Title:

Informal 'Sorter' Houses: A Qualitative Insight of the 'Shooting Gallery' Phenomenon in a UK Setting.

Running Title: Informal 'Sorter' Houses

First Author (and Corresponding Author):

Stephen Parkin PhD

Research Fellow

Human and Health Research Building (HHRG/02)

Institute for Research on Citizenship and Applied Human Science

University of Huddersfield

HD1 3DH

UK

Email: s.parkin@hud.ac.uk

Second Author:

Dr. Ross Coomber

School of Law and Social Science

University of Plymouth

Drake Circus

Plymouth

UK

PL4 8AA

Keywords: Shooting Gallery, Injecting Drug Use, Drug Settings, Harm Reduction, Risk Environment, Drug User Activism

Informal 'Sorter' Houses: A Qualitative Insight of the 'Shooting Gallery' Phenomenon in a UK Setting.

ABSTRACT
This paper considers the 'shooting gallery' phenomenon and presents findings from a sample of injecting drug users with experience of attending such premises in the South West of England (UK). Due to the reciprocal relationship within these settings, involving the provision of drugs for place, the term Informal Sorter House has been coined by the authors. The social organisation and associative health risks within Informal Sorter Houses were found to have resounding similarities with those previously identified within American settings. However, several differences were also noted. Namely, Informal Sorter Houses appear to be located within *a continuum of control* that contains regulated, unregulated and restored injecting environments and accordingly, it is suggested that such environments are in constant flux. A further difference relates to drug-user activism identified within such settings. This involves the establishment of an informal, street-based harm reduction practice that provides potential for future service development.

INTRODUCTION
Indoor settings of drug use have long fired the creative imagination of those interested in portraying fictional, semi-factual, or auto-biographical accounts of drug scenes. Such literary constructions of 'drug places' have embraced the gothic imagination of the Romantic poets (Hayter 1968); the xenophobia of opium dens (Dickens 1870/1980, Berridge 1999), alongside counter-cultural nihilism (Burroughs 1977), the heroin chic of urban deprivation (Welsh 1994) and the tragic fatalism of social outcasts with a penchant for the exotic (Miller and Campbell 2000, Tosches 2000). Furthermore, those attending such 'fictional' places are typically viewed prejudicially; as racial stereotypes in which particular groups of people are viewed as subordinate victims, exploited by misogyny and/or violence in which all are enslaved to the drug used within (Burroughs 1977, Dickens1870/1980, Goines 1971, Miller and Campbell 2000, Slim 1996). In short, and in the public mind at least, these extreme portrayals of place perhaps sensationalise and fetishise particular drug settings.

The relatively emotive term 'shooting gallery' (SG) however, is one that appears to have been accepted within academia to generically describe 'rooms or abandoned buildings where groups of addicts meet to inject heroin' (Snyder and Lader 1988; 69). Almost twenty years ago Murphy and Waldorf (1991) considered this to be then an outdated expression, yet it continues to be used as an all encompassing term to describe the communal settings of injecting drug use. However, this term perhaps sits uneasy in current research practice as it seems more appropriate to the argot of New York City during the 1960's (Fiddle 1967) than contemporary British settings. Such terminological unease may be further illustrated by the appropriation of the phrase by the mass media to pejoratively describe harm reduction initiatives known as safer injecting facilities (Associated Press 2007, BBC News 2003). Similarly, during the course of this research only 3 of 14 respondents made volitional reference to the term 'shooting gallery' – suggesting that it is not an appropriate expression in the local context. Nevertheless, the generic definition above, and use of the term, has been adopted for explanatory purposes in this paper and in no way should be interpreted as a term

representative of the local vernacular. Instead, the term 'informal sorter houses' (ISH) seems more appropriate, due to the reciprocal relationship situated within these settings (see below).

Typologies of Social Organisation.

Several attempts have been made to classify the variation of SG located in numerous North American cities based upon social organisation and economic orientation (Des Jarlais 1986, Murphy and Waldorf 1991). Within such settings, injecting drug users (IDU) could pay an admission fee to access the premises in order to use drugs and if required, could 'rent' injecting paraphernalia whilst within. Similarly, a wide range of related services could be purchased from a 'menu', including assistance with injection. Des Jarlais et al (1986) emphasise that this *monetary exchange* formalised availability and differentiated them from more 'informal' arrangements involving injections with friends, free of charge, in their own homes.

Ouellet et al (1991) further refine this informal/formal classification in defining the levels of authority and control that are imposed within and conclude that three different SG models operate throughout Chicago; namely, *cash*, *taste* and *free* galleries. 'Cash' SG operate similar to the aforementioned economic model but include house-rules to ensure the cleansing of needles and syringes (N/S) after each individual use. 'Taste' SG however, are based upon friendship networks, in which one friend allows another to inject in his/her premises. In exchange, the house owner is given a 'taste' (i.e. a small amount of the drug being used) by the visiting friend. In such settings there is less likely to be the large number of 'customers' requiring injecting space and as such there is less injecting equipment available for 'renting'. Visitors to 'taste' SGs did not actually perceive them as formal SGs due to their organisation premised upon sharing drugs (instead of cash payments). Finally, Ouellet et al (1991) defines 'free' SG as those located in public places where IDU congregate to inject drugs. In summary, Ouellet et al's (1991) classification of SG represent a hierarchical system of (informal) order and authority, in which greater controls exist in 'cash' SG, compared to the more disordered environment of the 'free' gallery.

It is perhaps noteworthy that there is a scarcity of research from Europe (and the UK specifically) concerning the social organisation and availability of SG in these nations. One exception to this rule concerns Klee's (1997) study of female injectors in the North-West of England, some of whom were also joint-proprietors of 'safe houses' (defined as 'meeting places for others to congregate to inject or .. obtain drugs', Klee 1997; 124). Although amphetamine sulphate was the main drug of choice within such premises, they were also accessed by heroin users. This created poly-drug using environments as heroin was exchanged for 'place', that in turn impacted upon the amount of substances injected by female proprietors (in both quantity and variety). Outwith Europe and the USA, Kimber and Dolan (2007) identified SGs that operate under the guise of legitimate business operations in Sydney (Australia). These SG appeared to provide an informal safety net in the event of drug-related harm (e.g. assistance with overdose).

Overview of 'Shooting Gallery' Ethnography.

Ethnographic depictions of SG environments typically portray volatile places characterised by violence, unsanitary conditions and social unease. Such conditions often relate to the marginalised or derelict setting of the SG, in which access to basic amenities (sanitation, water and electricity) is limited or non-existent (Murphy and Waldorf 1991, Bourgois 1998). Similarly, SG ethnography portrays the violent and retributive nature of IDU cliques in which

tensions may be exacerbated by the effects of various drugs that produce paranoia, violence and murderous intent (Bourgois 1998, Des Jarlais 1986). Such environmental conditions appear to have contributed towards poor injecting hygiene as various writers describe inadequate lighting in blood-stained premises in which IDU access previously used equipment (Des Jarlais et al 1986, Murphy and Waldorf 1991). Others have observed syringe-mediated drug-sharing in overcrowded SG settings and the potential for needlestick injury to occur from discarded needles (Bourgois 1998, Kimber and Dolan 2007, Page et al 1991). It is perhaps due to such desperate conditions that Murphy and Waldorf (1991) conclude that SG tended to be frequented and operated by those experiencing poverty and economic hardships.

Function and Purpose.

SG provide privacy for IDU to conceal an illicit activity from taking place in public settings, as a means of avoiding detection and/or arrest or as a means of concealing drug use from other family members. They provide IDU with convenient locations near to drug markets and as a means of avoiding withdrawal symptoms following immediate use after purchase (Des Jarlais et al 1986, Ouellet et al 1991), or as 'pit-stops' for sex workers to use drugs between clients (Murphy and Waldorf 1991). Similarly, SG provide a number of more socially-orientated functions including access to those who can assist others experiencing injecting difficulties (Carlson 2000, Murphy and Waldorf 1991); they provide environments in which information can be exchanged (relating to local drug markets, police surveillance) in which such interaction serves to consolidate a drug user identity (Des Jarlais et al 1986). Furthermore, SGs have been associated with an informal harm reduction strategy, in which IDU will feel 'safer' in the presence of others in the event of, for example, overdose (Kimber and Dolan 2007, Longshore 1996, Ouellet et al 1991, Page et al 1991).

In the American context however, SG provide access to injecting equipment and associated paraphernalia. This aspect of SG attendance cannot be understated as, in many States, access to injecting equipment is limited by numerous restrictions (Burris et al 2003).

Health Risk.

The constraints concerning N/S distribution in the USA have been found to establish micro-environments (SG) that provide opportunities for the direct and indirect sharing of previously used equipment, including the paraphernalia used for drug preparation (Des Jarlais et al 1986, Ouellet et al 1991, Latkin et al 1994, 1996). Furthermore, due to the multi-occupancy character of SG, persons *unknown* and socially distant to one another unwittingly share equipment (McKeganey et al 1998). This may be emphasised by Chitwood's (1990) study of injecting equipment collected from 3 SG in which, of almost 150 items collected, 10% tested positive for HIV-antibodies. Such findings led to the conclusion that 'needles/syringes used in shooting galleries are likely to serve as reservoirs and/or vectors of transmission' of HIV (Chitwood 1990; 150); to be confirmed in later qualitative observations regarding inappropriate N/S hygiene (Bourgois 1998, Ouellet et al 1991).

Ouellet et al (1991) remark that HIV-risk is variable throughout their typology of SG outlined above. Although conceding that HIV-risks do occur in each setting (in the form of sharing equipment) they also note that it is in the less controlled, more informal SGs that provide greater opportunities for viral transmission. Such opportunities relate to the lack of IDU social control found in more formal 'cash' orientated venues. Similarly, Fuller et al (2003) suggest that older injectors may initiate younger, less experienced IDU to SG environments

and therefore provide an epidemiological bridge for HIV transmission between different age groups.

FIELD OF RESEARCH

This research took place in the city of Plymouth, an historic maritime centre that is located in the South West of England in the county of Devon. Plymouth was built upon its coastal position, with the city's port playing a significant part in the development and expansion of the entire South West region since the fourteenth century (Gill 1966). In 2008, Plymouth has a population of 250,700 (Public Health Development Unit 2008), of which 64% are aged 16-64 (Government Office for the South West [GOS]. The city is predominantly 'white British' with less than 2% of the population comprising of ethnic groups (*ibid*). Employment in Plymouth is based upon four main areas; namely public administration (including defence), manufacturing, finance/retail, and health/social work (including education) (*ibid*). Unemployment in the city at the time of fieldwork stood at 5.8%; a figure that is comparable with the wider UK unemployment rate that in November 2008 rose to 5.7% (Associated Press 2008). According to Hay et al (2007), Plymouth has an estimated population of 2,180 problematic users of opiates and/or crack-cocaine for the year 2005-2006 (of which 51% [*n* = 1118] were aged 35-64). Of this total, 46% (n = 1,021) were estimated to be problematic *injectors*. At the time of writing almost 1,000 individuals were in receipt of drug treatment (Gannon 2008).

METHODS

This paper is based on results obtained from ongoing, doctoral research that is a qualitative study of micro-injecting environments, in which the primary research concerns the effect of place on health risk in the context of injecting drug use. More specifically this wider-study is concerned with the issue of *public injecting* and the way in which such outdoor environments impact upon drug-related hazard. As such, the collection of data pertaining to 'shooting galleries' in the local setting had not been an intended aim, as such phenomenon are typically located *indoors*. However, during semi-structured interviews the issue of communal, indoor injecting environments emerged as a 'secondary' theme with 14 of the 31 respondents recruited into this study. Accordingly, the authors concur with Millar et al (2008) in stating that the emergence of such secondary themes perhaps strengthens the findings presented below as such responses were initiated by respondents' own volition and without prompting by the interviewer.

Respondent Sample

The principal entry criterion for participation in the wider-research was that the respondent was a current injector with recent experience of public injecting (i.e. *in the last month*). Consequently, a non-random, purposive sample was utilised in respondent recruitment. Such sampling procedures appear appropriate when conducted amongst a sample of IDU that are typically 'hard-to-reach' and engaged in behaviour not necessarily typical of their wider peer collective (Maher 1997). This strategy provided 14 respondents with experience of attending 'shooting galleries' and as such successfully reached a population as similarly 'hidden' as 'public injectors'. Of these 14 respondents, 12 were male, and the overall average age of the entire sample being 33 years (range: 20-49 years). All respondents were currently unemployed and in receipt of benefits. Most (11/14) were without secure accommodation and resided in temporary accommodation (friends or hostels), and of those reporting homelessness, almost all were male (10/11). All respondents were current injectors in which

heroin was the drug of choice for all except one (amphetamine sulphate). The average injecting career was 12.5 years (range: six months - 31 years) and 9/14 respondents had previous experience of non-fatal overdose (indoors). These data are presented below in Table 1. Finally, none of the 14 respondents reported HIV+ or Hepatitis C+ (although 2 did not know their current viral status of these infections).

Table 1: Socio-demographic data of 14 Respondents with Experience of 'Shooting Gallery' Attendance in Plymouth (UK).

Field	Male	Female	Total
Gender	12	2	14
Age (Average)	33.4 years	31.5 years	33.1 years
Age (Range)	21 - 49 years	20 – 43 years	20 – 49 years
Unemployed	12	2	14
Home/Roof-less	10	1	11
Secure Housing	2	1	3
Heroin as Drug of Choice	11	2	13
Injecting Career (Average)	13 years	10.25 years	12.5 years
Injecting Career (Range)	0.5 – 31 years	1.5 – 19 years	0.5 – 31 years
Ever Overdose Indoors	8	1	9

Fieldwork within Agency Settings

All fieldwork occurred between February – September 2008, during which time semi-structured interviews took place in a variety of local agencies; each of which had a 'substance misuse' agenda attached to their service remit. These agencies were a needle exchange programme (known locally as a 'safer injecting service' - SIS), a drop-in centre for homeless people and a hostel providing temporary accommodation for rough sleepers (amongst others). With the support and assistance of these agencies, the fieldworker was able to attend each location on a weekly basis at pre-arranged times in order to make contact with respective service users. The contact procedures employed varied slightly within each setting and involved a system of semi-referral (drop-in centre), direct referral (hostel) and opportunistic contact (SIS). 'Semi-referral' involved keyworkers informally approaching individuals with known injecting careers as they accessed the drop-in facility and were asked if they would be interested in research participation. If the response was positive, they were introduced to the fieldworker who provided further details of the study. Similarly, a system of direct referral took place in a hostel setting as keyworkers identified 'new' clients with injecting drug problems seeking accommodation. These individuals were informed of the research (via a Participant Information Sheet) and if agreeable to participate, an appointment was made for the fieldworker to visit the client at a pre-arranged time. Opportunistic contact however involved the fieldworker making contact with individuals as and when they visited the SIS for injecting paraphernalia. At each location, individuals were given full verbal details of the study and the option to decline participation. Similarly, all interviews followed ethical procedures in terms of anonymity, confidentiality, informed consent and rights to leave when desired. Interviews were conducted in private office space provided within the various agencies and lasted 30-50 minutes. On completion, all respondents were given £10 cash. Semi-structured interviews were digitally recorded, transcribed *verbatim* and subject to

analysis using the qualitative software package NVivo 7. All research had full approval from the relevant Research Ethics Committees.

Definition of Terms

Although this paper addresses the 'shooting gallery' concept, this expression was never used by the fieldworker during interviews. Similarly, this was a term that was volunteered on only 3 separate occasions by the 14 respondents involved. On these occasions the relevant respondents used the term as a means of articulating specific environments (one of which was an outdoor site). The preferred term for communal indoor injecting environments by all respondents was typically at a 'friend's' or a 'dealer's (drug-seller) house'. However, the nature of the relationship between those visiting and those 'owning' such houses was based almost entirely upon a reciprocal relationship involving the exchange of drugs (mainly heroin) for space. In local parlance, the provision of drugs from one person to another (regardless of location) is termed 'a sorter'. 'Sorters' may be provided to assist friends' withdrawal symptoms, or as a means of verbalising drug-sharing amongst peers. However respondents also described 'sorters' as the unit of currency needed to access the premises of friends/dealers in order to use drugs. Due to this, the term 'sorter house' has been adopted by the authors to reflect both local arrangements and vernacular. It is also used as a means of differentiating it from the 'shooting gallery' Americanism. Within the latter, the exchange of cash as an entry fee formalised such settings, but in the present setting this was not the typical arrangement that determined access. Accordingly, the term 'informal' has been adopted to reflect this absence of monetary exchange, and used cumulatively with the above to establish the expression Informal Sorter House (ISH).

Of the 14 respondents concerned, 3 described their past and current experiences of providing their homes for the purposes of communal injecting drug use. In order to distinguish these respondents from those with experience of attending only (n = 11), the term 'house manager' has been adopted to differentiate from 'visitors'. Furthermore, of the 3 house managers concerned, one had previously been involved in low-level drugs supply to 'visitors' and was currently no longer involved in providing place or drugs; similarly, 2 current house managers continued to accommodate IDU but neither were involved in supply.

Throughout the findings section, reference is made to 'sin-bins'. This is the term used to describe receptacles for collecting used, discarded N/S; bins that are in*cin*erated when full.

FINDINGS

Data analysis provided valuable qualitative insights regarding the management of ISH settings from both social and health perspectives. Such settings were principally residential accommodation that was rented from the local municipal authority or housing associations. Some ISH were described as locations where drugs could be bought and used by those visiting, whereas others were described as friend's accommodation (usually a 'flat') that were also rented from the above agencies. Further settings described by two respondents were those within residential squats outwith the study area and consisted of multi-occupancy, derelict housing stock.

Respondents described a variation in the number of people accessing ISH for drug-related purposes, ranging from small groups of 4-5 individuals (consisting of members of immediate social networks; close friends) to larger scale, multi-occupancy settings containing up to 15 individuals at any one time. In these larger group settings, all visitors were not necessarily

known to one another although each had variable social connections to the house manager, based upon associative friendship ties and/or involvement in the local drug scene. Not surprisingly, it was house manager respondents that reported greater numbers of visitors within premises used for drug injecting. The drug used in these settings was typically heroin (smoked and injected), although one location was predominantly amphetamine-orientated (with some limited heroin use).

Several reasons were provided regarding the rationale for visiting ISH for injecting purposes. These related to a need for privacy and secrecy and as an alternative to injecting in public, street-based settings. For these reasons ISH were considered to be 'safer', as they minimised detection from police and the wider-public. Similarly, others attended ISH in order to purchase and use drugs *in situ* prior to moving on to other activities (e.g. shoplifting, sex work) and as such may be interpreted as locations of 'convenience'. Still others described purchasing and using *in situ* as means of avoiding withdrawal symptoms and because of an 'immediate' need to use drugs (due to dependency). Finally, some ISH were considered by IDU to be 'known' places to use drugs that also provided some degree of sociability. More specifically, IDU could visit such places with the expectation that they may be offered drugs by others already within. Examples of these varied motivations can be noted with the following illustrations:

> …. I only went in there to use, I felt safe to an extent that the police weren't going to come. An' I knew I weren't gonna get bashed about and stuff like that because they was people that I knew. So yeah, it was safer than being outside.
>
> *Male, Aged 49*

> I just bought the drugs and then they said, 'if you want, instead of going all the way back home, you can cook it up here'. And I did it up there (prepared) and I done it (injected).
>
> *Female, Aged 20*

Regardless of housing type involved, and the reasons for attending ISH, a number of themes emerged from the data that are presented below as two separate categories: namely 'social organisation' and 'health matters'.

Social Organisation of Informal Sorter Houses.

Due to the various descriptive accounts provided it was possible to situate ISH within a 'continuum of control' that consists of 'regulated', 'unregulated' and 'restored' injecting environments. This continuum became particularly apparent when comparing house manager accounts of ISH in which the variation of control within each setting appeared to correlate to their own individual circumstances (personal concerns surrounding housing, injecting drug use and socio-economic status) and ability (or otherwise) to regulate those that visited for injecting purposes. In short, it was the presence (or lack) of 'house rules' that determined the social nature of ISH, with regulated environments containing more codes of conduct than unregulated settings. 'Restored' environments however, were those that had re-emerged from a period of unregulated injecting practice, in which renewed attempts were made to manage and restrict the level of drug use that occurred within.

Regulated, Unregulated and Restored Informal Sorter Houses.
Regulated and restored ISH were located within rented accommodation and were the households of single males, whose visitors included both male and female IDU. Within such settings there were conditions regarding access and availability in which house managers attempted to monitor the number of people visiting their premises. This related to a need to avoid suspicion from wider community members that their accommodation was used for drug-related purposes. Similarly, although drug-selling may not have taken place within, there was a desire to maintain secrecy in order to prevent the venue being subject to police raids. As a means of regulating the flow of visitors, one house manager stated:

> …. and although you want to help (other IDU) the trouble is … the place becomes a fucking hitting-up shop man, and it ended up like '*this is the number one place in Plymouth*'. So … you want to avoid that. You don't want to attract attention. I had to make sure I regulated it properly, certain times of the day … and by 8 o' clock in the morning that was down-time for about four hours. Then the day started up again.
>
> *Male, Aged 42 (original emphasis)*

Within this illustration not only are the hours of availability made apparent (namely, a twenty-hour period between noon and 8am), but also the altruism of the house manager in providing injecting space for other IDU. (Of equal interest is the use of the term 'hitting-up shop' to self-define the ISH setting).

Several 'visitor' respondents provided accounts of unregulated environments that appeared to be characterised by unlimited access times and larger numbers of visitors with fewer social connections to one another. This in turn created volatile environments in which suspicion of others, theft of drugs, violence and intimidation led to some degree of social unease. For example:

> They (other visitors) were just drug users. And sometimes they'd come from different areas and we didn't know who they was and we brought 'em in thinking it was alright. And then it would kick off (turn violent) and there's not a lot you can do about that y'know.
>
> *Male, Aged 49*

In such circumstances it was common for visitors to adopt a strategy of leaving unregulated premises almost immediately after using drugs to avoid confrontation. Similarly, those visiting premises to purchase drugs from a seller stated they would attempt to identify individuals already within prior to making any decision on whether to stay. Namely, the presence of individuals known to be anti-social / problematic influenced decisions to leave after purchase.

A further defining feature of unregulated ISH was the shared experience of using drugs within unclean environments often containing discarded, used injecting equipment throughout the premises. This is evident in the following illustrations:

> … a lad's house I used to go round, there's no carpets on the floor, he and his Mum used to live in the front room. The kitchen, you could smell the kitchen half

> a mile down the road … and you go upstairs and there's a mattress on the floor, and there'd be blood on the walls. A lot of people used to use it.
>
> *Male, Aged 30*

Similarly:

> … they (used needles and syringes) were just everywhere, all over the place, you know what I mean? People were coming in, and like the buzzer would go, and someone would come up and say, 'Alright to come in and do one up?' and he'd (house manager) say 'oh erm…..go on then' (i.e. agreement).
>
> *Female, Aged 43*

A 'restored' environment however was one that reflected decisions by the house manager to resolve an unregulated ISH by *reinstating* various house rules. In such circumstances, the chaotic elements contributing to social unease were controlled, if not removed completely. This transition was noted in one respondent's attempts to assist a house manager in restoring a 'homely' atmosphere to the latter's rented accommodation. An arrangement had taken place between these individuals in which the female was given a room in exchange for exerting more strict controls concerning access and the management of injecting equipment. In so doing, she became the designated house manager and described the changed environment as a consequence of her restoration of control within the ISH.

> Before I moved in there, it was terrible, you know … there were no 'sin bins' and it wasn't….you know, I'm not bigging myself up or anything, but I like it to be clean. Just because I'm an addict doesn't mean I'm dirty. I don't like living in a dirty place, know what I mean? … He finds it very difficult to say no, and so that was a problem for him which I like to think I've made a lot easier. It is a lot quieter now than it was – and it's cleaner and safer than it was.
>
> *Female, Aged 43*

Sorters and Payments

An undisputed feature regarding the social arrangements within each setting described above was the provision of a 'sorter' by visitors to the respective house managers. This was an expectation held by both parties in which the provision of drugs secured access to the premises concerned, with the equal recognition that failure to provide/receive this payment would deny access. Heroin and amphetamine 'sorters', when prepared for injection, were provided using the calibration of a 1ml insulin syringe and typically involved the distribution of one fifth of the drug solute available within the barrel (i.e. 20 of the 100 microgram units). Preparation and distribution of the drug solute was described as involving 2 sets of equipment that were still contained within sealed wrappers and were considered 'clean' and 'unused'.

Other 'sorters' represented exchanges for other drug-related activity. For example, one visitor described the conditions surrounding the provision of injecting assistance to another visitor. In this respect, the exchange of drugs for injection (i.e. the 'sorter') required a greater number of units from the syringe, as evident in the following:

> It's like if you go round someone's house for a hit, if I come to your house, then I have to give you some of it. I can't come to your house and do gear (heroin) and not give you any. And the same as…if you say 'oh, I've got half a gram here – do

> a hit for me?' I'd say, 'yeah, but … 50 mil of it's mine'. You don't do nothing for nothing in the gear game.
>
> *Male, Aged 38*

Similar 'sorters' were provided amongst those that smoked heroin, in which there was also a mutual expectation of reciprocation. Furthermore, those that used drugs in premises where they purchased from the house manager *also* expected to participate in this exchange. One visitor regarded this as a means for the house manager/drug seller to 'earn their little bit extra by smoking a line' with their visitors. For others, the constant movement of people provided opportunities to accumulate a number of 'sorters' for use at a later time. As one house manager described:

> … I do sort of pace myself. … say for instance, you come into my flat and then somebody else comes in and you (both) put up drugs. I could have had yours when you come in and when the next person comes in, they give it me and I put it to one side.
>
> *Male, Aged 38*

In short, 'sorters' were considered to be valid and expected currency within the local drug economy; in which the provision of drugs to house managers provided access to premises where they could be used without interruption and detection on the street. Of all respondents in the sample, only one described making a cash payment (£5) to use heroin within a drug-seller's house. On reflection (i.e. during the interview) this individual voiced her concerns about such *financial* arrangements:

> At the time, it didn't really bother me 'cos I was ill. But looking back at it, it was pretty sad charging someone like (that). I just wouldn't do that if someone asked to do it at my house. It's not fair. If they're your friends – if you don't know em, fair enough, - but when they're your friends, I just think, you know, that they're in the same situation as you. Skint! And yet they take *more* money off (you).
>
> *Female, Aged 20 (emphasis added)*

Segregation, Exclusion and Violence Mediation.

Other organising aspects of ISH related to the house managers' own drug of choice. One house manager stated amphetamine as his preferred choice, but reported a recent increase in his heroin use. Despite his own drug preference, both heroin and amphetamine injectors visited his premises in which he reluctantly permitted access to the former. This reluctance was based upon his experience of witnessing several heroin-related overdoses in other locations and was fearful of such an event occurring within his home. This fear was premised on his limited knowledge on how to appropriately respond to such incidents and stated that if such events were to occur in his house he would attempt to emulate the actions of others he had previously observed in such situations. Accordingly, attempts were made in his home to segregate injectors of different drugs and the house manager encouraged the use of specific rooms for specific drugs (i.e. segregating amphetamine and heroin injectors).

Similarly, one visitor described the attempts of one house manager to purposely exclude heroin users whose appearance was too unkempt. This was considered a necessity in order to maintain the secrecy of the ISH, as the manager was fearful that those presenting with an

'addict identity' may alert relevant authorities of drug-related activity within his accommodation.

As intimated above, ISH in the local setting provided environments conducive to violence as a result of drug effects, disagreements or suspected theft. Several respondents described a number of violent episodes they had witnessed following such discrepancies. Within 'regulated' ISH such conflict was typically resolved by the house manager who would evict those causing problems. Within 'unregulated' ISH however, the violence was left unchecked resulting in damaged furnishings, theft of drugs and assault of other IDU. One house manager of a 'restored' ISH described how the introduction of a non-drug using 'security' guard assisted in transforming the previously unregulated environment to a more harmonious setting. Not only had the introduction of informal security denied access to particular IDU, but prevented intimidation from occurring within and was considered as an integral component in repairing community relationships with other neighbourhood residents; relationships that had been soured by the frequency and numbers of IDU attending the premises concerned. This is perhaps evident in the following account of restored social controls:

> The other neighbours, you know, they're afraid, they don't understand about drugs or anything like that and what they don't understand or know about, they're frightened of. The neighbours now will talk to me (and) the old lady across from us, if she's not very well she even taps on the door now and asks me if I can fetch her electric (pay her utility bill) …
>
> *Female, Aged 43*

Finally, despite respondents' wider claims that ISH provide 'safety' from circumstances surrounding public drug use, they were equally concerned about the lack of safety within indoor settings. Such insecurity related to the internal organisation of the various ISH described, the potential for violence and/or the uncertainty of spontaneous police raids upon premises suspected of drug-related activity.

Health Matters

Settings such as ISH, that contain ever-changing collectives of IDU, raise concerns relating to the management of risk behaviour and the opportunities for the transmission of blood borne viruses (including HIV and hepatitis). The following section summarises the ways in which house managers and visitors to ISH attempt to minimise these risks.

Needle Supply and Management

House managers within regulated ISH appeared to operate an informal, street-level, needle distribution service within their own homes. This was based upon decisions to personally obtain large quantities of N/S from local community pharmacies or a dedicated drug agency. Two house managers stated that they had previously collected up to 200 sets of N/S for use within their premises. Similarly, each reported that they also acquired large sin-bins in order for visitors to deposit used N/S after injecting. This process was considered an important aspect of providing space for drug use to occur and further confirms the regulated nature of such settings. Similarly, those involved in establishing such informal N/S distribution regarded this as necessary hygienic practice *because* it concerned their own homes. Visitors accessing regulated ISH were able to acquire N/S if necessary. This was confirmed by several visitor respondents who each stated that they did indeed receive injecting equipment in this

manner. When asked to determine the cleanliness of N/S availability, all concerned were adamant that injecting equipment had not been previously used. This assessment was based on accepting and using N/S that were still contained within plastic seals and were seen to be unopened and unwrapped. Other hygienic practice included house managers encouraging visitors to use communal sin-bins for N/S disposal; although one respondent noted that 'some people will actually take their (N/S) away with em' (on departure). That said, however, there also appeared to be some hesitancy by the house managers in returning the sin-bins when full. For example, one current house manager claimed to have several large bins waiting to be returned for incineration at the time of interview.

A similar arrangement was noted within accounts of a 'restored' ISH, but on this occasion the process was a more formalised process of actual needle *exchange* in conjunction with local drug services. This is evident in the following extract with a current house manager:

> I got in touch with (a drugs worker) and said 'can you bring me some sin-bins' and we started a needle exchange. So … we now get our sin-bins brought around and clean works, and everything that we need. And when we need to exchange them I phone up and we give the dirties back and exchange 'em for the cleans.
>
> *Female, Aged 43*

This example further illustrates the 'restoration' of internal controls within a previously chaotic environment, characterised by discarded needles and the potential for needlestick injuries.

Within 'unregulated' ISH however there appears to have been no mechanisms in place regarding the supply and management of N/S, whether used or unused. Indeed, within such settings there was an expectation that visitors would provide their own 'hit-kits' (injecting paraphernalia) and be responsible for their own injecting needs. This expectation was not necessarily shared by those visiting however, and the following extract perhaps illustrates this ambiguity of expectation concerning ISH attendance.

> I was sat there one day and this guy came in, big chap, and he said 'where's the pins (N/S) then?' And I said 'up the chemist!' (And he said) 'Yeah, well where are they? Come on! What's going on like?' And that's terrible you know, You're responsible for your own habit and your own drug use. (He was) getting leary (aggressive) 'cos these things weren't there for him when 'they should've been'. I said 'this ain't a chemist, it's a council flat!'So he went 'hahh hahh hahh' (sarcastic laughter) and he trotted off and went and got some like. … But it was kind of like……they just really expect it (N/S to be supplied for them).
>
> *Female, Aged 43*

Peer Injecting

ISH settings provide opportunities for visitors to be injected by other visitors and on occasion by the house manager. However, the latter were reluctant to participate in such practice as it was an activity they did not particularly enjoy. Similarly, house managers tended not to provide this as part of the regulations they imposed within their premises; regulations that were considered 'rules' no matter how needful visitors may be for injecting assistance:

> As a rule, NO! I'd say no (to peer assisted injecting). Some girl, she had nothing in her arms like, she wouldn't do her groin – her feet were done, her legs done, her hands, her arms, everywhere was done (all collapsed veins). The only place she had left was her neck and her groin, and she wouldn't do her groin for work (sex work).
>
> *Male, Aged 38*

Similar conditions applied if requests were made from visitors that the house manager did not know (socially or personally). This refusal was not necessarily based on social distance, but instead, upon not knowing the visitor's drug tolerance level and did not want to become complicit in any overdose that may occur. However, those known to house managers may receive assistance with injection if drug tolerance levels are known, or if they are observed having difficulties injecting. Similarly, opportunities for peer assisted injecting arose during amphetamine binges, in which repetitive drug injection coupled with long periods of sleeplessness contributed towards inadequate injecting technique and associated injury (e.g missing veins as a result of impaired vision).

Overdose

The issue of overdose within ISH settings provoked a number of emotive responses from both visitors and house managers that could be broadly interpreted as 'fearful'. House managers were concerned that visitors who overdosed may attract unwanted attention to their premises from the emergency services and took steps to limit this from happening. Such measures included refusing to inject others whose tolerance was unknown, or by limiting the number of heroin users on their premises. Other concerns were that too little was known regarding appropriate responses to assist with resuscitation.

Similarly, visitors appeared cognisant of the consequences of 'going over' (overdosing) in ISH premises. For example, one visitor described an occasion in which he had overdosed in an ISH and had been taken outside and left alone in a residential area, late at night, to be found by a passer-by. He was subsequently 'barred' from attending the ISH concerned and this exclusion was based upon the possibility of his overdose alerting the emergency services (police) of places used for drug purposes. Consequently, his social segregation was a means of maintaining the liberty of other IDU within the setting. This was not a unique experience and similar experiences were recounted throughout. For example:

> I've also seen it happen when they've got the person out the house … and they take him downstairs and put him on the grass outside. And then they phone an ambulance. Get em out the house, so the house don't get raided. … I've seen people die yeah, because they'd OD'd and they haven't had no ambulance called. And because other people, although they want to do a lot, they just want to get away from the situation. … And *bosh*, next thing you know, the bloke's dead.
>
> *Male, Aged 49*

One visitor described similar circumstances surrounding the death of a friend in which he found it difficult to contain his contempt for those involved:

> No, she didn't die there (in the street). She died in some fucking flat and they picked her up and moved her two doors down. An' left her there (in the street). Fucking dirty bastards.

Male, Aged 26

Limitations of the study

This study is based upon the responses of 14 individuals that had experience of attending various indoor venues that were used for communal drug injecting within a specific city in the South-West of England. Consequently, these findings may not be representative of similar settings located throughout the UK. Indeed, the authors decision to adopt the expression 'Informal Sorter House' may well reflect the regional specificity of these findings, as it is not known how widely understood the expression 'sorter' would be throughout the UK. Similarly, some concern may be expressed regarding the relatively small sample involved in producing this paper and concomitant claims of failing to achieve representativeness of these IDU settings. However, all respondents involved could equally be considered as representative of more hidden IDU populations as they describe participation in activities within settings of which very little is currently known in UK settings. Accordingly, these data provide valuable qualitative insights and foundations (but not *conclusions*) surrounding the social and health management of clandestine environments that can be developed by future research within the UK. Furthermore, it should be further stressed that such settings were not the primary focus of all interviews involved in the wider remit of this study. This cannot be overstated, as the primary research focused upon IDU views of injecting in public and semi-public (i.e. *outdoor*) locations. Nevertheless, the availability of such data perhaps presents suitable grounding for further development, particularly within the UK where there is a paucity of literature concerning such phenomenon.

DISCUSSION

Of the findings reported here, perhaps the most remarkable are the striking similarities regarding the social organisation of ISH and those obtained from American research into the 'shooting gallery' (SG) phenomenon. For example, there appears to be considerable commonality with such environments located in San Francisco (Murphy and Waldorf 1991), Chicago (Ouellet et al 1991) and Plymouth; in which informal operations of American settings have resounding similarities with this specific UK setting. There also appears to be similarities in the allocation of specific 'drug roles' (Friedman et al 1998) within American SG and the local ISH described here (such as house manager, drug-seller and peer-injectors). A further shared characteristic pertains to the lower economic status of all involved in such activity as most visitor respondents involved in this study were homeless, and all were unemployed and in receipt of benefits. Furthermore, the physical settings (housing stock) and visitor motivations for attending such places for drug use again have a great deal in common. Due to these multiple shared characteristics with American settings those concerns above, relating to a wider UK representativeness, may be somewhat neutered.

However, some notable differences between SG and ISH were also noted. Perhaps most significant is that relating to the ease of access to freely available injecting equipment as a result of a wider harm reduction strategy that has been incorporated into UK public health practice and policy. This is not necessarily the case in the USA, where local/regional restrictions apply concerning the distribution and availability of N/S in response to variation in HIV-infection rates, IDU risk behaviour and public health and law enforcement procedures (Burris et al 2009, McKeganey et al 1998). However, restricted access (past and present) to N/S has been identified as a principal reason for IDU attendance at shooting galleries; as they provide opportunities to 'rent' injecting equipment from gallery managers. The availability of N/S throughout Plymouth (UK) however has contributed towards *some* house managers

developing an informal, street-based, needle distribution service in which clean equipment may be provided as part of the exchange for 'safer' space to use drugs. This perhaps demonstrates commendable harm reduction practice as IDU consciously seek to minimise risks associated with HIV and hepatitis. However, it should be noted that no data are available from the present setting regarding the shared use of paraphernalia (cookers, swabs, filters) during the preparation of drug solutes within ISH. This perhaps needs urgent inquiry in order to maintain the harm reduction activism that has emerged within such settings.

A further consideration of local ISH settings is that they appear to operate along a continuum of control. Based on the respondent experiences described above, it is possible to chart a 'natural history' of ISH. This evolution begins with individual decisions to provide access to their homes for injecting drug use, in which friends and associates form the initial 'core group' of visitors. Numbers gradually increase as a result of social networking and houses become 'known' within the injecting fraternity as 'safe' places to visit to avoid detection. As a result of increased attendance, the house manger becomes responsible for the next stage of the continuum. This may involve providing access to sin bins and/or N/S, regulating the hours of availability and monitoring those who can/ not attend. If numbers continue to increase to the extent that unwanted attention is drawn to the ISH, (or in local parlance, 'get on top') then the manager may take the decision to close the facility or even relocate to another flat/house. Conversely, in the absence of such decision making, no such measures may be taken with all behaviour becoming unregulated. Within such settings, there is the potential for drug-related litter to amass unchecked and for the social environment to be volatile. Consequently, residents of neighbouring houses may become suspicious by this (and/or other anti-social) activity and inform the relevant authorities. At this point of the continuum, the ISH balances delicately between (house manger) closure and (public) exposure. If the house is not subject to self-closure it may shift towards a restored environment that is influenced by the chaos that evolves from increased social and injecting behaviour. This shift towards re-creating more covert and equally mundane environments may be informed by the house manager, close friends, a change of house manager, increased amounts of discarded equipment or even by informal warnings provided by agency representatives. In making such change, ISH continue to exist, in a more regulated and controlled form. From the experiences described here, such responses appear to be correlated with a desire to preserve and maintain residential accommodation and avoid eviction by the relevant bodies, whilst maintaining 'safe' places to administer drugs. However, unregulated ISH that do not self-censure, or evolve towards restored environments, will be exposed and possibly subject to police raids. Evidence of this can be found in local press reports concerning the closure of 'drug dens' (or 'drug shops'), as a result of drug 'dealing on a horrendous scale', '35 taxis bringing buyers to the property over a five-hour period' alongside images of police officers 'trawl(ing) through the filth' of 'addicts' (Saunders 2006). It is at this juncture, with the subsequent eviction of tenants, that the ISH continuum ceases to exist within unregulated settings; thus providing opportunities for other ISH to evolve elsewhere.

Although tentative suggestions, these findings relating to a continuum of control differ from the more 'static' representations of similar drug settings described by other research (Des Jarlais et al 1986, Murphy and Waldorf 1991, Ouellet et al 1991) and suggest that, in Plymouth at least, such locations are subject to flux and modification.

Finally, Coomber (2006) has previously suggested that the violence and chaos of drug markets is often over-reported by the mass media and unduly focussed on by *other researchers* and, as a result, these aspects become overstated. Likewise, the more routinised and mundane features of the daily lives of drug economy participants are similarly underplayed and thus *under*stated. Similar comparisons could perhaps be made here regarding previous research into the SG phenomenon in which there may have been an over-emphasis upon poverty, material deprivation and the sharing of injecting equipment. Indeed, whilst acknowledging that these features may occur in the local setting, this study perhaps also counters previous findings in illustrating the social and health *benefits* brought about by IDU cultural mediation. That is, such settings provide opportunities for the mediation of violence and harm as IDU seek to preserve and manage indoor environments appropriated for injecting practice. In short, it is suggested that IDU in the present setting seek to counter the chaos in order to maintain the mundane with regard to injecting practice.

Policy Implications

The social context of injecting drug use has been long established within sociological research (Bloor 1995, Draus and Carlson 2009, Howard and Borges 1970, McKeganey and Barnard 1992, McKeganey et al 1998) in which the social production of risk behaviour has been made equally apparent (Rhodes and Treloar 2008). Injecting drug use is not an individual activity but involves a complex interaction of social relationships situated in specific physical environments. Such socio-spatial complexities have been highlighted throughout this paper and it seems appropriate to suggest that ISH provide innovative opportunities for harm reduction practitioners to develop burgeoning drug user activism. For example, service users attending needle distribution centres requesting bulk provisions of certain items could be identified as possible conduits to wider harm reduction practice. This may involve the formalised provision of N/S (and associated paraphernalia) on a regular basis, delivered as an outreach service from needle distribution centres. Similarly, selected IDU could be encouraged to participate in overdose training in order to respond to such situations within ISH in a more appropriate and confident manner. Such training could extend to the administration of naloxone as reported in several North American cities (Kim et al 2009, Piper et al 2007). These suggestions do not seem incommensurate with previous research (Friedman et al 1998, Metsch et al 1999) that has identified the willingness and support of IDU to become involved in such drug-focused activism. Furthermore, such strategies would be infitting with 'low-cost pragmatic interventions to modify … injecting environments to maximise personal and community safety … and (foster) social responsibility in harm reduction' (Rhodes et al 2006; 1390).

Acknowledgements:

The authors would like to thank the two anonymous reviewers that provided useful comments on an earlier draft of this paper. This research was funded by an Economic and Social Research Council (GB) CASE Studentship and by Plymouth Drug and Alcohol Action Team. The views expressed in this paper are those of the authors and do not necessarily reflect those of the University of Plymouth or the funding organisations.

REFERENCES

Associated Press (2008). U.K. Unemployment Rate Jumps to 5.7 per cent. International Herald Tribune. http://www.iht.com/articles/ap/2008/10/15/business/EU-Britain-Unemployment.php, (Published 15 October 2008) (*Accessed 23 November 2008*)

Associated Press. (2007). S.F. Considers 'shooting gallery' for drug addicts. *MSNBC.com.* http://www.msnbc.msn.com/id/21367579/ *(Accessed 23 November 2008)*

BBC News. (2003). 'Shooting gallery' plan dismissed. *BBC News*, 9 June. http://news.bbc.co.uk/1/hi/scotland/2973664.stm *(Accessed 23 November 2008)*

Berridge, V. (1999). *Opium and the people. Opiate use and drug control policy in nineteenth and early twentieth century England.* Free Association Books, London.

Bloor, M. (1995). *The sociology of HIV transmission.* Sage Publications, London.

Bourgois, P. (1998). Just another night in a shooting gallery. *Theory, Culture and Society*, 15, (2) 37-66.

Burris, S. C., Strathdee, S. A., & Vernick, J. S. (2003). Lethal injections: The law, science and politics of syringe access for injection drug users. *University of San Francisco Law Review,* 37, 813-885.

Burroughs, W. (1977). *Junky*. Penguin Books, London.

Carlson, R. G. (2000). Shooting galleries, dope houses and injection doctors: Examining the social ecology of risk behaviors among drug injectors in Dayton, Ohio. *Human Organisation*, 59, (3) 325-333.

Chitwood, D. D. (1990). HIV seropositivity of needles from shooting galleries in South Florida. *American Journal of Public Health*, 80, (2) 150-52.

Coomber, R. (2006). *Pusher myths: Re-situating the drug dealer.* Free Association, London.

Dickens, C. and Garfield, L. (1870/1980). *The mystery of Edwin Drood*. Deutsch, London.

Des Jarlais, D. C., Friedman, S. R. and Strug, D. (1986). Aids and needle sharing within the iv-drug use subculture. In: Feldman, D.A. and Johnson, T.M. (Eds) *The social dimensions of AIDS. Method and Theory.* Praeger, New York. pp 111-126.

Draus, P. and Carlson, R. G. (2009). Down on main street: Drugs and the small-town vortex. *Health and Place*, 15, (1) 247-254.

Fiddle, S. (1967). *Portraits from a shooting gallery: Life styles from the drug addict world.* Harper and Row, New York.

Friedman, S. R., Furst, R. T., Jose, B., Curtis, R., Neaigus, A., Des Jarlais, D. C., Goldstein, M. F. and Ildefonso, G. (1998). Drug scene roles and HIV risk. *Addiction*, 93, (9) 1403-16.

Fuller, C. M., Vlahov, D., Latkin, C. A., Ompad, D. C., Celentano, D. D. and Strathdee, S. A. (2003). Social circumstances of initiation of injection drug use and early shooting gallery attendance: Implications for HIV intervention among adolescent and young adult injection drug users. *Journal of Acquired Immune Deficiency Syndromes*, 32, (1) 86-93.

Gannon, W. (2008). Plymouth Drug and Alcohol Action Team. pers comm. via email 05.12.08

Gill, C. (1966). *Plymouth. A New History: Ice Age to the Elizabethans.* David and Charles, Newton Abbot.

Goines, D. (1971). *Dopefiend*. Holloway House Publishing, Los Angeles.

Government Office for the South West (2008). *South West Key Facts.* http://www.gos.gov.uk/gosw/OurRegion/geographicareas/plymouth/ (*Accessed November 2008).*

Hay, G., Gannon, M., MacDougall, J., Millar, T., Eastwood, C., and McKeganey, N. (2007). *Estimates of the prevalence of opiate use and/or crack cocaine use (2005/06): South West Region.* Centre for Drug Misuse Research, University of Glasgow.

Hayter, A. (1968). *Opium and the romantic imagination*. Faber and Faber, London.

Health Promotion Agency. (2008). *Shooting Up: Infections among injecting drug users in the United Kingdom 2007. An update: 2008.* Health Protection Agency, London.

Kim, D., Irwin, K. S., and Khoshnood, K. (2009). Expanded access to naloxone: Options for critical response to the epidemic of opioid overdose mortality. *American Journal of Public Health,* 99(3), 402-407.

Kimber, J. and Dolan, K. (2007). Shooting gallery operation in the context of establishing a medically supervised injecting center: Sydney, Australia. *Journal of Urban Health*, 84, (2) 255-266.

Klee, H. (1997). Amphetamine injecting women and their primary partners: An analysis of risk behaviour. In: Catalan, J., Sherr, L. and Hedge, B. (Eds) *The impact of AIDS: Psychological and social aspects of HIV infection.* Harwood Academic Publishers, Amsterdam. pp 115-126.

Latkin, C., Mandell, W., Vlahov, D., Oziemkowska, M. and Celentano, D. (1996). People and places: Behavioral settings and personal network characteristics as correlates of needle sharing. *Journal of Acquired Immune Deficiency Syndrome and Human Retrovirology*, 13, 273-280.

Latkin, C., Mandell, W., Vlahov, D., Oziemkowska, M., Knowlton, A. and Celentano, D. (1994). My place, your place and no place: Behavior settings as a risk factor for HIV related injection practices of drug users in Baltimore, Maryland. *American Journal of Community Psychology*, 22, (3) 415-430.

Longshore, D. (1996). Prevalence and circumstances of drug injection at Los Angeles shooting galleries. *Crime and Delinquency*, 42, (1) 21-35.

Maher, L. (1997). *Sexed work: Gender, race, and resistance in a Brooklyn drug market.* University Press, Oxford.

McKeganey, N. and Barnard, M. (1992). *AIDS, drugs and sexual risk: Lives in the balance.* Open University Press.

McKeganey, N., Friedman, S. R. and Mesquita, F. (1998). The social context of injectors' risk behaviour. In: Stimson, G.V., Des Jarlais, D.C. and Ball, A. (Eds) *Drug injecting and HIV infection.* UCL Press, London. pp 22-41.

Metsch, L. R., McCoy, C. B., Shultz, J. M., Page, J. B., Phillippe, E. and McKay, C. (1999). Gender comparisons of injecting drug use practices in shooting galleries. *Population Research and Policy Review*, 18, 101-117.

Millar, C. L., Firestone, M., Ramos, R., Burris, S., Ramos, M. E., Case, P., Brouwer, K. C., Fraga, M. A. and Strathdee, S. A. (2008). Injecting drug users' experiences of policing practices in two Mexican-US border cities: Public health perspectives. *International Journal of Drug Policy*, 19, (5) 324-331.

Moore, A. and Campbell, E. (2000). *From Hell*. Top Shelf Productions, Portland.

Murphy, S. and Waldorf, D. (1991). Kickin' down to the street doc: Shooting galleries in the San Francisco bay area. *Contemporary Drug Problems*, 18, (Spring) 9-29.

Ouellet, L. J., Jiminez, A. D., Johnson, W. A. and Wiebel, W. A. (1991). Shooting galleries and HIV disease: Variations in places for injecting illicit drugs. *Crime and Delinquency*, 37, (1) 64-85.

Page, J. B., Smith, P. C. and Kane, N. (1991). Shooting galleries, their proprietors and implications for the prevention of AIDS. *Drugs and Society*, 5, 69-85.

Piper, T. M., Rudenstine, S., Stancliff, S., Sherman, S., Nandi, V., Clear, A. and Galea, S. 2007. Overdose prevention for injection drug users: Lessons learned from naloxone training and distribution programs in New York City. *Harm Reduction Journal*, **4**, (3) www.harmreductionjournal.com/content/pdf/1477-7517-4-3.pdf (*Accessed March 2009*)

Public Health Development Unit (2008). *Annual Report 2008/2009*. Public Health Development Unit, The Public Dispensary, Plymouth

Rhodes, T., Kimber, J., Small, W., Fitzgerald, J., Kerr, T., Hickman, M. and Holloway, G. (2006). Public injecting and the need for 'safer environment interventions' in the reduction of drug-related harm. *Addiction*, 101, (10) 1384-1393.

Rhodes, T. and Treloar, C. (2008). The social production of Hepatitis C risk among injecting drug users: A qualitative synthesis. *Addiction*, 103, 1593-1603.

Saunders, C. (2006). Drug den boarded up: 'if this was a small business it would have won an award'. *The Herald*. Plymouth, 10 November 2006, pp 1-5 (excluding 2-3).

Slim, I. (1996). *Pimp: The story of my life.* Canongate books, Edinburgh.

Snyder, S. H. and Lader, M. H. (1988). *Heroin: The street narcotic.* Burke Publishing Company Limited, London.

Tosches, N. (2000). *The last opium den*. Bloomsbury, New York.

Welsh, I. (1994). *Trainspotting*. Vintage, New Edition.