer are regarded as a value in itself and are taken for granted in the prevention of overdoses, and argues that “the patients’ rationale challenges the medical and public way of framing life” (Bartoszko, 2018, p. 196). Additionally, she suggests that the overdose narrative risks over-communicating physical and biological life, and under-communicating life as lived. Thus, “their personal and emotional experiences challenge the governing overdose thinking” (Bartoszko, 2018, p. 195).

Further, literature often presents overdose experiences in binary terms – with or without intention (Heale et al., 2003; Monico et al., 2021). This thesis shows how complex and changing feelings towards overdoses can be in reality. Other studies also show how various degrees of suicidal thoughts and behaviour are not captured within the categorical labels of “intentional” and “unintentional”, and that PWID often live in a social environment of marginalisation and overwhelming distress, which may involve suicidal ideation (Bohnert et al., 2010; Monico et al., 2021; Richer et al., 2013). This thesis thus shows the importance of an awareness of the possibility that avoiding death, the primary logic behind overdose interventions, is viewed with considerable indifference by some PWID (Hanoa et al., 2023; Moore, 2004). As Gjersing et al. write: “An overdose is always more than an accident” (Gjersing et al., 2011, p. 66).

This does not mean that harm reduction does not work. In the last decade, many countries have promoted various interventions, such as needle exchange programmes, to reduce the potential harmful consequences of injecting drug use. Studies have found these interventions to be effective in reducing high-risk behaviour (Lovell, 2002; Vlahov et al., 1997). Yet this

thesis illustrates that the everyday lives of PWID are characterised by various challenging living conditions, such as feelings of addiction, physical and mental health problems, unstable housing, broken relationships, and feelings of hopelessness and shame (Hanoa et al., 2023). This may speak to something more profound about social forces that might shape the participant's accounts, reflecting broader political, social and legal contexts, which may hinder addressing key factors in overdose deaths. Health consequences, on which many overdose prevention strategies are based, are thus not necessarily the most important priority in many PWID's lives.

6.4 Reducing stigma

Stigma plays a significant role in this thesis. Participants described feelings of stigma from the public, healthcare professionals and drug-using peers. This was based on experiences of enacted stigma such as hurtful comments from friends, exclusion from restaurants or dismissive attitudes from healthcare personnel. Hence, eliminating the stigma associated with injecting drug use remains a necessity in order to allow PWID to feel safe (Muncan et al., 2020). Potential avenues for reducing stigma may point to, for example, the need for societal level interventions that address these norms. Norwegian drug policy is evolving, moving from punitive to more supportive approaches. A drug reform was implemented in 2004, intended to ensure patient rights for people who use drugs, such as treatment for their drug use, and the need for specialised health services in order to reduce mental and somatic challenges (Gjersing & Amundsen, 2018). A recent drug reform was proposed in 2022 (Norwegian Parliament, 2022). Although the reform has not yet been adopted, a key goal is to reduce the stigmatisation of people who use drugs, and make it easier to reach them with supportive measures. The Reform Committee argues that decriminalisation may contribute to this goal. For instance, the use, acquisition, possession and storage of small amounts of illegal substances for personal use will remain illegal, but should no longer be subject to criminal prosecution (Norwegian Parliament, 2022).

The shift in societal understandings of drug use is also reflected in the implementation of heroin-assisted treatment in 2022 (Ellefsen, 2023). Heroin treatment is controversial, due to the drug's illegal status (Frank, 2013). Yet, although this is a trial project, the aim is to help people with opioid addiction to achieve a better quality of life, enhanced individual support, and to reduce the health risks associated with non-medical use of opioids (Oslo University Hospital, 2022). A recent study by Ellefsen et al. (2023) shows that patients express a high level of satisfaction with the treatment. The medical aspect contributed to an alleviation of the constant financial pressure to raise money for drugs, and is likely to have broader mental health benefits. The participants reported respectful interactions with staff, and the experience of having an influence on their own treatment. Strengthened health and social care approaches may contribute to less stigma and more unified healthcare. Yet this study illustrates that stigma is still important to address.

6.5 The meanings of life

This thesis illustrates how injecting drug use represents various social meanings of both risk and pleasure. However, considering the participants' living conditions and ambivalence towards survival, it is also important to address more existential questions such as hope, meaning and feelings of belonging (Gjersing et al., 2011). Biong & Ravndal (2007) suggest that drug use and suicidal behaviour in terms of life-threatening overdoses could be communicative and meaningful actions, and a movement "between death as an escape from pain and the hope of a life" (Biong & Ravndal, 2007, p. 246). They relate this to grief over feelings of loss, and challenges in fulfilling cultural ideals in terms of sobriety, work and close relationships. Not living their lives in a traditional or "normal" way may cause feelings of stress and frustration, as well as feelings of failure (Grønnestad & Lalander, 2014; Grønnestad & Sagvaag, 2016; Sandberg & Pedersen, 2009).

Biong (2013) emphasises the importance of professionals understanding overdoses as communication about specific life history events – gaining a deeper understanding of the "inside" perspective. Drug treatment and prevention programmes should also consider giving some attention to life-meaning issues in their intervention strategies (Nicholson et al., 1994). This may be facilitated by feelings of support and non-judgemental attitudes from staff, which are emphasised as important qualities in the relationship between staff and people in drug treatment (Frank et al., 2021). Similarly, Biong & Svensson (2009) stress the importance of a sensitive approach in every encounter, which may bridge motivational gaps in treatment for people who use drugs. Heale (2003) describes: "Suicidal thought and behavior are complex, and it is possible that more sensitive questioning could reveal some level of suicidal intent, while dichotomous questioning may reveal none" (Heale et al., 2003, p. 236). This includes a holistic understanding and supportive environment, as well as building trust, which is an important condition for such communication to occur (Biong, 2013; Gjersing et al., 2011; Sælør, 2015). Hope and finding life meaningful are crucial prerequisites for recovery among people with co-occurring mental health and substance use problems (Biong, 2013; Sælør, 2015; Grønnestad & Sagvaag, 2016).

6.6 Future perspectives

This thesis has highlighted the complexity of injecting and overdoses. Gjersing et al. (2011) emphasise that contexts and the individual's overall life situation need to be addressed in the overdose prevention work. Considering the participants' ambivalence towards life, it is key to examine this topic in future research. Although it may be difficult to make a distinction between suicide and overdoses, it could be beneficial if the supporting services were the same as for non-fatal suicides (Gjersing et al., 2011; Myhre et al., 2022; Walby et al., 2020). Gjersing et al. (2011) suggest interventions such as emphasising the importance of

enhanced relations to relatives and professionals, and close follow-up after non-fatal overdoses. As such, overdoses treated by the ambulance services may be an opportunity for additional follow-up/interventions (Gjersing & Bretteville-Jensen, 2015).

Furthermore, the most common overdose prevention interventions, such as opioid substitution treatment and DCRs, are tailored towards people who use illicit opioids such as heroin, or who inject. However, recent studies suggest new groups at an increased risk of overdose (Gjersing, 2023; Gjersing & Amundsen, 2022). These are individuals who died with other opioids as the underlying cause of death, and who had different characteristics compared to those with heroin as the cause of death. For instance, they less frequently had a drug-related diagnosis or had been charged with criminal offences, and had a higher socioeconomic status. Preventive measures and treatments need to be adjusted for these new at-overdose-risk groups. As such, there is a need for more knowledge to design interventions that also reach those at risk of pharmaceutical overdose deaths (Amundsen et al., 2023; Gjersing, 2023; Gjersing & Amundsen, 2022).

Overall, UNODC (2021) suggests that prevention remains a crucial approach to reducing drug use. They argue that “the increased number of people with drug use disorders globally calls for the scaling up of evidence-based interventions that take a multifactorial approach” (UNODC, 2021, p. 48). This includes communities – e.g. networks of people who use drugs or people in recovery – that can greatly support prevention efforts. People who use drugs should be included and empowered in all aspects of the design and implementation of service delivery. This aligns with the person-centred influence described in section 4.3, aiming to improve individual patient care processes and outcomes. This includes highlighting participatory approaches, in which the subjects of care are active agents related to their healthcare (Martin & Félix-Bortolotti, 2014). UNODC points to policy implications, stressing that “protecting the human rights of people who use drugs by treating them with dignity, removing stigma and providing equal access to health and social services need to be the underlying principles of all interventions related to drug use” (UNODC, 2021, p. 48). This means that all human beings have value as persons, with “personhood” implying that people have intrinsic and objective worth that transcends every other consideration (Okoro, 2020).

Ultimately, as Oscar described in the beginning of this thesis; PWID live their everyday lives with drug use in social environments that influence their perceptions of risk and survival. These perceptions are key in order to convey relevant harm reduction messages, and emphasise the importance of a person-in-context understanding, acknowledging that a human being is someone in constant dialogue with both the multifaceted, inner parts of themselves and the outer context they interact with (Klevan, 2017). Ultimately, this speaks for the importance of addressing the reasons behind PWID’s ambivalence towards survival, and not only individual behavioural change, which may contribute to the marginalisation of already marginalised people.

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Article 1

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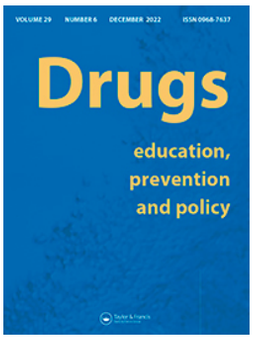

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"Hooked on the needle": Exploring the paradoxical attractions towards injecting drug use

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ABSTRACT

Injecting drug use is one of the leading risk factors for infections and drug-related deaths. Despite these risks, many people who inject drugs (PWID) continue to inject despite access to alternative intake methods. In this study, we explore this seemingly paradoxical attraction. We conducted 80 qualitative interviews with PWID, recruited from low threshold settings in five Norwegian cities, where we focus on the process of injection initiation and why PWID maintain such behaviour over time, despite associated negative consequences. The analysis shows how participants' experiences evolved from a fear of the needle, to embracing it as a meaningful practice. First, this involved social interaction and learning from other PWID, second, appreciating the intensity and speed of the intoxication, third, the positive ritual aspect of injecting, and finally, a devaluation of other modes of use. The study thereby helps expand upon and provide new understandings of the interactional process and cultural context of drug use, in which the interplay of social factors influences individual actions and promotes injecting over other modes of use. Future interventions for reducing the number of PWID thus need to consider how various social contexts impinge on, or even encourage, injecting drug use.

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Introduction

Injecting drug use is one of the leading risk factors for blood-borne infections, such as HIV and hepatitis C, and drug-related deaths (Degenhardt et al., 2011; Mathers et al., 2013). Despite these elevated risks, injection is still the preferred mode of use among many opioid and stimulant users (Degenhardt et al., 2017; EMCDDA, 2020), with an estimate of 11.3 million injecting drug users worldwide (UNODC., 2020). While epidemiological studies have provided a valuable overview of the practice and of the degree of associated risks (Rhodes et al., 2001), a growing body of qualitative literature shows that injecting drug use involves distinct meanings, shaped by social and structural factors (Guise et al., 2017). These perspectives offer an in-depth exploration of how injection initiation is experienced, the meanings and identities it can bring, and how initiation is shaped by contextual factors (Neale et al., 2005). Such perspectives also highlight the 'normalization' of drug injecting within particular social networks (Rhodes et al., 2011; Roy et al., 2008), which, over time, lead to new social roles and identities bound to injecting (Fitzgerald et al., 1999). These mechanisms may help explain the limited effectiveness of interventions that aim to prevent injecting drug use (Werb et al., 2013).

In addition to health risks, injecting drug use is also associated with an increased risk of abscesses and skin infections due to contaminated needles and incorrect injection routines (Phillips et al., 2012). Injecting drugs is also associated with a high degree of stigma which may contribute to economic and social problems, such as less access to employment, social exclusion and psychological problems (Lloyd, 2013; Simmonds & Coomber, 2009). Despite these well-known risks, the practice of injecting drug use may however be sustained by subjective logic that rationalizes risky behaviour (Mayock, 2005), by which PWID see injection as an acceptable, and even desirable, route of administration (Harocopos et al., 2009).

Following such a perspective, drug injecting also involves a certain level of autonomy, by which actors are attracted to such scenes by a desire for excitement, independence and belonging (Fast et al., 2009). As such, the individual trajectories towards injecting drug use unfold alongside dynamic and changing perceptions of risks that are relational and socially contingent (Mayock, 2005). These insights have led to an increasing focus on ecological approaches that seek to understand the ways in which structures, social processes and physical environments of drug scenes contribute to shaping risk among drug-using populations (Fast et al., 2009; Rhodes, 2002; Strathdee et al., 1997).

As Rhodes and colleagues (2011) argue, there is a large body of epidemiological research emphasizing individual-level factors in explaining initiation to injecting drug use,

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such as childhood and educational experience, early initiation to non-injecting drug use, and risk perceptions and practices. Without undermining the value of such epidemiological perspectives, they tend to highlight the importance of context, in which initiation to injecting drug use is also a process bound to social interactions (Rhodes et al., 2011). As such, the importance of peers and social networks is accentuated (Harocopos et al., 2009; Roy et al., 2008; Small et al., 2009), where the transition to injecting drug use involves a combination of social exposure, social influence and social learning (Sherman et al., 2002; Stillwell et al., 1999; Witteveen et al., 2006). These perspectives highlight how the paradoxical attractions towards injecting drug use are embedded within drug-using milieus, resulting from a social process enabled and constrained by socio-structural factors, in which the meanings associated with injections evolve through interaction (Guise et al., 2017). This invites further discussion of social interactionist theory and how it may inform an analysis of such drug-using behaviour.

A social interactionist perspective on injecting drug use

The concept of social interactionism places emphasis on the socially situated nature of individual action, and strives to describe the meanings and practices that persons produce when they do things together (Denzin, 1992). In his seminal conceptualization, Blumer (1969) argues that people act towards things on the basis of the meanings they apply to them. Importantly, such meanings are not ready-made, but rather derived from social interaction, in which actors modify and develop such meanings through an interpretive process (Blumer, 1969, p. 2). In its crudest form, the analytical focus of social interactionism is therefore to explore the processes by which individual behaviour is shaped through socialization (Battjes, 1984).

Following such a perspective, drug use may be viewed as a social behaviour that involves interactions such as buying and selling drugs, needles and paraphernalia, sharing injection equipment and using in places where other PWID gather (Kumar et al., 2016). This social context may thus influence and alter the perspectives of those involved, in which PWID learn important norms and rules, as well as acquire knowledge, which may be technical and practical, but also more emotionally anchored or embodied (Lalander, 2012; Richert, 2015). The initiation of the self into drug use is therefore a process derived from social interactions occurring in specific contexts (Rhodes et al., 2011). The identity transition associated with injecting drugs thus involves a process of becoming and constitutes a transition to a new symbolic identity (Järvinen & Ravn, 2011; Martin, 2010). The perspective of social interactionism thereby seeks to understand the social meanings, experiences and contexts of risk behaviour (Rhodes et al., 2001), and highlight the social environments and complex social negotiations that promote injecting drug use (Guise et al., 2017; Mayock, 2005; Sherman et al., 2002).

In this study, we employ such a social interactionist perspective and explore the narratives of a large group of PWID in Norway – a country in Europe with a relatively high and stable drug-induced death rate. In 2020 the rate was 6,1 per 100 000 inhabitants (EMCDDA, 2020; Gjersing, 2020). Our aim is to explore the various attractions towards injecting drug use, and how such practices are rationalized and sustained over time, despite the associated negative consequences. This study thereby provides not only insight in the complex trajectories towards injecting drug use, but also the various ways in which such behaviour is embedded with meaning and how it may help understand the seemingly paradoxical attractions towards injecting drug use. The intention of the paper is therefore not to explore the risks related to injecting drug use, but rather to understand the participant's experiences of injecting. This knowledge should help inform future harm reduction interventions targeting PWID.

Methods

The study draws on qualitative interviews with 80 PWID, recruited from low-threshold services in five Norwegian cities. Interviewees were on average 45 years old (range 23–63) and 77% were males; the sample reflects the overall population of people who inject drugs in Norway (Gjersing & Bretteville-Jensen, 2018). Majority of interviewees injected drugs on a daily basis. A total of 71% of the sample used multiple substances (mainly combinations of heroin, amphetamines and benzodiazepines), 19% mainly used amphetamines, and heroin was the main drug of choice for 10%.

Voluntary interviews were conducted during October 2019 and interviewees were recruited at low-threshold services such as health and social services, needle exchange programmes, homeless shelters, emergency food assistance programmes and drug consumption rooms. The services received information about the project in advance and informed PWID in order to motivate participation. Whilst most of the interviewees were recruited by service staff when researchers were present, some interviewees were recruited through snowball sampling or by the researchers themselves. Three researchers (first, second and third author) and two trained research assistants conducted the interviews. In order to create an atmosphere where the interviewees could talk freely and undisturbed, interviews were conducted in private spaces.

Qualitative research interviews were chosen in order to understand the lived experiences of PWID themselves. The interviews were semi-structured and open-ended, and we used an interview guide in order to ensure that key topics were covered. This guide included questions about topics such as thoughts on injections before injection initiation, positive and negative experiences with injecting drug use as well as experiences with other intake methods. The interviews lasted between 25–60 min, with an average of 45 min. Prior to gaining informed consent, we assessed individuals' level of intoxication, including their potential to provide informed consent and participate. We terminated two interviews, however, because we deemed it would be inappropriate and unethical to proceed, given the participants' heavy intoxication or poor mental health.

The interviews were recorded and transcribed verbatim. The analytic software tool HyperRESEARCH was used to systematically code the data. In total, 25% of the interviews were coded by two researchers to ensure sound interpretation and shared understanding of the data. Transcripts from the interviews were thematically coded and included a broad range of codes, such as reflections and narratives on injection initiation, risk and risk-prevention strategies and perceptions on injecting drug use, as well as other modes of use. Topics that emerged from the fine reading of the interviews were supplemented to the code list, finally consisting of 34 codes in total. As the topic of interest in the current study involved an investigation of the possible attractions towards injecting drug use, we focused the further analysis on the stories that were relevant to understand their prolonged careers as PWID, such as memories of their first injections, positive and negative drug effects, as well as detailed descriptions and how they prepared and injected drugs. All quotes in the relevant codes were then reanalysed, and helped identify common themes that led to the classification into the four main categories presented in the results: social interaction and learning from other PWID, appreciating the intensity and speed of the intoxication, the positive ritual aspects of injecting, and devaluation of other modes of use.

The project was approved by the Regional Committee for Medical and Health Research Ethics in Norway (REK). All interviewees were reimbursed NOK 200 (approximately 20 €) for their time, any identifiable information has been anonymized and the interviewees are referred to by pseudonyms.

Results

The analyses revealed a process in which participants evolved from being afraid of injecting drug use, to embracing it as their preferred mode of use. This process involved social interaction with more experienced peers and transfer of knowledge, an acquired appreciation of the rapid and intense sensation following drug injection, development of positive rituals involved in the injecting behaviour, as well as negative experiences or perceptions with other modes of use. The analysis thereby highlights the paradoxical attractions associated with injecting drug use and why PWID sustain such behaviour over time, despite the associated negative consequences.

Social interaction and learning from other PWID

Most interviewees described having had negative attitudes towards injecting drug use prior to their first injection. They associated it with uncleanliness, diseases and overdoses, and perceived that injections could lead to greater addiction and make it increasingly difficult to quit. Several also spoke of a fear of needles. In these narratives, they expressed deep concerns about injecting, about the breaking of barriers required to transition to injecting, and described it as a practice they would never initiate. Karl explained:

> I was afraid of everything that could go wrong. To push something in and maybe get acute blood poisoning – in a flash you're so ill that you can't account for yourself. I was afraid to do it.

Despite their initial fears, the interviewees spent time in social milieus where injecting drug use was widespread. Drugs were prepared, injected and the effects were observed, communicated and vividly described among their peers. Over time, by observing and interacting with other people using drugs, the interviewees described how they successively learned technical as well as practical skills for injecting. Kari, who used multiple substances, spoke of an initial fear of needles. Yet, by watching her friend inject, she described how she acquired practical knowledge – a process that helped diminish her fears:

> I actually had a fear of needles. Everyone said "you, who had a fear of needles, ended up as an injecting drug addict!" But it's different when you do it yourself. I kept a close eye on what my friend did, how he prepped it and stuff, and what he did when he was shooting. So, I sat alone, and there was no trouble, just boom and I made it on the first try.

In Kari's account, the informal process, in which she observed peers who injected, was an effective way of learning the necessary techniques to control her fears. As such, her everyday interactions among PWID facilitated a social platform for learning, in which the practical knowledge associated with injections was passed on. Others spoke of a similar process, and Asbjørn, who injected amphetamines on a daily basis, described how injecting was the norm within their social environment with drug-using peers:

> I was one of the boys and had joined the gang. It was a bit like, if you were going to use drugs, you had to inject it. You were told, that's the way to do it. There was only one way.

Asbjørn's quote illustrates how injections were taken for granted within the drug scenes. Karl expressed it similarly and recounted the stories he was told when he initially entered the milieu: '*Well, it was the typical story, you know, that you get a kick out of it and that it's a lot stronger*'. As such, the shared valuation of the effects was vividly described as well as explicitly recommended by peers. Similarly, Stig was told that: '*You have to try this!*' Thus, norms of use and shared knowledge about the drugs' effects were communicated within the participants' environments. In this way, injecting drug use was normalized and can be described as habituated within the users' social relations.

As well as verbal communication from drug using peers who explicitly expressed the benefits of injecting, the interviewees also described a more emotional and embodied communication stemming from the observable effects of injections. By spending time in an environment where injecting drug use was widespread, they grew curious about the effects. Mona explained: '*Everyone told me how good it was, and I had seen others shoot. It looked like they felt good.*'

Although the effects of injecting had been observed and described to them by other PWID, the effect was not immediately apparent. As such, the interviewees said that they needed to learn how to interpret the effects in order to value and experience them in 'the right way'. Mathias recounted that he was disappointed after his first injection. However,

after spending time with PWID, he described how he learned to recognize and enjoy the effects:

> I had expectations that something great would happen, that I would get very high. I just didn't quite understand it. But I did eventually, though.

Mathias's story exemplifies the importance of expectations in the PWID's initiations to injecting. Their observations and daily encounters with peers created a basis for anticipation, in which the effects of injecting were presented as pleasurable. However, this also involved learning how to interpret the effects and how to value injections as opposed to other modes of drug use.

The narratives presented among the interviewees indicate how their perceptions of injecting drug use evolved through social interaction. From deep concerns about the possible negative effects, they successively learned how to value injecting as pleasurable. These benefits were learned by interaction and illustrate the users' socialization into a culture of drug use where drug injections were the preferred method of use. As such, their stories highlight the importance of the social context of drug use, and how it may influence and alter the perspectives of those involved.

The rapid and intense sensations of the high

The stories presented by the interviewees were not only related to the social contexts of drug use, but also highlighted the importance of the pleasurable effects stemming from injections. Oscar had injected drugs since his early teens and described the beneficial sensations of injecting: '*It's nothing positive besides the high – it's just so damn good. That's why I am unable to stop*.' As such, the stories of the immediate and intense effects that were initially conveyed when the interviewees first entered the scenes were increasingly embodied through their own injecting experiences.

Hanne had injected drugs for over 15 years and still vividly described the attractions injections had for her:

> It's the immediate effect. You get it right away, as quick as possible. I've been screaming out: "OOOH, that's GREAT! This is better than an orgasm!" So, I would say that an orgasm is second place, a good shot of heroin is always number one [laughs].

Similar to Hanne's account, the interviewees spoke of injecting as a way to maximize the effects from the drugs, usually described in terms of a kick, euphoria, rush, orgasm or intensity. Oyvind explained:

> I only inject drugs. The rush comes right away. It takes 7-10-12 seconds and then you feel the kick. That's the main reason: the kick.

Several interviewees emphasized the intense effects of injections. However, after years of injecting drug use, the participants described difficulties finding a vein for injection, as well as increased tolerance and withdrawal symptoms. Although some interviewees explained that they still felt and desired the intense rush, injecting drugs was also an immediate means to relieve withdrawal symptoms and 'get well'. Hakon explained: '*It's the fact that it works in an instant. That you get well right away*.'

Similarly, Roger explained that he consumed drugs both orally and by injections. Although he believed that the level of intoxication could be the same, he preferred injections to 'get well' and explained it by the speed of the effect:

> You get well a lot faster. So [when taking the drugs orally], you have to wait 15 min, or half an hour. The best about injecting … It's just the immediate effect if you're sick.

Stories about being 'sick' and 'getting well' were repeated during the interviews, and implied injecting in order to stabilize and relieve withdrawal symptoms. Marie described an overwhelming feeling of comfort when she experienced withdrawal symptoms and injected drugs:

> It's a joy. The euphoria when you're standing there [in front of the stove boiling pills with water], and get it into your veins and you get well. You get a kick and … oooh, it feels so good when you're sick!

As well as withdrawal symptoms, injecting drugs was also perceived to relieve other types of discomfort or pains. These kinds of pains were often related to physical or emotional discomfort. Thomas struggled with physical pain from an accident some years ago. Although he had previously consumed painkillers orally, he explained his attraction towards injecting due to its instant pain-relieving effects. Others expressed the instant relief of emotional pain in terms of peace, numbness or protection from emotions. Arne described it as follows: '*I don't want to overdose, but to get the best high you almost have to tip over to an overdose*'. This was usually referred to as 'the head on the table' and implied a level of intoxication in which they were heavily asleep, almost on the edge of an overdose. Oscar elaborated:

> Preferably right on the edge of overdose, where you sit and you're almost dying. Then you're comfortably numb. Everything is comfortable, you're good and warm and relaxed. There are no stress factors in the universe. You just withdraw into yourself, and then you're just in a cotton bubble.

To sum up, the interviewees highlighted the rapid onset, the effective and intense sensations, as well as the pleasurable relief associated with injecting the drugs. Whether to feel the intense euphoria of the kick, or the pleasure and relief of discomfort or pain, the speed and the intensity of the effect were presented as key to understanding the users' continued injecting practices. Accordingly, the narratives that initially influenced their initiation to injecting were increasingly embodied and served to explain their prolonged careers as PWID.

The ritual aspects of injecting

The pleasures associated with injections were however not limited to their intoxicating effects. During interviews, the importance of rituals emerged when participants spoke about their injecting practices. This involved specific ways of organizing the injecting ritual, and they were usually detailed and covered numerous steps that served to maximize the drug's effects. Oyvind described his routine as follows:

> I have a ritual. First, I drink one litre of water. Then I eat a good bowl of oatmeal, and everything is clean and nice around me.

> Then I put the equipment there, and then I put the drugs there. At that point I have complete peace.

The quote illustrates how the use of drugs was performed in a fixed and ordered manner, both in terms of the administration of the drug as well as selection of the physical and private setting for use; peace and concentration, secluded from the outside world. Einar described it similarly:

> I went to the pharmacy and picked up Dolcontin [prescription opioid], and then I went home to cook it. If you cook it long enough, it turns yellow, then it turns a little greenish, and then you put the Dolcontin in and boil it and make sure everything is just right. Not too much water and not too little. A little ritual, every morning, almost like a kind of breakfast.

The latter quote indicates an instrumental function of the ritual; by preparing and administering the drug in certain ways, it maximized the benefit. Although some interviewees described rituals as personalized, like Hanne: '*It's your thing. Or if we're together, it's our thing*', rituals were in general perceived to be common among the interviewees, mastered through practice as well as by observing and learning from experienced PWID.

The interviewees believed rituals to be a central aspect of injecting, mainly described in positive terms such as expectations, joy, peace or excitement. Mathias explained: '*A part of the enjoyment is the rituals*'. Some interviewees described the whole ritual as being a meaningful part of injecting drugs, while others highlighted different parts of the injecting process as important. They highlighted the peaceful surroundings which promoted being calm and concentrated, the cooking and preparation of the drugs, as well as observing the blood mixing with the drug in the syringe, indicating that they had hit a vein, usually referred to as 'the answer' as Fredrik explained:

> When you inject, you get the answer when you stick the needle into a vein and you see the blood coming into the syringe – that's a kick in itself. I'm not the only one saying that.

Some explained how they perceived themselves to be addicted to the ritual as well as the drugs. Synne had consumed drugs by several modes of use, such as smoking heroin, but preferred injecting. When asked about her perceptions of injecting, she mentioned the speed of the effect, but also described how she felt addicted to the process of preparing the drugs for injection. She perceived the effect of the drugs as diminished without performing what she referred to as a ritual. Her reflection indicates how the ritual symbolized a positive outcome of the injection process:

> It's not the same when you get something that's already prepared. I guess it has something to do with my expectations, you know, it kind of builds up and I'm thinking "now I'm going to do it". I'm almost playing myself up a bit.

Synne's story exemplifies the importance of rituals for injecting drug use, in which the meaning of the ritual and the emotions it gave rise to seemed just as important as the drug itself. This further illustrates how experiences of the effects were influenced by expectations and pharmacology, where rituals served as a blend of both instrumental and symbolic meanings.

However, the interviewees described the use of needles to be the most important part of their ritual and perceived themselves to be addicted to the needle, referred to by the interviewees as 'hooked on the needle'. Einar explained:

> It turns into a ritual that you get addicted to. You get really needle-horny. You want to consume everything with a needle.

After years of injecting, Trygve had increasing difficulties finding veins. Yet, he found it difficult to consume drugs by other modes of use and explained it by being addicted to the needle as well as the drugs. If he was without access to needles, he said that he would save the drug rather than consume it by another method:

> If I don't have any equipment, I don't bother to sniff it. I can have half a gram for a day or two, until I get hold of the equipment. If I don't have any equipment, I'm less likely to use drugs.

Several interviewees echoed Trygve's experiences. Hege said that she preferred to inject pills and heroin separately, in order to perform two injections instead of one. Others described how they would happily inject water if they did not have access to drugs, in order to experience the act of injecting. Mathias explained:

> You almost get addicted to the needle. You can inject water just to get a shot. It feels like an itch in the veins, that you have to have it now. I have injected water 2–3 times and I'm not the only one.

Overall, the ritual aspect of injecting, as has been highlighted above, seemed to be a central part of the participants' practices. The ritual as a whole, or different parts of it, were described as an addiction in its own right, mainly in relation to the needle, in terms of satisfaction, calmness and concentration, indicating how the ritual symbolized a positive outcome of the injection process. As such, the interviewees described the ritual aspects of injecting drugs as addictive in themselves, influenced by perceptions, representations and the anticipation of injecting drugs.

Devaluation of other modes of use

Although injection was the preferred method of use among the interviewees, they had still consumed drugs by other modes of use, such as sniffing, smoking, drinking or by taking it orally. This was either prior to their injection initiation or if they had difficulties finding veins. However, amongst these participants, they all went back to injecting. Their narratives usually involved a devaluation of other modes of use.

A central factor expressed was the perception of injecting as more cost-effective compared to other modes of use. Bjorn had both smoked and injected heroin. When asked if he had considered switching from injecting to smoking, he explained the cost-effectiveness of injecting over smoking: '*You need a lot more [drugs] and it's more expensive. I can use 0.1 grams, and it makes me well. If I smoke it, I would have to use a lot more.*' Some interviewees recounted they were advised by peers about the cost-effectiveness of injecting. Although injecting involved more frequent use, it was perceived to be more economical in terms of lack of waste.

Gunnar said that he had tried smoking heroin, but perceived it to literally 'go up in smoke'. He explained:

> It's about the small amounts. 0.25 [grams], that's quite a small amount, and if you smoke it, a lot of it disappears in smoke. But, when you throw it all [the ingredients for preparing heroin for injection] in a cooker with water to boil it, then all of it stays there. So, there's all of these factors that make you prefer injections.

Another devaluating factor concerned negative experiences of other modes of use, particularly heroin smoking or snorting amphetamine. Interviewees associated smoking heroin with nausea from the smell or taste, and thus preferred injections. Synne explained: '*Some people smoke it. I almost get nauseous just by the taste and smell of it.*' Others described dental problems or nasal ulcers associated with frequent amphetamine snorting. In combination with advice from peers, they described harms from other modes of use to be one of the main reasons for continuing to inject. Dag used to snort amphetamine but switched to injecting due to the negative effects from snorting: '*I noticed that after I had sniffed a lot, my nose, throat and stomach got ruined.*' Whilst some of the devaluating narratives were described as personal experiences, others were based on information from other PWID. Stig explained: '*I know people who have had stomach ulcers and ulcers in the intestines and stuff. So, I don't think it's any better*.' Hege elaborated similarly:

> Smoking, yuck. I've never tried it, but I couldn't imagine it, either. Because of the taste. I started sniffing and it ruined my nose. I just got wounds and a lot of shit, so I stopped. I was afraid that I was going to get a stomach ulcer. So, the cleanest and best thing is to take it intravenously. That's what they say.

Hege's story further illustrates the assumptions of the interviewees. Based on information from other PWID, injecting drug use was perceived to be the cleanest, in terms of avoiding bacteria and impurities in the drugs with subsequent health harms. Thus, injecting was not perceived as more harmful than other modes of use.

Additionally, the interviewees who devaluated other modes of use highlighted their lack of skills, especially related to smoking heroin. Although some spoke of the positive effects of smoking heroin, such as less stigmatization and a high that enabled them to appear more 'normal', they had lower skills in smoking compared to injecting. The latter was, to a large degree, associated with self-confidence and status. Petter explained:

> I've never had the patience to learn the technique properly. I see that there's many who master it properly. If you learn to do it, it's probably a good way to do it.

Interviewees highlighted the practical knowledge needed to consume drugs and explained their long-term injecting drug use partly by lack of skills in other modes of use, such as smoking heroin. Trygve said:

> I've used heroin for 30 years and I've hardly smoked, it's crazy. I can't make it flow properly. It shouldn't be that hard. You just put a little bit on top there and then you just [inhale] (…) It's not out of the question [to smoke], I guess you just have to learn it.

To sum up, the interviewees spoke negatively about other modes of use and upheld positive views about injecting. Although most of them had less experience with other modes of use, they relied on the socially circulating stories within the drug scenes when denoting the negative consequences of smoking or sniffing drugs. This perspective was fuelled by their sensitivity to economic factors and lack of skills in these alternative methods of consumption, which caused a fear of not maximizing the effects of the drugs they bought. Importantly, these stories were intrinsically bound to their socialization within a user culture that favoured drug injection over other modes of use, highlighting the embodied knowledge, cultural norms and practical skills that guided their ways of doing drugs. As such, the social processes and physical environments of the drug scenes contributed to shaping their risk behaviour, by which they viewed injection as an acceptable and desirable route of administration.

Discussion

This study highlights the complex range of attractions towards injecting drug use. Based on an extensive number of interviews with PWID, the analyses show how these attractions involved social interaction and learning from other PWID, appreciating the rapid and intense sensation of injecting, a positive ritual aspect, as well as devaluation of other modes of use. However, the interviewees' accounts illustrated how their perceptions had evolved over time. They described having had feelings of anxiety and negative beliefs associated with injecting when they first started. After a while, they increasingly perceived injecting as constructive and valued. Whilst the participants accounted for a variety of social and physical harms due to their drug-using practices, the analysis demonstrates the paradoxical attractions of injecting drug use, in which the interviewees evolved from fearing the needle, to embracing it as a valued mode of use.

These evolving attitudes highlight the importance of social influences in PWID perceptions and negotiations of risks. While most of the interviewees acknowledged the dangers associated with their injecting practices, they were still heavily influenced by peers when addressing their initial trajectories and describing the pleasures they associated with injecting. As such, they had learned how to value injecting, despite their initial fears, and their interactions with drug-using peers enabled the acquisition of both technical skills and a more embodied knowledge that influenced their perceptions of risks and pleasure.

Similarly, Lalander (2001) describes drug use as a social process where experience and knowledge are internalized through social networks and embodied experiences, emphasizing the importance of a common habitus. Small et al. (2009) also demonstrate how injecting is heavily influenced by socially constructed perceptions, developed through social relationships with other PWID rather than a rational calculation of risks. Perceptions of risks are therefore relational and socially contingent, fuelled by subjective logic that rationalizes risky behaviour (Mayock, 2005). The paradoxical attractions of injecting drug use are thus highly embedded in the social processes and physical environments of drug scenes, which contribute to shaping risk among drug-using

populations (Fast et al., 2009; Rhodes, 2002; Strathdee et al., 1997). Such ecological perspectives thereby shift the unit of focus from individual risk factors, to social, political, and economic factors, as well as the importance of physical environments and how they interact with personal characteristics to determine health (Burris et al., 2004; Rhodes et al., 2005). As Duff (2007) argues, this is not to ignore the significance of choice and responsibility, but rather to emphasise how drug use behaviours are also shaped and transformed by contextual factors, and not least how they are rooted within shared social and symbolic meanings.

Findings highlight the participants' appreciation of the immediate and intense effects produced by injecting and this appeared to be key to understanding their sustained injecting careers. Similar associations have also been found in several other studies (Crofts et al., 1996; Fitzgerald et al., 1999; Goldsamt et al., 2010; Stillwell et al., 1999), and it is suggested that the promise and experience of a rush are particularly important for initiation to injecting drug use (Fitzgerald et al., 1999). We found that participants' stories of the immediate and intense effects that were initially conveyed when the PWID first entered the scenes were increasingly embodied through their own descriptions. Accordingly, the shared perspectives on the attractiveness of the effects, and the stories that sustained them, helped provide narratives and contributed to shaping conceptions of injecting as meaningful and pleasurable (Khobzi et al., 2009; Lalander, 2001).

However, the attractive effects of injections had not been immediately apparent among the interviewees and some expressed a need to learn how to interpret these effects in 'the right way'. Similar findings have been suggested by several scholars, arguing that shared perspectives and social norms contribute to perceptions on how drug effects are valued, expressed and interpreted among PWID (Becker, 1953; Lalander, 2001; Richert, 2014; Svensson, 2007). This highlights the importance of the interactional processes between experienced and novice PWID in defining effects as pleasurable (Harocopos et al., 2009; Khobzi et al., 2009), and further demonstrates the value of ecological perspectives in explaining the seemingly paradoxical attractions towards injecting drug use.

As we have demonstrated in this study, the pleasures associated with injecting drug use were bound to interactions, through which the interviewees learned both practical and technical skills, as well as to interpret the effects as pleasurable. Over time, the embodiment of this cultural knowledge was displayed by their narratives that sustained such pleasures and through their ritualized practices, which ultimately made them reject other modes of drug use. Despite the interviewees' risks of health harms, overdoses and ambivalence towards injecting drug use, these stories drifted within their social networks of PWID, and displays how the paradoxical attractions of injecting were embodied in making it a meaningful and rational practice. As such, the study shows the complexity of injecting drugs and how the practice of injecting is contingent on the cultural context of drug use, in which the interplay of social factors influences individual actions and help explain the prolonged careers of injecting drug use. If interventions are to encourage reductions in injecting drug use, there is a need to understand how different social situations and contexts impinge on and encourage such risky practises among PWID.

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Article 2

Hanoa, K., Bilgrei, O. R., & Buvik, K. (2023). Injecting Alone. The Importance of Perceived Safety, Stigma and Pleasure for Solitary Injecting. *Journal of Drug Issues*, DOI: 00220426231151377.

Article 3

Hanoa, K., Buvik, K., & Karlsson, B. (2023). Death Holds No Fear: Overdose Risk Perceptions Among People Who Inject Drugs. *Contemporary Drug Problems*, DOI: 00914509231164764.

Appendices

Forespørsel om deltakelse i forskningsprosjektet

" Risikofylte inntaksmetoder blant injiserende brukere: Behov for mer kunnskap "

Bakgrunn og hensikt
Dette er en forespørsel til deg om å delta i en forskningsstudie. Hensikten med denne studien er å få mer dybdekunnskap om risikohåndtering blant personer som bruker rusmidler med sprøyte, og om situasjonene der bruken foregår. Folkehelseinstituttet-Avdeling for rusmidler og tobakk og Helsedirektoratet finansierer prosjektet. Linn Gjersing er prosjektleder.

Hva innebærer studien?
Undersøkelsen består av et intervju som gjennomføres av en forsker eller forskerassistent. Intervjuet tas opp på en opptaker og varer i ca. 30-60 minutter. Du vil få 200 kr i kompensasjon for å delta. Etter intervjuet vil du aldri bli kontaktet igjen på noen som helst måte. Du skal ikke oppgi navn, telefonnummer, adresse, eller fødselsdato i intervjuet. Om du i løpet av intervjuet oppgir ditt eget eller andres navn så vil dette bli erstattet med et fiktivt navn når intervjuet transkriberes. Lydopptaket vil bli slettet når det er transkribert.

Hva skjer med informasjonen om deg?
Informasjonen fra intervjuet skal kun brukes slik som beskrevet i hensikten med studien. Intervjuene vil bli behandlet uten navn og fødselsnummer eller andre direkte gjenkjennende opplysninger. Sitater fra intervjuet vil kunne bli brukt i rapport(er)/artikler, men ditt navn eller karakteristikker som muliggjør identifisering vil ikke under noen omstendigheter bli inkludert. Materialet vil bli oppbevart på FHIs sikre nettverk og kun være tilgjengelig for prosjektmedarbeiderne.

Mulige fordeler og ulemper
Det tar ca. 30-60 minutter av din tid å delta i undersøkelsen, og for dette får du 200 kr i godtgjørelse, ellers har ikke prosjektet noen ulemper eller fordeler for den enkelte deltaker.

Frivillig deltakelse
Det er frivillig å delta i studien. Du kan når som helst, og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dette vil ikke få noen konsekvenser for deg. Siden det ikke er noen kobling mellom ditt navn og tekstdokumentet med ditt intervju vil du ved inklusjon få oppgitt en kode som du må ta vare på, for eksempel som et bilde på mobiltelefonen din. Dette er den eneste lenken mellom deg og intervjuet, og vi på FHI har ingen kodeliste som kobler denne koden med ditt navn. Denne koden er tilfeldig generert, og den blir lest inn først i intervjuet. Om du ikke ønsker at en slik kode skal leses inn, så vil dette bli sagt først i intervjuet og du vil måtte bekrefte muntlig i intervjuet at du ikke ønsker en slik kode.

Dersom du ønsker å trekke deg eller har spørsmål om studien, kan du kontakte prosjektleder Linn Gjersing på tlf. 406 48 711 eller epost linn.gjersing@fhi.no. Du må oppgi koden som du fikk ved inklusjon om vi skal slette dine data, ellers har vi ingen mulighet til å finne ditt intervju. Alternativt, kan Linn Gjersing kontaktes ved personlig oppmøte hos Folkehelseinstituttet-Sandakerveien 24C, bygg B1, 0473 Oslo mellom klokken 10 og 14 på hverdager. Om Linn Gjersing ikke er tilstede, kan du legge igjen beskjed i resepsjonen i Marcus Thranesgt 6 med navn og telefonnummer og dette vil bli videreformidlet til prosjektleder.

Rett til innsyn og sletting av opplysninger om deg
Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Dersom du trekker deg fra studien, kan du kreve å få slettet opplysninger om deg, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner. Siden det ikke er noen kobling mellom ditt navn og tekstdokumentet med ditt intervju vil du ved inklusjon få oppgitt en kode som du må ta vare på, for eksempel som et bilde på mobiltelefonen din. Dette er den eneste lenken mellom deg og intervjuet, og vi på FHI har ingen kodeliste som kobler denne koden med ditt navn. Denne koden er tilfeldig generert, og den blir lest inn først i intervjuet. Om du ikke ønsker at en slik kode skal leses inn, så vil dette bli sagt først i intervjuet og du vil måtte bekrefte muntlig i intervjuet at du ikke ønsker en slik kode.

Økonomi og rolle
Prosjektet finansieres av Helsedirektoratet og Folkehelseinstituttet-Avdeling for rusmidler og tobakk, men det kan på sikt være aktuelt å søke Forskningsrådet eller andre instanser om forskningsmidler for deler av prosjektet.

Forsikring
Deltakerne er dekket av pasientskadelovens regler under intervjuet.

Informasjon om utfallet av studien
Du har rett til å få informasjon om utfallet/resultatet av studien. Om du ønsker dette, kan du kontakte Rusfagsbiblioteket på Folkehelseinstituttet enten ved personlig oppmøte til Marcus Thranes gate 6, 0473 Oslo, ringe 401 04 227 eller sende en epost rusfagsbiblioteket@fhi.no.

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK sør-øst A	Anne Schiøtz Kavli	22845512	23.09.2019	28959
			Deres referanse:	

Linn Gjersing

28959 Risikofylte inntaksmetoder blant injiserende brukere

Forskningsansvarlig: Folkehelseinstituttet

Søker: Linn Gjersing

Søkers beskrivelse av formål:

For å forebygge overdoser er det er behov for mer kunnskap om hvordan personer som bruker rusmidler med sprøyte vurderer risikoen ved ulike inntaksmåter. Hva skal til for at de endrer inntaksmåte eller annen adferd tilknyttet sprøytebruken? Dette prosjektet har følgende formål: 1) Hvordan vurderer personer som bruker sprøyter risikoen ved ulike inntaksmåter og hva påvirker deres valg? Hva skal til for at de endrer inntaksmåte? 2) Hvorfor injiserer noen brukere alltid alene og hvorfor gjør andre det ikke? Hvilke vurderinger gjør brukerne selv når de injiserer og hva påvirker valgene de gjør? 3) Hvorfor eller hvorfor ikke brukes samme kanyle og pumpe flere ganger? 4) Hvorfor eller hvorfor ikke injiseres flere stoffer samtidig? Høsten 2019 skal det gjennomføres 60-80 fokuserte kvalitative intervjuer blant sprøytebrukere i fire byer (Oslo, Bergen, Stavanger/Sandnes/Trondheim). Deltakerne vil bli rekruttert gjennom ulike lavterskeltjenester og snowballing, og får 200 kr for deltakelse.

REKs vurdering

Hensikten med prosjektet er, slik komiteen forstår det, å undersøke rusmisbrukeres meninger om og holdninger til risiko ved ulike inntaksmetoder. Man ønsker å belyse bredde og variasjon i risikovurderinger rundt egen sprøytebruk.

Etter komiteens vurdering vil ikke prosjektet, slik det er beskrevet i søknad og protokoll, kunne bringe ny kunnskap om helse eller sykdom. Prosjektet faller derfor utenfor helseforskningslovens virkeområde.

Hva som er medisinsk og helsefaglig forskning fremgår av helseforskningsloven § 4 bokstav a hvor medisinsk og helsefaglig forskning er definert slik: «virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom».

Det er institusjonens ansvar å sørge for at prosjektet gjennomføres på en forsvarlig måte med hensyn til for eksempel regler for taushetsplikt og personvern.

Vedtak

Avvist (utenfor mandat)

Prosjektet faller utenfor helseforskningslovens virkeområde, jf. § 2, og kan derfor gjennomføres uten godkjenning av REK.

Med vennlig hilsen

Knut Engedal
Professor dr. med.
Leder

Anne S. Kavli
Seniorkonsulent

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK sør-øst A. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK sør-øst A, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag (NEM) for endelig vurdering.

PERSONVERNKONSEKVENSVURDERING Bruk retningslinje FO-JU-RE 013 ved utfylling. Den følger malen punktvis fra og med punkt 12.

I. Prosjektopplysninger

Prosjekttittel: Risikofylte inntaksmetoder blant injiserende brukere: Behov for mer kunnskap

Prosjektleder: *Linn Gjersing*

Prosjektets tilhørighet (avdeling/klynge): *Avdeling for rusmidler og tobakk*

Finansiering av prosjektet: *Helsedirektoratet og FHI*

Arkivnummer (P-360): 19/11466

Saksnummer i Prosjektdatabasen (PDB): Klikk her for å skrive inn tekst.

II. Rettslig grunnlag

A. Rettslig grunnlag for behandling av personopplysninger

Det må finnes et rettslig grunnlag for behandling av personopplysninger i forskningsprosjektet. Alle behandlingsgrunnlagene er angitt i personvernforordningen artikkel 6. Fyll ut med fritekst og henvisning til riktig alternativ i artikkel 6, eller bruk avkrysningen nedenfor hvor de grunnlagene som antas mest aktuelle for forskningsprosjekter er angitt som alternativer.

☒ **1. Den registrerte har samtykket til behandling av sine personopplysninger for ett eller flere spesifikke formål, jf. personvernforordningen artikkel 6 nr. 1 bokstav a).** *Legg ved kopi av samtykkeerklæring og informasjonsskriv.*

☐ **2. Behandlingen er nødvendig for**

☐ **a) å utføre en oppgave i allmennhetens interesse, jf. personvernforordningen artikkel 6 nr. 1 bokstav e)**,

☐ **b) å utøve offentlig myndighet som Folkehelseinstituttet er pålagt, jf. personvernforordningen artikkel 6 nr. 1 bokstav e),**

☐ **c) at Folkehelseinstituttet skal kunne oppfylle en rettslig forpliktelse, jf. personvernforordningen artikkel 6 nr. 1 bokstav c).**

Ved nr. 2 a), b) eller c), er det tilleggskrav om supplerende rettsgrunnlag, jf. personvernforordningen artikkel 6 nr. 3, og om i så fall må *ett* av følgende krysses av (se veiledning i retningslinje s.20)

☐ I. Behandlingen av personopplysninger forutsetter dispensasjon eller unntak fra taushetsplikt fra Helsedirektoratet eller REK etter helsepersonelloven eller helseforskningsloven. *Det er søkt eller søkes om slikt vedtak og vedtaket vedlegges personvernkonsekvensvurderingen når det foreligger.*

☐ II. Behandlingen av personopplysninger forutsetter vedtak om dispensasjon fra taushetsplikt for tilgjengeliggjøring av indirekte identifiserbare helseopplysninger fra lovbestemte registre etter helseregisterloven (§ 20). *Det er søkt eller søkes om utlevering og vedtaket vedlegges personvernkonsekvensvurderingen når det foreligger.*

☐ III. Behandlingen av personopplysninger faller inn under forskrift om befolkningsbaserte helseundersøkelser (helseregisterloven § 10).

☐ IV. Behandling av personopplysninger til forskning i henhold til personopplysningsloven § 8.

☐ V. Annet. Lov- eller forskriftshjemmel må angis og eventuelt begrunnes nærmere: Klikk her for å skrive inn tekst.

☐ **3. Behandlingen er nødvendig for formål knyttet til en berettiget interesse som forfølges av Folkehelseinstituttet eller en tredjepart, gitt at hensynet til den registrertes personvern ikke overstiger denne interessen, jf. personvernforordningen artikkel 6 nr. 1 bokstav f).**

B. Rettslig grunnlag for behandling av særlige kategorier av personopplysninger (for definisjon se retningslinje pkt 4)

Ved bruk av særlige kategorier av personopplysninger for eksempel helseopplysninger, må det i tillegg foreligge et særskilt grunnlag for å behandle denne typen opplysninger, jf. unntakene i personvernforordningen artikkel 9.

☐ **1. Den registrerte har gitt uttrykkelig samtykke til behandlingen av særlige kategorier av personopplysninger, jf. personvernforordningen artikkel 9 nr. 2 bokstav a).** *Legg ved kopi av samtykkeerklæring og informasjonsskriv*.

☐ **2. Behandlingen av særlige kategorier opplysninger er nødvendig for vitenskapelig forskning, jf. personvernforordningen artikkel 9 nr. 2 bokstav j) på grunnlag av** (f. eks. lovhjemlet vedtak, lov- eller forskriftshjemmel):

☐ a) Lovhjemlet vedtak, lov- eller forskriftshjemmel, se avkrysning i punkt A, nr. 2 a.

☐ b) Samfunnets interesse i at behandlingen finner sted overstiger klart ulempene for den enkelte og vilkårene i personopplysningsloven § 9 er oppfylt.

☐ c) Annet. Lov- eller forskriftshjemmel må angis og eventuelt begrunnes nærmere:

_____

☐ **3. Behandlingen av særlige kategorier av opplysninger er nødvendig til annet formål enn forskning, jf. alternativene i personvernforordningen artikkel 9 nr. 2 bokstav b) tom. i)**. Riktig henvisning til forordningen artikkel 9 nr. 2 bokstav b) tom. bokstav i) må angis og ved tilleggskrav om regulering i nasjonal rett må også lov eller forskriftshjemmel presiseres: Klikk her for å skrive inn tekst.

III. Er det behov for personvernkonsekvensvurdering?

Før behandlingen av personopplysninger i forskningsprosjekter starter skal man vurdere om det er nødvendig med en personvernkonsekvensvurdering, ved bruk av følgende kriterier:

☐ Involverer prosjektet eller undersøkelsen **særlige kategorier personopplysninger** (se definisjon punkt 4 i retningslinjen).

☐ Vil **to eller flere datasett**, herunder personopplysninger fra ulike registre, **sammenstilles**?

☐ Dreier det seg om en behandling av personopplysninger **i stor skala**, hensyntatt:

- antallet personer inkludert i prosjektet (mer enn 5 000 personer),
- volumet av personopplysningene som vil behandles (antall variabler, detaljeringsgrad),
- prosjektets varighet (kort, tidsavgrenset, permanent) og
- geografisk omfang (lokalt, regionalt, nasjonalt, internasjonalt)?

☐ Er behandlingen en **evaluering eller poengvurdering**, inkludert profilering og forutsigelse, blant annet av aspekter som helse, personlige preferanser eller interesser, pålitelighet eller adferd, plassering eller bevegelser?

☒ Omfatter prosjektet personopplysninger om **personer med særskilt beskyttelsesbehov**, f.eks. barn?

☐ Vil konteksten for behandlingen **begrense muligheten de registrerte har til å utøve sine rettigheter**, f.eks. vil det være vanskelig å gi god informasjon?

☐ Vil prosjektet ta i bruk **ny teknologi** eller brukes eksisterende teknologi til nye formål?

☐ Omfatter prosjektet noen form for **automatiserte avgjørelser**?

☐ Innebærer prosjektet en **systematisk overvåking**?

Hvis **svaret er ja på to eller flere av spørsmålene** om et planlagt prosjekt er det sannsynlig at dere må gjøre en personvernkonsekvensvurdering. Dersom en behandling oppfyller færre enn to kriterier, kan det hende det ikke er behov for en konsekvensvurdering, men det avhenger også her av en konkret vurdering.

Hva gjelder løpende prosjekter er det slik at for prosjekter som er gitt konsesjon av Datatilsynet, tilrådd fra personvernombudet eller gitt godkjennelse fra REK etter helseforskningsloven § 33 **for mindre enn 10 år siden og disse ikke har endret seg**, vil det ikke være behov for å gjøre en fullstendig ny personvernkonsekvensvurdering.

Se retningslinjen for personvernkonsekvensvurderinger FO-JU-RE-013, punkt 6, for mer veiledning.

☐ **Det er vurdert å være behov for personvernkonsekvensvurdering**. Skriv inn navn på leder som har gjort vurderingen:

Fyll ut resten av malen.

☒ **Det er vurdert at det ikke er behov for personvernkonsekvensvurdering**. Skriv inn begrunnelsen under. Dersom prosjektet bruker særlige kategorier av personopplysninger (ref. første avkrysning) skal PVO rådføres. Fyll deretter ut del III eller oppgi det rettslige grunnlag på annen måte, og send til godkjenner i ditt område:

Klikk her for å skrive inn tekst.

Forskningsprosjektet oppfyller ikke to av de angitte kriteriene og det er vurdert å ikke være sannsynlig at prosjektet vil medføre en høy risiko for forskningsdeltakernes rettigheter og friheter.

Navn på leder som har vurdert behandlingsgrunnlaget for personopplysninger i prosjektet (punkt II), samt behovet for personvernkonsekvensvurdering (punkt III). *Elisabeth Kvaavik*

Dato	Godkjent av (henhold til fullmakt)
8/10-19	Ole Trygve Stigen

Interview guide

(translated from Norwegian)

To the interviewer

The interview is based on a conversation where we will talk about specific topics. An aspect is that the form is relatively focused in order to avoid the interviews to be too long and that the conversations are directed in a certain direction. This interview guide is primarily an aid/tool for the interviewer to ensure that certain topics are covered. Each topic is outlined with some questions, but the quality of the data also depends on the interviewer's follow-up questions related to what the participants tell/share. Try to encourage participants to describe examples and specific stories. That is often what provides good data.

Reimbursement

All participants in the project are reimbursed with NOK 200. In order to get the reimbursement refunded in the project, the interviewers need to follow specific guidelines. For each interview, you must fill out a form where the following information is noted:

- Where and when the interview and reimbursement took place.
- How much; the number and amount per participant.
- Who distributed the reimbursement, and signature.

The possibility of discontinuing the interview

All participants may withdraw their participation after the interview. Since we do not collect any personal information, this needs to be handled differently than if we had names, etc. Thus, each participant will receive a code, consisting of a letter and a number, which they must use if they wish to withdraw from the project. Kristin will provide you with this code. Participants are encouraged to take a photo of it with their mobile phones. This code must also be recorded into the audio recorder at the beginning of each interview.

Introduction

- The interviewer introduces his/herself.
- It's very nice that you want to be part of this project!
- There are no right or wrong answers to the questions I ask; I am only interested in your opinions, perceptions, and experiences.
- These stories are important for understanding, and to enhance our knowledge about how some services that potentially may be improved.
- What you say will be transcribed and anonymized so that no one can know who said what.
- Don't be afraid to talk about the use of illegal substances; we won't take any action on that.
- Participation is voluntary, and you can discontinue the interview at any time.

START THE RECORDER

The person, and the initiation of injecting drug use:

- Could you start by telling a bit about yourself?
- Age
- Housing/living arrangement
- Job/source of income
- Could you describe the first time you injected drugs? Tell story!
- How did you learn what to do, and how to do it?
- What were your thoughts on injecting before you tried it yourself?
- How did you think about people who injected drugs?
- How did people talk about injecting drug use – how did they describe it (the effect)?
- What was attractive? What was negative?

Substance use and injecting:

So, I would like you to tell me about which substances you use today. Could you describe a typical day of drug use in your life?

- What kind of substances do you use
- How often?
- How do you use them?
- With whom? (Are you usually with someone or alone?)
- Where, and what times?
- Describe the situations!

Where do you like best/prefer to be when you inject drugs?

- Why is that?
- With whom?
- If alone, follow up!
- Where do you least like to be?
- Why is that?

I would like you to describe in a bit more detail how you perform your injections.

- Could you describe the whole process?
- Follow up questions on specific ways of doing it – why do you do it that way?
- How did you learn to do (these specific actions)?
- What happens if you don't do it that way?
- How do you know how much to take?

- What about variations in quality of drugs, how do you know?
- Where on your body do you inject? Why there?
- What is the best thing about injecting?
- What is the worst?
- Could you describe the effect?
- How is that, compared to other intake methods?

Where do you get the needles and syringes you use?

- Does it sometimes happen that you use the same equipment multiple times?
- Why/why not?
- Do you sometimes use multiple drugs in the same syringe/shot?
- If so, what is the reason for that?
- Could you describe how you do it?

How do you think about risks (of injecting)?

- What do you do to avoid an overdose?
- In which cases do you think one is most susceptible of an overdose?
- Who do you think is most susceptible of an overdose?
- Have you considered using a different intake method?
- If no, why not?
    - What is it about injecting that makes you not consider another method?
    - Positive and negative aspects
- If yes, why/what aspects?
    - Why haven't you started with it?
    - Positive and negative aspects
- Do you sometimes switch between different intake methods?
    - Which ones?
    - Why or why not?

Is there anything that we haven't talked about that you think is important to tell?

«Risikofylte inntaksmetoder blant injiserende brukere: Behov for mer kunnskap»

Skjema for utdeling av økonomisk godtgjørelse

Dette skjemaet må fylles ut etter hvert intervju

Hvor: ……

Når: ……..

Hvor mye: ……

Hvem (navn intervjuer): ……..

Jeg bekrefter at den økonomiske godtgjørelsen er gitt i henhold til gjeldende retningslinjer:

……..

Signatur og dato

”It’s like dancing with the Devil.” Exploring perspectives on risk, pleasure and overdose among people who inject drugs
Kristin Hanoa

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