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Pleasure, drugs, materiality and tensions in harm reduction in practice: The case of safer injection programmes

Marie Jauffret-Roustide
Centre d'Étude des Mouvements Sociaux (CEMS) (Inserm U1276/CNRS UMR 8044/EHESS), France; Baldy Center for Law and Social Policy, Buffalo University, USA; British Columbia Center on Substance Use, University of British Columbia, Canada

Abstract
Drawing on ethnographies of a public health programme called 'safer injection education' (where people inject drugs under the supervision of harm reduction providers), this article explores how the materialities of drug use (such as paraphernalia and space) intersect with habitual behaviours and expectations. The article compares the diverse accounts of people who inject drugs with the biomedical knowledge of professionals to argue that people experience different forms of pleasure which challenge clinical understandings of addiction as driven by a desire to alleviate the pain of withdrawal symptoms. The analysis also critiques the assumption that people who use drugs are enslaved or unaware of their behaviours, showing instead that they are well aware of their patterns of psychoactive substance use and actively manage them in order to increase pleasure, and produce expertise and agency. During safer injection education sessions, people who inject drugs challenge normative assumptions and prescriptions on drug-related risks, and deploy practices and accounts that resonate with narcofeminist approaches, which produces solidarity between peers, social transformation and new forms of resistance to prohibitionist drug policy regimes and the pathologisation of drug use.

Keywords
agency, harm reduction, materiality of drug use, narcofeminism, pleasure

Introduction

The materiality of drug use, including injecting drug use, can be expressed in multiple ways depending on the interpretive frameworks and cultural tools available to people who use drugs. While injection is considered a 'high risk' practice from a public health

Corresponding author:
Marie Jauffret-Roustide, Centre d'Étude des Mouvements Sociaux (CEMS) (Inserm U1276/CNRS UMR 8044/EHESS), Paris, 75006, France.
Email: marie.jauffret-roustide@inserm.fr

and biomedical perspective, people who inject drugs do so in order to maximise the drug's effects as well as to feel the pleasurable sensations. Thus, it is difficult to understand injection practices without reference to pleasure as a key motivation. People who inject drugs favour injection mostly because they consider this medium of consumption to be particularly efficient in that it speeds up and maximises the effects of their product. They can describe the effects of drugs, the direct physical sensation caused by this type of consumption as pleasurable or at least relieving. Memory plays also a central role in achieving pleasure for people who use drugs, who often cite sense memory associated with drug use, as triggers of bodily sensations (Dennis, 2016), such as feeling 'high' as one of their major motives for continuing injecting drug use despite some health risks that may result from this practice.

Habits and rituals also contribute to the experience of pleasure for people who use drugs. Howard Becker, as a major author in the field of drug sociology, showed that drug use is a social practice that requires a socialisation process to experience pleasure (Becker, 1953, 1963). This socialisation leads to the acquisition of specific skills, habits and rituals by regular learning processes and repeated contact with the drug scene. In his famous ethnographic essay on cannabis users, Becker argued that people who use drugs need to acquire different skills and knowledge to experience sensations of pleasure with drugs such as first learning to identify the effects of the product and then to appreciate them. In parallel with this learning process of feeling the sensations associated with drugs, people need to acquire codes and values specific to the social world of drug use which will enable them to belong to this specific social group, to conform to its norms and to attenuate the deleterious effects of prohibitionist drug policy regimes. To survive in a prohibitionist world that is 'hostile' to the practices of drug use (especially for drugs considered illegal), people need to acquire and then implement coping strategies called 'neutralization techniques' (Sykes & Matza, 1957). These strategies may help people who use drugs to distance themselves from the moral judgements they are subjected to and to limit their feelings of guilt (imposed by prohibition that labels their behaviours as deviants). To survive in this hostile political environment, people must derive personal benefits from drug practices that compensate for the social constraints.

The concept of pleasure is hard to grasp and to put into words. Indeed, unlike desire, which supposes a mental elaboration, pleasure refers directly to bodily sensations (Dennis, 2017). The experience of drug-related pleasure is closely associated with bodily sensations that may in part be the product of peer socialisation, but it must also be situated in context and practice. The context involves structural violence that prohibition imposes on people who use drugs and which constitutes a barrier to pleasure. Practice involves experiential knowledge about drugs and injection 'in the making', which constitutes a space that produces solidarity between peers, social transformation and new forms of resistance to prohibitionist drug policy regimes and the pathologisation of drug use. An ethico-political movement called narcofeminism has recently emerged to advocate for the rights of women and gender minorities who use drugs. Led by women who use drugs from the Eurasian Harm Reduction Association (EHRA) and the International Network of People who Use Drugs (INPUD), it recognises that people who use drugs and especially women experience different forms of stigma, punishment, control and surveillance in their lives. Narcofeminism is a political response that collectively aims to

build a 'world free of stigma, violence and oppressions' (EHRA, 2019) by publicly speaking about 'our bodies, our choices, our rights, our voices' (INPUD, 2023). Inspired by feminist approaches (Ettorre, 2004), it pursues activist strategies of resistance to a patriarchal world dominated by a prohibitionist and biomedicalised drug policy which emphasises the harms of drugs and advocates for abstinence-based forms of treatment.

In the area of public health, harm reduction policies implemented in the 1980s to 1990s during the AIDS epidemics have helped to establish a new understanding of injecting-related risks by focusing on the 'risk environment' (Rhodes, 2002). This approach shifts attributions of responsibility for viral transmission away from individual behaviours by highlighting the role of national policies (including prohibition of drugs and oppression of people who inject drugs) in shaping the risk and distribution of viral infections like HIV. Furthermore, harm reduction policy challenges former moral categorisations of people who use drugs as 'deviants' (from the prohibitionist lens) or 'drug addicts' (from the biomedical lens), two perspectives that consider people who use drugs as deprived of free will and rationality (Lie et al., 2022). Harm reduction policy approaches redefine who use drugs as capable of rational thought and responsible behaviours, such as managing one's health – as long as they receive accurate information and sterile drug use equipment (Moore & Fraser, 2006). Although harm reduction establishes a more progressive view of people who inject drugs, it still does not fully consider one of the major motivations for using drugs: experiencing pleasure (Moore, 2008; O'Malley & Valverde, 2004). As harm reduction professionals specifically seek to protect people who inject drugs from harms, they often pay too little attention to the benefits people pursue when using drugs, such as pleasure. Furthermore, as highlighted by Dennis, Pienaar and Rosengarten in their introduction to this collection, even in political contexts where harm reduction policies are implemented, drug use is still not considered a normalised practice and 'attracts widespread social opprobrium'. Indeed, because it aims to empower people who may be at higher risk of blood-borne-virus infections, harm reduction can be analysed as an instance of governmentality (Bondi, 2005; Fraser, 2004; Pereira & Scott, 2017). The concept of governmentality was coined by Michel Foucault to describe how and why the management of population health became a matter of national policy and how political power is exerted on and through individual bodies at the micro-level (Foucault, 2004). This concept makes it possible to describe a new kind of state intervention in liberal democracies. In such regimes, political power is not exerted through direct physical constraint on bodies as it was in the pre-revolutionary order. This does not mean that political power has less impact on its subjects, but simply that external and direct interventions have been replaced by discursive tools of social control that constitute governmentality: the promotion of concepts and social norms concerning health, bodies and self-responsibility. Thus, for Nikolas Rose, governmentality is defined as a kind of biopolitics, meaning a power exerted not by constraint, but at a distance through the internalisation of precepts and techniques inviting individuals to 'become experts in themselves, to establish a controlled relationship with their body' (Rose, 2007, n.p.).

In France, harm reduction was introduced between the late 1980s and mid 1990s, after a period dominated by the paradigms of imposed abstinence and psychotherapy, which tend to promote an image of people who use drugs as suffering subjects (Bergeron, 1999). Although the harm reduction movement was initiated by activists advocating for

better social inclusion of people who use drugs and the recognition of their status as citizens (Jauffret-Roustide, 2009), the French government then progressively implemented a biomedicalised model of harm reduction, focusing on the delivery of opioid substitution treatments (OST). This biomedicalised model of harm reduction is in line with the dominant model of addiction as a brain disease (Lie et al., 2022) and centres the risks of illicit drug use (here injecting drug use is considered a risky practice that can transmit blood-borne viruses if sterile injecting equipment is not used, e.g. if people share or reuse injecting equipment) (Jauffret-Roustide & Cailbault, 2018). This French model is associated with a 'weak version' of harm reduction, which reconciles a public health approach with repressive legislation toward drug use (Hunt, 2004). In fact, the French model does not take into account the rights of people who use drugs to use their bodies as they desire, unlike stronger versions of harm reduction implemented in other European countries such as the Netherlands, Switzerland or Portugal (Jauffret-Roustide et al., 2013). Within this model, health risks related to injection practices are now widespread in prevention discourses (Philipps & Stein, 2010) but injection practices are mostly discussed in relation to the harms they can cause rather than the pleasure people can experience. Some of these risks have been incorporated and normalised by people who inject drugs who adopt safer practices, but they are still not correctly addressed by health professionals who neglect the context of violence and stigma associated with these risks (Harris, 2020).

In the last decade, some French harm reduction organisations have developed a kind of intervention that addresses both health risks and pleasure related to injection practices. These interventions consist of training sessions in which people inject as harm reduction workers or volunteers observe, and then jointly discuss injection practices. Those safer injection training sessions started mainly during harm reduction interventions in informal party settings, before being trialled in a few harm reduction facilities. This approach has been implemented experimentally in France at a time when drug consumption rooms were not allowed by French legislation. Two non-governmental organisations, Médecins du Monde (MdM) (Doctors of the World) and Aides (an NGO fighting against HIV/AIDS), have been expanding this type of intervention over the last 15 years. These training sessions appear under different names depending on the organisation: Médecins du Monde refers to it as ERLI – which in French stands for '*Education aux risques liés à l'injection*' (translated as 'education on injection-related risks') (Cheyron, 2016a, 2016b); the NGO Aides chooses to add an 'A' which stands for '*accompagnement'* (accompaniment), so they use the acronym AERLI. Despite these different names, the interventions are based on the same objectives and processes. The principal objective is to minimise the harmful effects on health of injecting drugs – mainly blood-borne virus, overdose, abscesses and vein damage – by improving the safe-injecting knowledge of people who inject drugs and thus their ability to engage in prevention behaviour (Jauffret-Roustide & Debrus, 2023). In plain terms, this intervention is built around one live injection session during which the client will prepare their product and inject it in the presence of two supervisors (workers or volunteers). Each session offers an opportunity to discuss injection-related topics with the client, such as vein searching, avoiding bacterial and fungal infections, consumption management, or psychoactive effect maximisation. It starts with a worker-administered questionnaire about the client's objectives, such as for example working on vein location or on filtration techniques. The client also answers questions

about their recent drug use and injection habits. Workers watch the injection preparation but they only intervene in rare cases of a security breach. Then they make observations, discuss and evaluate the level of risk-taking with the client. These processes of observation and discussion constitute the common ground for safer injecting training sessions.

Despite the importance of addressing some risks associated to injection practices, pleasure should also be considered a legitimate topic (Race, 2017; Race et al., 2021) because it is central to the lives and experiences of people who use drugs. Recently, some critical drug scholars have drawn on conceptual elements from different post-structuralist approaches (Bundy & Quintero, 2017; Race, 2017) and assemblage thinking (Cañedo & Moral, 2017; Dennis & Farrugia, 2017), sometimes combining the two (Malins, 2017), to conceptualise pleasure in relation to drugs. In this essay, I combine this critical drug studies perspective with insights from narcofeminism by studying the role of pleasure in the experiences of people who inject drugs, how they interact and negotiate with harm reduction providers and how they deploy resistance strategies to patriarchal approaches to drugs use. My theoretical approach is in line with narcofeminism's conceptual framework in several respects. First, I argue that focusing on intimate experiences of people who inject drugs and revealing their experiential knowledge offers a more expansive understanding of harm reduction in practice. Second, my theoretical perspective overcomes the biomedical prism of risk attached to public health or the prism of guilt attached to prohibition, by highlighting instead the search for pleasure and the freedom to make informed choices that people who use drugs express in their practices and narratives. Third, I highlight that the relationship to drugs among people who suffer from multiple forms of oppression must not be apprehended only from the lens of vulnerability, but also from the lens of experiential knowledge, resistance to biomedical expectations and agency. My ethnography shows that pleasure can be experienced through the memory of previous experiences of injecting and through clients' injection habits. I sought to analyse the way harm reduction professionals and people who inject drugs handle the question of pleasure in their daily social interactions, by presenting three main issues: (1) experiences of pleasure related to rituals, habits and ambiance; (2) sensory memory of the first experience of injecting as both motivation for and obstacle to experiencing pleasure; and (3) how subjects with experiential versus professional knowledge can reconcile conflicting goals.

Methodology

The study on which this article draws was rooted in a community-based approach.[1] The NGO Médecins du Monde (MdM) asked our research team to provide a socio-anthropological analysis of their programme, to understand its impact on clients as well as on professionals and volunteers involved in the programme. MdM gave us access to all the programme's archives, allowed us to conduct ethnographic observations during injection sessions, and facilitated contact with the professionals and volunteers involved in the programme. The research protocol has been reviewed by the ethics committee of Paris Descartes University (Reference Number 2018-22). The methodology used in this research combined ethnographic observations and semi-structured interviews. A total of 95 injection sessions were observed as well as everyday activities in the structures,

group-work sessions, and supervision meetings about safer injection education. Nineteen semi-structured interviews were conducted with clients and 34 with supervisors (including harm reduction workers and volunteers).

The fieldwork took place in five different drug treatment centres and harm reduction facilities in the Paris area. One of these was an experimental mobile unit focussed on with safer injection education: a bus that was parked near an important Parisian drug scene. There were harm reduction facilities delivering guidance, sterile injecting equipment, and other paraphernalia. They also provided essential services to their clients, who for the most part live in very precarious conditions and are often homeless. These services include access to showers and washing machines; cereal, bread and coffee; and administrative support. The fifth service was a drug treatment centre providing opioid substitution treatments as well as social and medical support. In order to ensure the privacy of both supervisors and clients of the safer injection education programmes, the data used in this article are de-identified.

We adjusted our ethnographic observations according to the location and the type of centre under investigation: in the mobile unit, safer injection education was the only activity taking place every day. Here the presence of an external observer was well-accepted by clients, most of whom accepted the invitation to take part. This may be due to the fact that they are used to being observed by service workers while they inject so the presence of an external ethnographer was easily accommodated. In the four other centres, the safer injection education sessions were only one of many daily activities and took place in a separate space, only when requested by people who inject drugs. In those centres, the presence of an external observer was a bit more problematic, some people were not willing to be observed by a third person. We only collected ethnographic data during the sessions where people gave their consent. As ethnographers, we are conscious of unequal power relationships between participants and researchers and that ethnographers contribute to producing expectations of 'good' harm reduction practices among people who inject drugs (Campbell & Shaw, 2008). Indeed, this interaction contributes to shape specific discourses and practices during the presence of the ethnographer, even if we feel that they are 'authentic', especially when the interactions happen in harm reduction facilities. To protect participants' identities, pseudonyms are used throughout and participants are referred to as 'clients' (i.e. people who inject drugs), or 'supervisors' for harm reduction professionals and volunteers. The latter is because even if this safer injection education programme claims to guide and not impose, it is still a public health programme that 'supervises' people who inject drugs in order to reduce health risks.

Qualitative interviews were semi-structured, their length varied from 30 minutes to 3 hours. All the interviews were conducted in French. Only quotations for this article have been translated into English. The interview schedule for clients contained questions pertaining to their experiences of safer injection education programmes, past and present consumption and injection practices, as well as their life trajectory. The interview schedule for supervisors comprised questions about their experience of safer injection educations programmes, their career trajectory, their personal views on drugs, and their own consumption practices. We followed an inductive approach when conducting interviews and taking notes during observations, testing our hypotheses against the field data and readjusting our research questions where necessary in the course of fieldwork. The

interviews were audio-recorded and then transcribed in their entirety, before being coded using NVivo. We coded all of our data (ethnographic observations and semi-structured interviews) by using an iterative process of thematic analysis. Our research is part of a 'grounded theory' approach that aims to establish the implicit theory underlying the experience of pleasure in injection and the testing of harm reduction in practice, constructed in the interactions and exchanges between clients and supervisors during live injection sessions and afterwards discussions. Grounded theorising, viewed as a process, is characterised by an iterative logic, a constant back and forth between data collection and systematic analysis (Glaser & Strauss, 1967), which allows for greater adaptability to field contingencies. Primary coding identified categories from the empirical data. In the second stage of the analysis, the different categories were grouped together, in an effort to conceptualise them, in order to construct the final theory, i.e. the theory that would explain and understand the observed and categorised phenomena.

Experiences of pleasure related to rituals, habits and ambiance

First, the safer injection education programme gives a voice to people who are usually voiceless, with the aim to reduce epistemic injustice that affects people who experience various forms of oppression (Fricker, 2007) such as those who use drugs. People attending the programme can produce their own accounts of their injecting practices that are often silenced. This is in line with the narcofeminist approach which argues that auto-ethnographic narratives can give voice to people with lived, centering their insights and expertise. Our ethnographic work combined with semi-structured interviews showed how during sessions clients are producing an auto-ethnography about their practices that they share with supervisors who observe. It is quite an unusual situation in care because the discourses address the question of pleasure that is often neglected by drug treatment and harm reduction providers. People's narratives show that the experience of pleasure is embedded within rituals, habits and atmospheres and that it sometimes creates situations of discomfort or disagreements between people with lived experience and harm reduction providers.

During safer injection education sessions, people inject and experience the effects of the substance in front of two supervisors who watch closely in order to comment on injection technique and/or on the health risks the client may incur. Our ethnographic observations highlight that even before it is felt, pleasure affects the client and supervisors' relationship through the expectation of the effects of the product: supervisors sometimes feel that this expectation monopolises the attention of the client, who therefore cannot fully engage in the educational dialogue. Conversely, clients' accounts reveal how important it is for them to talk about their bodily sensations related to pleasure. After the injection, the client's facial and body language reveals more or less clearly the drug's effects and makes the sensation of pleasure visible. This also depends on the substance used, as a supervisor says about morphine sulphates (an opioid medication), which creates a rush more visible to an outside observer than heroin does:

> Even if they're not so inclined to let go, you can see it physically: when they really load up, they get a rush and they become all red and swollen like toads. (Gabin, supervisor)

Every person experiences the effects of consuming the same product differently according to its pharmacological composition and purity, the context of use, as well as personal memories of pleasure. Clients express very different views on pleasure: some say injecting opioids does not give them pleasure and that it only soothes their feeling of withdrawal, while others who have used it for decades report that they enjoy its effects and experience sensations of pleasure when injecting their drug of choice. The sensations are highly variable, not only between individuals who will have a completely different physiological response or apprehension of the effects of the same product, but also for the same individual, who may not always understand or express precisely why the effects are not always felt in the same way. The example of simultaneous sensations of itchy/scratchy effects and pleasure after injection is especially relevant:

> Then there's a rush with an itchy feeling, it can be a little random but it's nice. It scratches more or less. . . maybe depending on the dose or frequency. The more spaced out it is, the better it feels, at least. . . I guess, I'm not sure. Sometimes I even do two in a row because I'll feel the second one more. Sometimes, I don't know, you feel it, and sometimes you really don't feel anything. I don't know why.

After this client's narrative, we observed a particularly interesting interaction between a client and a supervisor that reveals differences in staff and clients' interpretations of a scratchy/itchy sensation when using opiates.

> **Sébastien, client:** [scratching himself] Oh that one felt good!
> **Georges, supervisor:** You know why you're itchy? It's an allergic reaction to the cutting agents.
> **Sébastien, client:** I wonder if there isn't more morphine in it.

This interaction shows that the user's itchy sensation will become a part of their memory of experiencing opiate-related pleasure. The itchy sensation will come to constitute a sign of the product's quality and also will be a part of the experience of pleasure, bodily evidence that the injection had worked. After this ethnographic observation about itchy sensations experienced after an injection, we asked other people who inject drugs if they experience similar sensations. Some of them mentioned that an itchy sensation has now become part of the pleasurable experience for them. When they inject, they are looking for this specific sensation of itchiness and/or scratchiness. Extensive literature has shown that rituals of use in terms of small acts (such as preparing the syringe/licking the needle) fulfil a structuring function for people who use drugs (Grund et al., 1996). Our ethnographic research shows that beyond practices, rituals can also include feelings that occur before, during or after the pleasurable effect of consuming the drug. The interaction also highlights a disagreement on the meanings of the itchy sensation. The client interprets it as a precursor to their sensation of pleasure whereas the supervisor interprets it as a harm

and more specifically as an allergic reaction related to the product itself or to its cutting agents.

These varying accounts point to the fact there is no 'scientific truth' because pruritus associated with opioid consumption is still considered a 'mystery' by pharmacological scientists (Ko, 2015). Furthermore, the pleasurable sensations associated with injecting drugs are not as mechanical as they are usually understood to be. Beside the neurobiological response to the pharmacological properties of a psychoactive substance, many other factors contribute to the experience: the psychological and physical states of the person injecting, and of course, the socio-spatial context (Duff, 2012). In the case of safer injection education sessions, we also asked people how this socio-spatial context affects their experiences of drug injections. During client interviews, one of the main motivations they expressed for engaging in education sessions was the opportunity to inject in a safer, cleaner, quieter space than the ones they are forced to use (streets, public bathrooms, cars or parking lots). When we asked them about how the programme could be improved, some suggested elements like background music, décor improvements, or a sofa to create a more welcoming or pleasant space. But in our ethnographic work, most clients did not suggest that the sanitary atmosphere of the spaces changed their experience, contrary to the narratives of people who attend drug consumption rooms in other surveys (Duncan et al., 2017). People who are used to injecting in riskier and less comfortable spaces usually said that they were satisfied to inject in a safe and clean space. However, both clients and supervisors often cited the supervisor's gaze as a factor that caused stress and disturbed the client when injecting and attempting to enjoy the substance's effects. We can also hypothesise that the presence of the supervisor and the researcher observing the injecting practice might have amplified this effect, interrupting the pleasurable effect for the client.

Pleasure is still an ambiguous space, even for those who experience it. For some clients, it may be difficult to talk about the pleasurable sensations of their high, which refers to emotions and bodily sensations, or to find words to describe the effects of the product:

Guillaume, supervisor: When you use Skenan [morphine sulphates], how do you feel?

Alexandre, client: I don't know. . . the rush gives me a nice scratchy feeling. . . ultimately, I think it feels good. Yeah, I feel it in my gut, because you can feel a little tense in your gut until you've taken it. I'd say that my gut tenses up.

This discussion also reveals that sometimes it may be difficult for people who inject drugs to express their feelings and views. One part of the explanation is that it is difficult to put embodied sensations into words. Another explanation may refer to the context of interactions. Indeed, the narratives are shaped not only by the dual interaction's situation between clients and supervisors but also by political forces and especially the structural violence imposed by prohibitionist policies on people.

Sense memory of first injection

Another topic highlighted by our ethnographic work is that of the memory of the first injection sensation, and how it can affect pleasure. A supervisor who practised opiate injection explains it is challenging and sometimes emotionally moving for him to witness a practice that used to be so important to him:

Daniel, supervisor: When I started to inject, I thought it was for pleasure or out of curiosity. But then it became a need, and when the need appeared, there was not much pleasure left. There was still a little pleasure because you expect the effects and you relate these effects to a time when you still felt pleasure. I observed on me the pleasure for several years. Every time you inject on yourself, the pleasure you feel is a little like the pleasure you used to have at the beginning, but it doesn't last as long. And then you ask yourself, why did I do that? And then comes the guilt, and you don't want to keep feeling guilty because you want to enjoy other things than the high. You want to be able to move, because when you're in withdrawal you can't move. So, you try to forget something you won't forget because it comes back every time you do this gesture. It's the infernal cycle. So now, when I see people butchering themselves, they can think at the same time 'I'm going to feel pleasure' and 'I can't take it anymore'. Many things are happening at the same time. So, I try to calm the person down in any way I can if I feel that the person is living a restless moment.

Interviewer: During a session? Does this restlessness come from the way the session is set up, or is it a compulsive mechanism?

Daniel, supervisor: I think it's because of both, because during a safer injection session, I really feel deeply connected to the person injecting. When I'm with my colleague, I try to stay mindful of everything, because we have to respond to emergencies, but I'm connected to the person. . . I don't know how to describe this moment, I think it has to do with my past. . .

Having experienced the effects of injecting opiates for years, this supervisor interprets clients' feelings based on his past experience and describes a complex admixture of emotions involving pleasure, regret and frustration. This interview extract also shows that the memory of a person's first injection can be paradoxical. It stands as both a unique and unattainable experience of pleasure, recorded in memory as a sensation that the person will try to reproduce at each injection without ever succeeding. It also references the connection Daniel has with people when they proceed to inject during a session. This connection refers to feelings, sensations, but also to expertise that people who use drugs are able to deploy including technical, pharmaceutical, social, institutional, physical and moral skills (Jauffret-Roustide, 2009). These 'life skills' give another perspective on

people who inject drugs in which drugs can be considered as ‘technologies of the self’ (Pienaar et al., 2020) and as ‘social and political agents’ which give skills to people that they can mobilise for themselves and for others (Duff, 2013).

It is also important to note that this event of first injection is not always remembered as pleasurable. As Howard Becker has shown for cannabis smokers, seeking out pleasure through drug use requires a learning process (Becker, 1963). First injections are sometimes unpleasant experiences. So it is rather the memory of the experience that may impact the pursuit of pleasure during subsequent injection experiences. Subsequent injecting experiences can play various functions, such as fulfilling the pursuit of pleasure, but also alleviating suffering and withdrawal. When mentioning these personal characteristics, supervisors often describe their own difficulties witnessing some situations or finding their place in the session. The observation that ‘many things are happening at the same time’ also reveals the complex role of supervisors to facilitate the client’s experience of pleasure while also monitoring and intervening if they are at risk of overdose. This double attention perfectly expresses the tensions that harm reduction encounters in practice. These narratives indicate that the ability to use a non-judgemental approach as promoted by harm reduction does not depend only on the goodwill of professionals. It can be demanding for them to deliver non-judgemental harm reduction guidance when they are practically exposed to situations and interactions that engender various emotional responses ranging from empathy to irritation or from desire or curiosity to disgust (Jauffret-Roustide & Debrus, 2023). These feelings are expressed by individuals but they are shaped by the prohibitionist drug policy regimes that regard illicit drug use as immoral and dangerous.

Reconciling conflicting goals: Experiential versus professional knowledge

The last point I would like to highlight is how experiential and professional knowledge may come into conflict during safe injection supervision. A client about to inject a product expects it to have pleasurable or relieving effects. This primary motive can be hard to reconcile with the educational goal of the safer injection education session. Supervisors provide guidance concerning health-related injection risks, and this guidance is based on scientific knowledge that does not take pleasure into account. This can sometimes create a deep chasm in the client’s set of priorities, as this account of a staff–client interaction reveals:

Bertrand, client: It’s really hard in the morning. The withdrawal wakes me up at 5am.

Majellan, supervisor: Did you know that Skenan (morphine sulphates) has a sustained effect if you take it as a sublingual? It can delay the withdrawal effect.

Bertrand, client: Yeah, but then there’s no rush. Maintaining an opiate addiction is difficult and expensive, so if I’m not even getting pleasure from the rush, I don’t really see the point. . . unless I take Actiskenan, all 200 mg at once. . .

Majellan, supervisor: The other good thing with sublingual is that you can rest your injection point.
Bertrand, client Yeah, but if I wanted to rest my injection point, I'd just do methadone. Considering the loss of pleasure with sublingual, I wouldn't take Skenan. If I'm gonna do an addictive opiate, I might as well get pleasure out of it.

While supervisors have different backgrounds and training, they often rely on harm reduction and pharmacological scientific literature to advise clients. This literature focuses mainly on avoiding health harms caused by drug use, or on the intended use of opiate medication. This knowledge, which has become a professional routine, considers the issue of pleasure as secondary, if not completely irrelevant. The last session extract shows how supervisors, who are mainly harm reduction workers, can struggle to answer the needs of the clients when relying on risk-oriented and pharmacological expertise. Sometimes, the different types of knowledge contradict each other. In those cases, the experiential knowledge of users is understood and labelled as a 'belief' and 'lay habit', in contrast with the evidence-based knowledge of the supervisors.

Although safer injection education sessions do not aim to enhance pleasure, some supervisors consider that acknowledging pleasure as one of the main motives of this practice helps to give more relatable advice to clients. Indeed, technical aspects such as product preparation and filtration are understood in significantly different ways when one takes pleasure into account. Sometimes, during the sessions, clients choose to prepare their product in a way that supervisors do not consider optimal, favouring pleasure over health. During one session, a client heated the Skenan (morphine sulphates), then filtered it with a cigarette filter. After the injection, one of the supervisors commented on the aspect of the solution:

Bernard, supervisor: Your product was cloudy.
Jean, client: Always is. [. . .] It feels better if it looks like milk.

After this first interaction, the supervisor suggested filtering the product with a wheel filter instead of the cigarette filter so as to avoid bacterial infection as well as excipients that could obstruct blood vessels. For harm reduction workers, pleasure comes from morphine, and morphine should be clear so as to avoid bacteria and blood vessel obstruction, and for the client, it also comes from the 'milky look'. The wheel filter procures a transparent solution, with less excipient and a better extraction of morphine. Supervisors explain this to clients on a regular basis, but they sometimes reply by referring to their own perceptions and sensations, as did this client, who explained that he prefers injecting a cloudy product because he perceives it as more 'loaded'. He will choose not to use the wheel filter in order to feel more pleasure because he imagines that the product will be excessively filtered otherwise, which would take away from the sensation of pleasure during the rush. The knowledge delivered by supervisors, which is mainly based on harm reduction literature, often conflicts with the experiential knowledge of people. It is very difficult to convince users with theoretical explanations when they experience a certain practice as more pleasurable. This interaction points to the more expansive enactment of

pleasure that people who inject drugs are allowing for and part of. This is a pleasure that is about more than pharmacodynamic reactions but the look of a substance, memories, habits and rituals. This different interpretation of 'what is a good product to inject' highlights the different norms and epistemes that clients and workers apply in their encounters.

Safer injection education sessions are not a typical social situation. They can create discomfort on both sides, as injection is considered to be a very intimate gesture that can be difficult to exhibit and witness. During a regulation meeting, while the team was trying to understand why one client did not wish to follow up their first session with a second one, a supervisor compared injection to masturbation. This comparison underlines the discrepancy between the aims and motivations of injecting drugs, and the aims and preoccupations of supervisors, who tend to focus on health and risks when they feel too much discomfort with pleasure. As Max (supervisor) explains: 'It's too intimate! Imagine you are asked to masturbate in front of two guys, and they are commenting: [mimicking; taking a serious and pedant tone]: "try to alternate with your right hand to rest the left one. Wait! Did you wash your hands first?" [returning to his usual tone]. Would you come back then?' During a safer injection education session, two aspects of injection come face-to-face and are difficult to reconcile: on the one hand, there is the intimate, private aspect of this practice involving the body and oriented towards pleasure or relief, and on the other, there is a technical and sanitary scrutiny based on concerns of harm reduction. During this unusual social interaction, determining adequate behaviours can be demanding for both parties, as their behaviours cannot be entirely guided by the usual social norms we rely on during regular interactions (Goffman, 1982).

These conflictual goals and disagreements expressed between supervisors and clients about the cause and the meaning of pleasure feelings can be considered an implicit strategy of resistance to dominant discourses that centre risk and harm, and apprehend people who inject drugs through a lens of vulnerability, deviance and pathology. By drawing attention to their narratives, experiential knowledge and power to act, people who inject drugs challenge normative assumptions and prescriptions on drug-related risks, and deploy practices and accounts that resonate with narcofeminist approaches.

Discussion

This ethnographic study highlights that safer injection education interventions can be the source of alliances, negotiations, misunderstandings and disagreements between attaining health and educational goals, and allowing people to pursue their expectations and to fully experience the effects of injection. Safer injection education is therefore a typical example of the tensions that harm reduction faces in practice. The examples of discussions about whether or not to heat up the product, or about the interpretation of itchy sensations after using Skenan (morphine sulphates) demonstrate the importance of taking into account the primary interest of clients in their product: feeling a pleasurable effect whatever name this effect might take: high, pleasure, relief, buzz, cure. If the most important aim of the safer injection education session is to help people to avoid health risks, the expression of expectations and experimentations of pleasure also takes place during sessions.

It is difficult for participants to consider this fact when the institutional frame of harm reduction and the scientific literature on which it relies does not. This new public health approach promoted by harm reduction officially professes value neutrality that can be considered politically effective (Keane, 2003). While harm reduction theoretically eschews moral judgement of drug consumption in principle, it reshapes that judgement into one of good practice from the point of view of biomedical prevention centring the expertise and agency of people who use drugs (Jauffret-Roustide, 2009). The analytical perspective taken in this article resonates with McLean's ethnographic work in New York on how harm reduction is producing different regimes of self-care for people who inject drugs and how people sometimes resist by refusing these new harm reduction norms and their biomedical assumptions about drug use (McLean, 2015). The narcofeminist framework offers a space to reposition people who inject drugs as having the power to think and act, and no longer as victims of oppressive prohibitionist and patriarchal regimes.

Even if people who inject drugs are partially expected to be responsible for managing risks by themselves, our ethnographic work shows that they might also be closely guided by harm reduction professionals or volunteers who encourage them to adopt safer injecting practices through soft strategies. Such strategies differ from prohibition's blunt, brutal strategies that produce vulnerability and stigma instead of agency. These soft strategies developed by harm reduction providers are in line with Moore's (2009) argument that people who use drugs do not always express resistance through opposition but also through negotiations and accommodations with professionals. In this case, it is interesting to note that the efforts to negotiate and accommodate are mainly expressed by professionals, and can be described as follows: sharing a feeling of closeness with clients by disclosing their own intimate past injecting experiences and/or having an open dialogue about sanitary guidelines that allows each participant to freely express their diverse experiences or views. Such an approach runs contrary to prohibition, which imposes only one view: drug use is a deviant practice that needs to be fought. Following a narcofeminist approach, these interactions and dialogues between clients and supervisors sometimes reveal the influence of prohibition and pathologisation of drug use that complicates discourse about pleasure even in some harm reduction situations. In harm reduction, pleasure is not forbidden but can produce discomfort, as our ethnographic work highlights (Jauffret-Roustide & Debrus, 2023).

Furthermore, harm reduction 'encourage[s] drug users to transform themselves into moral citizens through self-governance, aligning their ethical practices with the governing interests of authorities' (Pereira & Scott, 2017, p. 69). Harm reduction does not challenge individual responsibility as a major value of neoliberal societies, it just shifts its target: harm reduction reintroduces the possibility of conceiving people who inject drugs as exerting rationality and self-control by choosing safer modes of drug consumption. The traditional view, on the other hand, considers that drug use exists outside of free will and responsibility, as people seen as experiencing 'addiction' are considered enslaved to a substance. Focused on empowering people who use drugs to gain expertise on their own drug use and on limiting risky practices, thus acquiring citizenship (Jauffret-Roustide, 2009), harm reduction principles emphasise the need for individuals to become more responsible, to have a more reflexive approach to their bodies, and to take better

care of themselves (Fraser, 2004). But pleasure plays an important part in the economic rationale that underlies harm reduction's conception of the subject. In liberal theory, the economic agent chooses reward over risk, and pleasure can be considered a legitimate reward, one that, in our participants' experience, is often constituted by habits and sense memory.

Despite this favourable cultural ground for the discussion of pleasure, it is still a rare topic in harm reduction discourse (Holt & Treloar, 2008). This scarcity can be explained by the double use of pleasure as a tool by liberal governments: 'pleasure can be regarded as not only constituent of liberalism and its freedom – exemplified in the figure of the felicity calculus – but also as a variable technique for governing free individuals' (O'Malley & Valverde, 2004, p. 27). Pleasure is associated with reason: the term is used to qualify the moderate and reasoned enjoyment of productive citizens, while enjoyment that is considered unreasonable or presumably unwilled and uncontrollable, mainly that of the poor or the unproductive, is called craving or compulsion (O'Malley & Valverde, 2004; Pereira & Carrington, 2016). Thus, enjoyment that is considered problematic is never associated with the term pleasure and its more positive connotations, leading the authors to conclude that attributing – or denying – the term of pleasure according to the situations and the individuals at hand is a tool for liberal governance: 'Liberal government has thus accumulated a battery of pleasure-denying characterizations, each with its own discursive effectiveness, each linked with an appropriate set of governing techniques' (O'Malley & Valverde, 2004, p. 38). Illicit drug use, specifically by injection, is not considered a legitimate pleasurable practice, in part because of the high risk of blood-borne virus transmission that threatens not only the user but also society as a whole (Bergschmidt, 2004). That may explain why confronting pleasure challenges clients and supervisors alike in safer injection education sessions, and why discussing it can create discomfort.

Of course, analysing harm reduction in terms of neoliberal governance does not mean we understand all aspects of harm reduction programmes in the lives of those who actively participate in it – workers, volunteers or clients (Gowan et al., 2012). My intention in mobilising concepts of neoliberal governance and biopolitics is not only to propose a critique of the limitations of harm reduction, but to analyse it by establishing the broader context in which these social phenomena are situated. These concepts deepen our understanding of the structural forces at play in harm reduction programmes: the political and theoretical frame in which these safer injection programmes operate does have an effect on how workers and clients tackle the question of pleasure and whether they consider it a legitimate topic. To be funded and implemented, such public health programmes need strong justifications framed in evidence-based terms. In safer injection argumentation, as in most discourse of funded harm reduction programmes, the focus is on health risk, at the expense of other dimensions of drug experiences, which thus becomes more difficult to grapple with for people taking part in these interventions. Indeed, reconciling analyses of the embodied experience of drug use and the political, economic and theoretical contexts in which it takes place may allow more nuanced understanding of drug use, drug interventions and drug policy measures.

This conclusion can also apply to clients of safer injection sessions, and could even be extended to harm reduction workers: their work should not be reduced to preventing

infection risk, even in such health-oriented programmes as safer injection education sessions. This analysis suggests that harm reduction workers and volunteers care deeply about clients, and want to help them improve their general situation, which can be challenging on many levels: social, economic, psychological, relational, administrative. Therefore, focusing only on a health perspective, and understanding safer injection education programmes only as a biomedical intervention cannot convey a full understanding of harm reduction workers' activity, nor of clients' motivations and behaviours, particularly concerning the issue of pleasure (as a key feature of drug-related experiences). Addressing the question of pleasure requires adjustments from both sides to reconcile the conflicting goals of health education and the pursuit of pleasure or relief. This is especially the case in supervised injecting centres where harm reduction providers are present as supervisors, as in this study and in related ethnographic work conducted on drug consumption rooms (Duncan et al., 2017). Finally, the participant narratives presented here strongly resonate with narcofeminists' resistance to prohibitionist drug policy regimes that focus on risk and harm, at the expense of considering the pleasures and rewards of drug use.

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