Journal of Drug Issues
2017, Vol. 47(1) 4–24

DOI: 10.1177/0022042616678608
jod.sagepub.com
SAGE

An Exploration of Factors Associated With Methamphetamine Injection Among Street-Involved Drug Users and Dealers in Los Angeles: An Ethnographic Study

Kirsten E. Hunt-Howard[1]

Abstract

Based on fieldwork and ethnographic interviews, this article explores the subjective meanings and processes of injecting methamphetamine and risk taking among 38 participants involved in a street drug scene, including long-term methamphetamine users and dealers recruited in an inner-city Los Angeles neighborhood, as a means of gaining insight into the factors facilitating injection. There were a multitude of individual, structural, social, and spatial factors that may influence injection as a mode of methamphetamine administration, including economic conditions, perceived cost, and efficiency of specific routes of use; social role and collective identification with a street scene; physical and social settings; drug policy and fear of arrest; social network factors, including the influence of sexual partners, peers, and the normalization of injection; other drug use, including individual drug histories and preferences for specific routes of administration among particular drug users (e.g., black tar heroin); and characteristics of the local drug market.

Keywords

ethnography, methamphetamine, black tar heroin, route of administration, drug dealing, risk environment

A central nervous stimulant, methamphetamine (MA) comes in many forms and can be orally ingested, applied to mucous membranes, snorted, injected, or smoked (Anglin, Burke, Perrochet, Stamper, & Dawud-Noursi, 2000). MA use is geographically diverse with different sorts of the drug, routes of administration, and types of users found across the United States at various points in time (Maxwell & Rutkowski, 2008). According to Maxwell and Rutkowski (2008), unlike some other drug use patterns in the United States, epidemiological data indicate that the use of MA has been closely tied to the production and supply of the drug. According to the Drug Enforcement Administration (DEA, 2013), over the past decade, at least 80% of MA consumed in the United States is produced by Mexican-operated labs either in Mexico or to a lesser extent

[1]Columbia University, New York, NY, USA

Corresponding Author:
Kirsten E. Hunt-Howard, 5565 Kinston Avenue, Culver City, CA 90230, USA.
Email: kirstenehunt@outlook.com

in the United States, while the remaining percent is manufactured in domestic small toxic labs. While national trends are showing declines across the past decade, regional variability in MA abuse has persisted with the strongest effects experienced in the West and parts of the Midwest (Volkow, 2013).

MA remains a primary problem in the Los Angeles area. MA use has continued to increase in Los Angeles County according to indicator data reported for 2012, and smoking remains the most frequently reported route of use by primary MA admissions with a slight increase in injection. In addition, a marginal increase over 2011 levels of past-year injection of any drug was found among primary MA admissions (Brecht, 2013). Although epidemiological indicators provide useful data on the levels of use of particular drugs and specific routes of administration, they do not provide information on who, where, why, and how people decide to engage in such behavior. Although based on a non-representative sample, this article examines the subjective meanings and processes of injecting MA among social economically marginalized users and dealers to understand the multitude of factors that may influence injection as well as the social and physical environments in which it occurs, which has important implications for the development of public health outreach and intervention endeavors.

Research on route of administration is important as various risks are imposed by different methods of use. Due to the multitude of risks associated with injection, it is essential to analyze the perceptions and purposes of the injectors themselves, how they perceive risks, and if, or how, they attempt to avoid them (Estievenart, 2001). A growing literature has demonstrated how compared with other routes of administration, MA injection has been associated with a host of negative health and social implications, including more severe symptoms of dependence and an increased risk of contracting blood-borne viruses (BBVs) through the sharing of injection equipment and sexual behaviors (e.g., Marshall, Shoveller, Wood, Patterson, & Kerr, 2011).

Transitions in Route of Administration

The desire to mitigate the transition to injection has led to scientific interest in the factors that may facilitate or impede a transition to injection (Sanchez, Chitwood, & Koo, 2006). Indeed, the transition process is deemed a significant event in the construction of a drug career not only because of the health risks associated with injection, but additionally because of the tendency to become more deeply enmeshed in the drug subculture once the injecting career is established (Nasir & Rosenthal, 2009). Transitions in the route of drug use typically refer to a phenomenon wherein an individual who begins using a substance by one particular route subsequently substitutes that route for another; Thereafter, this new route is used in preference to the previous one (Irwin et al., 1996). Fieldwork indicated that participants often transitioned back and forth between routes of administration or used different modes of use concurrently.

Drug use transitions have been typically discussed in the literature for specific drugs, such as heroin (e.g., Neaigus et al., 2006; Roy et al., 2003). For instance, Neaigus et al. (2006) note that there are a multitude of factors that may increase an individual's vulnerability with regard to transitioning to injection drug use for heroin, including drug use practices; an inability to adjust to declines in purity, quantity, and availability and increases in drug price; drug dependence and drug treatment status; personal traumatic events, such as sex abuse; attitudes concerning the social status of drug injectors; fear of HIV/AIDS; and not being afraid of using needles to inject. Reasons provided for routes of use found among researchers studying transitions in amphetamine use and heroin use include the belief that injecting is more economical and provides a better rush (Darke, Cohen, Ross, Hando, & Hall, 1994, for amphetamine; Swift, Maher, & Sunjic, 1999, for heroin). In addition, respondents in Darke et al.'s (1994) study of transitions in amphetamine use believed that injection was a healthier route of use.

At present, there is a lack of a theoretically based understanding of the social dynamics surrounding transitions in drug use, including transitions from non-injecting to injecting drug use in the literature (Sherman, Smith, Laney, & Strathdee, 2002). It is not uncommon for the research and academic literature to imbue individuals and/or groups with explanatory power, which according to Maher and Curtis (1995) encourages overly simplistic explanations of phenomena related to drug use. The contemporaneous literature on transition is dominated by epidemiological studies, which focus on identifying multiple risk factors associated with the transition to injection (Sanchez et al., 2006). These studies have often centered on the role of drug users' familial and psychological backgrounds (Roy et al., 2003). Following the lead of Maher and Curtis (1995) and others (e.g., Rhodes, 1997), the present article seeks to shift the focus away from explanations that center on individuals and/or psychology by utilizing the concept of the "risk environment" (Rhodes, Singer, Bourgois, Friedman, & Strathdee, 2005) to analyze the discursive constructions of drug user's decisions concerning whether and how to administer MA. In this framework, four ideal types of environmental influence—physical, social, economic, and policy—are understood as operating in the context of three ideal levels of environmental influence—micro, meso, and macro. Interpersonal relationships, social and group interactions, and structural factors including laws, economic conditions, and/or social inequalities are some of the micro-, meso-, and macro-level forces (Rhodes et al., 2005) that interact to shape individual decision making and frames of meaning within the circumstances of daily life.

Method

Data collected for this analysis were obtained from ethnographic research conducted from 2010 to 2012 among what can be deemed a hidden sample of MA users and dealers situated primarily in an inner-city Los Angeles neighborhood that included injecting drug users (IDUs) and non-injecting heroin users (NIUs). Fieldwork was conducted in settings where MA and other drugs were bought, sold, and used, and in total 38 participants were recruited for in-depth interviews including MA and heroin users and dealers. Respondents were mostly long-term MA users and dealers who used MA on a near daily basis. The sociodemographic characteristics of the 38 respondents are included in Table 1. Study participants included 26 males and 12 females. The average age of respondents was 37 years old. The majority of participants were straight, unemployed, and had a below high school level of education. A majority of the research sample was near transient and to a lesser extent transient, in that they found shelter where they could by "couch surfing," staying at shelters, relatives' homes, at motels, or on the street. The study sample included 23 "low-level" MA dealer/users. Dealers were mostly Latino, White, and Filipino; and males ($n = 21$) outnumbered females ($n = 2$). Four sold ("juggled")[1] heroin as well as MA. MA dealers in the study reported selling to friends and known acquaintances and typically did not sell to strangers. Drugs were sold at the buyers' residence, from dealer apartments/houses, on the street, and at motels. All dealers were daily MA users and many were IDUs. Selling drugs, petty theft, auto theft, pan handling, and recycling cans were some of the sources of income in the informal sector, which were reported by informants.

A snowball sample and chain methodology was utilized to identify and recruit respondents. I initially approached an individual observed picking trash and smoking MA in a parking lot located in an inner-city Los Angeles neighborhood regarding participation in the study. After providing consent, he conducted an initial interview and agreed to introduce me to a social group of drug users located in the neighborhood that congregated at a local residence where MA was bought, used, and sold. The residence was inhabited by drug users, including MA dealers who paid for rent in cash and drugs, "couch surfing" drug users who slept on couches and mattresses placed in the living room, and drug users residing in makeshift tents in the backyard. The residence typically lacked running water due to unpaid bills and respondents living there were

Table 1. Sociodemographic Characteristics of Respondents (N = 38).

Respondents	No. of respondents	% of respondents
Gender		
Males	26	68
Females	12	32
Total N = 38; M age = 37 years old		
Race/ethnicity		
African American	4	11
Asian	4	11
Latino/a	14	37
White	16	42
Sexuality		
Straight	33	87
Gay/MSM	3	8
Bisexual/MSWM	2	5
Housing/living situation		
Owns apartment	1	3
Rental	8	21
Homeless/transient	22	58
Lives with someone	7	18
Education		
Some high school	37	97
Some college	1	3
College graduate	0	0
Employment		
Employed	5	13
Unemployed	33	87

Note. MSM = men who have sex with men; MSWM = men who have sex with women and men.

observed taking showers with buckets of water retrieved from a local water store. Although the majority of persons residing and visiting the house were primary MA only users including NIUs and IDUs, heroin primary IDUs who also used MA on a near daily basis resided there as well and both MA and heroin were sold at the residence. I spent numerous hours conducting fieldwork at this residence and at other locations, including other dealer and user residences, motels, vacant lots in the local neighborhood where "transients" temporarily lived, in recreational vehicles (RVs), and I occasionally accompanied respondents downtown to Skid Row where they traveled to purchase heroin and where some resided when there was no other place to stay.

The study design consisted of four components: (a) observations and unstructured interviews in sites where MA users and dealers congregated, (b) unstructured interviews with and observations of drug dealers as they made their sales, (c) semi-structured and in-depth interviews with MA users and dealers, and (d) a sociodemographic questionnaire. The study followed informed consent procedures and verbal consent was obtained. Participants were not provided with any incentives (e.g., money) to participate. The study procedures underwent review and were approved by the institutional review board. Interviews were tape recorded and transcribed. The average length of in-depth formal interviews was 3 hours. Interviews were focused on MA-specific drug use, other drug use and justifications for the use or non-use of specific drugs and modes of use, drug effects, contexts of use, injecting practices, history selling drugs, characteristics of the drug market, buyer–seller relationships, distribution hierarchies, fear of law enforcement and arrest. Field observations were recorded and all tape recordings were transcribed and coded according to a scheme developed over the course of data collection. A grounded theory approach that entails simultaneous data collection,

Table 2. Frequency of Drug Use in Past 6 Months Prior to Interview Among Respondents (N = 38).

	Number of respondents (% of respondents)		
	Daily/near daily	1-2 times per week	Monthly/occasionally
MA	28 (74)	9 (24)	1 (3)
Marijuana	2 (5)	0 (0)	3 (8)
Cocaine	0 (0)	0 (0)	1 (3)
Ecstasy	0 (0)	0 (0)	3 (8)
GHB	1 (3)	0 (0)	4 (11)
Heroin	9 (24)	3 (8)	1 (3)
Crack	0 (0)	1 (3)	1 (3)

Note. MA = methamphetamine; GHB = gamma-hydroxybutyrate.

analysis, and theory construction (Glaser & Strauss, 1967) was implemented to uncover patterns and themes, which were used to guide data collection and interviews with informants.

The Characteristics of Respondents' Drug Use

The majority of participants recruited for in-depth interviews were daily/near daily users of MA and some also injected heroin. Former crack smokers and cocaine injectors who switched to daily/near daily use of MA were recruited within this network as well. Drug-dealing NIUs and IDUs, who sold MA and to a lesser extent heroin purchased for resale downtown from sellers in an open-air market located around Skid Row, and buyers who purchased MA on a bi-weekly and monthly basis upon receipt of government checks were observed during fieldwork and recruited for in-depth interviews. Some respondents were former gang members and some reported affiliation with Mexican gangs. The characteristics of respondents' drug use for the past 6 months are illustrated in Table 2. MA, and to a lesser extent heroin, were the two most frequently used drugs reported by participants. The majority of participants (74%) used MA on a daily or near daily basis. Twenty-four percent (24%) used MA 1 to 2 times per week and only one person (3%), who was a primary heroin user, used MA on an occasional, near monthly basis. The sample included both primary and secondary users of heroin. Participants (24%) included nine daily/near daily users of heroin, three respondents (8%) who used heroin 1 to 2 times per week, and one occasional/near monthly heroin user (3%). Primary heroin users (N = 9) included not only participants, many of whom used MA on a daily/near daily basis, but also some who used MA when it was available, which may be weekly, monthly, or even bi-monthly depending, for instance, on the social setting. Participants also included N = 4 primary, daily/near daily MA users who reported using heroin to moderate the "negative" effects of stimulant drug use (e.g., wakefulness) and/or to "come down." Participants in the present study utilized a variety of methods of administering MA, including smoking, sniffing, and injecting. Sixteen out of 38 respondents (42%) reported injecting as their preferred method of using MA, two out of 38 (5%) reported sniffing, and 20 out of 38 (53%) smoking. This study is based on a non-representative sample.

Findings

Dealer IDUs: Social Identity and the Perceived Costs of Injecting Versus Other Methods of Use

For dealer IDUs, injection was used to regulate different perceived risks (Sotheran, Goldsmith, Blasco, & Friedman, 1999), including drug tolerance, economic expenditure, fear of arrest, and the costs of selling drugs in the street drug scene[2] and material and social context of poverty. Since

the late 1970s, the "hollowing out of the economic and social infrastructures," from tourism to apparel, by the increasing role of foreign trade and offshore investment has undermined the economic opportunities of Los Angeles residents resulting in the "pauperization of a generation of inner city youth" (Davis, 1992, pp. 308-309). Los Angeles has been at the epicenter of processes of global economic restructuring, including the exodus of good paying jobs and middle-class families from central cities. The availability of housing, real estate values, and a demographic shift has marginalized inner-city residents in Los Angeles where homelessness is endemic. Researchers on urban poverty have argued that the use of illegal drugs is both a part and parcel of oppressive social and economic circumstances, which results in a worsening of these conditions.

For respondents, selling MA was a means of survival in the context of poverty. The majority of dealers reported entering into drug selling as a means of affording use, which exacerbated use. A common sentiment that emerged in participants' narratives relating to MA distribution was that they were driven not only by economic necessity but also the search for self-dignity, autonomy, and community. This is similar to that found by Bourgois (1995) among impoverished crack dealers in New York City. As the inner-city poor have limited opportunities for work in the formal sector, they rely upon the informal sector and the individuals within it for various forms of support, which involves the building and cultivation of relationships through social drug use and selling, which was a source of status and identity. According to Strang, Des Jarlais, Griffiths, and Gossop (1992) (as cited in Draus & Carlson, 2006), the act of injecting may itself become an acute source of identity. They go on to claim that repeated risk taking may violate accepted social norms, but by confirming one's marginality in larger society it confers its own solidarity, which is reinforced through the sharing of risk as well as resources . . . shared practices of "hustling," "copping," and "shooting," repeated day after day, result in an identity that is completely "entangled" with the activity of illegal drug use.

In the context of poverty and chronic unemployment, drug dealers cultivated a street identity and sought the "respect" of their peer group through criminal involvement in drug and non-drug crimes and dealers were accorded a high status within the social hierarchy of the drug-using social group. This is indicated by a near transient dealer IDU who initially began selling MA to afford use as follows:

> Dealer IDU: I started smoking when this dealer was around in my neighborhood, he smoked, when I was around him, I smoked because that's what he's doing. I didn't have to sell, I just had people around so, I started selling to afford it, and at the time, the dealer said he was done with snorting it, that to boost the effect, get a direct effect, to try smoking it with snorting it. I first smoked it on a cigarette with tobacco. And to get a direct effect, my nostrils burned, both of them, I switched nostrils, used a different nose.

The initiation of the self into drug use is a process resulting from social interactions taking place in a context (Rhodes et al., 2011). According to Rhodes et al. (2011), rather than predetermined by pharmacological, biological, cognitive, or other essential structures, drug use and identity transitions are continuously subject to a process of becoming throughout the course of a "drug career." Initiation into injection thus entails a transition to a new symbolic identity (Rhodes et al., 2011). Macro-level determinants, including social economic exclusion, instability in housing, unequal access to basic resources, and discrimination, were some of the factors that propelled participants into the informal sector. Poverty, limited social capital, low economic returns from drug sales, threat of arrest, and the construction of "hustler" identities in the street scene were some of the frames of meaning through which drug sellers experienced and interpreted injection.

Although there are various methods of administering drugs, injection was preferred by some MA dealers, especially low-level sellers, as a means of controlling use and dealing based on the

belief that injections are more efficacious and act faster than other routes of ingestion. The above-mentioned dealer goes on to compare smoking and injecting MA:

> Dealer IDU: It's a different effect (when you smoke), it's more mellow, it's much slower (compared with injecting). When you melt away the shit, the effects are slower and doesn't last as long. That's why you need larger amounts, only if you have larger amounts, if not *its dysfunctional*, nothing constructive, is bad. If you can't get more it's a catastrophe, can't finish what you took apart, put together, you get burned out, that's why I started buying from him (dealer) a dime (US$10 amount of MA) a day and was, I should be making it (money) so I started selling when I started really using it. (Emphasis added)

For this respondent, the transition from smoking to injecting MA was compelled by the pursuit of a more powerful and efficient drug effect at a time when need exceeded supply (Strang, Griffiths, & Gossop, 1997). In this narrative, the transition from smoking to injecting was aimed at managing individual drug tolerance, the material conditions imposed by the structural circumstances of poverty, and drug supply (see Guise, Dimova, Ndimbii, Clark, & Rhodes, 2015).

Economic pressure and increasing dependency have been cited as an explanation for transitions from intranasal use to injecting among heroin users (e.g., Draus & Carlson, 2006). Johnson (1973) was one of the first to recognize the central importance of level of involvement in a specific drug subculture, as an intervening variable in drug use progression. Other researchers have noted the importance of involvement in illegal drug dealing (e.g., Jacobson & Zinberg, 1975). Dealer IDUs often reported that the transition to injection of MA was motivated by economic concerns, including cost and the need to limit their intake while selling drugs in the context of poverty. Compared with smoking, injecting was preferred as a way to control the cost, frequency, and quantity consumed. According to Valdez and Sifaneck (2004), it is not uncommon for control to be a reason associated with the transition to injection among lower level dealer-users. For some daily and near daily users of MA, they reported consuming greater amounts of the drug per drug use occasion and more frequent episodes per drug use day when smoking than with other routes of use. According to a daily user who switched from smoking to injecting,

> Dealer IDU: (I) use less when injecting than when (I) smoked, and spend less.

And a drug-dealing IDU claims,

> Dealer IDU: (I inject) so all the profits are not consumed.

Fieldwork indicated that the above-mentioned MA dealer, upon purchasing an 8-ball (3.5 g) of MA for resale sought to minimize personal drug intake by the following means:

> (The dealer) would remove .3 grams to .5 grams of MA for himself for personal use or approximately 3 rocks, which he preferred over powder for injection.

And according to a drug-dealing IDU,

> Dealer IDU: (I inject because) I have to make sure I have enough money to give to the person who fronted me.

Operating on a credit basis, in which a dealer is fronted drugs and then returns with cash for more drugs, requires that dealers constantly remain in control of their drug sales and use. This was frequently stated by dealer respondents, and according to dealer IDUs, injection could be more readily dosed and paced as compared with smoking, for instance, as the specific amount can be

accurately measured according to the cubic centimeters (cc) on the needle. The practice of using calibrations on the syringe suggests urgency and fear of interruption or arrest and the need for injections to be as quick as possible. Ease of measurement in the amount of solution and ease of transport may reduce risk of arrest and interruption in public settings by reducing visibility and minimizing transaction times (Rhodes et al., 1999). Indeed, for most dealers in the present study, smoking was associated with "messing up the money."

For some dealers, injecting has come to represent to those sharing a subcultural street hustler identity, an "oppositional cultural frame of reference," which differentiates them from "dysfunctional" users through displays of "controlled" drug use. In this sense, drug-taking behaviors functioned as resources that inform individual identities by reflecting group membership, or one's role or persona (Soller & Lee, 2010). Injecting MA, compared with smoking, was constructed by dealer IDUs as "functional" and as a form of symbolic capital that signified one's competence in the street drug scene, for instance, where the speed of drug use was valued for it allowed for dealer-users to mitigate against the threats of arrest and therefore enable the accumulation of (sub)"cultural" and (limited) economic capital in the context of poverty, transience, social economic exclusion, "mutual dependence" (Bourgois, 1998), and increasing drug use. According to Parkin (2013), the speed of injection may be considered a form of symbolic capital as a faster injector consequently becomes a more productive injector. These findings demonstrate how social roles in the street scene, and social and spatial contexts, interact with structural factors, including poverty, to influence patterns of drug use and perceptions regarding route of use. Having access to a steady drug supply, sharing with peers, and being able to maintain the costs of consumption without experiencing negative consequences were central markers of subculturally constructed identities among dealer-users in the street scene. Following Parkin (2013), injecting for dealer IDUs represents an embodied adaption to limited economic capital and a naturalized response to sharing resources.

For respondents, buying, selling, and using MA was a means of social integration (Mandelbaum, 1965) that provided access to informal networks of social and economic support and much-needed social relations in the context of inner-city poverty and lack of resources. MA was bought, sold, and used by near transient and non-homeless users and dealers within friendship networks and dealers reported "partying" with friends as a central preoccupation. Talking, socializing, watching TV, and using drugs were some of the central activities during "partying." For instance, a MA dealer claims,

> Researcher: What do you guys do? What's a typical day for you like?
>
> Dealer IDU: Walking around the neighborhood, like selling drugs, sitting at my friend's house watching TV, selling fucking drugs.

Selling and using MA established and defined social relations within the group and conferred status. According to a MA dealer,

> Dealer IDU: Smoking (MA) is very social and in (trendy), very in right now . . . (there are a lot of users), females, they party.
>
> Researcher: What do you mean by party?
>
> Dealer IDU: They will get a bag and smoke with friends in a group at someone's place and just chill, socialize.

Very close social relationships and intimate and frequent contact characterized drug distribution. For respondents, MA distribution and use were not separate spheres of activity and drug

procurement was a social activity that included buying, using, and sharing with peers, typically at the point of sale. In this context, distribution was part of a larger social formation that influenced how consumption was organized. A central function of drug taking was to maintain structures of kinship and drug consumption and distribution rituals facilitated social bonding within friendship networks, for instance, through rituals of drug sharing and collective drug taking at dealer residences ("party houses"). In this setting, MA was typically smoked and the passing of a glass pipe containing MA communicated a social relationship and sharing conferred status. When used in a group setting at private residences (e.g., party houses) to socialize with peers, dealers were expected to share smoked MA. As a rule, at the primary "party house" under study, MA injection was concealed by administering the drug in a bathroom or bedroom, usually alone, unlike smoking, which was not as it was a ritualized social activity that allowed users to dose and pace use according to activities such as talking and playing cards. Both users and dealers, including house dealers, reported injecting the drug in "private" rooms (e.g., bathroom) as a means of avoiding sharing the drug with peers. For dealer IDUs, injecting in private was a means of exercising control over use and one way of "saving face" and maintaining a positive social identity in lieu of breaching subcultural norms regarding drug sharing (Copes, Leban, Kerley, & Deitzer, 2014).

Relating with drugs, individuals reproduce their positions in the social hierarchy of the drug exchange network (Lindstrom, 1987). Following Lindstrom (1987), this is because, from an interpersonal perspective, when people exchange drugs they are converting one sort of substance (e.g., drug) into another (e.g., fictive kin). Drug users learn that the ability to avoid the grim fate of junkies, crack heads, and other sick addicts is indicative of strong character and places them higher in the drug-using hierarchy (Copes et al., 2014). According to Copes et al. (2014), shifting routes of administration, neglecting responsibilities, and alternative modes of procurement can all reflect succumbing to the drug, even if only doing so situationally. Dealer IDUs constructed a symbolic social identity as hustlers based on a distinction between controlled use (injecting) and out of control use (smoking) (Copes et al., 2014) by focusing on the route of administration, which reflected their motivations for injecting in the structural, spatial, and social risk environments. "Hustler" identities are often constructed through the forging of boundaries between "functional" users (insiders) and "dysfunctional" users (outsiders) (see Copes, Hochstetler, & Williams, 2008). Dealer IDUs rationalized injection in terms of the self-discipline needed to sell MA in the street scene by focusing on the economics of injection, which allowed them to construct a positive social identity as a "hustler."

Claims by participants that compared with smoking, injecting was a route of administering MA that enabled them to better control their drug use contradicts findings from some drug abuse studies that have shown that once people adopt injection, their use accelerates and more frequently becomes out of control, making it harder for them to manage their use due to increasing drug expenditure (e.g., Swift et al., 1999). This is because, contrary to that proposed by the addiction model of disease, which assumes that "drug injection" is a uniform epidemiological category in which injection monolithically signals the escalation of addiction (Mayock & Clatts, 2006), pattern and route of drug ingestion are often modulated by non-pharmacologic factors including regional habits of drug administration and specific motivations and contexts of use (e.g., Leri, Stewart, Tremblay, & Bruneau, 2004). Dealer IDUs navigated the market and their individual drug taking through a series of strategies aimed at minimizing risk of detection by law enforcement and maximizing the efficient absorption of the drug into their bodies in portions small enough to remain "high" (see Bourgois, Lettiere, & Quesada, 1997). The construction of "controlled" drug use by dealer IDUs reflects the moral economy of the street drug scene in which respect is derived from involvement in the drug economy, the sharing of drugs with peers, and the ability to effectively manage the costs of consumption without experiencing negative consequences, which was necessary for survival.

Physical Locations and the Social Context of Drug Injecting Sites

Social and physical space shaped the social meanings and motivations attached to drug-related behavior, including route of use and risk. According to Rhodes et al. (2005), injecting in public or semi-public places has been linked with urban disadvantage, homelessness, and fear of arrest due to high profile policing practices. Participants used injection to regulate perceived "situational risks" associated with MA use in semi-public and public settings such as fear of detection or arrest and "economic risks" related to the structural constraints imposed by poverty and transience. Dealer IDUs reported alternating between smoking and injecting, and for some participants without a permanent residence, injection was preferred because it was a less visible, quicker, and more efficient route of use in public settings. According to a near transient MA dealer who injects MA and heroin,

> Near Transient Dealer IDU: (When used on the street) You shoot. When you smoke, it's more fucking smoother (less intense, slower drug effect) now than it used to be. But that's just because, you know, you tried all kind of shit (illegal drugs).

Moreover, as indicated in the above vignette, drug use history, and heroin use in particular, may play a role in individual susceptibility to transitioning to MA injection. The role of other drug use will be further discussed in a subsequent section.

In the struggle between structure and agency, the embodiment of surveillance is fundamental among those involved in illegal activities related to drug use; this struggle is manifest in a series of reflexive and unconscious actions aimed at avoiding detection, interruption, and/or arrest (Parkin, 2013). For instance, a transient dealer IDU claims,

> Transient Dealer IDU: When I was staying in motels, had like a pound of crystal (MA) with me, fucking coming in and out (of the motel), I was shooting up (injecting drugs), had a lot of calls (drug sales), (I was) running around (selling drugs) . . . If I hit (inject MA) . . . It just makes me more aware, more on point, and more fucking down on everything, fucking be safe if you sell, you know.

Patterns of travel in the streets coupled with policing practices and secondary forms of surveillance (e.g., video cameras, air patrol) necessitated consumption to be urgent and fast, especially for transient dealer IDUs, and the belief that injection acted faster and was more efficacious than other routes of use precipitated injection among some MA users. Fear of arrest for possessing MA was exacerbated for dealers staying at motels and according to a transient dealer IDU, injection was preferred as it minimized the risk of being detected by law enforcement or others (e.g., motel staff) who may observe and/or smell MA smoke.[3] The dominant narrative of threat used to describe drug taking in semi-public and public settings rationalizes injection as a preferred route of MA use in the context of economic and physical insecurity resulting from transience, fear of arrest and interruption, and social economic marginalization, which illustrates the role of the physical, social, economic, legal, and policy environments in mediating the social meanings and practices of drug use.

Although not discussed in detail in the present article, research indicated that macro-level structural factors related to transience and poverty interacted with meso-level environmental factors including policing practices to increase risk taking among some IDUs in the micro-physical setting of semi-public and public locations because of fear of arrest. For instance, fieldwork indicated that the sociospatial context, or use at motels, exacerbated risk for some because of police practices and fear of arrest that prevented IDUs from traveling in and out to obtain "works." These respondents were more likely to report accidental or secondary sharing of drug injection equipment. Indeed, the illegality of MA and drug paraphernalia laws has fostered fear among some dealers and users in semi-public and public settings. IDUs often did not carry needles with

them when traveling on the street due to the fear of police harassment and arrest for possession of drug paraphernalia. Even in states such as California, where syringe possession has been decriminalized to some degree, drug injectors may still face arrest if their syringes are not stored in an approved container or have visible quantities of illegal drugs in them (California Health and Safety Code §11364.1). For these reasons, IDUs must still contemplate the legal ramifications of maintaining a supply of injection equipment in their possession (Wagner, Simon-Freeman, & Bluthenthal, 2013).

Other studies have documented that IDUs often react to police pressures in ways that increase risk by being less likely to carry injecting equipment, more likely to share syringes, and more likely to form covert "shooting galleries," which may lead to increased HIV risk behavior (Small, Fitzgerald, Kerr, Hickman, & Holloway, 2006). As a private place where drugs (MA and heroin) could be bought, used, and consumed and needles could be purchased, the main "party house" was considered a "safe" space for drug consumption, especially among transient users who feared arrest and harassment for carrying syringes and using drugs on the street. Needles were sold at the "party house" for US$1 that had been obtained from needle exchanges. *Many* IDUs in the study reported obtaining needles this way. The "actual" sterility of these needles was not addressed. For respondents, however, needles were purchased based on the belief that they were "clean." Ethnographic research indicated that law enforcement pressure had an impact on the sale of needles. As conveyed by a low-level heroin and MA dealer/juggler who injects drugs and sells needles at the "party house,"

> IDU: The police confiscated my container (containing needles). Now I have to go back to the needle exchange to get more and it's hard to get there.

According to Rhodes, Greenwood, and Robertson (2001), the social settings in which drugs are injected, and the influence such settings have on IDUs' capacity for risk reduction are themselves influenced by wider structural and political factors, such as drug-enforcement activities, housing, and geography.

Factors including not being able to obtain needles from the needle exchange due to the hours of operation and location of needle exchange sites, and lack of transportation (especially at particular hours) to obtain needles meant that needles often had to be cleaned and reused or saved for personal use. In Los Angeles, needle exchange sites were found to typically operate only on a few days during the week and not on weekends. As using drugs was dependent on having money for drugs or having access to drugs, use may occur sporadically making it more difficult to plan ahead to obtain needles from needle exchanges for drug injection. For instance, a MA injector may run into someone who wants to buy some MA and subsequently receives some for free from the sale, which would then be injected. As IDUs who engaged in low-level sales of this type did not have a regular customer base, they were dependent upon chance meetings on the street or running drugs as a favor for a dealer. Low-level transient runners who injected drugs thus likely constitute one of the highest risk categories for the contraction of HIV and other BBVs (see Small et al., 2005, for heroin injectors).

The Influence of Friends and Sexual Partners

Injection was reported within micro networks of sex partners, which illustrates how interpersonal relationships can influence pathways into drug injection (Rhodes et al., 2005). According to a heroin and MA user,

> IDU: I always had boyfriends that did downers, back then it would bother me when my boyfriend always nodded out. To be in the same place, because I was using crack, I didn't modify my crack use,

> I used crack with Xanax (pharmaceutical downer); my boyfriend did crack with heroin, but only smoked. My last boyfriend smoked heroin, but then started shooting up every day, now and again (mixed heroin with injected MA) with speed (MA) so I started injecting heroin and meth.

The meanings and practices associated with the sharing of injection equipment were also found to depend on particular micro-level factors, including interpersonal relationships (Rhodes et al., 2001). It was not uncommon for IDUs to report sharing needles with sex partners. According to a respondent who injects MA and heroin, he shares needles with his girlfriend regularly without cleaning them:

> Researcher: Do you share needles?
>
> IDU: We (male IDU and female IDU) share needles, we are boyfriend and girlfriend, of course I would wash out the needle with bleach, but we had unprotected sex so (I don't).

Whereas behavioral theorists assume that risk behaviors are the product of rational choice, a range of social factors exogenous to individuals influenced risk behavior that may be habituated as part of daily routines and social norms (Rhodes, 1997). In addition, risk taking and respondents harm reduction practices were shaped by material, policy, physical, and social contexts, including issues relating to needle accessibility.

The majority of IDUs reported use of cold water to clean syringes, a few reported using boiling water, and some used bleach when available. For instance, a MA IDU discusses risk reduction strategies as follows:

> Researcher: And what would be the circumstances when you share needles?
>
> IDU: You know, like a night where I (just say) fuck it and I'm at a buddy's house or at a house where they have something (MA) and you know and um, my buddy is going to hook me up and if it's fairly new I'll just bleach it, and, no big deal (if it's not available), you know, and . . . that's pretty much really if I just wanted to get *really* fucked up.

The sharing of unsterile syringes and injection equipment may be contingent upon receiving drugs for free in the context of scarce drug supply, inadequate economic funds, insufficient availability of "decontamination supplies" (e.g., bleach), and the scarcity of needles.

Characteristics of the Local Market, Drug Preferences, and the Injection of Another Drug

The present study found that factors including drug preferences and macro-structural factors in the risk environment, including characteristics of the local drug market, also facilitated injection for some. This is similar to the findings of Roy, Nonn, and Haley (2008) who argued that drug preferences and the local drug market interact to increase the risk of injection among street involved youth. According to Page and Singer (2010), drug use often takes place in cultural contexts where multiple drugs are used serially or in a mixture (e.g., speedball or mixture of heroin and cocaine). Researchers have argued that illicit drug users are cognizant of the effects of mixing those drugs and their poly drug use reflects their desire for specific altered states of consciousness in specific physical settings and/or social environs (Gorman, Nelson, Applegate, & Scrol, 2004). Nine primary heroin injectors (24%) reported using MA in a poly drug combination called "goofballs"[4] to combat symptoms of withdrawal from heroin and as a way to mitigate the sedative effects of the drug and to increase awareness, wakefulness, and to facilitate socializing,

especially in the context of "partying" at drug/party houses. Alternatively, some (N = 4) MA injectors (11%) used heroin to "come down" after a binge or to ease the side effects of anxiety and paranoia that were reported among some MA users, especially dealer IDUs.

Geographical location directly influenced the type of heroin that was available in Los Angeles, or black tar heroin, ("Black"), which was produced in Mexico. Black was often used in combination with MA by respondents and was associated with injection for both primary and secondary users of the drug. Distinct physical and chemical types of heroin exist and the chemical properties of black have implications for injecting practices and cooking methods. For instance, black tar heroin is dark brown to black, solid, vaporizable, of lower purity and despite its acidity, requires heat to go into aqueous solution (Ciccarone, 2009). Overall, as a method of administrating black tar, smoking was considered inefficient. According to respondents, because of its gooey consistency, black cannot be intranasally administered and smoking was not preferred as it resulted in a loss of the product and damaged lungs, therefore ushering in injection as a preferred route of use.

Respondents in the study purchased heroin in open-air markets on the street (e.g., Skid Row, downtown Los Angeles) and through networks of users. Dealers who were observed selling heroin in open-air markets in downtown Los Angeles packaged heroin in balloons, which was a tactic to avoid arrest. When packaged this way, the heroin could be easily swallowed. According to a heroin and MA user,

> IDU: (Heroin) dealers downtown package their heroin in different colored balloons. That's how they differentiate themselves from other dealers, is by the colored balloons. There are different colored balloons for different types of heroin and each group has its own mark. I like powder heroin, but it's impossible to get.

Heroin dependent users sold heroin purchased downtown for resale alongside MA as a means of defraying the costs of drug use. These respondents were all daily users and sold drugs as a means of providing access to resources including housing and networks of social support and as a way to afford drug use. Primary MA users in the study typically did not purchase heroin on the street in retail markets, but rather relied on peers who were primary heroin IDUs to obtain the drug most often in private settings. According to Andrade, Sifaneck, and Neaigus (1999), as some neophyte NIUs are dependent on intermediaries to gain access to drugs they may be at a higher risk of transitioning to injection.

For some heroin IDUs in the study, MA was used to reduce withdrawal symptoms from heroin use. According to several long-term heroin IDUs seeking to reduce their use of injected heroin due to vein collapse, as MA could be smoked in a glass pipe, IDUs smoked the drug, which they reported eased heroin "sickness" and lowered cravings for heroin. According to a long-term heroin IDU,

> Heroin IDU: When I use (MA) I don't use tar or want it like if I didn't smoke dope (MA).

Participants discussed the use of MA to directly modify the pharmacological effects of heroin and the use of heroin to directly modify the pharmacological effects of MA. Researchers studying poly drug users who combine heroin and crack have noted similar findings (e.g., Neaigus et al., 1998). For instance, some heroin injectors used MA to alleviate the sedative effects of the drug and to prevent heroin overdose. According to a heroin and MA injector,

> IDU: The thing is speed is going to lessen the effects of the heroin in the sense that it's less—that's why the shot they give you if you overdose on heroin, that's a shot of speed. One of the first things they do is give you a shot of speed. 'Cause it lessens the effects of the heroin. So if you mix the two

> together, you don't get the full shot of the heroin and sometimes, the speedball, sometimes the speed will be stronger than the heroin, other times the heroin is stronger than the speed so you have to put your own analogy to that.

In addition, a respondent who is a daily/near daily heroin user discusses his reasons for injecting MA as the search for a "more intense high." He states,

> IDU: It's a better high (injecting MA). . . . It's the rush.

In addition to increasing awareness and wakefulness, MA was also used in combination with heroin, by heroin primary/MA secondary IDUs, to facilitate socializing in the context of "partying." A long-term, daily heroin injector claims,

> IDU: But my drug of choice is heroin, not meth. I use meth socially and when it's offered to me.

Although based on a non-representative sample, the majority of primary heroin IDUs in the study reported initiating into intranasal use of MA, which was immediately followed by the transition to injection. In general, smoking was not preferred as a route of administering MA among the majority of long-term, primary heroin IDUs. For instance, according to a primary heroin IDU,

> IDU: It's a waste to smoke meth. I will only inject, I don't smoke meth at all even when it's offered to me, but I will put some in my needle.

And by the same token, a daily/near daily heroin user discusses transitions in route of MA use:

> IDU: I don't really smoke it. I just learnt how to smoke it in a pipe. I have sniffed it also, but I injected before I tried smoking it, sniffed it first, but I prefer injecting.

Both source and type of heroin are structural factors in the risk environment of drug users: source dictates distribution and type predicts practice (Ciccarone, 2009). As discussed by Rhodes et al. (2005), in accordance with that found among Puerto Rican crack cocaine smokers in Spanish Harlem by Bourgois (1995), in which social and economic marginalization intersected with a historical patterning of drug use norms to assist in the progression of the structuring of preferences with regard to drug of choice (crack) and method of administration (smoking) at the community level, structural economic factors (e.g., poverty) and characteristics of the local drug market, such as the type of heroin that was available (black tar), as a consequence of the specific geographical region's nearness to the Mexican border, intersected with the socialization of IDU networks and conduct norms to precipitate injection among poly drug users of MA and heroin.

In a study of transitions to heroin injection among NIUs, Neaigus et al. (2006) note that researchers have consistently found that NIUs who are former drug injectors are at higher risk of transitioning to injection drug use than NIUs who have never injected. The role of individual drug use trajectories that included injection of another drug as a factor contributing to injection of MA is indicated in the following vignette by a primary daily MA user that formerly injected cocaine on a daily basis, who discusses initiation into MA injection as a consequence of his drug use history, namely, his familiarity with injecting drugs (cocaine), and social interaction with MA injectors:

> IDU: When I (first) tried it (MA), I never even felt it and I was living at a hotel and my next door neighbor, they were hooked on meth and they were getting it every day and they just go, well just

> because you didn't get any good shit ("good" quality MA). And finally when they got a big bag one day and they came over, they put some in a spoon for me and he goes now do that right. And 'cause he knew I was injecting (other drugs, mostly cocaine). And so he goes, well here, and he put some in a spoon—and goes well try this. In addition, I put some water on it and I injected it. And so, he put some methamphetamine on the spoon for me without any water and I melted it in water and yeah, usually you put 20 units of water on it and it will double to 40. If it doubles, it's probably good. And (this was) about a couple tens (US$10 bags), a quarter gram (of MA).

For those individuals who are already susceptible to transitioning to injection drug use as a result of individual attributes (i.e., being heroin dependent, prior injection of another drug), social network influence may be a factor that increases the likelihood of transitioning to injection through direct communication or, indirectly, through exposure to and comparison with network members who participate in the behavior (Neaigus et al., 2006).

Social factors, including positive attitudes toward needle use among IDUs, including primary heroin users (and primary MA dealer IDUs), and the sense that injecting is of a higher status than smoking may indicate a lack of social distance between IDUs and NIUs, which may increase the likelihood that IDUs will be able to exert influence or pressure on some NIUs to start injection (Neaigus et al., 2006). A daily/near daily heroin injector who prefers to inject MA claims,

> Researcher: What do you do after injecting methamphetamine?

> IDU: I keep busy when I'm on it, around the (drug/party) house. I'm not like most people there that smoke it, who sit around and get stuck, have to pay them with five dollars' worth of shit (MA) just to get up and help out, they just take advantage, don't pay rent, rob people, sit around, and wait for a hit (of smoked MA).

Respondents used heroin and MA in varying combinations with each other. Poly drug users reported administering combinations of heroin and MA either consecutively or concomitantly and differences were found in terms of the motivations for use, sequencing of drug use, and routes of MA administration. Some primary daily users of heroin who also used MA and injected reported a practice in which the needle is filled with blood and injected partially, usually into the side of the neck, and then removed and re injected, which if needles are shared increased risk. Heroin injectors reported more difficulties with injection, including vein damage and had difficulties locating veins for injection.[5] Such difficulties with injection found among many long-term heroin IDUs may have affected individual drug preparation and injection practices. For instance, according to a heroin and MA IDU who "juggled" heroin, most long-term heroin users preferred simultaneously mixing, cooking, and injecting the drugs together:

> IDU: Most people I've seen that mix, and want to mix speed with black, do it, mix it right together, (in the cooker), draw with a filter or a cotton and cook it together.

Combining the drugs in a single "shot" increased the likelihood of a successful injection event, especially among long-term heroin IDUs suffering from vein damage. Ease of administration has been noted as a factor influencing drug use preferences and practices among opioid and crack injectors (Firestone and Fischer, 2008). Expectations about the purity of the drugs and desired effect were additionally found to affect drug use preparation and injection practices for some IDUs. A long-term heroin IDU and MA injector claims,

> IDU: If you really want the full effect of the two chemicals then you shoot it separately . . . with tar, you strain it through a cigarette filter when you draw into (a) syringe, so the cut might stay past the filter on the other side of the filter that way. Heroin, they don't step on (cut) to some degree, but

> heroin I get don't have much cut and the same way with the crystal (MA), but with the crystal, with the crystal, you want to mix it first in a plastic bottle top, then draw it up in the syringe to—do the speed ball right, but some people do dump it right in the cooker and mix it right in with their heroin in the cooker, but it's like it cannot be really be a speedball because heroin is a downer and speed is a upper and it's just cutting the strength of the heroin . . . Meth don't mix in a metal container like coke in a cooker or heroin tar because it lessens potency . . . (so, some) might do the tar, the tar first, and the speed separately right behind. Myself, would prefer for speedball, might not call that speed balling, but would do like the heroin first and then following that up with a second shot of purely speed. (When administered one after another) It's stronger, both products would be stronger. Even though it's still diluted . . . so (I am) usually smoking (MA) a lot of the times too, 'cause you're adding water to it for one, and putting the crystal in the water weakens the strength, by diluting it with water . . . it's a lot weaker speed.

Primary drug of use and levels of use of different drugs may also influence drug preparation and injection practices among some poly drug users of MA and heroin. According to a MA and heroin IDU,

> IDU: (Most people) have different tolerances and use their own judgment of amounts they are mixing. One person might like put essentially um, a point five (0.5 grams) amount of meth in and mix with point one (0.1) grams of black, heroin. And another may do half and half in even amounts and another may want the heroin to and speed to be like a 20, 20 (US $20 bag) of each.

It was not uncommon for neophyte or MA only injectors to report mixing the MA directly with the water in the needle for injection without removing any possible impurities, whereas users who injected MA and heroin simultaneously reported mixing the drugs in a cooker, which was heated and strained with cotton to remove any harmful cuts. A heroin and MA injector discusses MA injection preparation practices:

> IDU: You can mix the speed with a little water and put it into the needle on a plastic cap or in the needle and then you draw the heroin up, or you can mix it in your cooker if you're going to mix the shot. And you use cotton to draw heroin into the needle. You use a metal cap for the cooker, if you do say 40 milligrams of black and want to cut it down a bit so it doesn't like—to do a dime (US $10 dollars worth) or so of speed and mix it in the cooker together with a little bit of water and then mix it up with the lighter and heat it up and it sits for a little bit but—and use cotton to strain the cut off. You don't burn it; you have (added) water in it too. It's all liquid then. *But if you are going to do the speed by itself than you mix it directly in the needle with water.* You can put the water in the needle cap. (Emphasis added)

The practice of dissolving the MA directly in the needle, in which the needle is filled partially with water and then typically a few tiny rocks of MA are dropped into the needle and allowed to liquefy prior to injection, may reduce the risks of contracting BBVs if the needle is unused and unless the syringe is shared. Indeed, a better understanding of shifts and changes in poly drug use among heroin and MA users is essential, especially because transitions from non-injecting to injecting drug use may increase the likelihood of contracting HIV/BBVs.

Discussion

Rather than being an outcome of rational decision making, individual biology, psychology, or pathology, participants' narratives of MA injection revealed the role of myriad social, structural, economic, policy, and spatial/physical environmental factors in influencing the social meanings and motivations attached to drug taking and related risk. Similar to that reported by Fast, Krusi, Wood, and Kerr (2010), at the micro level, involvement in the street drug scene

and daily interactions with individuals and sites that provide access to and acceptance of various drugs and ways of using them, along with macro-level factors such as social economic marginalization, shaped the frames of meaning through which decision making occurred. Dealer IDUs typically discussed their decision to inject based on the economics of injection and the need to limit their drug intake in the context of risks associated with dealing, the social aspects of drug selling, increasing drug tolerance, fear of arrest, and the structural circumstances of poverty. Dealer IDUs sought to control personal consumption and drug selling, including drug tolerance and economic expenditure, by injecting, which was perceived to be a less costly, longer lasting, and more effective and efficient route of MA use compared with smoking. Dealer IDUs framed their decision making concerning injection as a route of MA administration in a way that constructed symbolic boundaries between "controlled" users and "out of control" users based on a distinction between smoking and injecting, which reflects social norms and values relating to involvement in the drug economy (Friedman et al., 1998) and motivations for use, including economic concerns and how to balance the structural circumstances of poverty and drug supply. For dealer IDUs, injection symbolized one's ability to successfully manage drug selling and personal consumption and signified one's level of "commitment" to the street scene.

A major theme that emerged in transient respondents' narratives concerning their motivations for injecting as a route of administering MA focused on structural and situational/spatial constraints, including risk of arrest and fear of interruption, in semi-public and public settings. For example, injection as a route of MA use was preferred by some on the street and at motels as it was perceived to be quicker, more easily hidden, and faster than smoking. The regime of surveillance, which has been primarily aimed at poor and minority populations (Garland, 2004) has been internalized and the embodiment of the economic and sociospatial dimensions of the microphysical environment facilitated injection and risk taking among some IDUs, especially transient users, in semi-public and public places. Research indicated that other factors in the risk environment that may foster injection as a preferred route of use among some individuals included the role of the social network and social relationships in normalizing injection. Other drug use, namely, heroin use, and conduct norms and pre-existing regional preferences for injection as a route of administration among heroin users, may also have facilitated injection among some participants that combined heroin and MA.

The findings from the present study illustrate the need for public health and outreach programs to move beyond the individualistic model of behavior change to an understanding of the multitude of material, social, policy, and physical environmental factors that influence drug and risk behavior. Fieldwork indicated a need for safer injection sites, and efforts should be focused on the settings in which drugs are used, for instance, by providing access to resources needed for safe injection at "party houses," as opposed to policing, which exacerbated risk. Reducing the fear associated with carrying needles, by changing drug policy and policing practices, may also help mitigate the spread of HIV/BBVs. Systemic changes in the structure of opportunity are also required to contend with the economic exclusion, discrimination, criminalization, and social suffering experienced by ethnic, class, and immigrant minorities on a daily basis.

Author's Note

This article is based on research conducted as part of the author's doctoral dissertation at Teachers College, Columbia University.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) received no financial support for the research, authorship, and/or publication of this article.

Notes

1. "Juggling"/"Juggler": Drug dependent users who initiate selling to defray the cost of their habit (see Furst, Herrmann, Leung, Galea, & Hunt, 2004, on heroin use and juggling).
2. Drug scenes have been defined as social and spatial drug-using and drug-dealing environments (Friedman et al., 1998).
3. Although methamphetamine has typically been described as odorless, extensive observations of participants consuming MA in the field indicated that the smoking of the drug emitted a distinctive odor. Although some respondents smoked MA at motels, for others, including IDUs encountered during fieldwork at a motel where MA was being bought, sold, and consumed, the belief that smoking was more "hazardous" than injection as police or others might detect the smell of smoke was discussed.
4. The term "goofballs" is derived from the 1940s when it referred to abuse of pharmaceutical barbiturates, which was correlated with crime, juvenile delinquency, and non-White countercultures (Rasmussen, 2008).
5. Although IDUs in the study, in general, preferred "mainlining" (intravenous injection) MA over "skin popping" (injecting below the skin), skin popping was observed on several occasions. For instance, a dealer IDU and a friend were observed skin popping MA at a motel, which reduced the risk of transmitting blood-borne pathogens. Skin popping MA was also reported among some long-term heroin injectors who had difficulties finding veins for injection.

References

Andrade, X., Sifaneck, S. J., & Neaigus, A. (1999). Dope sniffers in New York City: An ethnography of heroin markets and patterns of use. *Journal of Drug Issues*, *29*, 271-298.

Anglin, M., Burke, C., Perrochet, B., Stamper, E., & Dawud-Noursi, S. (2000). History of the methamphetamine problem. *Journal of Psychoactive Drugs*, *32*, 137-141.

Bourgois, P. (1995). *In search of respect: Selling crack in El Barrio*. Cambridge, UK: Cambridge University Press.

Bourgois, P. (1998). The moral economies of homeless heroin addicts: Confronting ethnography, HIV risk, and everyday violence in San Francisco shooting encampments. *Substance Use & Misuse*, *33*, 2323-2351.

Bourgois, P., Lettiere, M., & Quesada, J. (1997). Social misery and the sanctions of substance abuse: Confronting HIV risk and homeless heroin addicts in San Francisco. *Social Problems*, *44*, 155-173.

Brecht, M. (2013, June). Patterns and trends in drug abuse in Los Angeles County, California: 2012. In National Institute on Drug Abuse (Ed.), *Epidemiological trends in drug abuse: Proceedings of the community epidemiology work group* (Vol. II, pp. 146-158). Bethesda, MD: National Institutes of Health.

Ciccarone, D. (2009). Heroin in brown, black and white: Structural factors and medical consequences in the US heroin market. *International Journal of Drug Policy*, *20*, 277-282.

Copes, H., Hochstetler, A., & Williams, J. (2008). "We weren't like no regular dope fiends": Negotiating hustler and crackhead identities. *Social Problems*, *55*, 254-270.

Copes, H., Leban, L., Kerley, K., & Deitzer, J. (2014). Identities, boundaries, and accounts of women methamphetamine users. *Justice Quarterly*, *33*, 134-158.

Darke, S., Cohen, J., Ross, J., Hando, J., & Hall, W. (1994). Transitions between routes of administration of regular amphetamine users. *Addiction*, *89*, 1077-1083.

Davis, M. (1992). *City of quartz: Excavating the future in Los Angeles*. New York, NY: Vintage Books.

Draus, P., & Carlson, R. (2006). Needles in the haystacks: The social context of initiation to heroin injection in rural Ohio. *Substance Use & Misuse*, *41*, 1111-1124.

Drug Enforcement Administration. (FY 2013). *Performance budget congressional submission*. Washington, DC: U.S. Department of Justice.

Estievenart, G. (2001). Foreword. In T. Rhodes, G. Greenwood, & K. Robertson (Eds.), *Injecting drug use, risk behavior, and qualitative research in the time of AIDS* (pp. 5-6). Luxembourg, Europe: Office for Official Publications of the European Communities, European Monitoring Centre for Drugs and Drug Addiction.

Fast, D., Krusi, A., Wood, E., & Kerr, T. (2010). "I guess my own fancy screwed me over": Transitions in drug use and the context of choice among young people entrenched in an open drug scene. *BMC Public Health*, *10*, 126-136.

Firestone, M., & Fischer, B. (2008). A qualitative exploration of prescription opioid injection among street-based drug users in Toronto: Behaviors, preferences, and drug availability. *Harm Reduction Journal*, *5*, Article 30.

Friedman, S. R., Furst, R. T., Jose, B., Curtis, R., Neaigus, A., Jarlais, D. C. D., & Ildefons, G. (1998). Drug scene roles and HIV risk. *Addiction*, *93*, 1403-1416.

Furst, R. T., Herrmann, C., Leung, R., Galea, J., & Hunt, K. E. (2004). Heroin diffusion in the mid-Hudson region of New York State. *Addiction*, *99*, 431-441.

Garland, D. (2004). Beyond the culture of control. *Critical Review of International Social and Political Philosophy*, *7*, 160-189.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies of qualitative research*. Chicago, IL: Aldine Publishing.

Gorman, E. M., Nelson, K. R., Applegate, T., & Scrol, A. (2004). Club drug and poly- substance abuse and HIV among gay/bisexual men: Lessons gleaned from a community study. *Journal of Gay & Lesbian Social Services*, *16*(2), 1-17.

Guise, A., Dimova, M., Ndimbii, J., Clark, P., & Rhodes, T. (2015). A qualitative analysis of transitions to heroin injection in Kenya: Implications for HIV prevention and harm reduction. *Harm Reduction Journal*, *12*(1), 27-36.

Irwin, K., Edlin, B., Faruque, S., McCoy, H., Word, C., Serrano, Y., . . . Holmberg, S. (1996). Crack cocaine smokers who turn to drug injection: Characteristics, factors associated with injection, and implications for HIV transmission. *Drug and Alcohol Dependence*, *42*, 85-92.

Jacobson, R. S., & Zinberg, N. (1975). *The social basis of drug abuse prevention*. Washington, DC: Drug Abuse Council.

Johnson, B. D. (1973). *Marijuana users and drug subcultures*. New York, NY: Wiley.

Leri, F., Stewart, J., Tremblay, A., & Bruneau, J. (2004). Heroin and cocaine co-use in a group of injection drug users in Montreal. *Journal of Psychiatry & Neuroscience*, *29*, 40-47.

Lindstrom, L. (Ed.). (1987). *Drugs in Western Pacific societies: Relations of substance*. Lanham, MD: University Press of America.

Maher, L., & Curtis, R. (1995). In search of the female urban "gangsta": Change, culture, and crack cocaine. In B. R. Price & N. J. Sokoloff (Eds.), *The criminal justice system and women: Offenders, victims, and workers* (2nd ed., pp. 147-166). New York, NY: McGraw-Hill.

Mandelbaum, D. (1965). Alcohol and culture. *Current Anthropology*, *6*, 281-293.

Marshall, B. D. L., Shoveller, J. A., Wood, E., Patterson, T. L., & Kerr, T. (2011). Difficulty accessing syringes mediates the relationship between methamphetamine use and syringe sharing among young injection drug users. *AIDS and Behavior*, *15*, 1546-1553.

Maxwell, J. C., & Rutkowski, B. A. (2008). The prevalence of methamphetamine and amphetamine abuse in North America: A review of the indicators, 1992-2007. *Drug and Alcohol Review*, *27*, 229-235.

Mayock, P., & Clatts, M. (2006). *An ethno-epidemiology of injection drug use among high-risk youth in Ireland*. New York, NY, USA: National Development and Research Institutes Inc., National Institute on Drug Abuse (INVEST Fellow, Trinity College Dublin, Dublin, Ireland).

Nasir, S., & Rosenthal, D. (2009). The social context of initiation into injecting drugs in the slums of Makassar, Indonesia. *International Journal of Drug Policy*, *20*, 237-243.

Neaigus, A., Atillasoy, A., Friedman, S. R., Andrade, X., Miller, M., Ildefonso, G., & Des Jarlais, D. C. (1998). Trends in the noninjected use of heroin and factors associated with the transition to injecting. In J. A. Inciardi & L. D. Harrison (Eds.), *Drugs, Health, and Social Policy: Vol. 6. Heroin in the age of crack-cocaine* (pp. 131-159). London, England: Sage.

Neaigus, A., Gyarmathy, A., Miller, M., Frajzyngier, V., Friedman, S. R., & Des Jarlais, D. C. (2006). Transitions to injecting drug use among non-injecting heroin users: Social network influence and individual susceptibility. *Journal of Acquired Immune Deficiency Syndrome*, *41*, 493-503.

Page, B. J., & Singer, M. (2010). *Comprehending drug use: Ethnographic research at the social margins*. New Brunswick, NJ: Rutgers University Press.

Parkin, S. (2013). *Habitus and drug using environments: Health, place and lived-experience*. Farnham, Surrey: Ashgate Publishing Limited.

Rasmussen, N. (2008). *On speed: The many lives of amphetamine*. New York: New York University.

Rhodes, T. (1997). Risk theory in epidemic times: Sex, drugs and the social organization of "risk behavior." *Sociology of Health & Illness*, *19*, 208-227.

Rhodes, T., Bivol, S., Scutelniciuc, O., Hunt, N., Bernays, S., & Busza, J. (2011). Narrating the social relations of initiating injecting drug use: Transitions in self and society. *International Journal of Drug Policy*, *22*, 445-454.

Rhodes, T., Greenwood, G., & Robertson, K. (Eds.). (2001). *Injecting drug use, risk behavior, and qualitative research in the time of AIDS.* Luxembourg: Office for Official Publications of European Communities.

Rhodes, T., Singer, M., Bourgois, P., Friedman, S. R., & Strathdee, S. A. (2005). The social production of HIV risk among injecting drug users. *Social Science & Medicine*, *61*, 1026-1044.

Rhodes, T., Stimson, G., Crofts, N., Ball, A., Dehne, K., & Khodakevich, L. (1999). Drug injecting, rapid HIV spread and the "risk environment": Implications for assessment and response. *AIDS*, *13*, S259-S269.

Roy, E., Haley, N., Leclerc, P., Cedras, L., Blais, L., & Boivin, J. (2003). Drug injection among street youths in Montreal: Predictors of initiation. *Journal of Urban Health*, *80*, 92-105.

Roy, E., Nonn, E., & Haley, N. (2008). Transition to injection drug use among street youth: A qualitative analysis. *Drug and Alcohol Dependence*, *94*, 19-29.

Sanchez, J., Chitwood, D. D., & Koo, D. J. (2006). Risk factors associated with the transition to heroin injection: A street addict role perspective. *Journal of Urban Health*, *83*, 896-910.

Sherman, S. G., Smith, L., Laney, G., & Strathdee, S. A. (2002). Social influences on the transition to injection drug use among young heroin sniffers: A qualitative analysis. *International Journal of Drug Policy*, *13*, 113-120.

Small, W., Fitzgerald, J., Kerr, T., Hickman, M., & Holloway, G. (2006). Public injecting and the need for "safer environment interventions" in the reduction of drug related harm. *Addiction*, *101*, 1384-1393.

Small, W., Klain, S., Laliberte, N., Schechter, M. T., Oll, W., Klain, S., & Spittal, P. M. (2005). Incarceration, addiction and harm reduction: Inmates experience injecting drugs in prison. *Substance Use & Misuse*, *40*, 831-843.

Soller, B., & Lee, J. P. (2010). Drug-intake methods and social identity: The use of marijuana in blunts among Southeast Asian adolescents and emerging adults. *Journal of Adolescent Research*, *25*, 783-806.

Sotheran, J. L., Goldsmith, D. S., Blasco, M., & Friedman, S. R. (1999). Heroin sniffing as self-regulation among injecting and non-injecting heroin users. *Journal of Drug Issues*, *29*, 401-421.

Strang, J., DesJarlais, D. C., Griffiths, P., & Gossop, M. (1992). The study of transitions in the route of drug use: The route from one route to another. *British Journal of Addiction, 87*, 473-483.

Strang, J., Griffiths, P., & Gossop, M. (1997). Chasing the elusive dragon: The need for better definition. *Addiction*, *92*, 692-695.

Swift, W., Maher, L., & Sunjic, S. (1999). Transitions between routes of heroin administration: A study of Caucasian and Indochinese heroin users in South-Western Sydney, Australia. *Addiction*, *94*, 71-82.

Valdez, A., & Sifaneck, S. J. (2004). "Getting high and getting by": Dimensions of drug selling behaviors among American Mexican gang members in South Texas. *Journal of Research in Crime & Delinquency*, *41*, 82-105.

Volkow, N. D. (2013). *Methamphetamine: NIDA Research Report Series* (NIH Publication No. 13-4210). Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services. Retreived from https://www.drugabuse.gov/sites/default/files/methrrs_web.pdf

Wagner, K. D., Simon-Freeman, R., & Bluthenthal, R. N. (2013). The association between law enforcement encounters and syringe sharing among IDUs on Skid Row: A mixed methods analysis. *AIDS and Behavior*, *17*, 2637-2643.

Author Biography

Kirsten E. Hunt-Howard, PhD, is an anthropologist who has been working on issues relating to drug use and distribution since 1999. She is the co-author of several publications, including "Heroin Diffusion in the Mid-Hudson Region of New York State" in *Addiction*, "A Select Annotated Bibliography: Illegal Drug Research in Rural and Suburban Areas" in *Journal of Psychoactive Drugs*, and "The Impact of Stigma on Commercial Sex Workers, IDUs, and Those Who Trade Sex for Drugs" in *International Journal of Crime, Criminal Justice and Law*. Her interests include drug use, drug markets, risk, inequality, and the study of social problems.